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Kaye Wilson-Anderson DSN, MSN

University of Portland School of Nursing, wilsonb@up.edu

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Informed Consent: Elective Abortion

Kaye Wilson-Anderson, DSN, MSN

Associate Professor

University of Portland School of Nursing

615 SW 7th Street

Gresham, OR 97080

wilsonb@up.edu

503-724-7564 (c)

503-943-7729 (f)

Abstract

This article presents an overview of the history of informed consent, identifies the necessary elements of informed consent and provides a discussion of the controversy surrounding informed consent for an elective abortion. The most current scientific reports of risk and benefits of elective abortions are examined and essential information for informed consent for an elective abortion is identified.

Keyword: Elective Abortion, Informed Consent, Risk and Benefits of Elective Abortion

Informed Consent When Obtaining an Abortion

Since the 1973 legalization of abortion in the United States, approximately 48 million abortions have been conducted (Abortion in the United States, 2008; Guttmacher, 2008). Like any other elective surgery, an abortion requires an informed consent from the client. Federal and state laws, along with medical ethics, outline clearly what constitutes a client's informed consent. However, Wilson and Haney (2006) reported five out of seventeen women or 34 % of the sample reported that they did not feel they received adequate informed consent. Specifically, these five participants stated they should have been shown and explained the findings of their fetal sonogram, educated on fetal development and its relevance to their pregnancy, told of possible physical and emotional outcomes experienced by clients following an elective abortion and provided other options besides abortion with viable referrals. The findings of Wilson and Haney (2006) are similar to the findings of Reardon (1992) and Cassidy (2001). Each of these authors reported that women interviewed regarding their abortion experience described not receiving thorough and complete informed consent. Further, Cassidy (2001) documented the initiation of litigation in Texas regarding women's lack of informed consent prior to undergoing an elective abortion.

The study findings of Wilson and Haney (2006) regarding informed consent are recognized to be limited, but, based on these findings, it could be postulated that approximately 163,000 women in the United States to date, who have obtained an elective abortion, have done so without complete informed consent. These facts have led to the following questions:

What information must be part of informed consent for an elective abortion? Are women today receiving a thorough informed consent for an elective abortion? Do women consenting for an elective abortion receive equal informed consent as women who are consenting for other surgeries involving the removal of uterine content such as hydatidiform

moles, fibroids or tumors? In an effort to answer these questions, this article will examine the history of informed consent in the context of general medical care, as well as, the area of elective abortion both from the pro-choice and pro-life viewpoints.

Client's rights and informed consent began to be considered in the early 1900s and enforcement of informed consent gained greater strength in 1947 following the Nuremberg trials. Finally, in 1972, following the Tuskegee research outcomes, the client's rights to informed consent became a legal mandate (Informed Consent, 2009). Based on federal and state laws, informed consent is to contain the following four elements: the client fully understands their medical condition, has been told the risks and benefits of the procedure to be performed, is aware of alternative means to deal with his/her medical condition and agrees to the procedure voluntarily. Furthermore, informed consent is to be obtained when the client is not under duress and sufficient time has been provided for consideration of the procedure and alternate options, preferably not the day of the procedure (Anderson, Mike & Wearne, 2008). Additionally, informed consent must be obtained from clients considered of legal age and from the parent/legal guardian of clients who are minors (Informed Consent, 2009; Tillett, 2005). Most commonly, states define legal age as beginning at 18 or 21 years of age. However, in many states adolescents can be declared emancipated by the state when seeking healthcare related to contraception, abortion, pregnancy or sexually transmitted diseases. Currently, 32 states require some form of parental/adult notification prior to a minor consenting for an elective abortion. However, in the case of a health risk to a pregnant minor 34 states have provisions for a court to provide approval, 31 states allow a minor to sign in the event of a medical emergency and in the event of the pregnancy involving questionable sexual assault/incest or abuse, the parental involvement is waived in 14 states (Tillett, 2005; Parental Involvement in Minors' Abortions, 2010).

Pro-Choice Viewpoint

Pro-choice leaders argue that 23 states provide information prior to the abortion that is miss-leading and not supported scientifically (Gold & Nash, 2007). Misinformation is specifically cited in the area of providing women with descriptions of abortion procedures after the 12th week of gestation. Pro-choice leaders point out that most women who seek an elective abortion do so prior to the 12th week of gestation and, therefore, do not need to know information regarding termination procedures after the 12th week of gestation (Gold & Nash, 2007).

Additionally, pro-choice advocates propose that having women who are considering an elective abortion undergo an ultrasound is an unnecessary medical expense, and if the women do undergo an ultrasound, they do not need to be provided the results of the ultrasound. Finally, pro-choice leaders argue that due to poor scientific evidence, women who are considering elective abortions do not need to be told that women who undergo an elective abortion might have an increase risk for having breast cancer, future pregnancy complications, experience negative emotional outcomes or that the fetus might experience pain at the time of the abortion (Gold & Nash, 2007).

The National Abortion Federation holds to the following policy for informed consent prior to an elective abortion.

Standard 1: The clinician must ensure that accurate information is provided regarding the risks, benefits, and possible complications of abortion. This information may be provided either on an individual basis or in group sessions.

Standard 2: There must be documentation that the patient affirms that she understands the procedure and its alternatives; the potential risks, benefits, and possible complications; that her decision is uncoerced; and that she is prepared to have an abortion (Clinical Guidelines, 2008, p. 3).

Pro-Life Viewpoint

Pro-life proponents have spent considerable time and resources advocating for women and unborn children. Through these efforts, as of 2007, 33 states have specific laws and

policies that outline identified facts that should be included in the informed consent for an elective abortion. Of these states, 10 have passed legislation that specifically outlines the standard elements of an informed consent with the addition of providing information regarding the gestational age of the fetus. Further, 23 of these states have passed legislation that gives direction regarding verbal and written information that the client must receive during informed consent. Such information includes descriptions of various abortion procedures based on the gestation of the fetus, explanation of fetal gestation with specific focus on the fetus under consideration for abortion and potential risk to the woman for physical and emotional consequences following an abortion procedure. Additionally, some states require that the consent for an elective abortion be obtained at least 24 hours prior to the procedure (Gold & Nash, 2007).

Current Scientific Data

Many research studies have been conducted to examine the health outcomes and potential risk for women following an elective abortion (Calhoun, Handigian and Rooney, 2007; Lowery, Hardman, Manning, Hall and Anand, 2007; Wilson and Haynie, 2006). Wilson & Haynie (2006) provide a thorough historical review of 24 research studies regarding positive and negative outcomes experienced by women following an elective abortion from 1973 until 2001. Additional research has been reported that explores the concerns of increased risk for breast cancer in women who undergo elective abortions or take birth control pills (Lanfranchi, 2008). Also, Calhoun, Handigian, and Rooney (2007) reported finding an increased risk of premature births in women who had a history of elective abortions. Further, there continues to be research that explores the possibility of the aborted fetus experiencing pain at the time of the abortion procedure (Lowery, Hardman, Manning, Hall & Anand, 2007),

In Lanfranchi's (2008) article, she identifies that one of the major points of concern is

inaccurate reporting of side effects and potential problems women might experience following an elective abortion by scientist who are funded by the National Institutes of Health (NIH) and the National Cancer Institute (NCI). Lanfranchi (2008) reports that in 2005, a statistically significant number “15.5% of scientists”, who received funding from the NIH reported having changed their study findings because of pressure placed on them by their funding sources (pp. 12). Questionable reporting of scientific findings is further strengthened by the facts that not until 2006 did NCI report the link between birth control pills and breast cancer even though it had been reported in the literature for 20 years (Lanfranchi).

As recent as January 2008 the NCI reported that during pregnancy the estrogen levels in a woman’s body is low, when in fact the “estrogen levels increase by 2,000% by the end of the first trimester” (Lanfranchi, 2008, pp. 13). Lanfranchi sites two research studies (Lanfranchi, 2004; Breast Cancer Prevention Institute, 2007) that support the fact that breast changes after the 32nd week of pregnancy reduce the risk of breast cancer in women. These findings suggest that, when a pregnancy is interrupted prior to 32 weeks either through elective abortion or premature birth the woman’s risk for developing breast cancer is increased. Further, Lanfranchi documents multiple other discrepancies related to the link between breast cancer, elective abortions and the ingestion of estrogen containing birth control pills by the NCI and other well known medical resources. However, probably the most alarming point made by Lanfranchi is the reminder that due to the power and influence of the tobacco industry the link between tobacco products and cancer was down played to the American public for over 50 years. Thus, this author questions, if it is this same “type of power and influence” that may be keeping women from knowing that there are documented scientific findings that link elective abortions and the consumption of estrogen containing birth control pills to increased cases of breast cancer in women.

Another concern that is often not disclosed to women seeking an elective abortion is

the link between elective abortion and subsequent premature births. Calhoun, Handigian, and Rooney (2007) conducted a review of 59 English written national and international studies related to preterm births and abortion. Twenty nine of these studies reported a positive correlation between the number of abortions and the risk for preterm births with a CI of 95%. From these studies, 5 of the most recent studies (Ancel, Lelong and Papiernik et al., 2004; Martius, Steck, Oehler et al., 1998; Lumley, 1998; Zhou, Sorenson, Olsen, 2000; Henriët, Kaminski, 2001) were utilized to develop a model for calculating an estimated risk of early preterm births (EPB) among women who had undergone an elective abortion. Through the development of this mathematical model, these researchers estimated that women who undergo an elective abortion make up 31.5% of early preterm births in the United States. The estimated economical impact on the American health care system for these early preterm births includes: \$1.2 billion for infants who survive, \$1 billion for infants who either die shortly after birth, due to complications from (EPB) or who live with Cerebral Palsy. Calhoun, Handigian and Rooney did not evaluate the families' emotional trauma, obstetrical expense or the ongoing cost of caring for a developmentally delayed fragile child.

A final concern that is often not shared with women considering an elective abortion is the possibility that the fetus may experience pain. Lee, Ralston, Drey et al. (2005) concluded that the fetus could not interpret painful stimuli until after the 29 or 30 weeks of gestation. Gold and Nash (2007) report, that 9 out of 10 women undergo their elective abortions during the first trimester or before the 12th week of pregnancy and that 1% of all abortions occur at 21 weeks or later.

However, in rebuttal to the thought that the fetus does not experience pain, Lowery et al. (2007) explained that the neonatal pain occurs in two ways, cortical pain perception and stress response which occurs with the sensation of painful stimuli. Since the fetus cannot speak and express their pain, it is unclear as to the actual amount of cortical pain perceived by

the fetus but research has documented fetal movement to avoid painful stimuli during fetal surgery or intrauterine gestational procedures. As early as the 9th week of gestation peripheral pain receptor sites are noted and are “abundant at 20 weeks; a functional spinal reflex is present by 19 weeks; connections to the thalamus are present by 20 weeks; and connections to subplate neurons are present by 17 weeks with intensive differentiation by 25 weeks” (p. 275). These researchers go on to note that the effect of pain on the fetus has shown to lead to “altered pain threshold and abnormal pain-related behavior in later childhood” (p.280). Thus, it can be postulated that if aborted fetuses survived the abortion procedures, it would likely be documented that they have increased thresholds to pain and behaviors that reflects unusual response to pain (Lowery et al, 2007).

What Constitutes Informed Consent for an Elective Abortion?

As discussed earlier in this article based on the law and medical ethics, informed consent should consist of four elements. First, the client should be provided information that allows him/her to understand his/her medical condition. Secondly, the client should receive accurate data that describes the known risks and benefits of the procedure being considered. Thirdly, the client should be provided information concerning all alternate options of dealing with his/her current medical state. Finally, the client should voluntarily agree to the procedure and ideally the consent should not be obtained on the day of the procedure (Anderson, Mike & Wearne, 2008).

In keeping with these established guidelines, women who are considering having an elective abortion or any other type of surgical procedure should receive the following information during the informed consent procedure. These women must receive a complete explanation of their medical state. In the case of the elective abortion procedure this would include the following information: an explanation of the possible abortion options based on an ultrasound, viewing pictures of the ultrasound with full explanation of the ultrasound

findings and how the abortion procedure would be done. Secondly, all reported risks and benefits of the abortion should be given to the client. These risk and benefits are as follows: as with any surgery, there is a risk for having an infection, bleeding, pain and possible death. Specifically related to an elective abortion, research has reported that some women have experienced negative emotional and behavioral outcomes following the procedure such as depression, anxiety, increased use of alcohol/drugs and inability to bond with subsequent children (Wilson & Haynie, 2007;2008); research has also linked an increase in women's risk for breast cancer and the possibility of future pregnancies ending in premature births following an elective abortion (Lanfranchi, 2008; Calhoun, Handigian, and Rooney, 2007). In reference to benefits, some women who ended their pregnancies reported they were able to continue the life they desired (Wilson-Anderson, 2009). Third, women should be informed that some research does suggest the fetus might perceive pain during the procedure (Lowery et al., 2007). Fourth, women should be provided viable alternate options to having an elective abortion and the informed consent should not be obtained on the day of the abortion procedure (Clinical Guidelines, 2008).

Closing

Though the controversy surrounding elective abortions will most likely continue, healthcare providers are called to “do no harm to the client” and thus, no matter which side of the debate one finds themselves, as licensed healthcare providers, legal, ethical and moral standards must be maintained. The difference in being provided an informed consent concerning fetal development is reflected in the following two statements by women who underwent elective abortions, “[it] is really hard, because I know that there's a baby in there, and I have to make like this conscious effort to not make any connection ...and I felt very much like I'm making a decision to get rid of this baby ..., to kill it basically, and I still felt like it was the right decision for me” (Wilson-Anderson, 2009) and “if I had known it was a

baby I would have never done it[abortion]” (Wilson, 2003).

How women who have consented to an abortion or women who are consenting right now feel if they were informed that there is a risk that the fetus will or did experience pain during the abortion procedure, and that having an abortion could put them at greater risk for future premature births or breast cancer. Women considering an abortion, like all other clients contemplating a surgical procedure, must be provided the most current scientific reports of risk and benefits of an elective abortion. This will allow women to truly make an informed decision when considering an elective abortion.

Editorial Note: The opinions expressed by authors represent those of the authors and do not reflect the opinions of the editorial staff of The Online Journal of Health Ethics.

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