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Counseling the Abortion-Vulnerable Patient

Induced abortion is defined as a procedure done to end a pregnancy in such a manner as to avoid a live birth, i.e., intentional feticide. Many physicians will encounter patients considering intentional feticide (induced abortion) for various reasons. Such interactions present an opportunity not only to create a lasting bond with the patient, but also to open doors for her to explore possibilities she may not have considered, and thereby enable her to make a life-affirming decision. Given the importance of offering accurate information about induced abortion and continuation of pregnancy, this Guideline provides guidance and resources for the pro-life physician encountering an abortion-vulnerable patient.

Background

Epidemiology

According to the Centers for Disease Control, the percentage of U.S. pregnancies that were unintended declined from 43.3% in 2010 to 41.6% in 2019. Larger percentage declines in unintended pregnancy rates were seen among younger age groups, and those patterns were mirrored for pregnancy rates overall, declining by 52% for teenagers aged 15-19.[1] By 2011, unintended pregnancy rates[2] were highest among those who:

- Were 18 to 24 years of age
- Had low income
- Had not completed high school
- Were non-Hispanic black
- Never married, not cohabiting

Stulberg et al. reported in 2011 that 97% of practicing obstetrician-gynecologists in the United States encounter patients seeking intentional feticide (induced abortion).[3] Finer et al. (Guttmacher Institute) reported:

> …the two most common reasons (for having an abortion) were "having a baby would dramatically change my life" and "I can't afford a baby now"… A large proportion of women cited relationship problems or a desire to avoid single motherhood (48%). Nearly four in 10 indicated that they had completed their childbearing, and almost one-third said they were not ready to have a child. Women also cited possible problems

AAPLOG Practice Guideline. This document was developed by 5 authors on the Research Committee. Practice Guidelines are evidence-based documents informing pro-life providers with high-quality, peer-reviewed literature.

affecting the health of the fetus or concerns about their own health (13% and 12%, respectively).[4]

Definitions

The following definitions were modified from *Excellence of Care: Standards of Care for Providing Sonograms and Other Medical Services in a Pregnancy Medical Clinic.*[5]

The *abortion-vulnerable* patient is one who by continuing her pregnancy faces challenges and problems that she may feel unprepared or unable to manage. She may tell her physician that she is considering induced abortion, may feel that abortion is her only or best option, or simply may not have ruled out induced abortion. She may have a medical condition affecting her decision-making.

An *abortion-minded* patient is one who is planning to obtain an abortion or who has already initiated the process by making an appointment with an abortion clinic, having laminaria placed, or taking abortion-inducing drugs or herbs.

Although this Practice Guideline uses primarily the term "abortion-vulnerable" for the sake of clarity, the same counseling concepts and techniques may be applied as needed for an abortion-minded patient who is open to having a conversation.

Challenges

The practicing OB/GYN faces several challenges in counseling abortion-vulnerable patients. Clinic time may be limited, and patients may require more counseling time than is scheduled.[6-9] Some physicians may feel discomfort, or perhaps an inner conflict stemming from a desire not to condemn or alienate the patient while at the same time feeling an obligation to protect the life of the unborn. Patients themselves may feel uncomfortable discussing their circumstances because of coercion from partner or family or worries about school or finances.

Ethical Responsibilities

In counseling the abortion-vulnerable patient, fundamental values to consider are respect for the dignity of human life, and the duty to alleviate suffering and distress by working with community resources to help meet needs and eliminate obstacles, making life-affirming choices as easy as possible for the patient. Previously established ethical systems can be applied to counseling the abortion-vulnerable patient:[10-12]

Fidelity to the patient involves protection of confidentiality, a duty to provide accurate information concerning their health and that of their preborn child, and a commitment to remain available to help and support the patient as she works through her decisions.

Autonomy means that the patient ultimately decides the intended outcome of her pregnancy. The physician counseling her aims to improve her ability to make a well-informed decision. It is important for a pro-life OB/GYN to represent all data honestly.

Beneficence moves the physician to act for the benefit of both the maternal and fetal patients.

Non-maleficence is the responsibility to mitigate, while still respecting autonomy, any harm to either the maternal patient or her preborn child. This includes patient safety.

Justice means that with utmost respect for the dignity of *all* human life, we should do our best to ensure that every patient has accurate information concerning her health and that of her unborn baby and is offered support and counseling regarding viable options that enable her to continue her pregnancy, regardless of socioeconomic status, sexual orientation, or ethnic background.

General Counseling Technique and Content

Preparation is very important to good counseling of abortion-vulnerable patients. A physician can improve his or her counseling by considering counseling technique, community resources (including in-office literature and relationships with local pregnancy care centers), and evidence before being faced with an abortion-vulnerable patient.

While counseling content may vary from one patient to the next depending on individual patient needs, this Practice Guideline aims to provide the physician with a number of topics which can be considered for discussion. In general, it is wise to start by asking questions, expressing empathy, and learning about the patient's situation.

If the patient has brought up the subject of induced abortion, an appropriate opening question may be "How do you feel about abortion?" Some patients will express a belief that induced abortion is objectionable. She may say something like, "Well… I never thought I'd even consider it, but…" or "I never believed in it, but…" In this case, the physician may need only to encourage fidelity to her deeply held beliefs, then go on to discuss how to overcome hurdles and challenges that make continuing the pregnancy seem difficult. However, the practicing OB/GYN is likely to see women of diverse faith backgrounds whose situations are complicated, leading to a more complex decision-making process. The physician can help the patient to identify other areas of discussion, including perceived barriers to pregnancy continuation and avoiding coercion, many of which are listed in Box 1.

Table 1. Counseling topics for the abortion-vulnerable patient.
The woman's own feelings about parenting, adoption, and abortion
Perceived barriers to continuation of pregnancy
Your role in emotional support, encouragement, and obstetrical care if she continues the pregnancy
Your identity as a pro-life physician (i.e., she can trust you to provide care for her *and* her baby)
Open adoption
Dealing with pressure and coercion, even from people with whom the patient has a positive relationship
Fetal development
Fetal pain
Induced abortion procedures, including induced abortion by surgery or by chemical agent
Risks of abortion • Claims that abortion is safer than childbirth highly questionable, drawn from incomplete data • Preterm birth • Effects on mental health • Hemorrhage • Uterine perforation (surgical abortion only) • Injury to surrounding organs (surgical abortion only)

• Infection • Particular risks associated with self-managed induced abortion
Abortion pill rescue

Part of comprehensive counseling is to encourage the patient to gather as much information as possible and to take time to understand and consider it carefully.[7-13] Assure her that she does have options and that you will make yourself available in the decision-making process and for support during her pregnancy. Use language of empowerment to specifically advise her to resist coercion and focus on making a decision that she will be comfortable with for her entire life. As you listen to and counsel the patient, be aware of signs of human trafficking, listed in Box 2.

Table 2. Red flags for human trafficking.

Working and living conditions: • Is not free to leave or come and go as he/she wishes • Is in the commercial sex industry and has a pimp/manager • Is unpaid, paid very little, or paid only through tips • Works excessively long and/or unusual hours • Is not allowed breaks or suffers under unusual restrictions at work • Owes a large debt and is unable to pay it off • Was recruited through false promises concerning the nature and conditions of his/her work • High security measures exist in the work and/or living conditions (e.g., opaque windows, boarded-up windows, bars on windows, barbed wire, security cameras, etc.)
Mental health and behavioral conditions: • Is fearful, anxious, depressed, submissive, tense, or nervous/paranoid • Exhibits unusually fearful or anxious behavior after bringing up law enforcement • Avoids eye contact
Physical conditions: • Lacks medical care and/or is denied medical services by employer • Appears malnourished or shows signs of repeated exposure to harmful chemicals • Shows signs of physical and/or sexual abuse, physical restraint, confinement, or torture
Lack of control: • Has few or no personal possessions • Is not in control of his/her own money, no financial records or bank account • Is not in control of his/her own identification documents (ID or passport) • Is not allowed or able to speak for themselves (a third party may insist on being present and/or translating)
Other • Claims of just visiting and inability to clarify where he/she is staying/address • Lack of sense of time, or knowledge of whereabouts and/or of what city he/she is in • Has numerous inconsistencies in his/her story
Modified from the national Human Trafficking Resource Center

In counseling the abortion-vulnerable patient, avoid criticism, marginalizing her emotions, or telling her what to do.[6]

If possible, offer to perform (or order) an ultrasound. Dating the pregnancy, determining viability, and ruling out ectopic pregnancy will be necessary regardless of her decision. Ultrasound also affords the opportunity for your patient to actually see the life she is carrying. Women value the information gained from ultrasound.[14] While it is unclear exactly how many women choose life because of ultrasound,[15,16] experience has shown that many women choose to continue their pregnancies when allowed to see an ultrasound.[17,18]

Finally, it is generally useful to offer a follow-up appointment to continue your discussions, answer questions that have come up, or repeat the ultrasound examination. You may offer to see the patient and/or her family more frequently so that she can benefit from your understanding and willingness to listen. Let her know that you will make any referrals needed for her to receive the best care.

Clinical Questions and Answers

Q *I am faced with an abortion-vulnerable patient in my office now and I don't have time to sift through literature or form relationships with the local pregnancy care center. Who can help me right now?*

AAPLOG.org hosts multiple documents, such as this, that condense useful information. It also provides a list of pro-life physicians, who may have additional local resources or may form a referral base.

The following websites and hotlines will be useful. The first three sites listed provide comprehensive option counseling and do not refer for induced abortion.

- Optionline.org, call 1-800-712-HELP (4357)
- Options for Women, call 888-652-1140 or text "HELPLINE" to 313131
- Pregnancydecisionline.org, call 866-406-9327
- Lifetimeadoption.org is devoted to helping women understand and consider adoption.
- Care-net.org and Heartbeatinternational.org are websites devoted to pregnancy care centers, with a Christian emphasis.
- Abortionpillrescue.com provides a telephone hotline and online chat for women who have initiated an induced abortion with mifepristone and are reconsidering their decision. The website also provides information about chemical induced abortion and the reversal process.
- Live Action has a website called Abortionprocedures.com in which abortionists who have performed hundreds and even thousands of induced abortions describe the most prevalent abortion

procedures at every state of pregnancy, accompanied by medical animations.

- BraveLove (bravelove.org) is a pro-adoption movement dedicated to changing the perception of adoption by acknowledging birth moms for their brave decisions.
- When there is a concern about human trafficking, the National Human Trafficking Resource Center can be reached at 1-888-373-7888, or by texting "HELP" to 233733 (BEFREE). There is also an online chat available at www.humantraffickinghotline.org.

Q *How can a busy OB/GYN begin to establish rapport with an abortion-vulnerable patient?*

Try to create a suitable environment and a relationship with the patient that makes her feel comfortable and safe to express herself. It is helpful to show empathy and make an effort to understand her situation from her perspective. The patient must have a sense that the physician counselor is sincere. She must know that she can count on you and your staff to follow through with the support and help you offer.

Q *Are special laws in effect for minors participating in sex work?*

Yes. According to federal law, any minor under the age of 18 engaging in commercial sex is a victim of sex trafficking, regardless of the presence of force, fraud, or coercion.

Q *What about the case of the patient whose fetus has anomalies?*

Patients and their families who receive a life-limiting fetal diagnosis may choose perinatal palliative care, an active approach that manages symptoms of anxiety and isolation, and openly manages anticipatory grief. Perinatal palliative care has similar rates of maternal complications and maternal regret as induced abortion. Induced abortion has not been found to be an effective way to curtail or prevent grief when a life-limiting perinatal diagnosis is encountered, so parents may readily consider perinatal palliative care. Retrospective cohort studies demonstrate that perinatal palliative care is readily taken up by patients and healthcare professionals; limited prospective evidence suggests that perinatal palliative care may improve maternal anxiety, communication, and family relationships. Offering perinatal palliative care should be part of every obstetrician/gynecologist's counseling when adverse pre-natal diagnoses are made.[19,20] Please see AAPLOG's Practice Guideline Number 1, "Perinatal Palliative Care and Perinatal Hospice."

Q *What language can be used in a short time to describe fetal development?*

The following is an excerpt from the AAPLOG Patient Guide pamphlet: "Your unborn child is a person. At about 22 days after fertilization, your child's heart begins to circulate his or her own blood, unique from your own, and has a heartbeat that can be detected on ultrasound. At just six weeks after fertilization, your child's eyes and eyelids, nose, mouth, and tongue can be seen. Then just ten weeks after fertilization, your child can make bodily movements. Around week 19-21, your child can hear. From fertilization on, your child is a human being and a human person, uniquely distinct from you. Your child is alive, and every life is a previous and valuable gift."

Q *When can fetuses feel pain?*

A human fetus may feel pain by as early as 12 weeks' gestation, and fetuses respond to touch as early as 7.5 to 8 weeks.[21,22] For more information, refer to AAPLOG's Practice Guideline Number 2, "Fetal Pain."

Q *How much does abortion increase a patient's risk of subsequent preterm birth?*

Overwhelming evidence from more than 160 studies over fifty years points to a clear dose-response relationship between surgical induced abortion and subsequent preterm birth.

One prior surgical induced abortion is associated with statistically significantly higher odds of subsequent preterm birth, corresponding to a 13-14% risk, compared to the baseline rate of 10% in the United States. Two or more prior surgical induced abortions are associated with significantly higher odds of subsequent preterm birth, corresponding to an 18% risk of subsequent preterm birth, compared to the baseline rate. One prior surgical induced abortion is associated with significantly higher odds of having a subsequent very preterm birth (either 32 or 28 weeks' gestation), corresponding to a 2.3% risk, compared to the baseline rate of 1.5% in the United States.[23-51]

If an induced chemical abortion fails and requires surgical completion, the risk of preterm birth following surgical completion will be at least as high as a primary surgical induced abortion.

Helping patients understand why preterm birth is to be avoided can be helpful. Preterm birth can have both short-term and long-term health risks for the neonate. Short-term risks include the hurdles in respiratory and digestive function that neonatal intensive care patients deal with daily. In addition, preterm birth leads to an increased risk for some long-term complications, such as cerebral palsy, impaired vision and hearing, behavioral and psychosocial difficulties, and impaired cognitive development.[28,29]

Q *Is induced abortion safer than childbirth?*

One cannot state that induced abortion is safer than childbirth. To quote Dr. David Reardon, "It is almost impossible to accurately compare deaths related to induced abortion and deaths related to childbirth in the U.S. due to incomplete reporting, definitional incompatibilities, voluntary data collection, research bias, reliance upon estimates, political correctness, inaccurate and/or incomplete death certificates, incompatibility with maternal mortality statistics, and failing to consider other psychologic causes of death, including suicide."[52] Looking at population research done in other countries,[55-59] "we see a different conclusion, that women are far more likely to die in the year following an induced abortion than they are following childbirth." For more information, please refer to AAPLOG's *Top 10 Myths About Abortion,* page 28, "Abortion is Safer than Childbirth."[52-60]

Q *How much does abortion increase a patient's risk of mental health problems?*

It may be important for the abortion-vulnerable patient to understand that although many induced abortions are purportedly done to prevent or reduce mental health risks, the medical literature offers no evidence that induced abortion reduces mental health risk.[61,62] In fact, while some claim no induced-abortion-related mental health risk, there are numerous studies,[61-100] including a carefully designed meta-analysis in 2011,[63] revealing induced abortion as a significant risk factor for mental health problems. Summarizing the medical literature, Dr. Priscilla Coleman has stated, "For a significant number of women, abortion initiates a life trajectory characterized by feelings of grief, loss, alienation from others, and mental health challenges."[101]

Some risk factors place women at especially increased risk for mental health complications after induced abortion. These are detailed in AAPLOG's Practice Guideline Number 7, "Abortion and Mental Health." These include:

1. Perceptions of the inability to cope with the induced abortion
2. Low self-esteem
3. Difficulty with the decision
4. Emotional investment in the pregnancy
5. Perceptions of one's partner, family members, or friends as non-supportive
6. Timing during adolescence or being unmarried
7. Pre-existing emotional problems or unresolved traumatization
8. Involvement in violent relationships
9. Traditional sex-role orientations
10. Conservative views of induced abortion and/or religious affiliation
11. Intended pregnancy
12. Second trimester

13. Pre-abortion ambivalence or decision difficulty
14. Involvement in unstable partner relationships
15. Feelings of being forced into induced abortion by one's partner, others, or by life circumstances

For more information, please refer to AAPLOG's Practice Guideline Number 7, "Abortion and Mental Health."[102]

Q *Does induced abortion increase a patient's risk of breast cancer?*

There exists evidence that induced abortion of a first pregnancy, especially for teens and women over the age of 30, increases breast cancer risk. The mechanism is thought to be stimulation of stem cell breast tissue (Type 1 and 2) in early pregnancy but lack of terminal differentiation which occurs after elaboration of human placental lactogen (HPL) by the placenta after 20 weeks' gestation. HPL is required for terminal differentiation of breast tissue to lactational tissue, which is cancer resistant. Studies which look at the subset of women who abort after previous term pregnancies do not show as strong an association. There is biologic plausibility as well as epidemiologic evidence[109-128] for a causal association between abortion and breast cancer. Please see AAPLOG's Committee Opinion Number 8, "Abortion and Breast Cancer."[128]

Q *What options are available for a patient who has taken mifepristone but then changes her mind?*

For patients who have already taken mifepristone, but not misoprostol, there is as high as 68% chance of saving the pregnancy by following an abortion pill reversal protocol.[129] A patient who chooses this treatment should know that there is no evidence that her fetus is at increased risk for birth defects after she takes mifepristone.

Utilizing the data from the 2018 Delgado study,[129] two protocols can be recommended for women who change their minds after taking mifepristone and want to halt the chemical induced abortion process.

1. High Dose Oral Protocol
   Progesterone micronized, 200mg capsule – two by mouth as soon as possible and continued at a dose of 200mg capsule, two by mouth, twice a day for three days, followed by 200mg capsule, two by mouth at bedtime until the end of the first trimester. Oral progesterone should be taken with food to improve absorption. Micronized progesterone should be avoided in women with peanut allergies.

2. Intramuscular Protocol
   Progesterone, 200mg intramuscular as soon as possible and continued at a dose of 200mg intramuscular, once a day on days

two and three, then every other day for a total of seven injections. This protocol is suitable for women with peanut allergies. Some clinicians may choose to continue intramuscular treatment longer since this recommendation is based on relatively small numbers.

For more information, please refer to AAPLOG's Practice Guideline Number 6, "The Reversal of the Effects of Mifepristone by Progesterone."[130] Also, you may contact the Abortion Pill Reversal Network: abortionpillrescue.com.

Q *What risks should patients be made aware of who are considering self-managed induced abortion?*

Currently, more than 50% of induced abortions in the U.S. are induced abortions with chemical agents[131] and self-managed chemical abortion is being actively promoted.[132] In addition to the four-fold increased complication risk associated with chemical induced abortion, principally due to hemorrhage,[133] self-managed induced abortion carries additional significant dangers for patients. Because errors in gestational age estimation are bound to occur, there is a risk of consuming mifepristone in the second trimester when complication and mortality risk will be much higher. Risk of death from undiagnosed ectopic pregnancy and risk to future pregnancies from Rh incompatibility also present themselves with self-managed induced abortion.[132]

Summary of Recommendations and Conclusion

The following recommendations are based on good and consistent scientific evidence (Level A):

1. Physicians should provide significant support and encourage the patient to gather as much information as possible and take time to make a decision.
2. Patients may be counseled that induced surgical abortion and induced chemical abortions which need to be completed surgically increase risk for preterm birth in subsequent pregnancies.
3. An ultrasound is required prior to a medical/chemical abortion to document gestational age, viability of embryo/fetus, and intrauterine pregnancy to rule out ectopic pregnancy.

The following recommendations are based on limited and inconsistent scientific evidence (Level B):

1. Patients may be counseled that induced abortion causes increased risk for mental health problems and possibly breast cancer.
2. For patients who have taken mifepristone, there is as high as 68%

chance of saving the pregnancy by following an abortion pill reversal protocol.
3. Self-managed induced abortion carries significant additional risks to health.

The following recommendations are based primarily on consensus and expert opinion (Level C):

1. Physicians should prepare ahead of time to counsel abortion-vulnerable patients, in particular by studying the literature cited and by forming connections with local organizations that can offer these patients resources.
2. It is important for physicians counseling abortion-minded patients to listen to the patient and ask her about her own feelings about life, adoption, and abortion.
3. Physicians counseling abortion-vulnerable patients should avoid negativity, marginalizing emotions, and paternalism.
4. Experience has shown that many women choose to continue their pregnancies when they see their baby on an ultrasound monitor.
5. Women whose unborn child is diagnosed with a serious or lethal fetal anomaly should be aware of the availability of perinatal palliative care.
6. Pregnancy Care Centers should be used whenever possible.
7. Physicians counseling abortion-vulnerable patients should be aware of signs of human trafficking.

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The MEDLINE database, bibliographies of relevant guidelines, and AAPLOG's internal sources were used to compile this document with citations from 1985 to the publication date. Preference was given to work in English, to original research, and to systematic reviews. When high-quality evidence was unavailable, opinions from members of AAPLOG were sought.

AAPLOG Practice Guideline. This document was developed by 5 authors on the Research Committee. Practice Guidelines are evidence-based documents informing pro-life providers with high-quality, peer-reviewed literature.