

Misinformed Consent: The Medical Accuracy of State-Developed Abortion Counseling Materials

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Informed consent—the concept that individuals have a right to receive relevant, accurate and unbiased information prior to receiving medical care so they can make sound decisions regarding treatment—is a bedrock principle of medical ethics. Moreover, the obligation to provide such information is mandated by statute or case law in all 50 states. Under the banner of informed consent, a majority of states have enacted abortion counseling laws requiring physicians to provide specified information to women seeking abortions. Many of these laws require the state health department to develop detailed written materials that must be distributed to women prior to the procedure.

An analysis of these state-developed materials demonstrates that they do not always measure up to the gold standard of informed consent. Particularly with regard to certain hot-button issues, the information presented is either out-of-date, biased or both. In some cases, the state goes so far as to include information that is patently inaccurate or incomplete, lending credence to the charge that states' abortion counseling mandates are sometimes intended less to inform women about the abortion procedure than to discourage them from seeking abortions altogether.

The Tenets of Informed Consent

As stated, informed consent is both a legal obligation and an ethical principle. The requirement that medical providers obtain permission from their patients prior to providing treatment is embedded in the idea that individuals should be empowered to make autonomous decisions

regarding their own care. Accordingly, informed consent is a process through which accurate and relevant information is presented to a patient so that he or she is able to knowledgeably accept or forego medical care, based on an appreciation and understanding of the facts presented.

In general, the literature documenting the process of obtaining informed consent indicates that it involves three broad principles: disclosure, capacity and voluntariness. Disclosure requires the physician to provide accurate and adequate information on the benefits, risks, costs and alternatives of treatment; in this context, adequacy is often understood as the amount of information that the average patient would require to be an informed participant in the decision. Capacity refers to the patient's ability to understand and rationally process the information presented to him or her and to make health care choices based on this understanding. And voluntariness describes the patient's ability to make a decision free from coercion or any type of unfair incentives. According to attorney J. Steven Svoboda and colleagues, writing for the *Journal of Contemporary Health Law and Policy*, this requires the physician to "distance himself as much as possible from his personal preferences and values and to present interests at stake for the patient."

Politics vs. Public Health

States have been enacting "informed consent" mandates specific to abortion for decades, and 32 states currently have mandates in effect. In general, they require providers to inform a woman of the nature of the procedure and the

risks associated with it—as well as the risks of pregnancy and childbirth—and the “probable gestational age” of the fetus. In some cases, however, the statutes are biased on their face. In seven states, they mandate the provision of negative and unscientific information about abortion and its implications. In five other states, they require that the woman be told that the state favors childbirth over abortion.

Whether biased or not, abortion rights activists have tended to oppose counseling mandates specific to abortion, which they consider egregious examples of political interference in the doctor-

has yet to do so.) In most cases, the topics included in the materials were specifically required by law; in other cases, the topics had been selected at the discretion of the health department.

Our analysis reveals that although most of the information in the materials about abortion comports with recent scientific findings and the principles of informed consent, some content—specifically, that which is related to breast cancer, psychological impact, fetal pain and referrals for additional care—is either misleading or altogether incorrect. Also, the investigation demon-

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patient relationship. For its part, the American Medical Association has long opposed any legislative measure that would require “procedure-specific” informed consent. Nonetheless, the U.S. Supreme Court in 1992 ruled in favor of abortion-specific informed consent mandates in *Planned Parenthood of Southeastern Pennsylvania v. Casey*. In upholding Pennsylvania’s law requiring preabortion counseling, the Court said such mandates are permissible as long as the information the law requires to be given to the woman is “truthful and nonmisleading.”

In the *Casey* decision, the Court also affirmed the states’ authority to develop written materials detailing the abortion procedure and to require providers to distribute them. Given the propensity for states to take advantage of that authority, the Guttmacher Institute undertook a content analysis of state-written counseling materials to better understand the information physicians are required to distribute to women seeking an abortion. In July 2006, we conducted a 50-state investigation to discover in which states the health department had developed materials; we found that 22 states had done so, all under the direction of their legislatures. (One additional state, Oklahoma, has a law requiring the health department to develop materials, but the department

states that in a few cases, health departments acted to mitigate the potential harm of biased laws by publishing materials that are somewhat more balanced than the laws themselves. For example, laws in nine states require that the materials include information on the “possible detrimental psychological effects” of abortion; however, in all but two of these states, the materials describe a range of emotions—both positive and negative—a woman could experience.

Breast Cancer

Antiabortion activists have long held that having an abortion leads to an increased risk of developing breast cancer later in life. Until quite recently, they were able to take advantage of the fact that the science examining the potential link between abortion and breast cancer was inconsistent. In particular, they relied largely on a 1996 meta-analysis, a type of analysis that combines the results of various studies, which concluded that women who had had an abortion had significantly elevated risk of breast cancer.

Since that time, however, researchers and medical experts have taken another look at the studies and overwhelmingly have concluded that those finding a causal relationship between breast cancer and abortion are methodologically

MANDATED MATERIALS

State abortion counseling materials often include information that is medically inaccurate and biased.

	Breast Cancer and Abortion		Psychological Effects of Abortion		Includes Information on the Ability of a Fetus to Feel Pain	Referral Resources	
	Falsely asserts a possible link	Correctly reports no link	Falsely asserts only negative emotional responses	Correctly reports a range of emotional responses		Provided for crisis pregnancy centers	Provided for family planning services
U.S. TOTAL	5	1	7	11	5	20	13
Alabama				X			
Alaska	X			X*		X	X*
Arkansas				X*	X*	X	X
Georgia				X*	X*	X	
Idaho				X		X	
Kansas	X			X		X	X
Kentucky						X	
Louisiana				X		X	X
Michigan			X*				
Minnesota		X*		X*	X*	X	
Mississippi	X*					X	X*
Nebraska			X*			X	X*
North Dakota						X	X
Ohio						X	X*
Pennsylvania				X		X	
South Carolina			X			X	X
South Dakota			X*		X	X	X
Texas	X*		X		X	X	X
Utah			X			X	
Virginia				X*		X*	
West Virginia	X		X*			X	X
Wisconsin				X*		X	X

*Discussion of topic required by state law. Note: Oklahoma law requires that abortion counseling include state developed materials; as of September 2006, however, the materials had not yet been issued.

flawed. Moreover, in February 2003, after pulling together the world's leading experts to assess the association between certain reproductive events and the risk of breast cancer, the National Cancer Institute (NCI) issued a categorical statement: "Induced abortion is not associated with an increase in breast cancer risk." NCI further stated that this determination was "well-established," the institute's highest rating. A similar investigation conducted in 2004 by a panel convened by the British government came to the same conclusion.

Nonetheless, medically inaccurate claims of a link between induced abortion and breast cancer can be found in the required abortion counseling materials in five of the six states that have developed such materials (see table, columns 1 and 2). In two of these states, the health department was expressly directed by the legislature to include information on the abortion–breast cancer rela-

tionship; in the other three, the health department included the information without a specific state mandate to do so. All of these materials state that the evidence linking abortion with breast cancer is inconclusive. For example, the Texas materials state that there is no consensus in the medical community on the connection between abortion and breast cancer, and that further study is needed. Only the materials developed by the health department in Minnesota comport with NCI's determination that an abortion does not increase the likelihood of subsequently developing breast cancer.

Psychological Impact

Abortion opponents also claim that having an abortion will result in a barrage of negative mental health outcomes. This implication that abortion is psychologically riskier than carrying an unwanted pregnancy to term is misguided, as the most methodologically

sound research conducted over the past two decades does not find a causal relationship between abortion and severe negative mental health outcomes. In fact, according to a study published in the *Archives of General Psychiatry* in 2000, the best indicator for a woman's mental health after an abortion is her mental health before the abortion. And a review of the mental health literature by the American Psychological Association in 1989, as summarized in the Guttmacher Institute's May 2006 report, *Abortion in Women's Lives*, found that women feel the most distress before an abortion; after an abortion, women frequently report feeling "relief or happiness" (related article, Summer 2006, page 8).

In 19 states, the mandated materials include information on the psychological effects of abortion (see table, columns 3 and 4). In 11 of these states (including Oklahoma, where the materials have not yet been developed), the information is

included pursuant to a specific state law; in the other eight states, the information is provided without a specific legal mandate.

In 11 states, the information in the materials prepares women to feel a range of emotions after an abortion—from sadness to relief. Women are reassured that after the abortion, it is common to experience emotions that are simultaneously positive and negative. Professional counseling is suggested before and after the procedure so that a woman feels comfortable with her decision; counseling is specifically recommended if a woman experiences symptoms related to depression.

The materials in the remaining seven states provide a less balanced view of the emotions a woman may experience after having an abortion. In three of these states—Michigan, Nebraska and South Carolina—the materials exclusively detail negative mental health outcomes. In Nebraska, for example, the materials state that “some women experience reactions such as sadness, grief, regret, anxiety and guilt,” and information on the possible positive feelings is not included. Moreover, in South Dakota, Texas, Utah and West Virginia, the materials go even further, asserting either that a woman may experience suicidal thoughts or that she will suffer from what abortion foes call “postabortion traumatic stress syndrome.” Materials issued in West Virginia, for example, claim that after abortion many women suffer from symptoms including eating disorders, sexual dysfunction, suicidal thoughts and drug abuse. Notably, neither the American Psychological Association nor the American Psychiatric Association recognizes this disorder.

Fetal Pain

Another assertion that is often used by abortion opponents to discourage women from having abortions is that a fetus has the ability to feel pain; however, researchers have not been able to conclusively determine at what point in development, if at all, a fetus perceives pain. According to a 2005 article in the *Journal of the American Medical Association* analyzing the available research on brain development, the sensory system that is necessary to feel pain develops between 23 and 30 weeks’ gestation. For a fetus

to perceive pain, however, not only must the physical structures be in place, they must be able to transmit sensory information and the fetus must be able to interpret the information. The limited data available suggest that this is unlikely to occur until at least 29 weeks’ gestation.

Mandated information on the fetus’ ability to feel pain—arguably the most egregious example of medical inaccuracy in state abortion counseling materials—appears in the materials developed in five states (see table, column 5). In three of these states, the health department has acted under the direction of the legislature, whereas the other two have included the information without a legal mandate. (Two other states are worth noting here. Oklahoma law requires fetal pain to be included in the materials; however, the health department has yet to publish them. And, Illinois enacted a separate postviability law in 1984 that requires a physician to tell a woman obtaining an abortion after viability that the fetus may feel pain and to offer her the option of anesthesia for the fetus.)

The materials differ across the five states. Materials in three states (Arkansas, Georgia and Minnesota) identify 20 weeks as the point at which the fetus may begin to feel pain. In Arkansas and Georgia, the materials include a statement dictated by the legislature claiming that at 20 weeks’ gestation, “the unborn child has the physical structures necessary to experience pain” and that “unborn children seek to evade certain stimuli in a manner that in an infant or an adult would be interpreted to be a response to pain.” In Minnesota, the materials state that experts’ opinions differ over whether a fetus can feel physical pain at 20 weeks’ gestation or later in gestation.

In the two remaining states, the materials suggest that pain may be perceived even earlier in pregnancy. The South Dakota materials do not specify an age; instead, they state generally that an “unborn child may feel physical pain.” The Texas materials suggest that pain perception can occur as early as 12 weeks’ gestation, although “some experts have concluded that the unborn child is probably able to feel pain” at 20 weeks.

Notably, in all five states this information is required to be provided to every woman regardless of her stage in pregnancy.

Referrals

In *Casey*, the Supreme Court ruled that it is within the boundaries of informed consent for abortion counseling laws to require additional information that could be useful to a woman should she decide to continue her pregnancy. Accordingly, materials in 20 states provide directories with contact information for resources that offer a range of support services, including adoption services, financial assistance, child care, health services and prenatal care (see table, columns 6 and 7). The referral information can be

as brief as referring the woman to a toll-free hotline or as detailed as a list of organizations arranged by county or type of service provided.

In all 20 states, these directories include contact information for organizations commonly known as “crisis pregnancy centers” (CPCs). CPCs often bill themselves as organizations that provide comprehensive services and support to women with unplanned pregnancies, including abortion counseling, information on adoption, parenting classes, and baby clothes and equipment. According to a recent report released by Rep. Henry Waxman (D-CA), however, CPCs often provide false and misleading information to pregnant women about the health effects of abortion

Crisis Pregnancy Centers Provide ‘Erroneous Facts and Misinformation’

In July 2006, Rep. Henry Waxman (D-CA) released the results of an investigation examining the scientific accuracy of information provided by federally funded crisis pregnancy centers (CPCs), which have received over \$30 million in federal funds under the Bush administration since 2001. (According to the report, most of these funds are not used for abortion counseling, but instead for abstinence-only education.

However, CPCs receive additional federal funding for general “capacity building” activities.) The investigation was conducted by minority staff for the House Committee on Government Reform. Committee investigators called 25 centers that receive federal capacity-building grants, posing as pregnant 17-year-olds who were considering abortion and were seeking additional information on the procedure. The investigators reached a CPC staffer at 23 of the 25 centers.

According to the report, an overwhelming majority of the centers—20 of the 23—provided “false or mis-

leading information” on the physical and mental health risks of abortion to pregnant women. For example, eight centers told women that their chance of developing breast cancer will rise substantially if they have an abortion. One clinic in particular said there was a 50% greater chance that a woman will develop cancer after an abortion, whereas another said the likelihood could be as high as 80% greater.

In addition, seven centers informed the caller that there is an increased risk of fertility problems after abortion. One center told the caller that having an abortion “could destroy your chances of ever having children again.”

Also, 13 of the 23 centers told callers that having an abortion would cause a host of detrimental mental health outcomes. One center, for instance, said that after an abortion, the risk of suicide “goes up by seven times.” Others asserted that women could suffer from a range of negative outcomes such as guilt, numbness,

anxiety, drug use, eating disorders and sexual dysfunction.

Alarming, this investigation also highlighted the fact that CPCs often mask their antiabortion agenda to attract pregnant women who are seeking medical advice and dissuade them from obtaining an abortion. Many centers act under the guise of organizations that provide pregnant women with a comprehensive set of options, including abortion services, even though CPCs neither provide abortions nor referrals for abortions. After pulling together the results of the investigation, the authors concluded, “A pregnant teenager who relied on the information from these federally funded centers would make her decision about whether to give birth or terminate her pregnancy based on erroneous facts and misinformation.” The report demonstrates the extent to which CPCs grossly distort the facts when it comes to discussing the risks associated with abortion—all in an effort to promote an antiabortion message.

in hopes of dissuading them from seeking an abortion (see box). Furthermore, according to a June 2006 report by the National Abortion Federation (NAF), the extent to which CPCs “provide real services to women is not as great as they often lead women to believe.” Markedly, our analysis found that only two states, Georgia and Wisconsin, include a description of CPCs that clearly indicates that they may not provide comprehensive services and that they are antiabortion organizations.

Moreover, even though women considering abortion are, by definition, sexually experienced and at risk of experiencing a subsequent unplanned pregnancy, only 13 of the 20 states provide women with referral information for family planning services. Typically, these lists include contact information for local clinics where contraceptive devices and counseling can be obtained.

The Future of Abortion Counseling

Our analysis of state abortion counseling laws and materials reveals that policymakers and public health officials frequently disregard the basic principles of informed consent in favor of furthering a highly politicized antiabortion goal. And, all signs point to their continued interest in doing so. Abortion-specific “informed consent” legislation was introduced in 27 states this year. In some cases, the bills would establish new counseling mandates in states without such a requirement; in others, the bills would amend current counseling requirements. For example, legislation in 12 states would amend current law to require that women be given information on fetal pain. A bill in one state seeks to add information, although discredited, on the link between abortion and breast cancer.

This phenomenon, moreover, is not limited to state-level politics; it also plays a role on Capitol Hill. In 2004, the federal “Unborn Child Pain

Awareness Act” was introduced in both the House and Senate by Rep. Chris Smith (R-NJ) and Sen. Sam Brownback (R-KS). Similar to measures passed on the state level, the legislation would require abortion providers to recite a congressionally scripted statement that Congress

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has determined “an unborn child has the physical structures necessary to experience

pain.” The bill would also require providers to offer to administer anesthesia to the fetus. According to NAF, however, there is currently no established regimen for administering anesthesia to a fetus during an abortion procedure; NAF’s position is that anesthesia should not be administered to a fetus outside of a clinical trial, because doing so poses a risk to the woman.

Maintaining the scientific integrity of abortion counseling information goes beyond politics—it is a matter of sound public health policy. Despite the fact that the Supreme Court upheld the legality of abortion-specific mandates and said that a state could express its preference for childbirth over abortion, the Court did not clear the way for the provision of medically inaccurate information that effectively could negate a woman’s ability to make an informed decision regarding her own life and health. State and federal policymakers have an obligation to uphold the integrity of information related to the health effects of abortion when enacting these counseling laws, and state departments of health (as well as Congress, if it gets into the act) have an equal obligation when developing the materials. In the current political context, holding policymakers accountable to these informed-consent obligations may be an uphill battle, but it is no less urgent for being so. www.guttmacher.org