Chapter 18

Informed Consent and Abortion: A Woman's Right to Know

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Over the past 30 to 40 years patient autonomy – the principle that patients have the right to know about the nature and the risks of the treatments they are being asked to undergo – has become widely accepted. As a consequence, the idea of informed consent has also developed and become much broader. The courts have established that patients have the right to full information from their doctors about the risks involved in medical treatment, even when the risks are slight. Doctors who fail to provide full information about these risks, and to ensure that their patients have understood the information, are liable to prosecution.

Based on an analysis of nearly 500 medical studies, *Women's Health after Abortion* has documented significant risks associated with induced abortion. They include hemorrhaging, uterine perforation, infection, infertility, subsequent ectopic pregnancy, premature delivery, and death. Doctors have a duty to educate themselves about these risks, and to relay this new knowledge to patients contemplating abortion.

Informed Consent and Abortion: A Woman's Right to Know

The concept of informed consent has evolved considerably over the past century. It began with an early recognition that doctors should not violate the bodily integrity of another person without their permission. From there it progressed to the current concept that informed consent, properly understood, must be considered an essential ingredient of good patient care.

Most medical schools now foster some instruction in law and ethics, exploring the nuances of how truly informed consent is realized when doctors and patients enter into a discussion about proposed treatments or procedures. The concept of informed consent has been clarified and broadened by legal cases before the Supreme Courts of the United States and Canada, and by similar courts in other western countries. A legal precedent is often established when a lawsuit against a physician is advanced on behalf of a patient who has suffered a serious complication of a treatment or procedure about which they feel they were not properly warned. A number of patients have been successful and awarded damages by the courts.

Informed Consent in Law

Some of the principles involved in the current legal concepts of informed consent could apply directly to the situation where a woman is considering an induced abortion.[1] The following summary of pertinent health law is drawn from *Canadian Health Law and Policy* and *Legal Liability of Doctors and Hospitals in Canada*.

- The doctor is ultimately liable for information given to a patient, whether or not this has been delegated to a nurse or resident.

- The standard of disclosure has shifted to what a "reasonable or prudent" patient or person might want to know about a procedure, rather than what a "reasonable" doctor might disclose.

• Although the Supreme Court of Canada has allowed that doctors can withhold important information from patients for extenuating or other circumstances, this "therapeutic privilege"[2] should only be exercised in a truly exceptional situation and should not be used to interfere with the patient's right to be informed. Using the information to manipulate a patient's decision, or to protect the health care professional is "ethically inappropriate". The legal role of the information is to allow the patient to exercise choices that accord with his or her wishes.[3]

• Court cases have tended to focus on what the patient was told, but Canadian Chief Justice Bora Laskin has stated that the health care professional must make sure that the patient has understood what he or she was told, particularly if there is a language difference, or extensive technical detail given by the doctor.

• Common but minor risks such as pain after surgery must be disclosed. Rare risks must also be disclosed if they have serious or fatal consequences.

The following are examples of rare risks that were not disclosed to patients, but which resulted in the doctor being found liable:

- A fatal reaction to the dye used in an intravenous pyelogram. The risk ranges between one in 40,000 and one in 100,000.

- Stroke or paralysis from neck manipulation. Here the risk is between one in 100,000 and one in 300,000.

Elective procedures (for example induced abortion) require a greater degree of disclosure than emergency procedures.

Furthermore, the complications from induced abortion, as outlined in this book, carry a risk many times greater than those associated with diagnostic kidney procedures, neck manipulation, etc. It would not be surprising, therefore,

to see lawsuits due to failure to obtain proper informed consent to the abortion procedure.

Informing Consent Prior to Abortion

Although the practice of abortion has largely broken free of legal restraint in many western countries, intense ongoing social debate about its morality has distracted the medical profession from the type of close scrutiny to which other forms of surgery are subject. The findings of *Women's Health after Abortion* on the breadth of serious potential complications of induced abortion reported throughout the world literature, raise the question of just how informed is the consent obtained from women who presently seek abortion as a solution to an unwanted or troubled pregnancy.

The full realization of patient autonomy in this setting depends on three aspects of medical consent:

1. How *well informed* is the patient?
2. Is the patient fully *competent*, at that moment, to make such a major decision?
3. To what extent is consent given *voluntarily*?

Uninformed Consent

In the context of abortion, the likelihood of uninformed consent is very real. Aside from the natural reluctance of abortion doctors to disclose their true immediate surgical complication rate, these practitioners are not in a position to outline medium- or longer-term complications of the procedure, even if they were inclined to do so. Private abortion clinics do not provide after-hours care, or any form of higher-level care for complications such as excessive bleeding, uterine perforation, or systemic infection. Moreover, abortion doctors are unlikely ever to learn of later sequelae such as infertility, life-threatening ectopic pregnancy, subsequent birth prematurity (with its high rate of cerebral palsy), or the late complications of any needed blood transfusions. Nor are they trained to weigh the risks of non-gynecological complications such as breast cancer or depression. As this book documents, the potential complications of abortion are complex, and continue to be uncovered by new research,

as the first generation of women to whom abortion was widely available now reaches middle age.

U.S. courts have ruled that it is a doctor's "continuing duty" to inform patients, with up-to-date information, of potential risks. In a similar vein, the Canadian Supreme Court has ruled that manufacturers have a "continuing duty"[5] to inform customers of developing risks. Finally, the marked political polarization of the morality of abortion raises the question of whether individual or establishment bias may prevent these complications from being revealed, in the literature and in consent discussions, thus subverting a woman's access to full disclosure.

Competent and Voluntary

The competence of a woman seeking abortion is often assumed because of her young age and otherwise good health. However, competence is relative, and the highly charged atmosphere of an abortion decision may not be conducive to a woman who is emotionally vulnerable, and may be in the midst of a frank clinical depression. True respect for the woman's ability to make a potentially life-altering decision to abort her pregnancy recognizes that depression and other emotional issues may need to be addressed first, especially for a procedure that is almost always elective.

Finally, the voluntary nature of the abortion consent must be considered in context. Many women are referred by a family physician or clinic to a private abortion clinic or hospital gynecologist without an in-depth exploration of the potential risks and complications, on the assumption that "the specialist will deal with it". In fact, the procedure is often then "booked", and, at times, the first and only opportunity for a woman to enter into a discussion to inform her "consent" is on the surgical stretcher as a pre-operative patient, a highly coercive setting in which all of the individuals around her have an expectation of acquiescence.

A Woman's Right to Know

A British inquiry into the physical and psycho-social aspects of abortion found it difficult to establish how much informa-

tion is actually given to women prior to abortion. Medical practitioners in Australia and New Zealand have reported concerns over the dearth of information about risks given to women considering abortion. As well, the inadequacy of the current voluntary system of reporting by Statistics Canada and the World Health Organization has led some to call for mandatory reporting of abortion complications.

In order to regulate the timely disclosure of pertinent information to women by abortion providers, fourteen American states have enacted "women's right to know" statutes.[6] At time of writing at least ten other states are considering similar statutes. The Virginia statute mandates a 24-hour wait for women seeking abortion, requiring the facility to give women an explanation of abortion risks, dangers and alternatives, and then wait at least a day before performing the abortion.

The Louisiana Department of Health and Hospitals Act requires a physician to present a document outlining the risks of medical and psychological complications both of pregnancy and abortion, as well as showing various states of fetal development. Pennsylvania includes information about assistance available should the woman decide to carry her pregnancy to full term.

The American Supreme Court has upheld the constitutionality of laws that protect the right of informed consent prior to abortion. In its 1992 ruling upholding the Pennsylvania law the court declared, "In attempting to ensure that a woman apprehend the full consequences of her decision, the State furthers the legitimate purpose of reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed."[7]

Conclusion

The unique medical, psychological and political issues surrounding induced abortion pose a challenge to the often frail practice of informed consent. Since the only true choice is an informed choice, women who are considering an

abortion, and the doctors and other health workers who provide them, bear a particular responsibility to ensure that any consent is obtained with full and comprehensive disclosure of the potential risks, that it is fully understood, and that it is presented in a non-coercive setting.

Key Points Chapter 18

- The concept of informed consent has been clarified and broadened by the Supreme Courts of the United States and Canada, as well as by courts in other western countries.

- The courts have ruled that doctors have a "continuing duty" to be familiar with up-to-date information about potential and developing risks of treatments or procedures in order to inform patients properly.

- The standard of disclosure has shifted to what a "reasonable or prudent" patient might want to know about a procedure, rather than what a "reasonable" doctor might disclose.

- Common but minor risks must be disclosed, while rare risks must be disclosed if the consequences are potentially serious or fatal.

- The doctor must also ensure that the patient has understood what he or she has been told.

- Doctors who fail to inform their patients about the documented risks associated with induced abortion may be liable to prosecution in the courts.

Notes

1 Picard EI and Robertson GB. *Legal Liability of Doctors and Hospitals in Canada*. Toronto: Carswell, 1996; Chapter 3. 110-157.

Dickens BM. "Informed Consent: The Doctor's Duty of Disclosure" Chapter 5 in Downie J. and Caulfield T. *Canadian Health Law and Policy*. Toronto: Butterworths, 1999; pp. 117-141.

2 Dickens 1999. See n. 1, p. 137.

3 Dickens 1999. See n. 1, p. 118.

4 Picard and Robertson 1996. See n. 1, p. .127.

6 Picard and Robertson 1996 . See n. 1, p. 153.

5 Arkansas, Kansas, Louisiana, Michigan, Mississippi, Nebraska, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Utah, Virginia, and Wisconsin.

7 Planned Parenthood of Southeastern Pennsylvania v. Casey, 112 S. Ct. 2791, 2823-24 (1992).