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

Part 2

This article is a continuation of Research Bulletin, Vol. 10, No. 1, July/August 1996, Part 1 to further demonstrate that the information provided on informational or consent forms used by free standing abortion facilities is not tailored to the needs of the individual woman. Statements found in informational forms used by abortion facilities are being further examined for accuracy.

Incomplete Abortion

One abortion facility used a form entitled Disclosure of Alternatives, Benefits, and Risks which stated, “Sometimes all of the tissue is not removed from the uterus: this could cause cramps, heavy bleeding or infection. In order to remove that tissue, it may be necessary to do a repeat procedure at the clinic.”

Based upon the available studies, it appears that early abortions at 6 weeks gestation or earlier, or abortions at 13-14 weeks gestation by suction curettage abortion, when another method should be used, increase the risk of incomplete abortion. There is a significant likelihood of an incomplete abortion following first trimester abortion resulting in infection and hospitalization. A followup study by Scandinavian researchers 4-6 weeks following abortion by vacuum aspiration found that 4.8% had retained fetal parts, 11.1% had post-abortion bleeding greater than the normal menstrual period and 4.1% had pelvic inflammatory disease. Another earlier Scandinavian study found that hospital readmission following abortion was 4% with pelvic infections and retained fetal parts being the main causes. A New Zealand study found 2.4% of post-abortion women with retained fetal parts during the first trimester.

If an abortion is incomplete there is a 5-fold increase of ectopic pregnancy in the future compared to uninfected women. An incomplete abortion can also lead to infection, including sepsis or septic abortion. In one case where an abortion was incomplete and the fetal parts were retained, a woman developed a severe case of septic shock. This was partly due to failure to diagnose the problem which resulted in renal failure and required dialysis as a life support system. The statement on the abortion facility form fails to advise the woman of these possibilities and makes it appear that while there may be a possible problem, it can be readily resolved. This is not necessarily the case.
Cervical Injury

A statement regarding lacerations in an abortion disclosure form says that “in very rare cases, the cervix may be torn. A few stitches may be necessary to repair the tear.” Another form entitled Facts About Early Abortion similarly states: “It is possible that the cervical opening may be torn during the procedure. If it occurs stitches are sometimes required.”

According to the findings of the Joint Program for the Study of Abortion (JPSA) cervical injury is one of the most frequent complications of suction curettage abortion with an overall incidence of 1.03 per 100 abortions. Among the factors within the control of the abortionist, use of laminaria rather than rigid dilation has a strong protective effect (5 fold). Performance of the abortion by a resident rather than a medical doctor doubles the risk, and use of general anesthesia rather than local anesthesia increases the risk by 2.6 times. In addition to overt injury to the cervix during suction curettage, covert trauma is also important. Micro fractures of the cervix may occur during forceful dilation of the cervix, which may lead to persistent structural changes, cervical incompetence, premature delivery, and pregnancy complications.

Forceful dilation is very likely to occur because the vast majority of those performing abortions appear to use rigid dilators instead of laminaria. It has also been found that there is an increased risk to teenagers of cervical injury during suction curettage abortions compared to adults. Thus the statements on the abortion facility forms are false and misleading because it leads the reader to believe that if a cervical injury occurs all that is needed is a few stitches to repair the damage. However, there can be micro fractures as well as overt injury and possible miscarriage, premature delivery and pregnancy complications can result.

Bleeding or Hemorrhage

Some abortion informational or consent forms do not specifically mention bleeding or hemorrhage as a specific complication of abortion. One abortion facility which did so stated, “In a small number of cases there is more bleeding than is normally expected. Medication to reduce bleeding may be required, and an immediate repeat of the procedure may be needed to remove any material that is retained in the uterus. Hospitalization may be required depending upon the cause of the bleeding.”

According to Warren Hern in his text, Abortion Practice, extremely heavy bleeding is, or should be, rare in the first trimester with fewer than 1% of women experiencing a blood loss of 25 ml. or more. However, he states that those who are at 11-12 weeks gestation, have poor nutrition, are multiparous, recently delivered a child, or have fibroids, can experience uterine atony and bleed briskly.

Uterine atony is a special kind of bleeding. In one study it was described as the accumulation of about 125-700 ml. of liquid and clotted blood which may develop 1/2 to 1 1/2 hours after the abortion. This study found that 0.88% of women developed uterine atony but which could be reduced to 0.05% if intramuscular ergonovine was used. According to another authority, uterine atony can develop up to several hours after an abortion.

A British study which studied women in the 21-day period following first trimester or second trimester abortion found that hemorrhage occurred in 4.0% of the women. Blood loss greater than 500 ml. was reported by 1.3%. A loss of blood requiring a blood transfusion or further evacuation occurred in 1.2% of the women. Significant factors independently affecting the incidence of hemorrhage greater than 500 ml. were: period of gestation (7 fold increase if 12 weeks of gestation or more), place of operation (4 fold increase if abortion took place at a public hospital rather than a private facility), or smoking (62% increase). Again, some women are at much greater risk than oth-
ers for excessive bleeding, but the scanty information provided by the abortion facility never so indicates.

Warren Hern further states, "The unfortunate fact is that many abortion service providers do not keep their patients in a recovery area and under close enough supervision to make the diagnosis of Postabortal syndrome (PAS) [which is] uterine atony or hypotonia, i.e. low blood pressure prior to the patient's departure. Its management is simple in the immediate postoperative phase, but failure to treat it promptly may lead to a variety of more serious complications." The text provided examples where there was a delayed diagnosis of PAS for several hours in a hospital during which time the woman developed disseminated intravascular coagulation (DIC). Subsequently, a hysterectomy was performed. DIC is caused by trauma or sepsis. It breaks down the various functions of blood and leads to multiple organ failure. Unless emergency treatment is undertaken by eliminating the cause of the DIC and by infusion of replacement blood the person would likely die.

In another case, a suspected rupture of ectopic pregnancy was, in fact, PAS syndrome with redux bleeding through the fallopian tubes. During surgery, a cyst ruptured on the suspected side. Examination of the uterus revealed small quantities of tissue and several hundred millimeters of blood clots. According to the Centers for Disease Control, severe hemorrhaging accounted for 20% of abortion related deaths from 1972 - 1987. One way in which severe hemorrhaging results in death is if there is a laceration of the ascending branch of the uterine artery during the abortion. This is easily overlooked and may be accompanied by either intermittent, delayed, or temporarily controlled bleeding but which ultimately proves ineffective and the patient dies.

**Acute or Chronic Abdominal or Pelvic Pain**

According to former abortion clinic administrator Carol Everett, one of the questions asked by women considering abortion is, "Does it hurt? The answer was" No. You will feel a slight cramping sensation." This corresponds to the following statement frequently seen in abortion clinic informational or consent forms used for suction curettage abortions: "For most patients, discomfort is limited to menstrual-like cramping during and for 15-20 minutes after the procedure. Use of a local anesthetic injected into the cervix prior to surgery helps minimize discomfort."

**Acute Pain**

The information provided makes no disclosure that, for some women, the immediate pain from the abortion can be very severe, and not merely discomfort, slight, or menstrual-like cramping. Nor does it identify the risk factors for severe pain. The American College of Obstetricians and Gynecologists has admitted that abortion can cause acute pelvic pain, and research studies confirm it. An early study by researchers at Yale University Medical School found that a majority of the women undergoing a first trimester vacuum aspiration abortion reported that the abortion experience itself was quite painful. Severe pain was more likely to be reported by women who were anxious before or after the abortion and was 4 times more likely if the abortionist was inexperienced. In another study of first trimester abortion pain among women at a Massachusetts abortion clinic, 71% of the women reported abortion pain was more severe than menstrual pain and 20% reported that abortion pain was worse than or equivalent to labor pain. This study found that younger patients, those with pregnancies at increased gestational age, increased cervical dilatation, and fearfulness resulted in increased pain. In a Canadian study, younger women, and particularly teenagers, tended to report more severe pain at the time of their...
abortion than older women. Adolescents tended to rank pain in the range of pain from labor prior to childbirth, while adults tended to rank the pain from abortion at lower levels and about equal to non-terminal cancer pain or phantom limb pain. The Canadian study also found that self-reported depression, anxiety, fear or low pain tolerance tended to increase pain. In addition, social and moral concerns about abortion tended to increase pain. Gynecological characteristics such as uterus retroversion, history of menstrual pain and increased gestational age also tended to increase the pain from abortion. The authors stressed the importance of addressing the special needs of each woman facing an abortion.23 Other authors have also found that first trimester abortion is a painful and distressing experience and that there is a full range of pain intensity in women from abortion suggesting a highly individualized response.24

Chronic Pelvic or Abdominal Pain

The informational or consent forms make no reference at all to the fact that long term chronic pelvic or abdominal pain may result from abortion in significant numbers of women. A British study of women whose main complaint was abdominal pain found that women with a history of induced abortion reported abdominal pain to a significantly greater degree than women with a history of viable pregnancies (40% vs. 14%). Women with a history of PID were more likely to experience pain than women without PID. The women without PID reported their pain as “stabbing”. Many women also had deep pain from sexual intercourse, and post coital ache was also experienced by many of the women.25

In a recent U.S. study the overall incidence of reported later abdominal pain in a sample of 344 young Ohio women approximately 6 years post abortion was reported to be 12%.26 A Denmark study found that 2% of uninfected post abortion women and 12% of post abortion women infected with Pelvic Inflammatory Disease (PID) had chronic pelvic pain.27 A Swedish study of 382 women 5-6 years post abortion found that 2% of uninfected women had chronic pelvic pain, while 20% of post abortion women infected with PID had chronic pelvic pain.28

Chronic pelvic or abdominal pain can be very serious and be accompanied by many other adverse effects. Women with abdominal pelvic pain syndrome have been found to be significantly more anxious, depressed, and hostile, and have more somatic symptoms than other patients.29 Other research concluded these women exhibited significantly higher prevalence of major depression, substance abuse, adult sexual dysfunction, somatization, and history of childhood and adult sexual abuse than a comparison group.30 Another study found that they are more likely to use dissociation as a coping mechanism, to show current psychological distress, to see themselves as medically disabled, and to experience vocational and social problems.31 Chronic abdominal or pelvic pain can be long lasting. A Danish study found that only 31% of abdominal pain disappeared over a period of 5 years.32 Some women are hospitalized33 for abdominal or pelvic pain or seek treatment at emergency rooms of hospitals.34 Psychiatric counseling or treatment has not been successful in stopping the pain.35 Sometimes doctors will have women undergo a hysterectomy to attempt to eliminate the pain, but again this method is not effective.

Increasing Incidence of Adverse Physical, Reproductive, Psychological and Social Effects as Abortion is Repeated

Informational and consent forms make no distinction between a single abortion or repeat abortions. Yet a 1994-1995 Alan Guttmacher Institute study found that 45% of all U.S. women, and 60% of women age 30 or older are repeating abortion.36 Also, if a woman has already had one abortion she is 4-6 times more likely to repeat abortion compared with a woman who has an abortion for
Failure to consider a repeat abortion is a serious omission. A literature survey of medical and social risks from repeated abortion has identified at least 30 different psychological, physical, reproductive and other aspects of health and well-being which deteriorated among women as abortion was repeated. For example, as abortion is repeated, studies have reported that there is a 2-3 fold increased risk of ectopic pregnancy, low birth weight, miscarriage, or childbirth complications in subsequent pregnancies compared to no abortions or one abortion.

As abortion is repeated, women tend to be increasingly alienated in various ways. Various research studies have found that there is increased likelihood of women being isolated and they are more likely to have poorer interpersonal relationships, have more broken relationships with their male partner, or report having no male partner. They are also more likely to have been divorced and are more likely to report being in unhappy marriages.

A study of women in Atlanta, Georgia found that women repeating abortion were less likely to report a religious affiliation compared to women with one abortion. A Danish study found that women who repeat abortion have been found to increasingly be admitted to a hospital for psychiatric care, although the same study found that this was not the case for increasing numbers of childbirths. A study of women in a post-abortion support group at the Medical College of Ohio who reported poorly assimilating their abortion experience(s), found that those who had repeated abortion were more likely to be depressed and more likely to have considered or attempted suicide than women reporting a single abortion. A Greek study found that women repeating abortion are more likely to evidence symptoms of grieving and mourning.

Several studies (7 out of 10) have demonstrated an increased risk for breast cancer as abortion is repeated. As women repeat abortion they are more likely to smoke or use illicit drugs, including during subsequent pregnancies intended to be carried to term.

Abortion counselors do not take into account the significant differences in health and well-being of women as abortion is repeated. The same basic information is presented to women who are aborting for the first time, as well as women with a number of prior abortions.

Short term adverse psychological problems

Statements in typical abortion information or consent forms regarding possible psychological problems do not take into account that serious short-term as well as long-term psychological problems may result, among significant numbers of women. Also, the statements fail to take into account the wide range of adverse psychological and emotional reactions that may result. Possible serious psychological reactions include suicide, attempted suicide, admission to a psychiatric hospital, alcohol or drug abuse, anniversary reactions that sometimes appear to be suicide attempts, death anxiety, trauma, replacement pregnancies, or self-punishing behavior.

Some forms may fail to make any statement whatever relative to possible psychological problems after abortion. For example, consider the following statements which are typically found in abortion counseling information or consent forms: "Emotional problems after abortion are uncommon, and when they happen they usually go away quickly. Most women report a sense of relief, although some experience depression or guilt. Serious psychiatric disturbances such as psychosis or serious depression after abortion appear to be less frequent than after childbirth. "Positive negative, ambivalent feelings are natural after an abortion. Any of these negative or confused feelings tend to pass away with time. It is possible though rare to have a few days of depression. This may be due to hormonal changes that take place in our
body when a pregnancy ends, whether by abortion, miscarriage, or full-term delivery."

These statements would be false and misleading, at least for many of the women who obtain abortions in the U.S. In order to demonstrate that this is the case, it is necessary to compare the statements (or no statement) made in the information and consent forms at abortion clinics, with those in recent review articles which discuss the psychological effects of abortion. The review articles, published in 1990 and 1992 are authored by several psychologists all of whom support legalized abortion.61 One review article states that negative (psychological) reactions may arise from ambivalence or conflict at the time of the abortion. They say: "Ambivalence may engender a sense of loss. Conflict about the meaning of abortion and its relationship to deeply-held values or beliefs, perceived social stigma, or lack of support may also induce negative reactions." The review articles further state that women undergoing second trimester abortions, younger and unmarried women without children, women whose culture or religion prohibits abortion, and greater meaningfulness and intentionality of the pregnancy are at risk for psychological problems after abortion.61

However, none of the risk factors for negative psychological reactions following abortion from the review articles are mentioned in any of the informational or consent forms of the abortion clinics. In addition the women at risk for negative psychological problems represent a very large number. For example, about 10% of the abortions in the U.S. are after the first trimester; approximately 45% of the abortions in the U.S. represent young women aborting their first pregnancy; and about 80-85% of women who obtain abortions are unmarried.62 In addition, about 30% of women undergoing abortion in the U.S. state they are Catholics, and 18% state they are born-again Evangelicals.63 These are groups whose culture or religion prohibits abortion. Thus, it is readily seen that a large percentage of those women who obtain abortions are at risk for negative psychological reactions.

Long Term Negative Psychological Effects

None of the abortion clinic informational or consent forms advise women of the possibility of long term negative psychological effects from abortion. However, since 1987, there have been published at least three books which include data-based studies on long term negative psychological effects,64 several articles in medical or social journals,65 four doctoral dissertations, and at least two presentations made to professional organizations on long-term negative psychological effects.60 One study by researchers at the Medical College of Ohio was on women in a post-abortion support group who had abortions 1-15 years previously, and reported they had poorly assimilated their abortion experience. It was found that many women were ambivalent at the time of their abortion. Many felt coerced by boyfriends, doctors, or parents. Anxiety, somatoform disorders and dysthymia were prominent among the group. 48% had undergone psychotherapy after their abortion and a significant number had suicidal thoughts or suicidal attempts after their abortion. Anniversary reactions were clearly reported by 42% of the group. Those with multiple abortions evidenced more severe pathology than women with a single abortion.55

Another study which limited itself to women with only one abortion and no other identifiable trauma within 5 years, found severe grief reactions to be present in women an average of 11 years post abortion (1-26 year range).66 Post-traumatic stress disorder (PTSD) attributable to abortion has been found in at least 18.8% of women 3-5 years postabortion. (DSM-III-R criteria).67 Other studies have found long term guilt, anger or stress, depression, lower self-esteem, suicidal impulses and other long term negative psychological effects.60

Based on these studies, women who had abortions as teenagers, those repeating abortion, religious women, women
having second trimester abortions, and those reporting coerced abortions appeared to be particularly at risk for long term negative psychological effects.

Risks from Anesthesia

Abortion facility information or consent forms routinely advise women that there can be a toxic reaction, even possible death from various novocaine derivatives which may be used as an anesthetic. However, none of the forms examined compared the relative risks of local anesthesia with general anesthesia. This may be important because many abortion facilities do not limit themselves to local anesthesia. A 1981 survey of National Abortion Federation members found that only 58% used local anesthesia exclusively. A 1993 survey by the Alan Guttmacher Institute found that 33% of U.S. abortion facilities offered general anesthesia.

A Centers for Disease Control survey of U.S. women during 1971-1975 among women undergoing first trimester abortion by suction curettage, found that the incidence of uterine hemorrhage, uterine perforation, intra-abdominal hemorrhage and cervical injury were all significantly higher for general anesthesia compared to local anesthesia. Fever for 1 or 3 days and convulsive morbidity was significantly lower with general anesthesia. Further, since 1983, anesthesia complications from abortion have emerged as the most frequent cause of abortion mortality. Among the 13 anesthesia related deaths, 9 involved general anesthesia.

The CDC has stated that because of the increased morbidity and mortality from general anesthesia, women having abortions should be counseled regarding the pros and cons of local and general anesthesia use. It appears, however, that many abortion facilities do not do so.

Women who choose general anesthesia have been found to more frequently be repressors and have higher levels of psychological distress compared to women choosing local anesthesia. Thus, a primary reason for using general anesthesia appears to be patient comfort in order to attempt to repress the experience and alleviate psychological distress. Offering general anesthesia to women in psychological discomfort may inhibit her present ability to absorb information conveyed in counseling and encourage denial both in the present circumstances and also following the abortion which may lead to more mental health problems later.

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FOOTNOTES
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