Abortion Risk Factors: An Avenue for New Pro-Life/Pro-Woman Laws

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THE "PROTECTION FROM HIGH RISK and Coercive Abortion Act" is a bill that may dramatically change the national abortion debate. Sponsored by State Senator Richard White, it was introduced as Senate Bill 2677 before the Mississippi legislature during the 1998-99 session and is expected to come up again in the 1999-2000 session. Support for the bill has grown to the extent that other states, including Kentucky and Illinois, are considering introducing it in their legislatures as well.

If passed into law, the act will bring an end to assembly-line abortion practices and finally make it possible for women who have been injured by abortion to hold abortionists fully and properly accountable for failing to safeguard their health. A woman's consent to an abortion will be considered "informed, voluntary, and free from negligent and unnecessary exposure to risks" only if the following conditions have been met:

> (1) Before the physician recommends or performs an abortion, a qualified person has evaluated the woman to identify the presence of any known or suspected risk factors and informed her and the physician, in writing, or the results of this evaluation....
> (2) In the event that any risk factors were identified, the patient has been fully informed by a qualified person which risk factors exist, why these risk factors may lead to adverse reactions, and a detailed explanation of what adverse reactions may occur....
> (3) In the event that any risk factors were identified, the qualified person who has provided the screening and counseling has provided a written statement to the patient and the physician certifying, to the best of the qualified person's knowledge, that the patient fully understands and appreciates the significance of the risk factors discussed and her increased exposure to the related adverse reactions....[i]

This new legislation will be difficult to challenge in the courts because it

simply puts into law the standard of care presumed by the Supreme Court and endorsed by the medical community. According to the Supreme Court, "basic responsibility" for the abortion rests with the physician.[ii] While a woman may request an abortion, it is the physician's obligation to determine if the abortion may be dangerous. If an abortion is contra-indicated for medical reasons, which can include physical, psychological, and social reasons, the physician has a right and duty, in the best interests of the patient, to refuse to perform the abortion.

These rights and duties of physicians are widely recognized in medical textbooks on abortion.[iii] In addition, the American College of Obstetricians and Gynecologists,[iv] the National Abortion Federation,[v] and the Planned Parenthood Federation of America[vi] have all issued documents re-affirming or at least alluding to these duties. Indeed, Sylvia Stengle, executive director of the National Abortion Federation, has stated that at least one in five patients is at psychological risk from abortion due to prior philosophical and moral beliefs that are contrary to abortion. Regarding this "worrisome subset" of patients, Stengle states that there may be an ethical obligation for abortion practitioners to refuse to participate in the violation of a woman's conscience.[vii]

Unfortunately for women, however, this obligation is seldom met. In practice, abortion in the United States is provided on request, without the type of screening or counseling that is necessary to protect patients' health.

It is ludicrous to believe that abortionists can make informed recommendations for abortion when no one even knows what benefits, if any, are associated with abortion. Every claim that abortion is beneficial is based solely on the presumption that because women are requesting it, it must be helpful to them. Perhaps worst of all, in the present system of abortions on request, many women are being pressured into unwanted and harmful abortions for the benefit, convenience, or profit of others.

A LARGE BODY OF RISK FACTORS IS KNOWN

Risk factors for immediate physical complications from abortion include uterine abnormalities, multiple gestation, cardiovascular disease, renal disease, asthma, epilepsy, diabetes, venereal infection, intoxication or

drug use, obesity, and other pre-existing conditions.[viii]

There are also a wide variety of risk factors for delayed physical complications–most notably, the association between abortion and breast cancer. The risk of subsequent breast cancer is associated with abortion of a first pregnancy, abortion at a younger age, abortion performed on a woman with a family history of breast cancer, or a history of multiple abortions.[ix] A history of prior abortion (at least 45% of all abortion patients have had at least one abortion already) is also correlated with a wide variety of health risks, such as increased risks of sterility, miscarriage, and low birth-weight in future pregnancies.[x]

While the physical risks of abortion are significant, the published literature demonstrates that emotional and psychological complications following an abortion are even more common. Even the most dedicated of pro-choice researchers generally admit that "there is no virtually no disagreement among researchers that some women experience negative psychological reactions postabortion [sic]."[xi] The degree, frequency, and duration of emotional complications are still unknown, however. The lowest estimate for adverse outcomes is 6%, with typical reports ranging from 12 to 25%, and the highest estimates ranging up to 80%.[xii]

What is important for the purposes of this discussion, however, is not precisely how many women suffer post-abortion emotional problems,. Instead, it is important to recognize that there is general agreement concerning the risk factors that can *reliably predict* an increased risk of significant post-abortion psychological distress. Indeed, most of the research on pre-identifying risk-factors has been published by abortion proponents.[xiii]

The risk factors for post-abortion psychological maladjustments can be divided into two general categories. The first category includes women for whom there exist significant emotional, social, or moral conflicts regarding the contemplated abortion. The second category includes women who are experiencing developmental problems, which can include immaturity and pre-existing or unresolved psychological problems.

A summary list of established risk factors includes the following: conflicting maternal desires; moral ambivalence; feeling pressured by

others to abort; feeling that the decision is not her own or is her "only choice"; feeling rushed to make a decision; immaturity or adolescence; prior emotional or psychological problems, including poor development of coping skills or prior low self-image; a prior history of abuse or unresolved trauma; a history of social isolation, as indicated by having few friends or lack of support from one's partner or family; a history of prior abortions; or a history of religious or conservative values that attach feelings of shame or social stigma to abortion. Readers may refer to the addendum for a more complete list of these pre-identifying risk factors.[xiv]

These risk factors clearly suggest that a substantial number of women–most notably, the majority–are at risk of experiencing adverse psychological reactions to abortion.[xv] The conscientious physician would be legally and ethically bound to consider these risk factors when forming a recommendation, to advise the woman of the existence of these risk factors, and, in at least some cases, to refuse to perform the abortion until these risk factors had been alleviated through appropriate counseling.

MEDICAL OBLIGATIONS FOR PROPER SCREENING

All physicians considering a course of treatment have a duty to screen their patients for any predisposing risk factors, to inform their patients of these risk factors, and to make an informed medical recommendation as to whether or not the presume benefits of the procedure outweigh the risks. If the physician believes that the risks outweigh the benefits of any particular procedure, he should decline to perform that procedure.

The same standards apply to physicians performing abortions.[xvi] According to the ideal standard of care, proper pre-abortion counseling should include screening for all of the risk factors listed above, notifying the patient of any existing risk factors, and providing appropriate counseling or a referral to resources outside the clinic where these risk factors can be addressed or treated.[xvii]

Furthermore, after this initial screening, patients should routinely be instructed about *all* pre-existing risk factors, even those that the patient does not report. It is well-known that patients seeking abortion are more likely than other types of patients to conceal relevant information, such as

a history of prior abortions or the fact that they are being coerced into the abortion by others. In anticipation of such concealment, routine disclosure of all risk factors is necessary to ensure that the patient is given at least the opportunity to make an informed self-evaluation of her risk profile.

Proper screening, full disclosure of risks, and customized counseling for high-risk patients are time-consuming tasks. This is precisely why the standard of care in the abortion industry has fallen so low. Many abortion clinics are profitable because they depend on high volume and fast turnaround. This means that they operate on an assembly-line basis that allows 30 minutes or less for intake, screening, evaluation, and counseling of each patient. This violation of patients' rights must be stopped.

ENSURING THE LEGAL OBLIGATION FOR PROPER SCREENING

The Protection from High Risk and Coercive Abortion Act recognizes that inadequate screening clearly endangers patients' health. This alone is basis for recovery of damages for reckless endangerment. The Act also would correct numerous imbalances in laws and court rules governing abortion malpractice litigation. These imbalances provide an undue advantage to abortionists and tend to protect the abortion industry's low standard of care.

One such imbalance is the short statute of limitations that normally allows injured parties to sue only up to two years after undergoing a medical procedure. The new act would allow women to sue for abortion-related injuries for up to two years after they have *recovered* from any physical or psychological injuries related to the abortion. This provision recognizes that abortion is different from other medical procedures. It can cause psychological disabilities, such as intense feelings of shame, guilt, and self-punishing behavior, that make it difficult or impossible for injured women to seek compensation for their injuries while suffering from abortion-related trauma. It is only after a woman has achieve a significant emotional healing that she can effectively cooperate with her attorney in pursuing a malpractice claim.

Of special concern are cases in which a woman desires to have her child but is under pressure from her male partner, or from his or her

parents, to have an unwanted abortion.[xviii] Clearly, physicians and counselors should be held accountable for failing to properly screen for coercion. In addition, if abortion counselors cooperate with the coercing parties by attempting to convince the girl or woman to submit to the unwanted abortion, the proposed law would allow her to hold the abortion provider liable for the wrongful death of her wanted child.

DUTY TO MAKE INFORMED MEDICAL RECOMMENDATIONS

While a woman may initiate a request for an abortion, it is the duty of the physician to evaluate her, identify the factors that make her pregnancy a problem in her life, examine all the options that may resolve the problem, and provide her with an informed recommendation as to what the most appropriate course of treatment should be.[xix] A physician who ignores these duties and merely provides abortions on request should be held accountable for a serious malfeasance of duty.

In forming a medical recommendation for abortion, physicians should not only be aware of predictive risk factors for physical or psychological complications, but they should also have a sound medical basis for determining in what circumstances an abortion is likely to be beneficial. If a woman has one or more risk factors, and there is no clear evidence that she is likely to benefit from an abortion, it is difficult to see how a physician could justify proceeding with a contra-indicated procedure.

Very little research, if any, has been done to identify the situations in which abortion is most likely to improve a woman's life or well-being. Furthermore, there is little, if any, research that has attempted to measure the degree of any benefits. Instead, there is a widespread and untested presumption that if an abortion does not measurably hurt a woman's life, then it must have benefitted her life. But there is no logical basis for assuming that lack of harm correlates to positive benefit.

Humans are extremely adaptable. Some mothers who have been denied abortion will subsequently claim that they never wanted an abortion in the first place.[xx] Speaking to a reporter from *The London Express* in 1967, British physician Aleck Bourne expressed his opposition to legalized abortion by saying that easy access to abortion would be

a "calamity" for women: "I've had so many women come to my surgery and pleading with me [sic] to end their pregnancies and being very upset when I have refused. But I have never known a woman who, when the baby was born, was not overjoyed that I had not killed it."[xxi] Many crisis pregnancy counselors and other physicians who have successfully encouraged abortion-minded clients to choose birth have reported similar experiences.

In short, while an abortion can always eliminate a pregnancy, it is very unclear when, if ever, it helps to solve the problem that made the pregnancy problematic. For example, many women seek abortion in the hope of saving a relationship, but the bulk of the evidence shows that they seldom achieve this goal. Abortion is more likely to destroy relationships than to improve them. Other women abort to protect or advance their careers. But there is not even one published study that shows that abortion actually helps them to do so. Furthermore, it is possible and even likely that temporary career advantages, if any, are outweighed by the physical and psychological complications these women suffer from abortion.

CONCLUSION

The Protection from High Risk and Coercive Abortion Act would protect patients' rights simply by putting the ideal standard of care into statute and by making it easier for injured patients to hold negligent abortion providers liable for injuries. Juries would be given the opportunity to hear medical testimony that would support the view that abortion was contra-indicated and not medically justified. In short, the act would compel abortion providers to act like doctors who are obligated to use good medical judgment. In too many cases, abortionists are simply selling their skills to any desperate person who has enough cash, even if that person is totally ignorant of the risks she is facing.

In summary, the challenge this bill represents to abortion proponents has been well articulated by Dr. Philip Ney:

We should remember that in the science of medicine, the onus of proof lies with those who perform or support any medical or surgical procedure

to show beyond reasonable doubt that the procedure is both safe and therapeutic. There are no proven psychiatric indications for abortion. The best evidence shows abortion is contraindicated [sic] in major psychiatric illness. There is no good evidence that abortion is therapeutic for any medical conditions with possible rare exceptions. In fact, there are no proven medical, psychological, or social benefits.... If abortion was [sic] a drug or any other surgical procedure about which so many doubts have been raised regarding its safety and therapeutic effectiveness, it would have been taken off the market long ago.[xxii]

Table 1:

RISK FACTORS PREDICTING
POST-ABORTION PSYCHOLOGICAL SEQUELAE

(Reference Key: bold - Statistically Validated Study; *italicized - Clinical Experience, Soft Data;* normal - Literature Review)

I. CONFLICTED DECISION

A. Difficulty making the decision, ambivalence, unresolved doubts: 1,2, **3**, **10**,13,**14**,*18*,*23*,**25**,**29**,**34**,37,**38**,**40**,**46**,**49**,**52**,53,55,**56**,**57**,61

1. Moral beliefs against abortion: 61
   a. Religious or conservative values: 1,2,**5**,*23*,**34**,**39**,**40**,*48*,**49**,54,**56**,**58**,**59**
   b. Negative attitudes toward abortion: 1,**8**,27,**57**
   c. Feelings of shame or social stigma attached to abortion: 2,61
   d. Strong concerns about secrecy: 50
2. Conflicting maternal desires: 1,**29**,**30**,**33**,**34**,**46**,*51*
   a. Originally wanted or planned pregnancy: 1,13,*23*,27,**29**,53,**57**,**59**,61
   b. Abortion of wanted child due to fetal abnormalities: **3**,**7**,13,*18*,**19**,20,**26**,27,**28**,*41*,61
   c. Therapeutic abortion of wanted pregnancy due to maternal health risk: **3**,13,15,*18*,20,**26**,27,37,42,**49**,54,55,61
   d. Strong maternal orientation: **34**,*48*
   e. Being married: 1, **10**
   f. Prior children: **25**,*48*,54,**58**,**60**
   g. Failure to take contraceptive precautions, which may

indicate an ambivalent desire to become pregnant: **6**

h. Delay in seeking an abortion: 1,2,**26**

3. Second or third trimester abortion: 1,20,**26**,27,**39**,42,**49**
4. Low coping expectancy: 1,27,**29**,**30**

B. Feels pressured or coerced:
13,*16*,*18*,27,**34**,*43*,*45*,*48*,**49**,50,*51*,**52**,55,61

1. Feels decision is not her own, or is "her only choice": **14**,,*18*
2. Feels pressured to choose too quickly: **17**,*24*

C. Decision is made with biased, inaccurate, or inadequate information: **17**,*48*,**49**

Comment: h. . Preoccupation with fantasies of fetus, including sex and awareness of due date

II. PSYCHOLOGICAL OR DEVELOPMENTAL LIMITATIONS

A. Adolescence, emotional immaturity: 1,*4*,**9**,**11**,15,*16*,**17**,27,**29**,**32**,**33**,42,*48*,50,54

B. Prior emotional or psychiatric problems: **3**,**5**,**6**,13,15,*18*,20,22,*23*,**25**,**26**,**34**,37,**40**,42,*47*,*51*,54,**57**,61

1. Poor use of psychological coping mechanisms: 2,**29**,**34**,61
2. Prior low self-image: **33**,**34**,*43*,*48*,**52**,61
3. Poor work pattern or dissatisfied with job: **6**,**52**
4. Prior unresolved trauma or unresolved grief: *48*,*51*
5. A history of sexual abuse or sexual assault.: *23*,*31*,*51*,61
6. Blames pregnancy on her own character flaws, rather than on chance, others, or on correctable mistakes in behavior: **29**,**30**,**36**
7. Avoidance and denial prior to abortion: **12**,27
8. Unsatisfactory or mediocre marital adjustment: **6**
9. Past negative relationship with mother: **5**,**40**

C. Lack of social support: 1,**9**,27,**33**,**46**,54,55,**56**,**58**,61

1. Few friends, unsatisfactory interpersonal relations: **6**,**52**
2. Made decision alone, without assistance from partner: **35**
3. A poor or unstable relationship with male partner: **6**,**25**,**34**,**40**,*43*,53
4. Single and nulliparous: **9**
5. Separated, divorced, or widowed: **14**
6. Lack of support from parents and family (either to have baby or to have abortion): 2,**8**,**9**,*18*,27,**29**,**33**,**35**,**52**,**56**
7. Lack of support from male partner (either to have baby or to
have abortion):: 2,**6**,**8**,**9**,*18*,**25**,27,**29**,**33**,**34**,**35**,42,**46**,**52**,53
8. Accompanied to abortion by male partner: 21,**30**
9. Living alone: **56**

D. Prior abortion(s): 13,37,*43*,*48*,**52,58**

E. Prior miscarriage: **58**

F. Less education: **58**

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NOTES

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i. The Protection from High Risk and Coercive Abortion Act, Section 3.

ii. *Roe v. Wade*, 410 U.S. 113 at 166 (hereafter *Roe*): "[T]he abortion decision in all its aspects is inherently and primarily a medical decision, and basic responsibility for it must rest with the physician."

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x. A. Tzonou *et al.*, "Induced Abortions, Miscarriages, and Tobacco-Smoking as Risk Factors for Secondary Infertility" in *Journal of Epidemiology and Community Health* 47, No. 36 (1993); A. Levin *et al.*, "Association of Induced Abortion with Subsequent Pregnancy Loss" in *JAMA* 243, No. 2495 (1980); M. T. Mandelson *et al.*, "Low Birth Weight in Relation to Multiple Induced Abortions" in *Public Health* 82/3 (1992) 391-94. These citations are examples only. Additional citations could be added.

xi. Wilmoth, "Abortion, Public Health Policy, and Informed Consent Legislation" in *Journal of Social Issues* 48/3: 1-17. See also Anne Baker, "Counselor's Corner" in *Hope News* (The Hope Clinic for Women, Ltd., Granite City IL, Dec. 1994), pp. 2-4.

xii. In 11 studies, reviewed by P. Dagg, searching for various long-term negative psychological effects of abortion, the lowest incidence-rate reported was 6% and the highest was 32%, the average reported rate being 15%. Dagg, "The Psychological Sequelae of Therapeutic Abortion–Denied and Completed" in *American Journal of Psychiatry* 148/5 (May 1991) 578-85 (Table 2). Another major study found that 49% of 360 women experienced psychological maladjustments post-abortion. E. M. Belsey *et al.*, "Predictive Factors in Emotional Response to Abortion: King's Termination Study–IV" in *Social Science and Medicine* 11 (1977) 71-82. Still other researchers have reported even higher rates by accounting for women who refuse to participate in follow-up programs precisely because they have had, or continue to experience, psychological stress related to the abortion and do not wish to aggravate this stress by participation in the study.

xiii. See, for example, N. E. Adler *et al.*, "Psychological Factors in Abortion: A Review" in *American Psychologist* 47/10 (1992) 1194-1204; Belsey *et al.*, *op. cit.*; H. P. David, "Post-Abortion and Post-Partum Psychiatric Hospitalization" in *1985 Abortion: Medical Progress and Social Implications* (London: Ciba Foundation Symposium 115, 1985), pp. 150-64; and U. Landy, "Abortion Counseling–A New Component of Medical Care" in *Clinics in Obstetrics and Gynecology* 13/1 (1986) 33-41.

xiv. D. C. Reardon, "Predictive Factors of Post-Abortion Maladjustment: Clinical, Legal, and Ethical Implications" at the American Psychiatric Association Annual Meeting, San Diego CA, May 17-22, 1997.

xv. Over 70% of women having abortions are doing so against their conscience, with 74% agreeing with the statement "I personally feel that abortion is morally

wrong, but I also feel that whether or not to have an abortion is a decision that has to be made by every women for herself"–see *The Los Angeles Times* Poll, March 19, 1989. See also M. Zimmerman, *Passages Through Abortion* (New York: Praeger, 1977), and D. Reardon, *Aborted Women: Silent No More* (Chicago: Loyola Univ. Press, 1987). Some 30 to 55% report feeling pressured to abort by others, and a similar percentage express some desire to keep the child (Zimmerman, Reardon). Approximately 45% of abortions are for women with a prior history of abortion, and over one-fourth are for teenagers. In addition, some trauma experts estimate that as many as one in three women has been sexually abused in childhood–see Judith Herman, *Trauma and Recovery* (New York: Basic Books, 1992), p. 30. It is likely that the percentage of women having abortions who have a prior history of abuse, trauma, or other psychological problems is as high as, or higher than, that for the general population.

xvi. M. Borton, *op. cit.*; see also *Ambulatory Maternal Health Care and Family Planning Services Policies, Principles, Practices*, ed. F. Barnes (Committee on Maternal Health Care and Family Planning Planning, Maternal and Child Health Association, American Public Health Association, Interdisciplinary Books and Periodicals for the Professional and Layman, 1978).

xvii. Hern, pp. 84, 86-87.

xviii. Hern, pp. 80, 81.

xix. ACOG Executive Board, *Statement of Policty–Further Ethical Considerations in Induced Abortion* (Washington, D.C.: ACOG, 1977), p.2.

xx. See H. David *et al.*, *Born Unwanted: Developmental Effects of Denied Abortion* (New York: Springer, 1988).

xxi. Valentine Low, interview with Aleck Bourne, "The Rape that Really Changed Our Minds about Abortion" in *Evening Standard* (Feb. 28, 1992), p. 20.

xxii. P. G. Ney, "Some Real Issues Surrounding Abortion, or The Current Practice of Abortion is Unscientific" in *The Journal of Clinical Ethics* 4, No. 2 (1993) 179-80.