

NEGLIGENT PHYSICAL OR EMOTIONAL INJURY RELATED TO INDUCED ABORTION

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I. INTRODUCTION

Despite the U.S. Supreme Court's decriminalization of induced abortion in *Roe v. Wade*¹ in 1973, the right still exists to recover civil damages for negligence in the performance of an induced abortion. However, in order to realize the possibility for recovery of civil damages from abortion related injuries, it is necessary to become acquainted with the range of fact situations which may give rise to an abortion injury, determine the exact nature of the negligence which led to the injury, and ascertain the scope of the physical and emotional damage. This article is limited in scope to instances in which those directly involved in abortion committed negligence or when other acts of negligence resulted in a woman obtaining an abortion which she did not initially desire or request. Claims of injury based upon theories of wrongful birth, wrongful life, or negligent prenatal testing will not be included.

This article is primarily directed to the attorney who is considering whether to represent someone seeking to recover damages for an abortion-related injury. Some of the potential advantages of litigating abortion malpractice cases include: (1) it permits direct confrontation between the injured party and those allegedly responsible for the negligent conduct; (2) it holds accountable those responsible for the negligent conduct, especially in the absence of formal enforceable regulations; (3) existing legal

1. 410 U.S. 113 (1973).

procedures are in place which are specifically permitted under *Roe v. Wade*;² (4) in each state there is an existing body of medical malpractice laws of which abortion malpractice is an integral part; (5) litigation may uncover a systematic pattern of wrongdoing which may lead to action by public officials; and (6) just compensation may be obtained by those who have been injured by abortion. Some possible disadvantages of litigating abortion malpractice cases include: (1) cases are generally limited to errors in the technique of abortion and do not directly challenge the practice of abortion itself; (2) cases are expensive to litigate; (3) cases require a high level of expertise, not only because medical malpractice is a specialized area, but also because of unique problems associated with abortion; (4) potential expert witnesses may not be willing to participate because of the subject matter; (5) cases may become politicized; and (6) the plaintiff's lifestyle and abortion's general stigma may limit recovery.

This comment gives an overview of abortion-malpractice law among the various U.S. jurisdictions. Section II examines several theories under which abortion-related claims may be brought and details the elements of such claims. Section III discusses various ways in which doctors and other medical personnel have been found to breach their duty to women under their care. Finally, Section IV looks at specific types of injury and damages that can give rise to an abortion-malpractice claim.

II. THEORIES OF RECOVERY

A. *Medical Malpractice/Negligence*

The most common type of abortion-related claim is medical malpractice under a negligence standard. Medical malpractice occurs when there are errors of omission or commission by health care professionals that fall below the normal or appropriate standard of care. To succeed in an action for medical malpractice, the plaintiff patient must establish that: (1) a legally recognized duty of care was owed to the plaintiff by the defendant health care professional or a

2. "If an individual practitioner abuses the privilege of exercising proper medical judgment the usual remedies, judicial and intra-professional, are available." *Id.* at 166.

person acting in the capacity of a health care professional; (2) the defendant breached this duty of care;³ (3) the plaintiff suffered a legally recognized injury and has been damaged as a result⁴ and (4) the injury was caused by the breach of duty.⁵

Proper selection and preparation of cases can result in plaintiffs' verdicts in most cases. A 1985 review of medical malpractice cases that resulted in injury from abortion procedures found that jurors held for plaintiffs in 67 percent of the cases.⁶ These cases involved missed⁷ or incomplete abortions,⁸ failure to diagnose an ectopic pregnancy,⁹

3. Failure to establish the proper standard of care will be fatal to plaintiff's case. *Sponaugle v. Pre-Term, Inc.*, 411 A.2d 366 (D.C. App. 1980) (in medical malpractice action for failure to remove an IUD prior to performing an abortion, plaintiff's medical expert failed to state his opinion in terms of a "reasonable medical certainty" and, therefore, judgment was entered for the defendant and affirmed on appeal); *S.A. v. Thomasville Hospital*, 636 So. 2d 1 (Ala. 1993) (plaintiff's expert failed to establish standard of care where woman suffered post-abortion complications and underwent hysterectomy which resulted in summary judgment for the defendants); *Northern Trust Co. v. Upjohn Co.*, 572 N.E.2d 1030 (Ill. App. 1991) (woman who allegedly suffered brain damage as a result of abortion, failed to establish standard of care applicable to defendant); *Baker v. Gordon*, 759 S.W.2d 87, 99 (Mo. App. 1988) (in malpractice action for negligent recommendation of an abortion, plaintiff failed to establish standard of care required when a patient who has an abnormal pap smear is pregnant).

4. W. PAGE KEETON ET AL., *PROSSER AND KEETON ON THE LAW OF TORTS* § 30 (5th ed. 1984).

5. See BARRY F. FURROW ET AL., *HEALTH LAW, CASES, MATERIALS AND PROBLEMS* (3rd ed. 1997); WARREN M. HERN, *ABORTION PRACTICE* (1990); Thomas W. Strahan, *Major Articles and Books Concerning the Detrimental Effects of Abortion*, The Rutherford Institute: Charlottesville, VA, Dec. 1996; David C. Reardon, *Abortion Malpractice*, Life Dynamics Denton, TX (1995); Gary W. Roberts, *Medical Malpractice in Abortion Cases*, 3 AM. J. TRIAL AD. 259 (1979).

6. *Personal Injury Verdict Reviews*, 9 PHYSICIAN & HOSP. NEGL., Sept. 16, 1985.

7. A 1985 Center for Disease Control study found that the overall rate of missed abortions where the woman left the abortion facility thinking she had an abortion, but did not, was 2.3 per 1000 abortion procedures. A.M. Kaunitz, *Abortions that Fail*, 66 OBSTET. & GYNECOL. 533 (1985).

8. The incidence of first trimester suction curettage abortion which left fetal parts for which women needed to be rehospitalized appears to be in the range of 2.4% - 4.8%. Peter Sykes, *Complications of Termination of Pregnancy: a Retrospective Study of Admissions to Christchurch Women's Hospital 1989 and 1990*, 106 N.Z. MED. J. 83 (1993) (from a few days to six weeks following first trimester's suction curettage abortion, 2.4% - 2.6% of women were readmitted to hospital for retained products of conception. At 14+ weeks of gestation using prostaglandin abortion method, 7.8% were readmitted with retained products of conception); K. Dalaker et al, *Early Complications of Induced Abortion in Primigravidae*, 70 ANNALES CHIRURGIAE ET GYNAECOLOGIAE 331 (1981) (follow-up study 4-6 weeks after suction curettage abortion, 4.8% of Scandinavian women had retained fetal parts); F. Jerve & P. Frylling, *Therapeutic Abortion*, 57 ACTA OBSTET GYNECOL SCAND 237

laceration or perforation of the uterus or bladder, formation of scar tissue, sexual dysfunction, and infertility.¹⁰ In addition to these physical injuries, many plaintiffs sustained severe emotional trauma.¹¹ The compensatory verdicts ranged from \$10,600 to \$608,640 and averaged \$307,373. Other serious abortion injuries that may be litigated include the death of the woman,¹² perforation of the bowel, cervical laceration,¹³ post-abortion infections,¹⁴ amniotic fluid

(1978) (4% of women readmitted to hospital with pelvic infections, retained fetal parts being the main cause).

9. An ectopic pregnancy is the union of the egg and sperm and its subsequent development outside the uterus, usually in the fallopian or eustachian tube. The reported incidence of ectopic or tubal pregnancy concurrent with attempted induced abortion ranges from 1.35 per 1000 procedures to 8.7 per 1000 procedures. H.K. Atrash et al., *Ectopic Pregnancy Concurrent with Induced Abortion: Incidence and Mortality*, 162 AM. J. OBSTET. GYNECOL. 726 (1990) (reporting incidence of 1.35 per 1000 from 1970-85); Steven R. Goldstein et al., *An Updated Protocol for Abortion Surveillance with Ultrasound and Immediate Pathology*, 83 OBSTET. & GYNECOL. 55 (1994) (A New York city abortion facility reported an incidence of ectopic and tubal pregnancy concurrent with first trimester induced abortion of 8.7 per 1000).

10. One study by Health Resources, Inc., a private health-care consulting firm in Chicago, reportedly found that at least 310 abortion-related personal injury suits were filed in Cook County, Illinois from 1971 - 1985. Of these, 140, or nearly one-half, came from women who claimed to be sterile. Camille Otto, *Should Abortionists Be Sued?*, FOCUS ON THE FAMILY CITIZEN, Nov. 1988, at 4.

11. Helen P. Vaughan, *Canonical Varieties of Post-abortion Syndrome* (Institute for Pregnancy Loss, Portsmouth, N.H.) (1990) at 35-36 (post-abortion syndrome, especially anger and guilt, is more likely and has greater severity when accompanied by a medical complication); Anne C. Speckhard & Vincent M. Rue, *PostAbortion Syndrome: An Emerging Public Health Concern* 48 J. OF SOC. ISSUES 95 (1992).

12. See generally Hani K. Atrash et al., *Legal Abortion in the United States; Trends and Mortality*, 35 CONTEMP. OB/GYN 58 (1990) (death of the woman from abortion is most common particularly among young, minority women. Frequently, general anesthesia has been used (or misused)); R.M. Selik et al., *Behavioral Factors Contributing to Abortion Deaths: A New Approach to Mortality Studies*, 58 OBSTET. & GYNECOL. 630, 631-32 (1981) (delay in abortion until 13 weeks or later, incomplete abortion, perforation of the uterus, use of instillation procedure when D&E should have been used, and failure to refer patient to another doctor when appropriate, were listed as behavioral factors in deaths from legal induced abortion).

13. Cervical injury has been found to occur in approximately one out of 100 suction curettage abortions. In addition to overt injury, micro fractures of the cervix may occur during forceful dilation of the cervix, which may lead to persistent structural changes, cervical incompetence, premature delivery, and pregnancy complications. K. Schulz et al., *Measures to Prevent Cervical injuries During Suction Curettage Abortion*, THE LANCET, May 28, 1983, at 1182. The use of laminaria instead of rigid dilators has been found to reduce cervical injury 5 fold. *Id.* See e.g., U. Landy & S. Lewit, *Administrative, Counseling and Medical Practices of National Abortion Federation Facilities*, 14 FAM. PLAN. PERSP. 257

embolism,¹⁵ disseminated intravascular coagulation,¹⁶ adult respiratory distress syndrome,¹⁷ pulmonary embolism,¹⁸ uterine rupture,¹⁹

(1982) (finding that 89% of National Abortion Federation members surveyed always or usually used metal dilators); R.G. Wheeler & K. Schneider, *Properties and Safety of Cervical Dilators*, 146 AM. J. OBSTET. GYNECOL. 597 (1983) (concluding that osmotic dilators are superior to metal dilators for cervical dilation).

14. Post-abortion infections include endometritis (inflammation of the inner lining of the uterine wall), salpingitis (inflammation of the fallopian or eustachian tube), pelvic inflammatory disease or PID (inflammation of the genital tract and a major cause of infertility); peritonitis (inflammation of the abdominal cavity), and sepsis or septic abortion. Acute complications resulting from septic abortion include adult respiratory distress syndrome, septic shock, death of woman, renal failure, abscess formation and septic emboli. Chronic complications from septic abortion include infertility, pelvic adhesive disease, pelvic pain and ectopic pregnancy. SEBASTIAN FARO & MARK PEARLMAN, *INFECTIONS AND ABORTION* 42 (1992).

15. Amniotic fluid embolism, an unusually catastrophic condition, is a sudden rush of amniotic fluid containing placental or fetal tissue fragments into maternal circulation. Frequently it is fatal. Although it can occur in a first trimester suction curettage abortion, it is much more likely to occur in connection with a second trimester abortion. See e.g., Herschel W. Lawson, et. al, *Fatal Pulmonary Embolism During Legal Induced Abortion in the United States from 1972 to 1985*, 162 AM. J. OBSTET. GYNECOL. 986 (1990); Steve L. Clark, et. al, *Amniotic Fluid Embolism: Analysis of the National Registry*, 172 AM. J. OBSTET. GYNECOL. 1158 (1995).

16. Disseminated intravascular coagulation (DIC) is caused by trauma or sepsis. It breaks down the various functions of the blood and leads to multiple organ failure. The reported incidence of coagulopathy (defined as non clotting hemorrhage and hypofibrinogenemia) associated with first trimester abortion is 8 per 100,000 abortions; with D&E abortions it is 191 per 100,000 abortions) and with saline instillation abortions, it is 658 per 100,000 abortions. M.E. Kafriksen et al., *Coagulopathy and Induced Abortion Methods: Rates and Relative Risks*, 147 AM. J. OBSTET GYNECOL 344 (1983); see e.g., Robert M. Hardaway, *Organ Damage in Shock, Disseminated Intravascular Coagulation, and Stroke*, 18 COMPREHENSIVE THERAPY 17 (1992); Rodger L. Bick & William F. Baker, Sr., *Disseminated Intravascular Coagulation Syndromes*, 6 HEMATOL. PATHOL. 1 (1992).

17. Adult respiratory distress syndrome (ARDS) is diffuse damage to the small cells of the lung accompanied by an excessive accumulation of water in the cells of the lung. It can occur from such etiologies as amniotic fluid embolism, sepsis, overdose or toxicity from various medications or chemicals, or in connection with DIC. Kenneth R. Niswander & Arthur T. Evans, *MANUAL OF OBSTETRICS: DIAGNOSIS AND THERAPY* 90 (4th ed. 1991).

18. Pulmonary embolism is an obstruction of pulmonary arteries, most frequently by detached fragments of clots from a leg or pelvic vein, especially following an operation or confinement to bed. Pulmonary embolism is known to occur in adolescents or adults following induced abortion. D. Bernstein et al., *Pulmonary Embolism in Adolescents*, 140 AM. J. DISEASES OF CHILDREN 667 (1986). R. Nudelman et al., *Pulmonary Embolism in a 14 Year Old Following an Elective Abortion* 68 PEDIATRICS 584 (1981); A.M. Kimball et al., *Deaths Caused by Pulmonary Thromboembolism After Legally Induced Abortion*, 132 AM. J. OBSTET GYNECOL 169 (1978). An overall rate of 2.2 cases of pulmonary embolism per 10,000 induced abortions has been reported. H.W. Lawson et al., *Fatal Pulmonary Embolism During Legal Induced Abortion in the United States from 1972 to 1985*, 162 AM. J. OBSTET

adhesions,²⁰ loss of consortium, and emotional distress.

Based on the available data, it appears that there are many thousands of potential abortion malpractice cases. A 1992 national hospital discharge summary estimated that there were 14,000 women diagnosed with complications following abortion, and ectopic or molar pregnancies.²¹ Also, it estimated that there were 7000 women diagnosed with genital tract and pelvic infection following abortion, and ectopic or molar pregnancies.²² The vast majority of these

GYNECOL 986 (1990) (among the reported 213 deaths from legal abortion from 1972-85, 21% were due to air, blood clot or amniotic fluid embolism. The risk of death from embolism was higher among minority women, women aged 34-44 years of age, and women with abortions at later stages of pregnancy).

19. Uterine rupture may occur in women with an undilated cervix in connection with a prostaglandin induced abortion or other amniofusion abortion, sometimes in connection with oxytocin to induce labor. WARREN M. HERN, *ABORTION PRACTICE* 193, 280 (1990). Uterine rupture has also been reported when using mifepristone and prostaglandin in a second trimester abortion. J. E. Norman, *Uterine Rupture During Therapeutic Abortion in the Second Trimester Using Mifepristone and Prostaglandin*, 102 BR. J. OBSTET. GYNAECOL. 332 (1995); A scar from a previous Cesarean section is a risk factor for uterine rupture during second trimester saline abortion. S.G. Levrant and M. Wingate, *Midtrimester Uterine Rupture*, 41 J. REPROD. MED. 186 (1996).

20. Adhesions, sometimes known as Asherman's Syndrome or uterine synechiae, are inflammatory bands that extend from one moist or wet surface to another in the uterus. Adhesions may be a consequence of negligence from use of a D&C or recurettage when more conservative methods should have been used. S. Lurie et al., *Curettage After Mid-trimester Termination of Pregnancy: Is It Necessary?*, 36 J. REPROD. MED. 786 (1991). Adhesions can require hospitalization and cause pelvic pain, menstrual abnormalities, habitual abortion, ectopic pregnancy, infertility, and possibility cervical pregnancies; S.M. Klein & C.R. Garcia, *Asherman's Syndrome: A Critique and Current Review*, 24 FERTILITY & STERILITY 722 (1973), D. Dicker et al., *Etiology of Cervical Pregnancy: Association with Abortion, Pelvic Pathology, IUD's and Asherman's Syndrome*, 30 J. REPROD. MED. 25 (1985). The possibility of uterine synechiae as a complication should be explained to women contemplating abortion even though, in general, the risk of complication is very slight. F. GARY CUNNINGHAM, et al., *WILLIAMS OBSTETRICS* 598 (20th ed. 1997).

21. Listed Diagnosis for patients discharged from short-stay non-Federal hospitals - females aged 15-44, Vital and Health Statistics. Detailed Diagnosis and Procedures National Hospital Discharge Survey, 1992, Series 13, No. 118, U.S. Dept. of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, Aug., 1994. The same hospital discharge survey also listed 27,000 missed abortions, and 8,000 unspecified incomplete abortions in addition to complications and genital tract and pelvic infections. Some of the missed and incomplete abortions would very likely include a substantial number from induced abortions.

22. Molar pregnancies, sometimes called hydatidiform mole, are malformed intrauterine pregnancies similar to a cyst and which apparently degenerate over time. A molar pregnancy may be present if there is a positive pregnancy test. There are two types: complete and partial. A complete molar pregnancy is characterized by diffuse swelling of the

complications and infections are likely to be abortion related, because there is a higher rate of induced abortion (about 1 in 4 live births) compared to ectopic (about 1 in 53 live births) or molar pregnancy (1 in 1500 live births). Many of these may represent potential abortion malpractice cases, but there are few resultant claims or law suits. Approximately 1.5 million induced abortions occur annually in the U.S. and up to 21,000 women suffer injuries sufficiently serious to require hospitalization;²³ however, a 1991 study of 500 obstetric and gynecological malpractice claims revealed that only 5 percent were abortion related.²⁴ Cases in the following sections involve physical or reproductive injury and include examples of negligent diagnosis, use of unqualified personnel, utilization of substandard procedures, or failure to provide follow-up care or assistance.

B. Intentional Infliction of Emotional Distress

In order to establish recovery for the intentional infliction of emotional distress, one must demonstrate that (1) the defendant acted intentionally or recklessly, i.e., the conduct was "extreme and outrageous;" (2) the actions of the defendant caused the plaintiff's emotional distress; and (3) the emotional distress of the plaintiff was

chorionic villi (blood vessels of the membrane covering the embryo) and diffuse trophoblastic hyperplasia (the developing cell layer covering the developing embryo) in the absence of embryonic or fetal tissues. A partial molar pregnancy exhibits focal swelling of the chorionic villi and trophoblastic hyperplasia with embryonic or fetal tissues usually present. Ross S. Berkowitz et al., *Case-Control Study of Risk Factors for Partial Molar Pregnancy*, 173 AM. J. OBSTET. GYNECOL. 788 (1995). Molar pregnancies cause vaginal bleeding, and can cause significant medical complications unless they are removed by hysterectomy or sometimes evacuation. The reported incidence in the U.S. is about 1 per 1500 live births. D. P. Goldstein & R. S. Berkowitz, *Current Management of Complete and Partial Molar Pregnancy*, 39 J. REPROD. MED. 139 (1994). Sometimes molar pregnancies can cause the death of the woman. L. M. Koonin et al., *Maternal Mortality Surveillance, United States, 1979-1986*, 40 M.M.W.R. No. SS-1:1 (1991) (listing 14 deaths from molar pregnancy from 1979-1986).

23. The American College of Obstetricians and Gynecologists has taken the position that "properly performed abortion poses minimal risk to women." GUIDELINES FOR WOMEN'S HEALTH CARE 128 (American College of Obstetricians and Gynecologists, Washington, DC) (1996) [hereinafter GUIDELINES].

24. Charles J. Ward, *Analysis of 500 Obstetric and Gynecologic Malpractice Claims: Causes and Prevention*, 165 AM. J. OBSTET. GYNECOL. 298 (1991).

severe.²⁵ Liability may be imposed not only for intentional acts, but also when the defendant acts recklessly in deliberate disregard of a high degree of probability that emotional distress will follow.²⁶

In *Wall v. Pecaro*,²⁷ the plaintiff allegedly sought medical treatment from the defendant regarding a tumorous growth in her mouth.²⁸ According to the complaint, the defendant urgently and repeatedly recommended that the plaintiff submit to unnecessary treatment. The recommended treatment included surgical removal of some of her head's internal structure and tissues, as well as the abortion of her 5-1/2-month-old unborn child.²⁹ The defendant allegedly told the plaintiff, several times, even after termination of their relationship, that if she failed to undergo these procedures, her cancer would spread rapidly.³⁰ Plaintiff brought an action for intentional infliction of emotional distress.³¹ Although plaintiff's complaint was initially dismissed, the appellate court ruled that the complaint had stated a cause of action, although yet unproven, and remanded the case to the trial court.³²

The repeated urging of abortion as necessary "medical treatment" has occurred in other situations where it might be the basis of a suit for intentional infliction of emotional distress. According to press reports, a Planned Parenthood clinic in Indiana repeatedly contacted a minor girl on a daily basis, urging her to have an abortion. Finally, Planned Parenthood arranged for an out of state abortion despite the strong objections of the girl's mother.³³ Other abortion related claims in various contexts, based on allegations of intentional infliction of

25. 4 STUART M. SPEISER, CHARLES F. KRAUSE & ALFRED W. GANS, *THE AMERICAN LAW OF TORTS* (1987, 1997) §16.13 - 16.22 (intentional or reckless infliction of emotional distress).

26. RESTATEMENT (SECOND) OF TORTS § 46.

27. 561 N.E.2d 1084 (Ill. App. Ct. 1 Dist. 1991).

28. *Id.* at 1085.

29. *Id.*

30. *Id.* at 1085-86.

31. *Id.* at 1085.

32. *Id.* at 1089.

33. In a recent related incident a woman was convicted of a crime in a Pennsylvania court for taking a minor girl out of state to obtain an abortion without the mother's knowledge or consent. (citations omitted); *Multi-Million Dollar Suits Filed in Indiana After Teen Abortions*, NAT'L RIGHT TO LIFE NEWS, July 30, 1987, at 5.

emotional distress, have frequently been unsuccessful.³⁴

C. Negligent Infliction of Emotional Distress

Virtually all states recognize that there is legal liability for the negligent infliction of emotional distress in addition to recovery for physical injury and accompanying pain and suffering.³⁵ Specific criteria differing from state to state, must be established before a claim may be successfully asserted and proven. Many states still require some manifest physical injury or require that the party claiming injury be in a "zone of danger" before allowing recovery.³⁶ Other states, such as New York,³⁷ and California,³⁸ do not require physical injury in order to recover for negligent infliction of emotional distress. The trend in various other states is toward not

34. *Boykin v. Magnolia Bay, Inc.*, 570 So.2d 639 (Ala. 1990) (claim of tort of outrage, i.e. intentional infliction of emotional distress by parents against abortion facility was dismissed because recovery is limited to those who are actually present when the tort was committed); *Przybyla v. Przybyla*, 275 N.W.2d 112 (Wis. App. 1978) (husband had no claim against wife for intentional infliction of emotional distress where wife exercised legal right of abortion after she allegedly falsely misrepresented and deceived her husband about her intentions to seek an abortion).

35. See generally William A. Barton, *RECOVERING FOR PSYCHOLOGICAL INJURIES* (2nd ed. 1990); *POSTTRAUMATIC STRESS DISORDER IN LITIGATION: GUIDELINES FOR FORENSIC ASSESSMENT* (Robert I. Simon ed., 1995); John O. Ward, *A HEDONICS PRIMER FOR ECONOMISTS AND ATTORNEYS* (1992) (discussing recoveries for emotional injury and loss of enjoyment of life); Thomas E. Eller, *Informed Consent Civil Actions for Post-abortion Psychological Trauma*, 71 *NOTRE DAME L. REV.* 639 (1996) (discussing emotional injury arising from non-consent in abortions).

36. See, e.g., *Muchow v. Undblad*, 435 N.W.2d 918 (N.D. 1989) (requiring bodily harm for claim of negligent infliction of emotional distress); *Humes v. Clinton*, M.D., 792 P.2d 1032 (Kan. 1990) (barring recovery for emotional distress caused by physician's failure to warn about possible physical and psychological consequences of obtaining abortion where no physical injury occurs); *Abbey v. Jackson*, 483 A.2d 330 (D.C. 1984) (requiring an allegation of resultant physical injury to state a cause of action in abortion malpractice case based upon negligent infliction of emotional distress).

37. *Martinez v. Long Island Jewish-Hillside Medical Center*, 519 N.Y.S.2d 53 (A.D. 2 Dept. 1987), 518 N.Y.S. 2d 955 (Ct. App. 1987) (no physical injury required where there was a special likelihood of genuine and serious mental distress); *Ferrara v. Bernstein*, 81 N.W.2d 895, 597 N.Y.S.2d 636, 613 N.E.2d 542 (N.Y. Ct. App. 1993) (severe cramping sufficient physical injury to recover for emotional distress).

38. See, e.g., *Palm v. United States*, 835 F. Supp. 512 (N.D. Cal. 1993) (negligent infliction of emotional distress under California law); *Jacoves v. United Merchandising Corp.*, 11 Cal. Rptr. 2d 468 (Cal. Ct. App. 2d 1992) (accompanying physical injury not required in order to recover for negligent infliction of emotional distress).

requiring any manifest physical injury or recognizing a minimal physical injury as sufficient. For example, a North Carolina court held that severe pain is considered a physical injury,³⁹ and a Kentucky court held that being subjected to X-rays is a sufficient manifest physical injury to recover for mental suffering.⁴⁰ If severe pain is considered a physical injury, the chances for recovery of damages due to negligent infliction of emotional distress are greatly increased. Often, the woman may have no other physical injury other than acute or chronic pelvic or abdominal pain.

Emotional distress may not require a physical injury when there is a breach of an implied contract or if a consensual relationship between the physician and the patient causes the emotional distress. This was the holding by an Alabama court in a 1981 case.⁴¹ More recently, Iowa recognized that medical professionals have a duty to provide ordinary care to avoid causing emotional harm to patients.⁴² This case law precedent can be very helpful in recovering for negligent infliction of emotional distress which results from induced abortion.

Cases discussed below illustrate that damages for emotional distress following induced abortion were granted (1) when there was injury to the plaintiff resulting from negligent counseling, diagnosis, or abortion technique, or (2) when there was a violation of a legal

39. *Ledford v. Martin*, 359 S.E.2d 505, 507 (N.C. Ct. App. 1987).

40. *Deutsch v. Shein*, 597 S.W.2d 141 (Ky. 1980).

41. *Taylor v. Baptist Medical Center*, 400 So.2d 369, 374 (Ala. 1981); *see also* *Geibel v. United States*, 667 F. Supp. 215, 220 (W.D. Pa. 1987) (recognizing a malpractice claim for emotional distress based on injury induced by physician through "words or actions" as well as direct injury from therapeutic and diagnostic procedures).

42. *Oswald v. LeGrand*, 453 N.W.2d 634 (Iowa 1990) (in this case, which ended in a spontaneous abortion, it was alleged that the physician went off call when the plaintiff was in a hysterical state and about to deliver; that a nurse described the fetus, not as a baby, but only as a "big blob of blood"; that the medical personnel were extremely rude and insensitive, and did not determine whether the child was born alive. The court held that the plaintiff's claim did not have to be supported by expert testimony to determine whether the defendants departed from professional standards). Poor treatment by abortion clinic personnel has also been found to be a significant factor for negative long-term psychological problems; *see also* Catherine A. Barnard, *The Long-term Psychological Effects of Abortion*, (Institute for Pregnancy Loss, Portsmouth, N.H.) (1990); Helen P. Vaughan, *Canonical Variates of Post-Abortion Syndrome*, (Institute for Pregnancy Loss, Portsmouth, N.H.) (1990) (42% of women reporting post-abortion syndrome at crisis pregnancy centers reported negative interaction with abortionist and staff.).

duty owed to a woman who was, or who became pregnant, thus setting in motion a reasonably foreseeable chain of events which resulted in an abortion related injury. Under these criteria, a much wider range of persons may be potentially liable for emotional injuries from abortion than simply those who are directly involved in the abortion procedure itself. The following cases were placed in certain categories for convenience, but may also fit into other categories.

1. Interference with Conscience or Religion

The leading case allowing recovery for emotional injuries which resulted from an induced abortion without a manifest physical injury is *Martinez v. Long-Island Jewish- Hillside Medical Center*.⁴³ In this case an action was brought in a New York state court by the plaintiff and her husband to recover damages for personal injury based on medical malpractice. The plaintiff had been misinformed by her obstetrician that "massive doses" of a steroid would cause her unborn child to develop a cleft palate and suffer such severe brain damage that the child would be unable to breath without machines and would be permanently institutionalized.⁴⁴ The plaintiff, despite her strong religious beliefs to the contrary was ultimately persuaded to undergo an abortion.⁴⁵ The defendant's advice was based on the erroneous and unverified belief that the plaintiff had taken 500 milligrams of a steroid four times a day over a four week period.⁴⁶ In fact, the actual dosage was only 0.5 milligrams, an amount not likely to harm the unborn child.⁴⁷

At the trial, the plaintiff testified with verification by her psychologist that she believed abortion was a sin unless there were exceptional circumstances.⁴⁸ The plaintiff also testified that when she discovered these exceptional circumstances did not exist, she suffered mental anguish and depression from needlessly committing

43. 122 A.2d 122, 122 (N.Y. App. Div. 2d 1987).

44. *Id.*

45. *Id.*

46. *Id.*

47. *Id.*

48. 518 N.Y. 2d 955 (N.Y. 1987).

an act in violation of her deep-seated convictions.⁴⁹ She also said that for five years she was in a “state of shock” and could not leave the house. She said, “Not a day goes by that I don’t think of this child.”⁵⁰

The jury found that the abortion was in violation of the plaintiff’s firmly held beliefs and returned a \$275,000 verdict in her favor. However, the trial court judge reduced the verdict to \$125,000 for the plaintiff, and \$25,000 for her husband.⁵¹ After a number of appeals, the New York Court of Appeals found that the defendants had a duty to correctly ascertain the dosage of plaintiff’s medication. In the event the dosage appeared abnormally high, the defendant also had a duty to verify the dosage with the prescribing physician.⁵² It also found that where there was a special likelihood of genuine and serious emotional distress, the consequences were foreseeable that it would have a serious psychological impact on the plaintiff. Therefore, the court determined that the message and the events flowing from it were the proximate cause of the plaintiff’s emotional harm.⁵³ The appeals court eventually upheld the verdict, as reduced by the trial court, and ruled that there was sufficient evidence for the plaintiffs to recover for emotional injuries based upon the defendant’s negligence.⁵⁴

Martinez is the landmark abortion case recognizing a legal right to recover for emotional injury without the requirement of any manifest physical injury. The case, however, has at least three important aspects which helped establish the basis for elimination of the requirement of physical injury. First, there was a violation of consent because of the mistake of fact relative to the steroid dosage. Second, the evidence clearly established that the induced abortion violated the plaintiff’s conscience. Third, evidence established that the plaintiff would not have had the abortion if she had received accurate information and diagnosis of her condition.⁵⁵

49. *Id.*

50. *Id.* \$150,000 Awarded for Emotional Distress in New York Abortion Case, NAT’L RT. TO LIFE NEWS (National Right to Life Committee, Washington, D.C.) July 16, 1987, at 4.

51. 518 N.Y.2d 955 (N.Y. 1987).

52. *Martinez*, 122 A.2d at 123.

53. *Id.* at 124.

54. 133 A.2d 264, 265 (N.Y. App. Div. 2d 1987).

55. *See Reynier v. Delta Women’s Clinic*, 359 So.2d 733 (La. App. 1978) (plaintiff sued on a theory of lack of informed consent but lost as she failed to show she would not

Martinez was a very difficult case to win and went through numerous appeals.⁵⁶ The primary difficulty was the lack of manifest physical injury. New York state negligence law did not recognize a cause of action for the loss of a child in the context of abortion, stillbirth, or miscarriage. Therefore, the plaintiff's victory established an important precedent, which substantially increased the potential scope of recovery for abortion-related emotional injury.

The violation of conscience of women who undergo induced abortion is not limited to the facts in *Martinez*. Most women who undergo induced abortions apparently violate their conscience in the process.⁵⁷ Pressure or influence from others to undergo abortion is a major factor. Also, a pregnancy may precipitate a crisis situation where the woman feels alone and resorts to primitive coping methods. Further, abortion counseling methods concentrate almost exclusively on bodily or reproductive issues without consideration of the inherent morality of abortion or the woman's religion.⁵⁸

Violation of conscience can have possible legal implications. Virtually all state constitutions protect the individual's rights of conscience and religion. For example, the New York state constitution states: "The free exercise and enjoyment of religious profession and worship, without discrimination or preference, shall forever be allowed in this state to all mankind."⁵⁹ Other state constitutions are similar to Minnesota's which states:

The right of every man to worship God according to the dictates of his own conscience shall never be infringed . . . nor shall any control of or interference with the rights of conscience be permitted . . . but the liberty of conscience hereby secured shall not be so construed as to excuse acts of

have had the abortion if the risk were known); *Mathis v. Morrissey*, 13 Cal. Rptr. 2d 819, 11 C.A.4th 332 (1992) (in a medical malpractice action alleging failure to disclose, the plaintiff has the burden of proof with respect to materiality).

56. 519 N.Y.S.2d 53 (A.D. 2 Dept 1987), 518 N.Y.S.2d 955 (Ct. App. 1987); 122 A.D. 122, 504 N.Y. S.2d 693, 694 (1986).

57. Thomas Strahan, *Induced Abortion as a Violation of Conscience of the Woman*, NEWSLETTER (Ass'n for Interdisciplinary Research in Values and Social Change, Washington, D.C.) Sept-Oct. 1995, at 1.

58. *Id.*

59. NEW YORK CONST. Art. I, § 3.

licentiousness or justify practices inconsistent with the peace or safety of the state.⁶⁰

The Minnesota Constitution grants affirmative rights of conscience and does not simply attempt to restrain governmental action.⁶¹ Liberty of conscience may be invoked against infringement by private actors. Thus, if the conscience of a woman is violated when she undergoes an abortion, there may be a basis for a tort claim or other legal relief based on violation of a state constitution.

2. The Emotional Injury from Missed Abortion

In *Shirk v. Kelsey*,⁶² the plaintiff brought an action for medical malpractice and negligent infliction of emotional distress against an abortionist, who attempted to perform an abortion on plaintiff at National Health Care Services in Peoria, Illinois. It was plaintiff's second abortion.⁶³ After the attempted abortion, while she was in the recovery room, the plaintiff experienced severe pain and cramping.⁶⁴ She was very upset about the abortion and knew it was a mistake.⁶⁵ A nurse came in and told her she would have to undergo a second suction procedure because all of the tissue had not been removed.⁶⁶ After the defendant performed a second abortion procedure, the nurse told the plaintiff there was no chance she still could be pregnant.⁶⁷ However, after returning home, the plaintiff continued to bleed, had more severe cramps and unusual clotting, and experienced a loss of bladder control.⁶⁸ She returned to the defendant who performed a pelvic examination and told her she had a urinary tract infection

60. MINN. CONST. Art. 1, § 16.

61. T.J. Fleming & J. Nordby, *The Minnesota Bill of Rights: "Wrapt in The Old Miasmal Mist,"* 7 *HAMLIN L. REV.* 51, 67 (1984); 40 *MINN. STAT. ANN.* § 609.28 (West 1987) states: "Whoever, by threats or violence, intentionally prevents another person from performing any lawful act enjoined upon or recommended by the religion which the person professes is guilty of a misdemeanor." (Emphasis added.)

62. 617 N.E.2d 152 (Ill. App. Ct. 1d 1993).

63. *Id.* at 154.

64. *Id.*

65. *Id.*

66. *Id.*

67. *Id.*

68. *Id.* at 156.

which required an antibiotic.⁶⁹ The defendant did not repeat a pregnancy test or perform an ultrasound.⁷⁰ Plaintiff asked the defendant whether she still could be pregnant and the defendant said she could not.⁷¹ At the trial, plaintiff provided expert testimony that, in the Peoria (Illinois) area, a diagnostic ultrasound procedure was a recognized and accepted method to determine whether the plaintiff was still pregnant.⁷² This was especially true where scant tissue was found because it enabled a doctor to rule out an ectopic pregnancy.⁷³

After plaintiff's mother determined that the plaintiff was still pregnant, the plaintiff went to the hospital and delivered a baby boy who lived for about 90 minutes.⁷⁴ As a result, the plaintiff testified,

I've had a lot of nightmares. I wake up nights reliving the baby's birth, the baby's death. I relive having the abortion. I go through a terrible mourning (sic) period a month before the baby's death. I'm detached from my husband and my kids for at least a month before and weeks afterward. It puts a lot of strain on my marriage because I'm not really fit to be around.⁷⁵

She also testified that she still mourns her son's death every year which was her "worst nightmare."⁷⁶ She also felt she was being "repaid" for the two abortions she had undergone.⁷⁷

On appeal, the court held that the defendant was negligent in not repeating the pregnancy test or performing ultrasound and upheld a jury verdict based on negligence for \$300,000.⁷⁸ This amount was reduced 25 percent by the jury for plaintiff's comparative negligence.⁷⁹ The appeals court also reversed a punitive damage

69. *Id.* at 154.

70. *Id.*

71. *Id.*

72. *Id.* at 156.

73. *Id.*

74. *Id.* at 155.

75. *Id.*

76. *Id.*

77. *Id.*

78. *Id.* at 161.

79. *Id.*

award because it ruled that the defendant had not acted willfully or with wanton disregard of the plaintiff's rights.⁸⁰

Because *Shirk* involved a second abortion, it is likely that the extent and seriousness of the emotional injury was increased, even in the absence of a missed abortion and subsequent childbirth. As a woman repeats the abortion procedure, there is evidence of: (1) guilt and mourning as a reaction to the loss of an object of ambiguous desire,⁸¹ (2) an increase in the likelihood of depression,⁸² and (3) increased proclivity toward suicide.⁸³ Women with repeat abortions have also been reported to be more isolated and have more difficulty in getting along with others.⁸⁴ Other studies have found that women who undergo subsequent abortions are more likely to make the decision for abortion alone,⁸⁵ have shorter relationships with males,⁸⁶ or report unhappiness in their marriage.⁸⁷ The plaintiff's testimony in *Shirk* supports the findings of these studies. It is common for women to feel self-reproach or believe that they are being punished for having an abortion. In *Shirk*, all of these reactions were intensified, apparently as a result of the stark reality of the birth and short life of the baby.

In *Ferrara v. Bernstein*,⁸⁸ which also involved a missed abortion, the plaintiff went for an abortion at Lincoln Medical Practice, where about 150 abortions were performed weekly. The abortion was performed by an abortion provider, who used the facilities with the approval of the defendant.⁸⁹ The defendant also provided

80. *Id.* at 162.

81. D. Naziri & A. Tzavaras, *Mourning and Guilt Among Greek Women Having Repeated Abortions*, 26 OMEGA 137, 137 (1992-93).

82. K. Franco et al., *Psychological Profile of Dysphoric Women Postabortion*, 44 J. AM. MED. WOMEN'S ASS'N 113 (1989).

83. *Id.*

84. Ellen W. Freeman et al., *Emotional Distress Patterns Among Women Having First or Repeat Abortions*, 55 OBSTET. & GYNECOL. 630, 634 (1980).

85. C. Berger et al., *Repeat Abortion: Is It A Problem?*, 16 FAM. PLAN. PERSP. 70, 74 (Mar./Apr. 1984); E. Szabady & A. Klinger, *Pilot Surveys of Repeated Abortion*, 14 INT'L MENTAL HEALTH RES. NEWSLETTER 6 (1972).

86. M. Bracken & S. Kasi, *First and Repeat Abortions: A Study of Decision-Making and Delay*, 7 J. BIOSOCIAL SCIENCE 473 (1975).

87. Szabady & Klinger, *supra* note 85, at 6.

88. 613 N.E.2d 542 (N.Y. 1993).

89. *Id.* at 543.

administrative and follow-up services.⁹⁰ The abortion provider told the plaintiff he was going to perform the abortion and explained the procedure. After performing the abortion, he did not tell her anything about the need for any follow-up visits.⁹¹ He later came into the recovery room, took her blood pressure, and asked her how she felt. He told her she might experience some cramps and, if they became severe or painful, to take Tylenol instead of aspirin.⁹² When the plaintiff prepared to leave the facility, a nurse in the reception area told her to call and make an appointment for a follow-up visit two weeks later; however, the nurse did not offer to make an appointment at that time.⁹³

One week after the abortion, the Lincoln Medical Facility received a pathology report which suggested that the plaintiff might still be pregnant.⁹⁴ The facility did not advise the plaintiff. There was evidence that if the plaintiff had been advised of the unsuccessful abortion she would have undergone a second abortion.⁹⁵ During the week following her abortion, the plaintiff called and made an appointment for a follow-up visit two weeks after the date of the abortion. During the second week after the abortion, she felt cramps and took Tylenol.⁹⁶ Plaintiff rescheduled her appointment, but when her condition worsened she asked her boyfriend to take her immediately to a hospital.⁹⁷ While in the hospital, she experienced more cramps and went to the ladies room [because she felt "pressure"].⁹⁸ While on the toilet, she had a spontaneous miscarriage and delivered a 4 ½-inch baby boy into the toilet.⁹⁹ She looked down, saw him hanging from her and started to scream.¹⁰⁰ She was rushed in a wheelchair with the fetus on her lap, still attached by the umbilical cord to an operating room where a doctor delivered the placenta. The

90. *Id.* at 543.

91. *Id.*

92. *Id.*

93. *Id.*

94. *Id.*

95. *Id.* at 543.

96. *Id.*

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.* at 543.

doctor held up the fetus and said, "This is a fetus . . . a baby . . . it is not just some tissue passed."¹⁰¹

The plaintiff sued the defendant for negligent infliction of emotional distress which resulted in post-traumatic depression, nightmares, and sleeplessness.¹⁰² She also became withdrawn and was reluctant to resume intimate sexual relations with men for a substantial period of time.¹⁰³ She consulted a psychiatrist, who testified at the trial that the plaintiff still suffered from emotional trauma.¹⁰⁴ The jury returned a verdict of \$315,000, which was reduced by the trial court to \$125,000 and represented \$20,000 for pain and suffering and \$105,000 for emotional distress.¹⁰⁵ On appeal, the state's highest court held that: plaintiff was entitled to an award for physical pain and suffering experienced during the abortion or miscarriage; plaintiff was entitled to damages both for emotional distress suffered when she witnessed the miscarriage of her fetus and proved physical injury distinct from any injuries suffered by the fetus;¹⁰⁶ and the evidence was sufficient to establish a prima facie case showing that the medical staff was a substantial cause of the plaintiff's injury for not advising her about the lab report which indicated a failed abortion.

As in *Ferrara*, when the pathology report indicates a possible missed or incomplete abortion, National Abortion Federation standards require that "there must be an appropriate mechanism for contacting the patient and informing her of the significance of the pathology laboratory's report."¹⁰⁷ In *Ferrara*, the defendant apparently did not have such procedures in place, or, if he did they were inoperative. In either scenario the result was the same: the plaintiff was not notified of the results of the pathology report. Possible medical malpractice, which leads to an increased likelihood of missed abortions, includes: performing an abortion at less than seven weeks

101. *Id.* at 543.

102. *Id.*

103. *Id.*

104. *Id.*

105. *Id.*

106. *Id.* (finding implicitly that severe cramping was a sufficient physical injury to recover for negligent infliction of emotional distress).

107. See generally NATIONAL ABORTION FEDERATION, STANDARDS FOR ABORTION CARE (1987).

gestation,¹⁰⁸ failing to use a large enough cannula for the gestational age¹⁰⁹ or not large enough for multigravidas,¹¹⁰ failing to diagnose a uterine anomaly,¹¹¹ failing to diagnose an ectopic pregnancy,¹¹² and perforation of the uterus.¹¹³

Missed abortions, as a result of attempted induced abortion, are not rare. According to the 1992 Hospital Discharge Summary for U.S. women between 15-44 years of age, there were 27,000 hospitalizations for missed abortions.¹¹⁴ If all of these hospitalizations resulted from attempted induced abortions in the first trimester, it would represent about two percent of all first trimester abortions. A Johns Hopkins Hospital study found that the incidence of missed abortions below seven gestational weeks was six percent.¹¹⁵ According to 1992 CDC data, approximately 14.1 percent of U.S. abortions were less than seven gestational weeks.¹¹⁶ Based upon approximately 1.5 million abortions annually, about 12,700 of the 211,500 abortions at less than seven gestational weeks would be missed. A 1985 study by the CDC reported that 2.3 women per 1000 induced abortions, at twelve weeks gestation or less, left the abortion

108. Milagros F. Atienza et al., *Menstrual Extraction*, 121 AM. J. OBSTET. GYNECOL. 490, 492 (1975) (the incidence of missed early abortion, i.e., less than seven weeks gestation was 6%).

109. Andrew M. Kaunitz, *Abortions that Fail*, 66 OBSTET. & GYNECOL. 533, 535 (1985).

110. *Id.* (failed abortions were twice as common among multigravidas as among women with no previous pregnancies. It was suggested that suction cannulas (apparently of the same size) are less likely to aspirate the products of conception in a multigravidas uterus); see e.g., Waldo L. Fielding, *Continued Pregnancy After Failed First-Trimester Abortion*, 63 OBSTET. & GYNECOL. 421 (1984).

111. *Id.* (failed abortions were more than 90 times more likely to occur in women with uterine anomalies, such as a bicomuate uterus, as among women without such anomalies).

112. HERN, *supra* note 19, at 178.

113. Koonin et al., *supra* note 22, at 388.

114. Listed Diagnosis for patients discharged from short-stay non-Federal hospitals - females aged 15-44, Vital and Health Statistics. Detailed Diagnosis and Procedures National Hospital Discharge Survey, 1992, Series 13, No. 118, U.S. Dept. of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, Aug., 1994. The same hospital discharge survey also listed 27,000 missed abortions, and 8000 unspecified incomplete abortions in addition to complications and genital tract and pelvic infections. Some of the missed and incomplete abortions would very likely include a substantial number from induced abortions.

115. Kaunitz, *supra* note 109, at 535.

116. L.M. Koonin et al., *Abortion Surveillance—United States 1992*, 45 M.M.W.R. No. 45SS-3:1 (1996).

facility with the false belief that they had an induced abortion.¹¹⁷ Therefore, approximately 3000 women annually left with the mistaken belief that they had an abortion (based on approximately 1.3 million having induced abortions at twelve gestational weeks or less).

According to press reports, the doctor who performed the abortion in *Ferrara* had his license to practice revoked by the New Jersey Board of Medical Examiners. The board claimed that he had displayed “a consistent pattern of gross malpractice and negligence and incompetence,” failed to treat post-abortion complications, and written up “false and inaccurate” medical records.¹¹⁸ According to the article, the doctor claimed that his problems were the result of professional “burnout” caused by the stress of performing more than 2600 second trimester abortions over a period of four years.¹¹⁹ Thus, the plaintiff in *Ferrara* was only one of many victims injured by him. Directing the matter to public attention by litigation can serve both the public interest as well as the private interests of the parties involved.¹²⁰

3. Negligent Counseling or Diagnosis by Professionals Resulting in Abortion Injury

Even though a professional person does not actually perform an abortion in a negligent manner or negligently advise a woman to obtain an abortion does not exempt him from liability. In certain instances, a professional may be liable for damages if his negligence sets in motion a chain of circumstances which results in injury to the woman as a result of her abortion. An example is found in *Lynch v.*

117. Kaunitz, *supra* note 109, at 533.

118. *Abortonist Garrett Loses License*, NAT'L RT. TO LIFE NEWS, May 28, 1987, at 4.

119. *Id.*

120. *Terra v. Dept. of Health*, 604 N.Y.S.2d 644 (Sup. Ct. 1993) (an obstetrician-gynecologist was suspended after it was determined that (1) 24 abortions were performed on patients, only two of whom were actually pregnant; (2) important information was not obtained and requisite tests were not performed before obstetrician-gynecologist performed abortion procedure, and (3) there was no indication in the records that patients were ever told they were pregnant); *Brown v. Univ. of State of New York*, 537 N.Y.S.2d 655 (Sup. Ct. 1989) (a doctor was suspended for 2 years for negligent practice of medicine on one or more occasions and failure to maintain adequate patient records. Among the doctor's acts of negligence were (1) an incomplete abortion of 17 week fetus, (2) failure to diagnose ectopic pregnancy, and (3) failure to record facts regarding administration of anesthesia, description of external genitalia examined, and whether patient experienced pain).

Bay Ridge Ob/Gyn Associates.¹²¹ The plaintiff had not had a menstrual period for over three months, and her home pregnancy tests were negative.¹²² The plaintiff consulted with the defendant gynecologist who visually examined the plaintiff, with no ensuing blood or urine analysis, and informed the plaintiff that she was not pregnant.¹²³ The defendant prescribed the hormonal drug Provera without explaining any of the attendant risks.¹²⁴ After the plaintiff had the prescription filled, she became aware from the warning label that the drug posed a serious risk of producing congenital birth defects if taken during early pregnancy.¹²⁵ Relying on the defendant's advice that she was not pregnant, the plaintiff took the drug as prescribed.¹²⁶ When plaintiff continued to not menstruate, she consulted another gynecologist who ascertained plaintiff's pregnancy from lab tests.¹²⁷ This gynecologist also cautioned plaintiff about the potentially harmful effects of Provera on a fetus in early states of development.¹²⁸ The plaintiff had an abortion because she feared that these results had occurred.¹²⁹

Plaintiff then brought a malpractice action, alleging that the defendant was negligent in diagnosing her as not being pregnant and prescribing a drug without warning of its inherent risks.¹³⁰ Plaintiff further alleged that the defendant's negligence forced her to decide between having a congenitally defective child or submitting to an abortion in violation of her personal, moral, and religious convictions.¹³¹ The defendant argued that the abortion itself, rather than defendant's conduct, was the superseding cause of plaintiff's emotional distress.¹³² The Court of Appeals, reversing the lower court's decision, ruled that the plaintiff had stated a viable malpractice action not based on injury inflicted on the fetus.¹³³ Additionally, the

121. 532 N.E.2d 1239 (N.Y. 1988).

122. *Id.* at 1240.

123. *Id.*

124. *Id.*

125. *Id.*

126. *Id.*

127. *Id.* at 1240.

128. *Id.*

129. *Id.*

130. *Id.*

131. *Id.*

132. *Id.* at 1241.

133. *Id.* at 1242.

court held that the choice to have an abortion was not, as a matter of law, a superseding cause.¹³⁴

Similarly, in *Gum v. Gclshahl, M.D.*,¹³⁵ the defendant doctor also prescribed the drug Provera to induce the plaintiff's menses.¹³⁶ When the plaintiff realized she was pregnant, the defendant advised her to get an abortion because of possible damage to the fetus.¹³⁷ The plaintiff did so and suffered psychological trauma as a result.¹³⁸ The jury returned a \$65,000 verdict, based on the defendant's negligence in failing to perform a conclusive pregnancy test and for prescribing a drug harmful to her fetus.¹³⁹

Abortions which occur because of genetic indications have been found to be particularly stressful for the women involved as well as their husbands and families.¹⁴⁰ One study found that the vast majority of women experienced acute grief reactions which persisted for months with some women requiring psychiatric consultation.¹⁴¹ Sometimes fathers are adversely impacted in particular and marital stability is threatened where there are abortions for genetic reasons.¹⁴² Also, abortions based upon genetic indications have resulted in mild to severe negative reactions among other children in the family.¹⁴³

134. *Id.* at 1241.

135. Case No. 88-5-1374 (Summit Co. Court of Common Pleas, OH, January, 1990).

136. *Id.*

137. *Id.*

138. *Id.*

139. See also *Gamble v. Mintz & Eastwood Hospital*, No. 77 (Tenn. App. 1991) LEX VITAE 12(2):5, (Spring/Summer 1991) (a grant of summary judgment for defendant was reversed in a medical malpractice action where a woman allegedly aborted her child due to the possibility that the child would be born with defects after her doctor prescribed medication potentially harmful to the child and exposed the woman to radiation).

140. Aliza Kolker & B. Meredith Burke, *Grieving the Wanted Child: Ramifications of Abortion After Parental Diagnosis of Abnormality*, 14 HEALTH CARE FOR WOMEN INT'L 513, 513 (1993).

141. Bruce D. Blumberg et al., *The Psychological Sequelae of Abortion Performed for a Genetic Indication*, 122 AM. J. OBSTET. GYNECOL. 799, 805 (1975).

142. J. Lloyd & K.M. Laurence, *Sequelae and Support After Termination of Pregnancy for Fetal Malformation*, 290 BR. MED. J. R. 907, 909 (1985).

143. Regina M. Furlong et al., *Pregnancy Termination for Genetic Reasons: The Impact on Families*, 10(1) SOC. WORK IN HEALTH CARE 17, 17 (1984).

4. Recovery for Emotional Damages from Abortion after Motor Vehicle Negligence Involving Pregnant Women

Professionals who are directly involved with abortion or who counsel women of reproductive age are not the only individuals who may be liable for negligence and damages arising out of an emotional injury from abortion. Persons who are negligent in motor vehicle accidents involving pregnant women may also be held liable for damages incurred as a result of a subsequent abortion. For example, in *Cozzitorto v. Andrews*,¹⁴⁴ the plaintiff sustained minor injuries when her automobile was struck in the rear by the defendant's automobile. The defendant admitted liability for the automobile accident.¹⁴⁵ The plaintiff received X-rays from a chiropractor.¹⁴⁶ She later discovered she was pregnant and had an abortion based on her chiropractor's advice. The plaintiff sued the defendant contending that the defendant was responsible for her emotional distress, which directly resulted from the abortion.¹⁴⁷ The defendant filed a cross-complaint against the chiropractor for negligently advising the plaintiff to have an abortion.¹⁴⁸ The plaintiff was awarded \$37,075 from the defendant and the defendant recovered \$10,538 from the chiropractor on the cross-complaint.¹⁴⁹

In the Pennsylvania case of *Werner v. Eichman*,¹⁵⁰ which settled prior to trial, the claimant's automobile was struck in the rear by the defendant's vehicle. Claimant suffered multiple back strains as a result and underwent an abortion.¹⁵¹ The case was settled for \$75,000 despite the defendant's claim that the abortion was unnecessary and that she had failed to properly inform her doctor about her pregnancy prior to treatment for other injuries.¹⁵²

144. Case No. 327380 (Sacramento Co., CA, 1989).

145. *Id.*

146. *Id.*

147. *Id.*

148. *Id.*

149. *Id.*

150. Case No. 84-08616 (Montgomery Co., PA, 1988).

151. *Id.*

152. *Id.*

III. TYPES OF BREACH

A. *Statutory Based Claim—Uterine Laceration and Subsequent Infection*

The leading case in the area of abortion malpractice liability, based upon a violation of a statute or ordinance, is *Vuitch v. Furr*.¹⁵³ *Vuitch* was an appeal of a denial of the defendant's motion for a directed verdict after the entry of a jury verdict for the plaintiff.¹⁵⁴ In the course of performing an abortion, the defendant doctor lacerated the plaintiff's uterine wall.¹⁵⁵ The defendant attempted to suture the laceration and kept the plaintiff overnight at his abortion facility despite his knowledge that the overnight stay was prohibited by the act under which the facility was licensed.¹⁵⁶ The facility was licensed as an Ambulatory Surgical Treatment Center which, under District of Columbia regulations, prohibited overnight stays of patients.¹⁵⁷ Violation of the act was punishable by a fine of \$300 or imprisonment for not more than 90 days.¹⁵⁸ The plaintiff was discharged after two days and then taken the next day by relatives to a hospital.¹⁵⁹ The hospital examination revealed that a recent, unsutured laceration in the cervix had left a hole leading from the vagina to the abdominal cavity.¹⁶⁰ The plaintiff had developed peritonitis as a result of the two-day retention, which infected the uterus and necessitated a hysterectomy. A doctor performed a hysterectomy and removed fetal tissue from the plaintiff's abdomen, which had not been removed during the abortion.¹⁶¹ The court held that, under these circumstances, there were reasonable grounds for the jury to find medical

153. 482 A.2d 811 (D.C. App. 1984).

154. *Id.* at 813.

155. *Id.* at 814.

156. *Id.*

157. *Id.*

158. Ambulatory Surgical Treatment Licensure Act, 24 D.C. Reg. 6836 (1978), §§ 103(a) (Definitions), 202(e) (Application), 305 (Post-operative Requirements), and 503 (Penalty).

159. *Vuitch*, 482 A.2d at 814.

160. *Id.*

161. *Id.*

malpractice.¹⁶²

The court also found that the defendants violated the provisions of the Ambulatory Surgical Treatment Center Licensure Act and committed an intentional tort.¹⁶³ It further found that the defendant doctor and his wife were personally liable for the damages, despite the fact that the abortion facility was incorporated. The doctor's wife was held personally responsible because she was familiar with the law prohibiting overnight stays without proper licensing, held the position of secretary-treasurer of the corporation, and knew about the facility's practice of treating surgical complications and retaining patients overnight.¹⁶⁴ The violation of a statute or ordinance, as in this case, was held to be a reasonable ground for medical malpractice.¹⁶⁵ The criminal penalties for violation of the law and the fact that the defendants were found to have committed an intentional tort, provided the basis for the defendants' personal liability.

In order to determine whether to consider a malpractice claim based upon violation of a statute, ordinance, or regulation, one first must determine if the site where the abortion occurred is a doctor's office, outpatient facility, free-standing or hospital-based ambulatory surgical center, or hospital. Different regulations may apply depending on the type of facility. The American College of Surgeons has also classified ambulatory facilities providing surgical services as Class "A", "B", or "C." The classification is based on two factors: whether the surgery is considered minor or major and the method of anesthesia use.¹⁶⁶

162. *Id.* at 824.

163. *Id.*

164. *Id.* at 820-24. The case contains a detailed discussion of personal liability by piercing the corporate veil and has subsequently been frequently cited in that regard. See *District of Columbia v. Campbell*, 580 A.2d 1295, 1303-04 (D.C. App. 1990); *Global Credit Services v. AMISB*, 508 N.W. 2d 836, 842 (Neb. 1993); *T.V. Spano Bldg. v. Dept. of Natural Resources*, 628 A.2d 53, 61 (Del. Supr. 1993); see also, *Physician Malpractice-Abortion* 69 ALR 4th 882 (disregard of statute or ordinance may lead a court or jury to conclude that the doctor has a tendency to disregard externally imposed mandates of practice); see also, Stephen B. Presser, *PIERCING THE CORPORATE VEIL* (1997).

165. If a statute or ordinance is enjoined by a court as of the date of the injury, it has been held that tort liability cannot be based upon violation of the portion enjoined. *Eubanks v. Brown*, 604 F. Supp. 141 (D. Ct. Ky. 1984); *Eidson V. Reproductive Health Services*, 863 S.W.2d 621 (Mo. App. 1993).

166. *GUIDELINES*, *supra* note 23, at 25-26. See also *GUIDELINES FOR OPTIMAL OFFICE-*

The Guidelines for Women's Health Care, recently published by the American College of Obstetricians and Gynecologists, states that, "All legal requirements must be met, and clinicians who perform abortions should be aware of state statutes and regulations regarding abortion services."¹⁶⁷ Further,

Abortions may be performed in a physician's office, an outpatient clinic, a freestanding ambulatory surgical facility, or a hospital. Ambulatory care facilities should meet the same standards of care for abortion services as for other services. Physicians who perform abortions in their offices should provide for prompt emergency treatment or hospitalization of patients in the event that a complication occurs. Clinics and freestanding ambulatory care facilities should have an established mechanism for transferring patients who require emergency treatment to a nearby hospital.¹⁶⁸

Various other governmental statutes, ordinances or regulations may also be helpful in establishing the duties of a health care professional. The various duties and responsibilities of physicians,¹⁶⁹ nurses,¹⁷⁰ counselors,¹⁷¹ laboratory technicians,¹⁷² or other health care

BASED SURGERY, (American College of Surgeons, Chicago, Ill.) (1994).

167. *Id.*, at 129.

168. *Id.*

169. *See e.g.*, 49 PA. CODE § 16.61 (1961) on Unprofessional and Immoral Conduct which sets forth some 19 specific and detailed types of unprofessional conduct of physicians; MO. ANN. STAT. § 334.100 (West 1989) entitled "Denial, Revocation or Suspension of License-Restatement," which lists 24 specific causes for discipline of physicians by the State Board of Registration of the Healing Arts.

170. *See e.g.*, KY. REV. STAT. § 314.011 (Michie 1995) (which defines registered nursing practice and specifically recognizes that the standards of the American Nurses' Association or other nationally accepted organizations of registered nurses apply to authorized nursing acts). For a source that describes the duties and responsibilities of nurses in the legal context generally, *see* G. W. GUIDO, *LEGAL ISSUES IN NURSING* (2nd ed. 1997).

171. A Virginia statute, applicable to counselors, sets forth the various types of counseling situations which require a licensed counselor, at least some of which would apply to those holding themselves out as counselors at abortion facilities; VA. CODE ANN. § 54.1-3500 (Michie 1994) (defining counseling and the practice of counseling); VA. CODE ANN. § 54.1-3501 (Michie 1994) (listing exemptions of requirements of licensure). Missouri defines licensed professional counselors at MO. ANN. STAT. § 337.500 (West 1989) (Definitions),

professionals are frequently found in statutes or regulations, sometimes in considerable detail. Existing state malpractice law may also provide the basis for establishing the necessary legal duty.¹⁷³

B. Septic Abortion—Failure to Follow-Up

In *S.R. v. City of Fairmont*¹⁷⁴ the plaintiff went to Pittsburgh, Pennsylvania to have an abortion performed at the Allegheny Reproductive Health Center (Allegheny Center).¹⁷⁵ At the time, she was a student at Fairmont State College in West Virginia. After filling out routine forms, she saw an obstetrician-gynecologist (ob/gyn) who worked at the Allegheny Center.¹⁷⁶ The ob/gyn had contracted with the Allegheny Center through Infertility Services, a Pennsylvania medical professional corporation, to do abortions at Allegheny Center and was paid by them.¹⁷⁷ The doctor owned all of

MO. ANN. STAT. § 337.505 (West 1989) (Exempted Professions and Occupations), and MO. ANN. STAT. § 337.530 (West 1989) (Violation).

172. See e.g., The Clinical Laboratory Improvements of 1988, a Federal act which requires federal oversight for all laboratories, including physicians offices, that perform tests that examine human specimens for the diagnosis, prevention or treatment of any disease, impairment of health, or health assessment. A statutory scheme is established for registration and licensing such laboratories and also maintaining a list of laboratories determined not to be in compliance. See generally, GUIDELINES, *supra* note 23, at 225-230, Appendix F.

173. See e.g., *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972) (informed consent); *Cobbs v. Grant* 502 P.2d 1 (Cal. 1972) (informed consent); *Mackey v. Greenview Hospital, Inc.*, 587 S.W.2d 249 (Ky. App. 1979) (failure to take a careful medical history of patient found to be a basis for liability) (see 2 AM. LAW MED. MALP. § 6.13 for discussion of *Mackey*); *Corn v. French*, 298 P.2d 1973 (Nev. 1955) (signed written consent form not controlling); *Yorston v. Pennell*, 153 A.2d 255 (Pa. 1959) (a physician must consider the history given by the patient and failure to do so may constitute malpractice); *Schafer v. Lehrer*, 476 So.2d 781 (Fla. App. 4 Dist. 1985) (fraudulent concealment); *Clair v. Reproductive Health Services*, 720 S.W.2d 793 (Mo. App. 1 1986) (tolling of medical malpractice statute is proper where there was allegation of fraudulent concealment and refusal to disclose records of patient's treatment); *Henry v. Deen*, 310 S.E.2d 326 (N.C. 1984) (alleged civil conspiracy relating to alteration of medical records); *Childs v. Weis*, 440 S.W.2d 104 (Tex. App. 1969) (minimal contact between health care professionals and a woman needing medical treatment may establish physician-patient relationship); see also 17 A.L.R.4th 132 (1986) for what constitutes physician-patient relationship for malpractice purposes.

174. 280 S.E.2d 712 (W. Va. 1981).

175. *Id.* at 714.

176. *Id.*

177. *Id.*

the stock in Infertility Services. The Allegheny Center had advertised its abortion services in the Fairmont area and had listed a toll-free number in the Fairmont telephone directory.¹⁷⁸ It also did similar advertising and had telephone listings in Wheeling, Clarksburg, and Morgantown, West Virginia.

At the time of the abortion by Dr. Wadwha, there was evidence that certain fetal parts had not been removed. One of the medical records prepared by the doctor contained the statement: “?? [sic] complete-fetal parts seen.”¹⁷⁹ However, the plaintiff was apparently discharged without being so advised.¹⁸⁰ When the plaintiff returned to Fairmont, she developed cramps, vaginal bleeding and fever.¹⁸¹ She went to Fairmont General Hospital, but its personnel were apparently unsuccessful in diagnosing the exact nature of the problem.¹⁸² She went into shock. Ultimately, she was transferred to the West Virginia Medical Center where the personnel there were able to save her life.¹⁸³ However, before the undelivered fetal parts were removed, the plaintiff developed acute renal failure¹⁸⁴ arising from the septic abortion. The plaintiff, in the absence of a kidney transplant, had to rely upon ambulatory peritoneal dialysis as a life support system.¹⁸⁵

Plaintiff brought suit in a West Virginia court, alleging medical malpractice against the Allegheny Reproductive Health Center, Infertility Services, and the City of Fairmont.¹⁸⁶ The plaintiff

178. *Id.* at 714.

179. *Id.*

180. *Id.*

181. *Id.*

182. *Id.*

183. *Id.*

184. See N. Kevin Krane, *Acute Renal Failure in Pregnancy*, 148 ARCH. INTER. MED. 2347, 2347 (1988) (stating that infectious causes of acute renal failure include septic abortion).

185. *S.R.*, 280 S.E.2d at 714.

186. Defendant admitted that the West Virginia court had jurisdiction over Allegheny Center under its long-arm statute, W. VA. CODE § 31-1-15 (1996). However, the attorneys for Infertility Services contested the jurisdiction of the West Virginia court because it was a Pennsylvania corporation and had not done business in West Virginia. *Id.* Therefore, the trial court dismissed Infertility Services from the suit and the issue was appealed. *Id.* The appeals court reversed the order which had dismissed Infertility Services from the suit. *Id.* The receipt of a direct economic benefit from solicitations in West Virginia, was held to be sufficient to establish personal jurisdiction under the West Virginia long-arm statute. See also *Stills v. Gratton*, 55 Cal.3d 698, 127 Cal. Rptr. 652 (1976) (doctor who performed

contended that the doctor knew the abortion was not complete, but permitted her to return to West Virginia without arranging for or advising her on proper follow-up care, except to call Allegheny Center if she had problems.¹⁸⁷ The appeals court held that Infertility Services was required to arrange for a competent source of treatment in West Virginia that could intelligently provide follow-up care in the light of the probable unsuccessful abortion.¹⁸⁸ The breach of duty to provide follow-up care caused substantially increased injury.

S.R. is an example of the failure of a doctor to advise, refer, monitor, and provide appropriate aftercare. Although the doctor recognized that the abortion appeared to be incomplete, the patient was discharged without warning or making arrangements for monitoring or other assistance. Nor was there any evidence that the doctor ever submitted the recovered portion of the fetal remains for further pathological or histologic examination. By failing to do any of these things, the defendant doctor violated the standards and guidelines of The American College of Obstetricians and Gynecologists (ACOG). According to ACOG Standards for Obstetric-Gynecologic Services:

Removed tissue should be submitted to a pathologist for examination. Routine pathologic examination of tissue may not be necessary, however, following the elective termination of a pregnancy in which fetal or embryonic parts can be identified. In such instances, the physician should simply record a description of the gross products of conception. The patient should be informed of operative findings, including the results of the tissue examination.¹⁸⁹

Subsequent ACOG guidelines issued in 1996 modified this standard and now state:

incomplete abortion has a continuing duty of care despite living in different city from patient).

187. *S.R.*, 280 S.E.2d at 714.

188. *Id.*

189. THE AMERICAN COLLEGE OF OBSTETRICIANS-GYNECOLOGISTS, STANDARDS FOR OBSTETRIC-GYNECOLOGIC SERVICES 65 (1989).

Before the patient is released from the facility, aspirated tissue should be examined to verify that villi or fetal parts are present. If villi or fetal parts cannot be identified with certainty, the tissue specimen should be sent for further histologic examination and the patient alerted to the possibility of an ectopic pregnancy. If the tissue suggests a molar pregnancy the patient should be so informed and appropriate management instituted.¹⁹⁰

The incidence of incomplete abortion following first trimester abortion is not rare. Studies by Scandinavian and New Zealand researchers found that between 2.4 percent to 4.8 percent of women had retained fetal parts and required hospitalization when evaluated up to six weeks post-abortion.¹⁹¹ Delay in treatment, as in *S.R.*, can result in serious life-threatening infection. The importance of not delaying care is underscored in a medical text on abortion which states, "The major difficulty in preventing the septic complication associated with abortion is not having had the opportunity to examine the patient in the early stages of the infection."¹⁹²

The issues surrounding the failure of abortion facilities to provide adequate follow-up care to women who have had abortions are complex. Many women are self-referrals¹⁹³ and may not provide the name of a doctor at the time of their abortion. Also, many find the abortion to be a negative experience, and do not desire to return to the

190. GUIDELINES, *supra* note 23, at 129.

191. K. Dalaker et al., *Early Complications of Induced Abortion in Primigravidae*, 70 ANNALES CHIRURGIAE ET GYNAECOLOGIAE 331, 331 (1981) (4.8% of women had retained fetal parts 4-6 weeks following abortion by vacuum aspiration); Fritjof Jerve & Petter Fylling, *Therapeutic Abortion*, 57 ACTA OBSTET GYNECOL SCAND 237, 237 (1978) (3.9% hospital readmissions with pelvic infections and retained fetal parts being the main causes); Peter Sykes, *Complications of Termination of Pregnancy: A Retrospective Study of Admissions to Christchurch Women's Hospital, 1989 and 1990*, 106 N. Z. MED. J. 83, 84 (1993) (2.4 - 2.6% of women had hospital admission for retained products of conception after first trimester abortion; 7.8% of women with abortions at 14+ gestational weeks had hospital admission with retained products.)

192. SEBASTIAN FARO & MARK PEARLMAN, INFECTIONS AND ABORTION 83 (1992).

193. Uta Landy & Sarah Lewit, *Administrative, Counseling and Medical Practices of National Abortion Federation Facilities*, 14 FAM. PLAN. PERSP. 257, 257 (1982) (A 1981 survey reported that 70% of National Abortion Federation member facilities accept patients who come to the facility without an appointment or referral).

abortion facility for follow-up care.¹⁹⁴ Others may give fictitious information or may move shortly after the abortion, so it may be difficult or impossible to locate them.¹⁹⁵ Also, some abortionists travel from city to city doing abortions, and may be in a given city only once a week. Other women attempt to recontact the abortion facility but receive unsatisfactory or inaccurate responses from unqualified personnel.

*C. Negligent Diagnosis of Ectopic Pregnancy—
Failure to Read or Properly Interpret Report*

In *Williams v. Robinson*,¹⁹⁶ the plaintiff, Maurine Williams, went to Summit Medical Center seeking an abortion. The abortion was performed by the defendant, Dr. Ralph Williams, who used the suction curettage method.¹⁹⁷ After the abortion, the plaintiff was taken to a recovery room where the nurse gave her either a prescription or actual antibiotic tablets, and told her she should not take sit-down baths or engage in sexual intercourse for the next three weeks.¹⁹⁸ She was also told to return for a follow-up visit in three weeks. This was the plaintiff's second induced abortion.¹⁹⁹ The next morning, the plaintiff noticed she was feeling different than she had after the earlier abortion. She had morning sickness and was experiencing cramping and spotting. She also believed that she should be experiencing heavier bleeding.²⁰⁰ After four days, when the symptoms still had not

194. Pentti Joupila et al., *Observations on Patients Two Years After Legal Abortion*, 19 INT'L J. FERTIL. 233 (1974) (a Finnish study attempted to contact 562 women two years after a legal abortion, but only 25% returned to the facility for follow-up. The rest either had an unknown address, or were unwilling to take part in the discussion of an experience with negative personal associations).

195. A representative of a Phoenix (Az.) abortion facility reported that two-thirds of the women who have had abortions will never be heard from again. She was quoted as saying, "We'll call the number they've listed, and it will be nonexistent." Susan Reed, *The Abortion Clinic: What Goes On*, PEOPLE WKLY., Aug. 26, 1985, at 106; Catherine A. Barnard, *The Long-term Psychological Effects of Abortion* (Institute for Pregnancy Loss, Portsmouth, N.H.) (1990) (in a study of 984 women who had abortions at a Baltimore area abortion facility during 1984-86, only 160 could be contacted 3-5 years later.)

196. 512 So. 2d 58 (Ala. 1987).

197. *Id.*

198. *Id.*

199. *Id.*

200. *Id.*

disappeared, the plaintiff called the toll-free number for Summit Medical Center.²⁰¹ A woman answered the phone and the plaintiff asked to speak to a nurse. She was informed that a nurse was not available, but the woman asked if she could help.²⁰² The plaintiff described her symptoms and explained that she felt she was still pregnant. The woman replied that the cramping and spotting were normal, and as to the morning sickness, it was simply a “neurotic reaction” to the abortion.²⁰³

The plaintiff’s symptoms continued, prompting the plaintiff to call the facility again eight days after the abortion. Yet another time, the plaintiff was told that a nurse was not available, but another person was called to the phone.²⁰⁴ This person told the plaintiff that her symptoms were not abnormal. There was no evidence that the defendant doctor was ever advised of the calls.²⁰⁵ However, shortly thereafter, the plaintiff experienced sharp pains in her stomach. When she got up and tried to go to the bathroom, she fainted. An ambulance was called, and with the help of a neighbor, the plaintiff was taken to the hospital. She underwent emergency, life-saving exploratory surgery which revealed a pregnancy in one of her fallopian tubes.²⁰⁶

The plaintiff then filed suit against the doctor who performed the abortion and against Summit Medical Center.²⁰⁷ The plaintiff claimed that both had been negligent in not advising her of the risk of the abortion procedure, failing to provide post-operative care, failing to use the degree of skill and care required, failing to warn of the dangers of ectopic pregnancy, and failing to diagnose an ectopic pregnancy.²⁰⁸ The defendant doctor claimed there were two pregnancies, one uterine and the other in her fallopian tube. Therefore, he was not negligent.²⁰⁹

The trial court dismissed the plaintiff’s claim, even though the plaintiff submitted a damaging affidavit of an expert forensic

201. *Id.* at 58.

202. *Id.*

203. *Id.*

204. *Id.*

205. *Id.* at 64 (Houston, J., dissenting).

206. *Id.* at 59.

207. *Id.*

208. *Id.*

209. *Id.* at 65 (Houston, J., dissenting).

pathologist. The affidavit stated that the defendant doctor violated the appropriate standard of care by failing to diagnose the ectopic pregnancy and failing to provide proper follow-up care.²¹⁰ The defendant's operative report stated that the products of conception were normal and that the fetal age was six weeks.²¹¹ This, however, conflicted with the pathology report which showed only compact and spongy decidual endometrium and chorionic villi, and no fetal tissue.²¹² The plaintiff's expert stated that the defendant doctor violated the standard of care when he relied solely on the existence of chorionic villi to exclude the possibility of an ectopic pregnancy.²¹³ It was also alleged that the defendant doctor had not read the pathology report in which there was no mention of a fetus or embryo.²¹⁴ According to the defendant doctor, the fetus was microscopic; however, the plaintiff's expert stated, in reliance upon medical articles on the subject, that the fetus was 22-24 millimeters in size at six weeks and could have been readily seen.²¹⁵ The appeals court reversed the dismissal of the plaintiff's claim because there were genuine issues of material fact.²¹⁶

A leading text on abortion techniques states, "[w]hen a scanty amount of tissue or only decidual tissue is obtained, the patient should be warned that she may have an unruptured tubal pregnancy."²¹⁷ No such warning was ever given to the plaintiff, even after the report from the pathology lab was received.²¹⁸ Thus, there appeared to be a failure to warn as well as negligence in not reading the pathology report.

The case was allowed to proceed despite the fact that the plaintiff had signed a Consent to Abortion form which contained the following language:

I understand that having an abortion involves some risks to

210. *Id.* at 62.

211. *Id.* at 63.

212. *Id.* at 60.

213. *Id.* at 61.

214. *Id.* at 62.

215. *Id.* at 63.

216. *Id.*

217. HERN, *supra* note 19, at 169.

218. *Williams*, 512 So.2d at 62.

me, including the following: . . . Ectopic pregnancy or pregnancy in the tubes . . . [followed by] . . . an abortion procedure will not necessarily terminate such a pregnancy . . . I understand that the doctor and the clinic make no guarantee regarding the abortion. . . . If the abortion is incomplete, I understand that the procedure may have to be repeated or I may still be pregnant.²¹⁹

This language was not controlling, possibly because the doctor did not advise the plaintiff of the unfavorable test results, which had life threatening consequences due to the delay. Thus, there was a basis for the trier of fact to determine that the defendant was negligent.²²⁰ Furthermore, a physician has a duty to inform a patient of the nature and hazards of disease or treatment. Although the consent form disclosed that a tubal pregnancy was a possibility in the context of a missed or incomplete abortion, it did not disclose the potentially life-threatening serious consequences of such a pregnancy.²²¹

The consent form might also be deemed a contract of adhesion. An adhesion contract is typically a standardized form offered to a consumer of goods or services on essentially a "take it or leave it" basis without offering a realistic opportunity to bargain. Such a contract is offered under such circumstances that the consumer cannot obtain the desired product or services except by acquiescing and signing the form contract. The concept of adhesion contracts has been applied in the context of abortion.²²² Additionally, a provision in

219. 512 So.2d 58, 64 (Houston, J., dissenting).

220. Jack W. Shaw Jr., Annotation, *Malpractice: Failure of Physician to Notify Patient of Unfavorable Diagnosis or Test*, 49 A.L.R.3d 501 (1973); see also *Corn v. French*, 289 P.2d 173 (Nev. 1955) (this landmark case held that, in a malpractice action, the fact that the patient signed a consent form did not foreclose inquiry into negligent conduct in determining the advisability and necessity of an operation).

221. W.M. Moldoff, Annotation, *Malpractice: Physician's Duty to Inform Patient of Nature and Hazards of Disease or Treatment*, 79 A.L.R.2d 1028 (1961).

222. *Broemmer v. Abortion Services of Phoenix, Ltd.*, 840 P.2d 1013 (Ariz. 1992) (en banc)(unenforceable contract of adhesion); *Sanchez v. Simmons*, 467 N.Y.S.2d 757 (N.Y. 1983) (arbitration clause in "Consent to Abortion" form furnished by physician and signed by patient could not be invoked to compel arbitration in medical malpractice action since it had not been demonstrated that patient had made an informed and knowledgeable waiver of her constitutional right to trial by jury).

an abortion consent form that prohibited the patient from filing suit has been struck down on public policy grounds.²²³

*D. Negligent Diagnosis of Ectopic Pregnancy—
Nursing Negligence*

In *Baker v. Metro Health*,²²⁴ the twenty-four-year-old plaintiff received a \$100,000 settlement after having a hysterectomy. This procedure was necessitated by the doctor's failure to diagnose an ectopic pregnancy.²²⁵ The plaintiff had irregular bleeding and pain over a 12 week period. She was seen by nurses at a health maintenance organization (HMO). Several pregnancy tests were positive, but an ultrasound showed no fetus in the womb.²²⁶ A radiologist's report was equivocal.²²⁷ The nurses failed to report to, or obtain opinions from any medical doctors or ob/gyn specialists. The plaintiff underwent a dilatation and curettage which caused a rupture of the fallopian tube where the ectopic pregnancy had occurred.²²⁸ As a result, the plaintiff required an emergency hysterectomy. Plaintiff sued the HMO, alleging that the defendant's staff was negligent in failing to diagnose the plaintiff's ectopic pregnancy.²²⁹ The case was settled for the defendant's \$100,000 policy limits.²³⁰

Baker is an example of nursing malpractice. Whether nursing malpractice exists is determined by examining nursing standards, which include: state nursing practice acts; standards of professional organizations, such as the American Nurses Association and the Association of Women's Health, Obstetric and Neonatal Nurses; institutional standards; and standards of such organizations as the National Abortion Federation.²³¹ The standards of the American

223. *Olson v. Molzen*, 558 S.W.2d 429 (Tenn. 1977) (exculpatory contract signed by patient as a condition of receiving abortion was invalid as contrary to public policy).

224. 7 VERDICTS AND SETTLEMENTS, No. 7, July, 1987 at 155.

225. *Id.*

226. *Id.*

227. *Id.*

228. *Id.*

229. *Id.* at 155.

230. *Id.*

231. *Id.* (statement of expert witness in abortion injury malpractice case involving alleged negligence of a nurse).

Nurses Association state, “[n]urses must be aware of their own individual competencies. When the needs of the client are beyond the qualifications and competencies of the nurse, consultation and collaboration must be sought from other qualified nurses, other health professionals, and other appropriate sources.”²³² The defendant was negligent because its nurses failed to adhere to this standard.²³³

*E. Negligent Diagnosis of Ectopic Pregnancy—
Failure to Convey Results of Pathology Report*

In *Lepage v. Ojeda and Eastland Women's Clinic*,²³⁴ the plaintiff suffered the loss of her right ovary and fallopian tube after the defendant doctor failed to diagnose an ectopic pregnancy.²³⁵ The plaintiff had sought an abortion from the defendant doctor. Prior to the abortion, the plaintiff had experienced cramping and bleeding.²³⁶ The defendant diagnosed the plaintiff's symptoms as an incomplete spontaneous abortion and performed a D&C.²³⁷ Two days later, the defendant received a pathology report indicating that the plaintiff had a possible ectopic pregnancy, but the defendant apparently failed to notify the plaintiff of the results.²³⁸ One month later, the plaintiff's fallopian tube ruptured. The plaintiff suffered the loss of her right ovary and fallopian tube.²³⁹ The plaintiff sued the defendant, alleging medical malpractice based upon failure to diagnose an ectopic pregnancy and the jury awarded her the sum of \$217,000.²⁴⁰

232. AMERICAN NURSES ASSOCIATION, CODE FOR NURSES WITH INTERPRETIVE STATEMENTS 11 (1985).

233. See also *Berdyck v. Shinde*, 613 N.E.2d 1014 (Ohio 1993) (nurses deviated from standard of care by failing to recognize signs and symptoms presented by patient, failed to keep patient under close supervision, and failed to make the appropriate report of her symptoms to physician); *Elam v. College Park Hospital*, 183 Cal. Rptr. 156 (Cal. App. 1982) (in another case involving nursing negligence related to ectopic pregnancy, it was held that a hospital is liable under the doctrine of corporate negligence for the negligent conduct of independent physicians and surgeons who are not employees or agents of the hospital).

234. Case No. 89-4171-NH (Macomb Co., MI, Feb. 5, 1991).

235. *Id.*

236. *Id.*

237. *Id.*

238. *Id.*

239. *Id.*

240. *Id.*

The National Abortion Federation (NAF) requires that "there must be an appropriate mechanism for contacting the patient and informing her of the significance of the pathology laboratory's report."²⁴¹ The failure to advise the plaintiff within a reasonable time of the results was likely deemed sufficient evidence of malpractice and the cause the injury. If a woman seeks an abortion, the opportunity exists for an unruptured ectopic pregnancy to be diagnosed. However, most are not frequently diagnosed. In a four year study of 41,753 abortions at two Planned Parenthood facilities, only two of 11 unruptured pregnancies were actually diagnosed.²⁴² The study noted that as many as 40 percent of the women were not surveyed due to faulty follow-up; however, the authors believed that the number of ectopic pregnancies was probably much higher.²⁴³ The Center for Disease Control (CDC) has reported that, between 1970-1985, the estimated rate of ectopic pregnancies—concurrent with attempted induced abortions—was 1.35 per 1000 abortions.²⁴⁴ A more recent study by a New York city abortion facility has found an incidence of concurrent ectopic or tubal pregnancies at the time of first trimester abortion to be 5.9 per 1000 abortions.²⁴⁵ Thus, there is considerable potential for negligence.

In some cases, the failure to identify an ectopic pregnancy at the time of the abortion, has resulted in the death of women.²⁴⁶ In a study published by the CDC, covering the period from 1972-1984, twenty four women were identified who underwent an attempted induced abortion and died as a result of a ruptured ectopic pregnancy shortly thereafter. The failure to diagnose the ectopic pregnancy before the woman left the facility was deemed the cause of their deaths.²⁴⁷ Further, in 1992, 113,000 U.S. women were reportedly hospitalized because of an ectopic or tubal pregnancy, and between 1979-1986

241. NATIONAL ABORTION FEDERATION, STANDARDS FOR ABORTION CARE 10 (1987) [hereinafter STANDARDS].

242. Leonard A. Schonberg, *Ectopic Pregnancy and First Trimester Abortion*, 49 *OBSTET. & GYNECOL.* 73, 74 (1977).

243. *Id.* at 75.

244. Atrash et al., *supra* note 9, at 726.

245. Steven R. Goldstein et al., *An Updated Protocol for Abortion Surveillance with Ultrasound and Immediate Pathology*, 83 *OBSTET. & GYNECOL.* 55, 57 (1994).

246. *See generally* Atrash, *supra* note 9.

247. *Id.*

death from ectopic pregnancy represented 343 maternal deaths out of 1363 (24.9 percent) reported by the CDC during that period.²⁴⁸ Since at least 1988, improved diagnostic methods have been available which may be utilized by abortion facilities to identify ectopic pregnancies on site, while the woman is still at the facility.²⁴⁹

In 1990, a modified method was reported which combines the use of ultrasound diagnosis to determine if the gestational sac is present, together with a particular level of hCG (the hormone which signifies a woman is pregnant).²⁵⁰ This sonographic-pathologic diagnostic method is reportedly effective in diagnosing 90 percent of the cases of ectopic pregnancy before rupture.²⁵¹ Due to its effectiveness, there is much less likelihood of serious injury or possible death. It may now, therefore, be considered medical malpractice for an abortion facility not to use this sonographic-pathologic method for on-site screening.

F. Recovery for Abortion Injury after Negligent Exposure of Pregnant Woman to X-Rays

In *Deutsch v. Shein*,²⁵² the plaintiff, a patient of the defendant doctor, sued the defendant for physical and mental pain and suffering. The plaintiff decided to terminate her pregnancy by abortion after the defendant exposed her to diagnostic X-rays while she was pregnant without testing her for pregnancy beforehand.²⁵³ Prior to the decision

248. Lisa M. Koonin et al., *Maternal Mortality Surveillance, United States, 1979-1986*, 40 SS-2, MORBIDITY AND MORTALITY WK REP. 1, July, 1991. Listed diagnosis for patients discharged from short-stay non-Federal hospitals, females aged 15-44. VITAL AND HEALTH STATISTICS. Detailed Diagnoses and Procedures. National Hospital Discharge Survey, Series 13, No. 118, U.S. Dept. HSS, PHS, Centers for Disease Control and Prevention, Aug. 1994.

249. Steven R. Goldstein et al., *Combined Sonographic-Pathologic Surveillance in Elective First-Trimester Abortions*, 71 OBSTET. & GYNECOL. 747, 747 (1988); Steven G. Kaali et al., *Updated Screening Protocol for Abortion Services* 76 OBSTET. & GYNECOL. 136, 136 (1990).

250. Goldstein et al., *supra* note 249, at 747; S. G. Kaali et al., *Updated Screening Protocol for Abortion Services*, 76 OBSTET. & GYNECOL. 136 (1990).

251. Richard E. Leach & Steven J. Ory, *Modern Management of Ectopic Pregnancy*, 34 J. REPROD. MED. 324 (1989); Catherine A. Churgay & Barbara S. Apgar, *Ectopic Pregnancy: An Update on Technologic Advances in Diagnosis and Treatment*, 20 PRIMARY CARE 629 (1993).

252. 597 S.W.2d 141 (Ky. 1980).

253. *Id.* at 142.

to undergo the abortion, the plaintiff had seen various articles which stated that X-rays, administered to a pregnant woman, could injure the fetus.²⁵⁴ She also consulted her pediatrician, who stated that abortion was "medically indicated," but refused to advise her whether to have an abortion.²⁵⁵ She also discussed the situation with her priest and her family.²⁵⁶

At the trial, the defendant introduced expert testimony which said that the amount of diagnostic radiation administered did not warrant a therapeutic abortion.²⁵⁷ The jury found that the doctor had been negligent, but that the negligence was not a substantial factor in causing the injury. Therefore, the trial court dismissed the plaintiff's claim.²⁵⁸ On review, the Kentucky Supreme Court reversed the trial court and held that the doctor's negligence was the legal cause of the plaintiff's injury.²⁵⁹ The court reasoned that the act of exposing the woman to X-rays was sufficient physical contact to support a claim for mental suffering.²⁶⁰ The court then remanded the case to the trial court for a retrial on the amount of damages, which they insisted should not exceed \$250,000.²⁶¹

This abortion could have been prevented if the plaintiff had received accurate, timely, and precise information on the exact amount of radiation she had received and its effect, if any, on her unborn child. From the case, it appears that the defendant doctor or her pediatrician could have provided such information.²⁶² A recent article provides a number of examples where medical professionals casually suggest abortion—whenever they think there might be a risk to the mother or unborn child—without any real familiarity with the medical literature on the subject.²⁶³

254. *Id.* at 143.

255. *Id.*

256. *Id.*

257. *Id.*

258. *Id.*

259. *Id.* at 146.

260. *Id.*

261. *Id.* at 147.

262. *Id.* at 145.

263. See generally Thomas Goodwin, *Medicalizing Abortion Decisions*, 61 FIRST THINGS 33 (1996).

G. Abortion Without Consent/Abandonment

Abortions performed without the woman's consent have resulted in liability. In *Gemmel v. Lebed, M.D.*,²⁶⁴ the plaintiff had experienced gynecological problems and visited the defendant gynecologist. She told the gynecologist that she thought she was pregnant, but the defendant failed to give her a pregnancy test.²⁶⁵ He scraped her uterus to remove benign polyps and, without telling her, aborted her 12 week old unborn child.²⁶⁶ Three months later, she learned she had been pregnant when another doctor, who had examined the pathology reports on the tissue, asked her, "Why did you have that done when you were pregnant?"²⁶⁷ Plaintiff instituted a suit for medical malpractice against the defendant.²⁶⁸ "The woman was totally devastated," said her lawyer. The plaintiff's husband also died within a year of the abortion.²⁶⁹ At the time of trial, seven years after the abortion, the plaintiff was 45 years old. A psychiatrist testified at the trial that the plaintiff would suffer from "obsessive ruminations" about the child "for the rest of her life."²⁷⁰ A jury awarded the plaintiff the sum of \$1 million dollars.²⁷¹ Among the cases examined to date, this is the largest jury verdict in an abortion malpractice case, except where the woman has died as a result of an abortion. Among the probable reasons for the substantial verdict was testimony by the plaintiff's psychiatrist that the plaintiff would suffer the effects of the loss of her child for the rest of her life.²⁷² This established that there was substantial, long-lasting emotional injury. Second, it appears that the defendant's conduct was outrageous. Third, the plaintiff's age, in conjunction with the death of her husband shortly after the abortion, made it very likely that she would never bear any more children. The state law was also favorable to the plaintiff's position. Under

264. Case No. ____ (Common Pleas Court, Philadelphia, PA., Oct. 1986). See generally *AMERICAN LIFE LEAGUE NEWS*, Mar. 19, 1987.

265. *Id.*

266. *Id.*

267. *Id.*

268. *Id.*

269. *Id.*

270. *Id.*

271. *Id.*

272. *Id.*

Pennsylvania law, a tort founded on lack of informed consent is an intentional tort, i.e., a battery, and therefore the issue of negligence is not germane.²⁷³ The sole remaining issue was the amount of damages.²⁷⁴

In *Wright v. Germantown Hospital and Phatak*,²⁷⁵ another Pennsylvania case, the plaintiff was in the fifth month of her pregnancy and consulted a doctor who advised her to go to the emergency room of a hospital.²⁷⁶ At the hospital, another doctor diagnosed that a miscarriage was inevitable and began a drug-induced abortion, against the wishes of the plaintiff.²⁷⁷ The doctor then left the hospital, leaving an intern in charge.²⁷⁸ The intern failed to remove some fetal parts.²⁷⁹ The intern consulted the doctor by phone for further instructions.²⁸⁰ Several hours later, the remaining fetal parts, including the child's head, were aborted on the plaintiff's bed and were seen by the plaintiff.²⁸¹ The jury verdict for the plaintiff's emotional distress was \$114,000.²⁸²

The malpractice in *Wright* was not limited to the performance of an abortion without consent. The Pennsylvania code of unprofessional and immoral conduct includes as an aspect of unprofessional conduct "the [delegation of] a medical responsibility to a person when the physician knows or has reason to know that the person is not qualified by training, experience, license, or certification to perform the delegated tasks."²⁸³ In *Wright*, the doctor left the

273. Moore v. Raeuchle, 604 A.2d 1003 (Pa. 1992).

274. Grouse v. Cassel, 615 A.2d 331, 335 (Pa. 1992).

275. Case No. 87/5362 (Common Pleas Court, Philadelphia, PA, 1992).

276. *Id.*

277. *Id.*

278. *Id.*

279. *Id.*

280. *Id.*

281. *Id.*

282. The drug used to induce abortion in *Wright* was most likely a prostaglandin. If so, there is a significant likelihood of an incomplete abortion. One study found that 7.8% of women obtaining prostaglandin abortions at more than 14 weeks gestation were readmitted to a hospital because of retained fetal parts. Peter Sykes, *Complications of Termination of Pregnancy: A Retrospective Study of Admissions to Christchurch Women's Hospital 1989 and 1991*, 106 N. Z. MED. J. 83 (1993).

283. 49 PA. CODE § 16.61 (a) (14) (1997); see also *Berneco v. Prospect Hospital*, 162 A.D.2d 235, 558 N.Y.S.2d 600 (1st Dept. 1990) (alleged failure of a gynecologist to properly supervise a nurse anesthetist which resulted in an abortion-related death, is a question of

hospital, leaving an intern in charge. It appears, however, that the intern was not qualified by training or experience to carry out a drug-induced abortion. When it went awry, the intern had to obtain instructions by telephone. Furthermore, nonprofessional conduct also includes abandoning a patient. In *Wright*, it appears that the doctor left but “failed to give notice to the patient of the physician’s intention to withdraw in sufficient time to allow the patient to obtain necessary medical care.”²⁸⁴ That is yet another instance of unprofessional conduct. The abortion in *Wright* occurred during the second trimester. Studies have found that women who have second trimester abortions are more likely than women who have first trimester abortions to report severe long-term stress reactions.²⁸⁵ They are also more likely to participate in religiously oriented post-abortion support groups several years after their abortion.²⁸⁶ Also, women who abort wanted pregnancies are very likely to view the abortion as a loss of hopes and dreams.²⁸⁷ Therefore, even without the trauma of seeing fetal parts and being subjected to an unconsented procedure, long-lasting emotional distress is likely for such women who have an abortion.

H. Abortion Involving Minor Without Parental Consent

In the Texas case of *Clement v. Riston, M.D.*,²⁸⁸ the plaintiff, a minor, suffered severe emotional distress after she underwent an abortion performed by the defendant doctor. The plaintiff claimed that the defendant failed to get proper parental consent before performing the abortion.²⁸⁹ The defendant contended that the parental consent code was unconstitutional and that any emotional distress was

fact).

284. 49 PA. CODE § 16.61 (a) (17) (1997).

285. See ANNE C. SPECKHARD, THE PSYCHO-SOCIAL ASPECTS OF STRESS FOLLOWING ABORTION 34 (1987) (50% of abortions occurred in the second or third trimester compared to about 10% generally).

286. See generally JEANETTE VOUGHT, POST-ABORTION TRAUMA: 9 STEPS TO RECOVERY 70 (1991).

287. Kolker & Burke, *supra* note 140, at 513.

288. Case No. B131022 (Jefferson Co., TX, Oct. 8, 1990).

289. *Id.*

caused by the plaintiff's relationship with one of her high school teachers and the football coach.²⁹⁰ The jury returned a verdict of \$20,000 for the plaintiff.²⁹¹

This verdict appears to be too low considering the factual situation. The plaintiff is at long-term risk for emotional injury. Women who have had abortions as teenagers are more likely than other women to join such groups as Women Exploited by Abortion;²⁹² participate in post-abortion support groups because of guilt, grief or loss;²⁹³ or suffer severe adverse long-term reactions because they poorly assimilated their abortion experience.²⁹⁴ One reason for the additional risk to teenagers is the frequent coercion by others to obtain an abortion,²⁹⁵ as evidenced by the facts in *Clement*. Also, teenagers are more likely to lose their sense of innocence and idealism after a traumatic event.²⁹⁶

Abortions performed on minors involving school officials or abortion facility personnel, without the knowledge or consent of parents, has arisen in other cases. In *Arnold v. Board of Education of Escambia County, Alabama*,²⁹⁷ a counselor and vice-principal of a public school allegedly coerced a minor student and the putative father, also a minor, into deciding to obtain an abortion.²⁹⁸ The school officials also allegedly urged the students to refrain from consulting with their parents prior to making a decision.²⁹⁹ The court held that the allegations stated a cause of action for violation of civil rights, partially because the school officials had acted "under color of law."³⁰⁰

290. *Id.*

291. *Id.*

292. See DAVID REARDON, ABORTED WOMEN SILENT NO MORE 4 (1987) (in survey of women exploited by abortion members, 45% had abortions at age 19 or less).

293. See VOUGHT, *supra* note 286, at 70 (39% had abortions at age 19 or less).

294. Franco, *supra* note 82; Nancy B. Campbell et al., *Abortion in Adolescence*, ADOLESCENCE 813, 815-17 (1988) (49% of women in post-abortion support groups had abortion as teenagers).

295. Wanda Franz & David Reardon, *Differential Impact of Abortion on Adolescents and Adults*, 27 ADOLESCENCE 161, 167 (1992).

296. Joel Osler Brende, *Post-Trauma Sequelae Following Abortion and Other Traumatic Events*, 7(1) ASS'N FOR INTERDISCIPLINARY RES. VALUES AND SOC. CHANGE 1 (July/Aug. 1984) (unwanted or botched abortions likely to be a cause of trauma).

297. 880 F.2d 305 (11th Cir. 1989).

298. *Id.* at 308.

299. *Id.* at 309.

300. *Id.* at 311.

In *Boykin v. Magnolia Bay Inc.*,³⁰¹ a minor and her parents brought a claim for damages, including intentional infliction of emotional distress, against an abortion facility for performing an abortion on their daughter without their knowledge or consent.³⁰² The minor had lied to the facility about her age.³⁰³ The court ruled that the minor was in *pari delicto*³⁰⁴ as a result of her misrepresentation and could not recover damages.³⁰⁵ This also barred the parents from making any derivative claims.³⁰⁶ Additionally, the parents' parental rights claim, because it was not based on the state statutory parental consent law, was dismissed.³⁰⁷

In *Cole v. Delaware League for Planned Parenthood*,³⁰⁸ the plaintiff, a minor, claimed that she was rendered sterile as a result of an abortion at the defendant's facility.³⁰⁹ The defendant's employee, who was neither a nurse nor a physician, gratuitously assumed a fiduciary duty to counsel the plaintiff.³¹⁰ The employee then breached that duty by failing to inform the plaintiff of alternatives to an abortion, risks of abortion, biological information regarding the development of the unborn child, and possible long-term complications.³¹¹ The case was remanded to the trial court to

301. 570 So. 2d 639 (Ala. 1990).

302. *Id.* at 640.

303. *Id.*

304. *Id.* In *pari delicto* means "in equal fault"; "in a similar offense or crime"; "equal in guilt or in legal fault."

305. *Id.* at 641-42.

306. *Id.* at 643.

307. *Id.*

308. 530 A.2d 1119 (Del. 1987).

309. *Id.* at 1120.

310. *Id.* at 1121.

311. The U.S. Supreme Court has held that a doctor can delegate abortion counseling to a qualified person. *Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 448 (1993). In *Akron*, the Court held that "the crucial question is whether she obtains the necessary information and counseling from a qualified person, not the identity of the person from whom she obtains it." *Id.* at 448. The Court further stated that "nor do we imply that a physician may abdicate his essential role as the person ultimately responsible for the medical aspects of the decision to perform the abortion." *Id.* The Court also stated in a footnote that, "we do not suggest that appropriate counseling consists of simply a recital of pertinent medical facts. On the contrary, it is clear that the patients' needs for information and an opportunity to discuss the abortion decision will vary considerably . . . such an opportunity may be especially important for minors alienated or separated from their parents." Thus, for most patients, the mere provision of a printed statement of relevant information is not

determine whether the case was instituted before the expiration of the applicable statute of limitations.

In *Eidson v. Reproductive Health Services*,³¹² a wrongful death suit was brought by the parents of a 14-year-old girl who committed suicide a few weeks after having an abortion.³¹³ The girl had been brought to a Planned Parenthood facility for a pregnancy test by her 21-year-old half-sister.³¹⁴ An abortion appointment was scheduled at the defendant's facility. Although the half-sister knew otherwise, the deceased girl answered, "No" to the questions "Have you ever received counseling?" and "Have you ever been hospitalized other than for childbirth."³¹⁵ In fact, the deceased girl had been hospitalized for psychiatric problems and had received counseling previously for aggressive behavior and conduct disorder.³¹⁶ Following the abortion, the girl stopped taking care of herself and became withdrawn and depressed.³¹⁷ An expert witness testified that the suicide was a direct consequence of the depression, and that the abortion was "the straw

considered counseling. *Id.* at 449 n.41.

The Court, in permitting delegation of abortion counseling, said "the importance of well-trained and competent counselors is not in dispute." *Id.* (citing the AMERICAN PUBLIC HEALTH ASSOCIATION (APHA) RECOMMENDED GUIDELINE 654 & NATIONAL ABORTION FEDERATION STANDARDS 2 (1981)).

The standards of APHA or the National Abortion Federation (NAF), though possibly establishing the usual customary practice, do not reflect what is necessarily prudent. However, only a few courts have rejected a customary medical practice test. *See e.g.*, *Helling v. Carey*, 519 P.2d 981, (Wash. 1974); *Nowatske v. Osterloh*, 543 N.W.2d 265 (Wis. 1996); and *Lundahl v. Rockford Memorial Hospital Association*, 235 N.E.2d 671, 674 (Ill. App. 2d 1968) (stating that "what is usual or customary procedure might itself be negligence"). This is the case with abortion counseling. For example, neither the APHA or NAF standards require counseling on fetal development; yet, failure to provide such information may result in severe psychological injury to post-abortion women. *See e.g.*, Thomas Strahan, *Misrepresentation of Ignorance of Fetal Development as a Factor in Psychological Injury Following Induced Abortion*, Newsletter (Ass'n for Interdisciplinary Research in Values and Social Change, Washington, D.C.) May-June 1996 at 1.

312. 863 S.W.2d 621 (Mo. Ct. App. E.D. 1993); *see also* *In the Matter of Anonymous*, 599 So.2d 1213 (Ala. Civ. App. 1992) (subsequently overturned on appeal where a court of civil appeals denied a minor's request for a parental abortion consent waiver. The trial court ruled the young woman was not sufficiently mature to decide for herself and the abortion would not be in her best interests because of her possible feelings of guilt).

313. 863 S.W.2d at 621.

314. *Id.* at 623.

315. *Id.*

316. *Id.* at 622-23.

317. *Id.* at 624.

that broke the camel's back."³¹⁸ However, the jury found in favor of the defendant, and this was affirmed on appeal, because the court held that the alleged negligence did not proximately cause the suicide.³¹⁹

I. Abortions Resulting from Mistakes of Relevant and Material Facts

Another type of abortion injury, similar to abortions without consent, occurs when the plaintiff mistakenly believes the validity of a certain relevant and material fact which results in her decision for abortion. For example, in *Johnson v. United States*,³²⁰ a suit was allowed under the Federal Tort Claims Act where a female member of the U.S. Army donated blood at a blood drive at a military hospital.³²¹ She was informed she had HIV.³²² She was also told that the baby she was carrying would be born with AIDS.³²³ Based on that information, the plaintiff had an abortion.³²⁴ A later test showed she did not have HIV.³²⁵ She was permitted to sue based upon a claim of negligent advice, which resulted in her having an unnecessary and unwanted abortion. The court, in allowing the suit, held that the activity, i.e., blood donation, was a civilian activity and not a military one, and did not arise out of or in the course of activity incident to military service.³²⁶

In a California case,³²⁷ the plaintiff was sexually assaulted and

318. *Id.* at 627.

319. *Id.* at 621. A recent Finnish study found that suicide among women after induced abortion was 6 times higher than after childbirth and 3 times higher than women in general. Mika Gissler et al., *Suicides after Pregnancy in Finland, 1987-1994: Register Linkage Study*, 313 BR. MED. J. 1431, 1431 (1996).

320. 810 F. Supp. 7 (D.D.C. 1993).

321. *Id.* at 8.

322. *Id.*

323. *Id.*

324. *Id.*

325. *Id.*

326. *Id.* at 9-10.

327. Names Withheld, CALIFORNIA JURY VERDICT AND SETTLEMENT REPORTS (1990); see also *Johnson v. City of Bremerton*, Case No.89-2-00218-5 (Kitsap Co., Washington). 12 LEX VITAE 2 (Spring/Summer 1991) (this case, involving a former police detective and her employer, was settled where the police officer claimed that she suffered a nervous breakdown after she was forced to assist a rape victim in obtaining an abortion and to package the aborted infant as evidence).

brought suit for negligent security against the defendant.³²⁸ Shortly after the rape, the plaintiff, recognizing she was pregnant and believing it to be the result of the rape, obtained an abortion.³²⁹ Later, she found out that her husband had fathered the unborn child.³³⁰ Her resulting emotional distress required ongoing psychiatric counseling.³³¹ The husband claimed loss of consortium.³³² The case was settled for \$115,775, which included the husband's loss of consortium.³³³

In *Pardini v. Trent M.D. and Mendocino Coast District Hospital*,³³⁴ the defendants performed an abortion on the plaintiff when she was not pregnant.³³⁵ She claimed in her suit that the false information that she was pregnant caused her psychic trauma.³³⁶ She also claimed that she was negligently treated and that the pregnancy tests were misread.³³⁷ A jury returned a \$15,000 verdict for the

328. Charles Plovovich, Annotation, *Recovery for Loss of Consortium for Injury Occurring Prior to Marriage*, 5 A.L.R.4th 300 (1981).

329. *Id.*

330. *Id.*

331. *Id.*

332. *Id.*

333. Because of the current status of abortion law, the husband's right to special damages or loss of consortium is most likely derivative and depends upon the wife's successful suit for damages. For a general discussion of medical expenses due to injury to wife as recoverable by her or her husband, see A.L. Schwartz, Annotation, *Medical Expenses Due to Injury to Wife as Recoverable by Her or by Husband*, 21 A.L.R.3d 1113 (1969); 10 AM. JUR. PROOF OF FACTS 97 (wife's damages for loss of consortium); See also Michael P. Sullivan, Annotation, *When Must Loss-of-Consortium Claim be Joined With Underlying Personal Injury Claim?*, 60 A.L.R.4th 1174 (1988) (for a discussion of when a loss of consortium claim must be joined with an underlying personal injury claim). Also, an action for loss of consortium based on non-marital co-habitation may be recognized in some states, such as California, if the relationship is "stable and significant." Charles Plovovich, Annotation, *Recovery for Loss of Consortium for Injury Occurring Prior to Marriage*, 5 A.L.R.4th 300 (1981); see also Sonja A. Soehnel, Annotation, *Action for Loss of Consortium Based on Nonmarital Cohabitation*, 40 A.L.R.4th 553.

334. Case No. 52083 (Mendocino County, CA, 1987); Performing abortions on women who are not pregnant is not as unlikely as it may seem. See e.g., *Pennsylvania Casualty Company v. Simopoulos*, 369 S.E.2d 166 (Va. 1988) (abortionist was preparing to perform an abortion on a policewoman who was not pregnant); *Shkolnik v. Nyquist*, 399 N.Y.S.2d 483 (1977) (doctor diagnosed pregnancy based on a male's urine sample); *Terra v. Department of Health*, 199 A. D.2d 577, 570, 604 N.Y.S.2d 644 (3 Dept. 1993) (OB/Gyn performed 24 abortions on patients, only two of whom were actually pregnant).

335. *Id.*

336. *Id.*

337. *Id.*

plaintiff.³³⁸

The most common pregnancy testing procedure is the detection of human chorionic gonadotropin (hCG). Misinterpretation can occur if the provider misunderstands the sensitivity of the pregnancy test used, the test is conducted too early to detect the elevation of hCG levels, the test is not performed exactly according to the instructions, or the patient has potentially interfering conditions. Abnormal pregnancies such as ectopic pregnancy, spontaneous or missed abortion, malignancy, and trophoblastic disease can cause misleading pregnancy test results.³³⁹

IV. SPECIFIC TYPES OF INJURY/DAMAGES

A. Uterine Perforation—Miscalculation of Gestational Age

In *DeJesus v. Moon*,³⁴⁰ which settled prior to trial, the plaintiff became pregnant and requested that the defendant doctor perform an abortion. The defendant performed neither a pregnancy test nor a sonogram.³⁴¹ After a vaginal examination, the defendant expressed concern that the pregnancy might be more than the 11 weeks the plaintiff had calculated.³⁴² Although the defendant was not equipped for second trimester abortions, he agreed to perform a dilation and curettage (D&C)³⁴³ for an extra \$100 instead of the suction curettage routinely used in the first trimester.³⁴⁴ The defendant commenced the D&C while the plaintiff was under general anesthesia. During the procedure, the defendant perforated the plaintiff's uterus.³⁴⁵ He then unsuccessfully attempted to perform a dilation and evacuation

338. *Id.*

339. Kenneth R. Niswander & Arthur T. Evans Manual of Obstetrics 19-20, 275 (5th ed. 1996).

340. LAW. WK.-USA, June 20, 1994, at B10.

341. *Id.*

342. *Id.*

343. Dilation and Curettage (D&C) is dilation of the cervix and curettement of the inner lining of the uterine wall.

344. LAW. WK.-USA, *supra* note 340, at B10.

345. *Id.*

(D&E)³⁴⁶ to remove the fetal remains. The plaintiff was transferred to a nearby hospital where a laparotomy³⁴⁷ was performed. The doctors discovered a 10-centimeter laceration in the uterus. Fetal parts were consistent with a 14-week gestation. A super-cervical hysterectomy and removal of the left ovary and its fallopian tube was subsequently performed.³⁴⁸ The case was settled in favor of the plaintiff for \$500,000.³⁴⁹

One common error in diagnosis occurs when a doctor relies solely upon the woman's estimate of gestational age. The standards of the National Abortion Federation standards require that "abortion providers must determine gestational age as accurately as possible prior to the choice of procedure. Tools to accomplish this include a screening pelvic examination, history and general examination, ultrasound scan, and consultation."³⁵⁰ Women may have erroneous notions of gestation if there is a history of irregular menses, failure to recognize or denial of the fact of pregnancy,³⁵¹ or bleeding that was interpreted as menses.³⁵² Accurate gestational age is particularly important if uncertainty exists about whether the age is still within the first or second trimester. In these time periods, the suction curettage procedure and the dilation and extraction model have been used respectively. A leading text on abortion techniques states:

346. Dilation and evacuation (D&E), usually done in second trimester abortion, is the dilation of the cervix, usually with laminaria or osmotic dilators, and removal of fetal parts in pieces by the use of forceps followed by curettage of the uterus.

347. Laparotomy is an incision into the loin.

348. LAW WK.-USA, *supra* note 340, at B10.

349. *Id.*

350. NATIONAL ABORTION FEDERATION, STANDARDS FOR ABORTION CARE: ETHICAL STANDARDS I (1986, 1990).

351. G. S. BERGER ET AL., SECOND TRIMESTER ABORTION PERSPECTIVES AFTER A DECADE OF EXPERIENCE, Henry P. David, *Chapter on Social Issues* 228 (1981) (listing late recognition or denial of pregnancy until signs and symptoms become obvious as a reason for second trimester abortion).

352. GUIDELINES, *supra* note 23, at 114 (among the causes of abnormal genital bleeding are menstrual dysfunction or pregnancy.); M. B. Bracken & S. V. Kasi, *Delay in Seeking Induced Abortion: A Review and Theoretical Analysis*, 121 AM. J. OBSTET. GYNECOL. 1008 (1975).

First trimester patients who are found to be 11-12 weeks from the last menstrual period should be given an ultrasound examination if there is any doubt in the examiner's mind concerning the length of pregnancy. . . It is very easy to mistake a 16-week pregnancy for a 12-week pregnancy at this stage.³⁵³

The standards of the American College of Obstetricians and Gynecologists also require the use of ultrasound if the gestational age is uncertain or needs verification.³⁵⁴

In addition to assessing gestational age, the use of ultrasound has been demonstrated to be valuable in the reduction of uterine perforations in: second trimester abortions;³⁵⁵ second trimester abortions complicated by acute retroflexion, acute anteversion, or cervical stenosis (narrow canal); cases where lower uterine segment fibroids are present; or in otherwise difficult or hazardous procedures³⁵⁶ in post-abortion uterine curettage.³⁵⁷ Ultrasound has also proven useful in the examination of women who are hemorrhaging for residual trophoblastic tissue,³⁵⁸ the examination of the uterine cavity for retained fetal parts,³⁵⁹ the identification of missed abortions,

353. HERN, *supra* note 19, at 69.

354. The American College of Obstetricians and Gynecologists: Washington, D.C., Technical Bulletin No. 187, Dec. 1993.

355. P. D. Darney & R. L. Sweet, *Routine Intraoperative Ultrasonography for Second Trimester Abortion Reduces Incidence of Uterine Perforation*, 8 J. ULTRASOUND MED. 71 (1989).

356. M. D. Hornstein et al., *Ultrasound Guidance for Selected Dilatation and Evacuation Procedures*, 31 J. REPRODUCTIVE MED., 947, 950 (1986); Robert L. Goldenberg & Richard O. Davis, *The Use of Ultrasound as an Aid During Difficult Abortion Procedures* (letter), 148 AM. J. OBSTET. GYNECOL. 826 (1984) (the authors also stated that ultrasound should be valuable in reducing the incidence of retained products of conception, failed procedures, and perforations that may complicate difficult abortion operations).

357. Roberto Romero et al., *Sonographic Monitoring of Postabortal Uterine Curettage*, 151 AM. J. OBSTET. GYNECOL. 51 (1985).

358. R. Achiron et al., *Transvaginal Duplex Doppler Ultrasonography in Bleeding Patients Suspected of Having Residual Trophoblastic Tissue*, 81 OBSTET. & GYNECOL. 507 (1993).

359. M. Stone, M. G. Elder, *Evaluation of Sonar in the Prediction of Complications after Vaginal Termination of Pregnancy*, 120 AM. J. OBSTET. GYNECOL. 890 (1974); S. Haddad et al., *Sonographic Demonstration of Endometrial Fluid Collection Following Termination of Pregnancy*, 79 OBSTET. & GYNECOL. 703 (1992).

including ectopic pregnancy;³⁶⁰ the confirmation of pregnancy, the sighting of trapped calvaria (a portion of the skull); the location of the gestational sac, placenta, or fetus; and the identification of cysts.³⁶¹

Although perforation of the uterus does not, of itself, prove negligence,³⁶² there are a number of possible situations where failure to properly diagnose or examine the woman prior to the abortion, or to use proper abortion techniques may establish negligence. The likelihood of uterine perforation is increased if the doctor: (1) is inexperienced;³⁶³ (2) underestimates the length of gestation;³⁶⁴ (3) uses forcible or rigid dilation by using metal dilators as opposed to laminaria tents, Dilipan or Lamichel;³⁶⁵ (4) uses general anesthesia instead of local anesthesia;³⁶⁶ (5) fails to position his fingers to protect against abrupt relaxation of the cervix;³⁶⁷ (6) fails to make the correct judgment of the uterine position and size immediately prior to the abortion;³⁶⁸ or (7) fails to use ultrasound, especially in the case of second trimester abortions.³⁶⁹ The use of an unnecessary instrument

360. Steven R. Goldstein et al., *An Updated Protocol for Abortion Surveillance With Ultrasound and Immediate Pathology*, 83 *OBSTET. & GYNECOL.* 55, 58 (1994); Rafael F. Valle & Rudy E. Sabbagha, *Management of First Trimester Pregnancy Termination Failures*, 55 *OBSTET. & GYNECOL.* 625, 625 (1980).

361. See generally HERN, *supra* note 19.

362. *Hitch v. Hall*, 399 A.2d 953 (Md. Ct. Spec. App. 1979); *Senesac v. Associates in Obstetrics and Gynecology*, 449 A.2d 900 (Vt. 1982).

363. David A. Grimes et al., *Prevention of Uterine Perforation During Curettage Abortion*, 251 *J. AM. MED. ASS'N* 2108, 2109 (1984); Kenneth F. Schulz et al., *Measures to Prevent Cervical Injury During Suction Curettage Abortion*, 1 *THE LANCET* 1182, 1184 (1983) (similar findings for cervical injury compared to uterine perforation).

364. S. Beach Conger et al., *A Cluster of Uterine Perforations Related to Suction Curettage*, 40 *OBSTET. & GYNECOL.* 551, 551 (1972).

365. Burritt W. Newton, *Laminaria Tent: Relic of the Past or Modern Medical Device*, 113 *AM. J. OBSTET. GYNECOL.* 442, 447 (1972); see generally Kypros H. Nicoladies et al., *Lamichel: a New Technique for Cervical Dilation Before First Trimester Abortion*, 90 *BR. J. OBSTET. GYNAECOL.* 475 (1983).

366. David A. Grimes et al., *Local Versus General Anesthesia: Which is Safer for Performing Suction Curettage Abortions?*, 135 *AM. J. OBSTET. GYNECOL.* 1030, 1034 (1978); see generally H. Trent Mackay et al., *Safety of Local Versus General Anesthesia for Second-Trimester Dilatation and Evacuation Abortion*, 66 *OBSTET. & GYNECOL.* 661 (1985).

367. CUNNINGHAM et al., *supra* note 20 at 597.

368. Peter J. Moberg, *Uterine Perforation in Connection with Vacuum Aspiration for Legal Abortion*, 14 *INT. J. GYNAECOL. OBSTET.* 77, 77 (1976).

369. Phillip D. Darney & Richard L. Sweet, *Routine Intraoperative Ultrasonography for Second Trimester Abortion Reduces Incidence of Uterine Perforation*, 8 *J. ULTRASOUND MED.* 71, 71 (1989).

which results in a uterine perforation may also establish negligence.³⁷⁰ Those individuals who fail to obtain an adequate medical history or properly examine a woman prior to abortion may also be liable because the particular condition of certain women increases their risk of a perforated uterus.

Women are more likely to experience perforation if they: are obese,³⁷¹ have one or more children,³⁷² have experienced a recent childbirth,³⁷³ have an anteflexed or retroflexed uterus,³⁷⁴ have had an abortion in connection with sterilization,³⁷⁵ or have a uterine anomaly.³⁷⁶ The reported incidence of uterine perforations in connection with a first trimester abortion is much higher if laparoscopy³⁷⁷ is used as an aid in determining the incidence.³⁷⁸ Although some uterine perforations may rapidly become sealed,³⁷⁹ they have been reported to multiply more than 100 times the normal risk of abortion-related death due to infection³⁸⁰ and death due to

370. Gunnel Lindell & Folke Flam, *Management of Uterine Perforations in Connection with Legal Abortions*, 74 ACTA OBSTET GYNECOL SCAND 373, 375 (1995) (unnecessary use of blunt curette or polyp forceps may result in uterine perforation).

371. Michael K. White et al., *A Case-Control Study of Uterine Perforations Documented at Laparoscopy*, 129 AM. J. OBSTET. GYNECOL. 623, 625 (1977).

372. Grimes et al., *supra* note 363, at 2111.

373. Suneeta Mittal & Sneha Lata Misra, *Uterine Perforation Following Medical Termination of Pregnancy by Vacuum Aspiration*, 23 INT. J. GYNAECOL OBSTET. 45, 46 (1985).

374. Niels H. Lauersen & Stanley Birnbaum, *Laparoscopy as a Diagnostic and Therapeutic Technique in Uterine Perforations During First Trimester Abortions*, 117 AM. J. OBSTET. GYNECOL. 522, 525 (1973).

375. I-Cheng Chi & Paul Feldblum, *Uterine Perforations During Sterilizations by Laparoscopy and Minilaparotomy*, 139 AM. J. OBSTET. GYNECOL. 735, 736 (1981).

376. HERN, *supra* note 19, at 184.

377. Laparoscopy is a visualization technique for examining the peritoneal cavity by use of an instrument passed through the abdominal wall.

378. Steven G. Kaali et al., *The Frequency and Management of Uterine Perforations During First Trimester Abortions*, 161 AM. J. OBSTET. GYNECOL. 406, 406 (1989) (15.6 unsuspected perforations per 1000 procedures were discovered during direct laparoscopic visualization.); Michael K. White et al., *A Case-Control Study of Uterine Perforations Documented at Laparoscopy*, 129 AM. J. OBSTET. GYNECOL. 623, 623 (1977) (an overall rate of 30.4 per 1000 procedures occurred during laparoscopic sterilization).

379. George J. L. Wulff, Jr. & S. Michael Freiman, *Elective Abortion Complications Seen in a Free-Standing Clinic*, 49 OBSTET. & GYNECOL. 351, 355 (1976).

380. David A. Grimes, *Fatal Septic Abortion in the United States, 1975-1977*, 57 OBSTET. & GYNECOL. 739, 742 (1981).

hemorrhage more than 1000 times the normal risk.³⁸¹ In addition, perforation is reported to be the single most frequent complication of curettage requiring hysterectomy as a form of treatment.³⁸²

When the method of abortion is changed, as in *DeJesus v. Moon*, it is not sufficient merely to agree upon the cost. The doctor must obtain additional informed consent from the woman. National Abortion Federation standards require that "facilities should provide to patients written descriptions of the abortion procedure. . . and the risks and benefits involved in the particular abortion procedure the patient will undergo. . . . Patients must be supplied with materials that accurately pertain to their circumstances."³⁸³ Further, in-house policies and procedures established by the abortion facility may be violated as well. Many abortion facilities limit abortions to the first trimester; however, an abortion during the fourteenth week of gestation is a second trimester abortion which requires a different method—usually D&E.³⁸⁴ Most abortion facilities and providers may not be equipped or experienced for this. Also, abortion facilities may have established certain medical criteria limiting the types of women who can obtain an abortion at their facility. Thus, in any malpractice litigation, it is essential during discovery to determine the practices and procedures of the particular abortion facility.

The plaintiff in *DeJesus v. Moon* underwent her abortion under general anesthesia. Women who have general anesthesia, versus local anesthesia for suction curettage of 12 or fewer weeks of gestation, are significantly more likely to have uterine perforations or lacerations,

381. David A. Grimes et al., *Fatal Hemorrhage from Legal Abortion in the United States*, 157 SURG. GYNECOL. OBSTET. 461, 466 (1983).

382. David A. Grimes et al., *Hysterectomy as Treatment for Complications of Legal Abortion*, 63 OBSTET. & GYNECOL. 457, 460 (1984).

383. STANDARDS, *supra* note 241, at 5.

384. HERN, *supra* note 19, at 123, 223. (Unlike first trimester abortion, in which suction curettage has emerged, midtrimester abortion is beset with numerous technical problems that are considerably more difficult to resolve. The uterus is larger and requires special instruments for vaginal termination and getting these instruments past the cervix without damaging it is more difficult. The fetus is larger and more difficult to get through the cervix either with induction or with instruments. The signs of fetal life on expulsion and the repugnance of dismemberment plague the alternatives in midtrimester abortion) (preparation for a second-trimester D&E outpatient service requires a quantum leap in expenditure for equipment and instruments).

uterine hemorrhage, intra-abdominal hemorrhage, or cervical injury.³⁸⁵ Similarly, use of general anesthesia likely results in uterine perforations in second trimester dilation and extraction abortion.³⁸⁶ General anesthesia is more likely to be elected by women who are in psychological distress or repressing their feelings at the time of the abortion.³⁸⁷ Since 1983, general anesthesia has become the leading cause of abortion-related death in the U.S.³⁸⁸ It is unlikely that plaintiffs are ever advised of these additional risks of morbidity and mortality.

B. Serious Abortion-Related Infections

Cases involving abortion-related infections have not been as frequently litigated as the overall incidence of post-abortion infections might suggest.³⁸⁹ However, in *Scholte v. Planned Parenthood*,³⁹⁰ a case involving a California clinic, allegedly a clinic doctor negligently performed an abortion which resulted in a life-threatening infection requiring hospitalization. According to reports, the case was settled for an undisclosed amount in March 1991.³⁹¹

In *T.L. Wiggins v. James L. Waters, Jr.*,³⁹² a Georgia case, the plaintiff was rendered sterile when the defendant doctor allegedly

385. Christopher Tietze & David A. Grimes et al., *Local Versus General Anesthesia; Which is Safer for Performing Suction Abortions?*, 135 AM. J. OBSTET. GYNECOL 1030, 1032 (1979); H. Trent Mackay et al., *Safety of Local Versus General Anesthesia For Second-Trimester Dilatation and Evacuation Abortion*, 66 OBSTET. & GYNECOL. 661, 664 (1985).

386. H. Trent Mackay et al., *Safety of Local Versus General Anesthesia for Second-Trimester Dilatation and Evacuation Abortion*, 66 OBSTET. & GYNECOL. 661, 664 (1985).

387. Glenda C. Polk-Walker, *Counseling Implications in a Client's Choice of Anesthesia During a First or Repeat Abortion*, 28 NURSING FORUM 22 (1993).

388. Herschel W. Lawson et al., *Abortion Mortality, United States 1972 Through 1987*, 171 AM. J. OBSTET. GYNECOL. 1365, 1365 (1994).

389. The reported incidences of untreated post-abortion infections has been as high as 43% in the medical literature. The use of antibiotics, although effective in some cases, is unable to effectively treat a substantial number of women. For a recent review on the subject see Thomas W. Strahan, *Lack of Individualized Counseling Regarding Risk Factors for Induced Abortion*. Newsletter (Ass'n for Interdisciplinary Research in Values and Social Change, Washington, D.C.) July-Aug. 1994 at 1.

390. See generally Case No. 349599 (Cal. Sup. Ct. 1990) (Cited in 12(2) LEX VITAE 5 (1991)).

391. *Id.*

392. Case No. D-21147 (Fulton Co., GA, 1987).

performed an abortion improperly. The plaintiff claimed that the defendant's negligence caused an infection in her uterus and fallopian tubes.³⁹³ The jury returned a \$20,000 verdict in the plaintiff's favor.³⁹⁴

Uterine injury, such as a perforation or laceration, has been identified as a risk factor for the type of infection described in *Wiggins*.³⁹⁵ A serious post-abortion infection requiring hospitalization, as described in *Scholte*, would most likely include sepsis or septic abortion. Possible causes of septic abortion include an incomplete abortion; perforation or laceration of the uterus, cervix or bowel; or hemorrhaging.³⁹⁶ The presence of chlamydia or gonorrhea, as well as other bacteria or viruses at the time of abortion, greatly increases the likelihood of post-abortion infections such as endometritis, salpingitis, or pelvic inflammatory disease.³⁹⁷ Teenagers are more likely to be infected than older women.³⁹⁸ Despite the

393. LRP Publications, JURY VERDICT RESEARCH (1993) LRP Publication no. 1440.

394. *Id.*

395. FARO & PERLMAN, *supra* note 192, at 43-46.

396. *Id.* at 74.

397. M. Barbacci et al., *Post-Abortal Endometritis and Isolation of Chlamydia Trachomatis*, 68 AM. J. OBSTET. & GYNECOL. 88 (1986) (10% of women with chlamydia at the time of abortion had post-abortion endometritis compared to 3.5% of non-chlamydia women); R. T. Burkman et al., *Untreated Endocervical Gonorrhoea and Endometritis Following Elective Abortion*, 126 AM. J. OBSTET. & GYNECOL. 648 (1976) (14.7% of women with gonorrhoea at the time of abortion had post-abortion endometritis and 5.4% were hospitalized compared to 3.3% endometritis and 1.1% hospitalization for women who did not have gonorrhoea.); T. Radberg & L. Hamberger, *Chlamydia Trachomatis in Relation to Infections Following First Trimester Abortion*, 154 ACTA OBSTET. & GYNAECOL (Supp. 93) Abstract No. 65 (1980) (23.4% of women with chlamydia at the time of abortion had post-abortion pelvic inflammatory disease compared to 4.4% of uninfected women.); B. Stray-Pedersen et al., *Induced Abortion: Microbiological Screening and Medical Complications*, 19 INFECTION 305/9 (1991) (pelvic inflammatory disease developed significantly more often in untreated chlamydia-positive (22.7%), Mycoplasma hominis-positive (8.1%) and Group B streptococci-positive (6.1%) women compared to women without these microbes (0.5%). The results of screening should be available before the abortion, allowing patients to be treated pre- or operatively); Per-Goran Larsson et al., *Mobiluncus and Clue Cells as Predictors of PID After First Trimester Abortion*, 88 ACTA OBSTET GYNAECOL SCAND 217 (1989); Per-Goran Larsson et al., *Incidence of PID After First Trimester Legal Abortion in Women with Bacterial Vaginosis After Treatment with Metronidazole: A Double-Blind Randomized Study*, 166 AM. J. OBSTET. GYNECOL 100 (1992).

398. Stellan Osser & Kenneth Perrson, *Postabortal Pelvic Infection Associated with Chlamydia Trachomatis Infection and the Influence of Humoral Immunity*, 150 AM. J. OBSTET. GYNECOL. 699, 701 (1984) (Chlamydia positive women age 13-19 were significantly more likely to develop post-abortion endometritis (28.1%) compared to women age 20-24 (22.7%), or women age 25-29 (20%). Also, chlamydia positive post-abortion

substantially increased risk of infection following abortion, if chlamydia or gonorrhea or other bacteria or virus is present, many abortion clinics do not test for their presence prior to the procedure. If the clinic does offer such tests, they are optional and at extra cost.³⁹⁹ Even if such tests are performed at the abortion facility, results are normally not available until after the performance of the abortion; hence, it is quite possible that the woman may never know the results.⁴⁰⁰

women aged 13-19 were also more likely to develop post-abortion salpingitis (21.9%) compared to women age 20-24 (13.6%).

399. Although Planned Parenthood distributed a flyer entitled "Curious About Chlamydia?" in 1984, it contained no warnings that chlamydia, if present at the time of abortion, greatly increased the likelihood of post-abortion infections. A review of informational and consent forms used by Planned Parenthood affiliates in the mid- to late 80s also failed to warn women that chlamydia, gonorrhea, or other bacteria or viruses, if present at the time of abortion, increased the likelihood of post-abortion infections. *Facts About Early Abortion*, Planned Parenthood of Minnesota (July, 1985). This is despite the fact that by 1980 and in the years following, many articles had appeared in the medical literature to warn about the problem. In another instance involving an abortion facility which is part of a national chain, a review of the records for possible malpractice, following an abortion in December 1992, revealed that a test for gonorrhea had been done, but none for chlamydia. Again, the informational and consent forms used by the facility failed to warn the woman about the increased risk for post-abortion infection if chlamydia, gonorrhea, or other bacteria or viruses were present. *Patient Consent Form Counseling Guide*, Fargo Women's Health Organization, Inc. (October 1992). In addition, a major abortion clinic in the midwest did not list chlamydia testing in their detailed brochure listing their services which was used in the late 80's. Ruth A. Bolton, PHYSICAL EFFECTS OF ABORTION IN POST-ABORTION TRAUMA 89-90 (1991).

400. *Recommendations for the Prevention and Management of Chlamydia Trachomatis Infections*, 1993, 421 No. RR-12 M.M.W.R. 7 (1993) (women undergoing induced abortion should be screened for chlamydia infection); B. Stray-Pedersen et al., *Induced Abortion: Microbiological Screening and Medical Complications*, 19 INFECTION 305/9 (1991) (the results of screening should be available before the abortion, allowing patients to be treated pre- or peroperatively); Lars Heisterberg, *Prophylactic Antibiotics in Induced First-Trimester Abortion*, 154 UGESKR. LAEGER. 3056 (1992) (women applying for abortion should be examined for c. Trachomatis and positive cases treated no later than the time of abortion.); D. Avonts & P. Piot, *Genital Infections in Women Undergoing Therapeutic Abortion*, 20 EUR. J. OBSTET. GYNEC. REPROD. BIOL. 53 (1984) (depending on the prevalence of c. Trachomatis, in a given population, screening followed by selective treatment or prophylactic use of antimicrobial medication for all women is indicated to prevent post-abortum infections); P. Wein et al., *Postabortal Pelvic Sepsis in Association with Chlamydia Trachomatis*, 30 AUST. N. Z. J. OBSTET. GYNAECOL. 347 (1990) (all patients, especially those younger than 25 years, presenting for termination of pregnancy, should be screened and have treatment commenced for c. Trachomatis prior to the operative procedure); Gary K. Stewart & Deborah Kowal, *Chapter on Abortion in MANUAL OF OUTPATIENT GYNECOLOGY*, 234-241 (Carol S. Havens et al. eds., 2d ed. 1980) (listing as routine

This omission can greatly affect the risk of post-abortion infections, such as pelvic inflammatory disease. The issue of informed consent is implicated because the extent of the risk is unknown at the time consent is given. Further, if the type of bacteria or virus is known beforehand, then the necessity for an appropriate type and dosage of an antibiotic, would be known.⁴⁰¹ Appropriate treatment, or lack thereof, is a real issue.

According to the Center for Disease Control guidelines, women who are at high risk for chlamydia or gonorrhea include those with a history of multiple sex partners, a sexual partner with multiple contacts, sexual contact with persons of culture-proven sexually transmitted disease or history of repeated episodes, or attendance at clinics for sexually transmitted disease.⁴⁰² However, various medical history forms routinely used at abortion facilities during 1985-1992 did not screen for at-risk women.

There is controversy over whether antibiotics should be administered after an abortion.⁴⁰³ Some abortion clinics may routinely

preabortion investigative procedures: hemoglobin or hematocrit count, an Rh determination, gonorrhea and chlamydia screening, and a pregnancy test.); GUIDELINES, *supra* note 23, at 134 (routine screening for chlamydia is not recommended for all women but should be done for any patient with risk factors).

401. D. A. Eschenbach, *Bacterial Vaginosis and Anaerobes in Obstetric-Gynecologic Infection*, 16 CLINICAL INFECTIOUS DISEASES (Supp. 4) S282 (1993) (anaerobic infections of the upper genital tract are common. antibiotic regimens designed to inhibit anaerobes markedly reduce morbidity); Per-Goran Larsson et al., *supra* note 397, at 100. (metronidazole treatment is effective only against anaerobic bacteria associated with bacterial vaginosis and not against *c. Trachomatis*).

402. SEXUALLY TRANSMITTED DISEASE GUIDELINES, Center for Disease Control 31/No.2S M.M.W.R. 35S, Aug. 20, 1982 (pregnant women at particular risk for chlamydial infections should have cultures taken if possible at their first prenatal visit. Important risk factors include the following: a pregnant woman who is unmarried, is less than 20 years old, resides in a socially disadvantaged community (e.g. inner city), has other sexually transmitted diseases, has reported late for prenatal care, has partners with nongonococcal urethritis, has nongonococcal purulent endocervicitis, or a bacterial urinary tract infection. SPECIAL POPULATIONS, Center for Disease Control, 42 No.RR-14 M.M.W.R. 8-9, Sept. 24, 1993 (CDC recommended the following screening tests for pregnant women: syphilis, hepatitis B surface antigen, *Neisseria gonorrhoeae*, *Chlamydia Trachomatis*. RECOMMENDATIONS FOR THE PREVENTION AND MANAGEMENT OF CHLAMYDIA TRACHOMATIS INFECTIONS, 1993, 42/ No. RR-12 M.M.W.R. 1, Aug. 6, 1993 (women undergoing induced abortion should be screened for chlamydial infection) at 7.

403. HERN, *supra* note 19, at 167; E.T. Houang, *Antibiotic Prophylaxis in Hysterectomy and Induced Abortion. A Review of the Evidence*, 41 DRUGS 19 (1991) (concludes that an antibiotic regimen for induced abortion that is both efficacious and well

provide antibiotics or furnish a prescription to obtain them.⁴⁰⁴ Others may do so only if there are indications of a possible infection, i.e., temperature of 38 degrees centigrade or above. Merely providing a prescription, however, may not be sufficient. The prescription may not be filled because of the patient's lack of funds or may not be taken as prescribed. Even if antibiotics are taken, some women may delay seeking further treatment because they believe that the antibiotics will prevent any infection or they feel that it is too difficult to obtain help at a public hospital.⁴⁰⁵

Antibiotics may eliminate 80-90 percent of post-abortion infections.⁴⁰⁶ However, antibiotics are considerably less effective or may not eliminate or reduce infections if the woman is under 20, has had no previous births, has had two or more sexual partners, or has had PID, gonorrhea, or untreated lower genital tract infections.⁴⁰⁷ Sterility may still result even if antibiotics eliminate infections. For example, one study reported that despite antibiotic therapy, women—who have at least one episode of salpingitis—have a 21 percent chance of involuntary infertility as compared to only a three percent chance

tolerated has yet to be found).

404. U. Landy & S. Lewit, *Administrative, Counseling and Medical Practices of National Abortion Federation Facilities*, 14 FAM. PLAN. PERSP. 257 (1982); FACT SHEET *What is Abortion*, (National Abortion Federation, Washington, D.C.) (1992).

405. FARO & PEARLMAN, *supra* note 192, at 73-74.

406. P. Levallois & J. E. Rioux, *Prophylactic Antibiotics for Suction Curettage Abortion: Results of a Clinical Controlled Study*, 158 AM. J. OBSTET. GYNECOL. 100 (1988); Larsson et al., *supra* note 397, at 100, 102 (antibiotics reduced incidence of PID from 12.2% to 3.6%).

407. Tai-Kuen Park et al., *Preventing Febrile Complications of Suction Curettage Abortion*, 152 AM. J. OBSTET. & GYNECOL. 252 (1985) (antibiotics were about twice as effective among women with one or more previous births compared to women with no previous delivery); Patrick Levallois & Jacques-E. Rioux, *Prophylactic Antibiotics for Suction Curettage Abortion: Results of a Clinical Controlled Trial*, 158 AM. J. OBSTET. & GYNECOL. 100 (1988) (among women with a history of gonorrhea or nulliparous women with multiple sex partners, antibiotics were less effective); E. Dari et al., *The Prophylactic Effect of Doxycycline on Postoperative Infection Rate After First-Trimester Abortion*, 70 OBSTET. & GYNECOL. 755 (1987) (antibiotics were less effective among women with a history of PID); J. L. Sorensen & I. Thranov, *A Double-Blind Randomized Study of the Effect of Erythromycin in Preventing Pelvic Inflammatory Disease After First Trimester Abortion*, 99 BR. J. OBSTET. GYNAECOL. 434 (1992) (erythromycin did not reduce PID among women with previous PID, those less than 20 years of age, women who were nulliparous or those with no previous pregnancies).

for a control group.⁴⁰⁸ Even short delays in seeking care following abortion can significantly increase the likelihood of sterility or ectopic pregnancy. One study found startling results among women with gonorrhea, chlamydia, or related pelvic inflammatory disease. Specifically, those who delayed care—for three or more days after the onset of pain—were 2.6 times more likely to develop impaired fertility than those who sought care promptly.⁴⁰⁹ Women with a history of prior induced abortions were likely to delay care.⁴¹⁰ Post-abortion infections can also affect future pregnancy outcomes. A recent study found that having a previous abortion would significantly increase the risk of neonatal sepsis in a subsequent pregnancy.⁴¹¹ Neonatal sepsis has a high rate of infant mortality and is frequently complicated by meningitis. Surviving children frequently have neurological defects.⁴¹²

C. Pain and Suffering

Once legal liability has been established for personal injury, one may recover damages for the pain and suffering resulting from the injury.⁴¹³ Pain and suffering consists of three distinguishable components: physical pain; mental suffering, which arises from awareness of physical pain; and mental anguish, which encompasses unpleasant mental consequences caused by the injury, which are not directly related to pain. Pain and suffering should not be confused with other elements of general damages, such as loss of enjoyment of life, disability, loss of earning capacity, or permanent injury.⁴¹⁴

408. L. Westrom, *Incidence, Prevalence, and Trends of Acute Pelvic Inflammatory Disease and Its Consequences in Industrialized Countries*, 138 AM. J. OBSTET. GYNECOL. 880 (1989) (despite antibiotic therapy, women who have had at least one episode of salpingitis, have a rate of 21% involuntary infertility).

409. Susan D. Hills et al., *Delayed Care of Pelvic Inflammatory Disease as a Risk Factor for Impaired Fertility*, 168 AM. J. OBSTET. GYNECOL. 1503 (1993).

410. *Id.*

411. M. Germain et al., *Reproductive History and Risk Neonatal Sepsis*, 9 PEDIATRIC & PRENATAL EPIDEMIOLOGY 48 (1995).

412. *Id.*

413. *See, e.g.,* W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS, § 203 (5th. ed. 1984).

414. MARILYN MINZER et al., DAMAGES IN TORT CASES, Vol. 1 § 4.02[2] (Rel. 34-April 1996).

Abortion-related injuries include each of the elements of pain and suffering. The American College of Obstetricians and Gynecologists has recently acknowledged that acute pelvic pain may be caused by the abortion itself.⁴¹⁵ In some instances, the severity of this acute pain is similar to the pain of childbirth or cancer. It is more likely to be severe among teenage women.⁴¹⁶ Severe acute pain is more likely to occur if women: were anxious before or after the abortion, reported depression, or had moral or social concerns about abortion.⁴¹⁷ Severe acute pain is more likely to be reported with an inexperienced abortionist.⁴¹⁸ Gynecological characteristics such as uterus retroversion, history of menstrual pain, and increased gestational age at the time of abortion have also been found to increase acute pain from abortion.⁴¹⁹ Long lasting (six months or more) chronic pelvic or abdominal pain can result from induced abortion and has been found to be more likely to occur in women with post-abortion pelvic inflammatory disease.⁴²⁰ Pelvic pain has been reported in women with adhesions⁴²¹ or salpingitis,⁴²² both possible sequelae from induced abortion. Women with chronic abdominal pain also may report pain from sexual intercourse or post-coital ache which indicates the

415. GUIDELINES, *supra* note 23, at 174.

416. E. Belanger et al., *Pain of First Trimester Abortion: A Study of Psychosocial and Medical Predictors*, 36 PAIN 339 (1989); Lee Gsellman, *Physical and Psychological Injury in Women Following Induced Abortion: Akron Pregnancy Services Survey*, Newsletter (Ass'n for Interdisciplinary Research in Values and Social Change, Washington, D.C.) Sept.-Oct. 1993, at 1 (both immediate and later abdominal pain was reported in a sample of primarily teenage postabortion women).

417. *Id.*

418. M. B. Bracken, *A Causal Model of Psychosomatic Reactions to Vacuum Aspiration Abortion*, 13 SOC. PSYCHIATRY 135 (1978).

419. Genie M. Smith et al., *Pain of First Trimester Abortion: Its Quantification and Relations with Other Variables*, 133 AM. J. OBSTET. GYNECOL. 489 (1979); Nancy Wells, *Pain and Distress During Abortion*, 12 HEALTH CARE FOR WOMEN INT'L 293 (1991).

420. Lars Heisterberg, *Factors Influencing Spontaneous Abortion, Dyspareunia, Dysmenorrhea, and Pelvic Pain*, 81 OBSTET. & GYNECOL. 594 (1993); L. Heisterberg et al., *Sequelae of Induced First-Trimester Abortion. A Prospective Study Assessing the Role of Postabortal Pelvic Inflammatory Disease and Prophylactic Antibiotics*, 143 AM. J. OBSTET. GYNECOL. 76 (1986).

421. S.M. Klein & C.R. Garcia, *Asherman's Syndrome: A Critique and Current Review*, 24 FERTILE STERIL. 722 (1973).

422. L. Westrom, *Effect of Acute Pelvic Inflammatory Disease on Fertility*, 121 AM. J. OBSTET. GYNECOL. 707 (1975).

possibility of significant sexual dysfunction in the future.⁴²³ Long lasting somatoform disorders and physical symptoms, such as abdominal pain, headaches, and chest pain, have been found in women who report a poor assimilation of their abortion experience. This is particularly true of women who experience anniversary reactions.⁴²⁴ Post-abortion women also have been found to have an increased likelihood of severe pain in subsequent childbirth compared with women who do not abort their pregnancies.⁴²⁵

Women with chronic pelvic or abdominal pain are significantly more anxious, depressed, and hostile. They also have more somatic symptoms than other patients.⁴²⁶ These women exhibit a significantly higher prevalence of major depression, substance abuse, adult sexual dysfunction, somatization, and childhood and sexual abuse than a comparison group.⁴²⁷ Another study found that these women are more likely to use dissociation as a coping mechanism, to show current psychological distress, to see themselves as medically disabled, and to experience vocational and social problems.⁴²⁸

D. Mental Anguish and Loss of Enjoyment of Life

Both short-term (two years or less) and long-term negative psychological reactions occur as a result of induced abortion. These negative psychological reactions may result in severe mental anguish, substantial loss of enjoyment of life, disability or other long-lasting

423. C.M. Stacey & P.E. Munday, *Abdominal Pain in Women Attending a Genitourinary Medicine Clinic: Who Has PID?* 5 INT'L J. STD & AIDS 338 (1994).

424. K. Franco et al., *Psychological Profile of Dysphoric Women Post-Abortion*, 44 J. AM. MED. WOMEN'S ASS'N 113 (1989); K. Franco et al., *Anniversary Reactions and Due Date Responses Following Abortion*, 52 PSYCHOTHER. PSYCHOSOM. 151 (1989); J.O. Cavenar et al., *Aftermath of Abortion: Anniversary Depression and Abdominal Pain*, 42 BULLETIN OF THE MENNINGER CLINIC 433 (1978).

425. Gerd Fridh et al., *Factors Associated with More Intense Labor Pain*, 11 RES. IN NURSING & HEALTH 117 (1988).

426. J.C. Slocumb et al., *Anxiety and Depression in Patients with the Abdominal Pelvic Pain Syndrome*, 11 GEN. HOSP. PSYCHIATRY 48 (1989).

427. E. Walker et al., *Relationship of Chronic Pelvic Pain to Psychiatric Diagnosis and Childhood Sexual Abuse*, 145 AM. J. PSYCHIATRY 75 (1988).

428. E.A. Walker et al., *Dissociation in Women with Chronic Pelvic Pain*, 149 AM. J. PSYCHIATRY 534 (1992); See e.g., J.J. Bonica, "History of Pain Concepts and Therapies" in 1 THE MANAGEMENT OF PAIN (J.J. Bonica ed.) (1990) (discussing chronic pain syndrome).

injury, or death. These problems are not necessarily limited to women, but may also include men,⁴²⁹ other family members,⁴³⁰ or anyone involved with the abortion.⁴³¹

Mental anguish, stress, trauma, or other negative psychological reactions are more likely to occur among post-abortion women if the abortion resulted in a physical injury or other medical problems.⁴³² Women who had abortions as teenagers suffer more severe psychological distress.⁴³³ Possible serious psychological reactions include suicide,⁴³⁴ attempted suicide,⁴³⁵ admission to a psychiatric hospital,⁴³⁶ alcohol or drug abuse,⁴³⁷ anniversary reactions that sometimes appear to be suicide attempts,⁴³⁸ death anxiety,⁴³⁹ trauma,⁴⁴⁰

429. See generally Phil McCombs, *Remembering Thomas*, 4 THE POST-ABORTION REV. (Elliot Institute, Springfield, Ill.), Fall 1996, at 1; Thomas Strahan, *Portraits of Post-Abortive Fathers Devastated by the Abortion Experience*, NEWSLETTER (Ass'n for Interdisciplinary Research in Values and Social Change, Washington, D.C.) Nov./Dec. 1994, at 1.

430. See Regina M. Furlong & Rita B. Biack, *Pregnancy Termination for Genetic Reasons: The Impact on Families*, 10 SOC. WORK IN HEALTH CARE 17, 17 (1984); R. K. McAll & F.M. McAll, *Ritual Mourning in Anorexia Nervosa*, THE LANCET, Aug. 16, 1980, at 368, 368; Anita H. Weiner & Eugene C. Weiner, *The Aborted Sibling Factor: A Case Study*, CLINICAL SOC. CASEWORK J., 1984, at 209.

431. K. McAll & W. Wilson, *Ritual Mourning for Unresolved Grief After Abortion*, 80 S. MED. J. 817, 821 (1987).

432. Cynthia D. Martin, *Psychological Problems of Abortion for the Unwed Teenage Girl*, 88 GENETIC PSYCHOLOGY MONOGRAPHS 23, 85 (1973); Helen P. Vaughan, *Canonical Variates of Post-abortion Syndrome* (Institute for Pregnancy Loss, Portsmouth, N.H.) 1990, at 36.

433. See generally W. Franz & D. Reardon, *Differential Impact of Abortion on Adolescents and Adults*, 27 ADOLESCENCE 161 (1992).

434. E. Joanne Angelo, *Psychiatric Sequelae of Abortion: The Many Faces of Post-Abortion Grief*, 59 LINACRE Q. 69, 69 (1992).

435. K. Franco et al., *Psychological Profile of Dysphoric Women Post-Abortion*, 44 J. AM. MED. WOMEN'S ASS'N 113, 114 (1989).

436. Henry P. David et al., *Postpartum and Postabortion Psychotic Reactions*, 13 FAM. PLAN. PERSP. 88, 89 (1981); Ronald Somers, *Risk of Admission to Psychiatric Institutions Among Danish Women who Experienced Induced Abortion: An Analysis Based on National Record Linkage*, DISSERTATION ABSTRACTS INT'L 2621-B (1979).

437. See D. A. Frank et al., *Cocaine Use During Pregnancy Prevalence and Correlates*, 82 PEDIATRICS 888, 892 (1988); A. K. Lassen & S. Wilsnack, *Sexual Experience and Drinking Among Women in a U.S. National Survey*, 15 ARCHIVES OF SEXUAL BEHAVIOR 363, 379 (1986); E. R. Morrisey & M. A. Schuckit, *Stressful Life Events and Alcohol Problems Among Women Seen at a Detoxification Center*, 39 J. STUD. ALCOHOL. 1559, 1560 (1978); A. S. Oro & S. D. Dixon, *Perinatal Cocaine and Methamphetamine Exposure: Maternal and Neonatal Correlates*, 111 J. PEDIATRICS 571, 575 (1987).

438. See generally C. L. Tishler, *Adolescent Suicide Attempts Following Elective*

compulsive behavior,⁴⁴¹ replacement pregnancies,⁴⁴² sexual dysfunction,⁴⁴³ dysthymia,⁴⁴⁴ depression,⁴⁴⁵ or self-punishing behavior.⁴⁴⁶

According to a number of studies, women who have additional abortions apparently have more serious adverse psychological reactions as compared to women who have a first time abortion. These reactions include: no religious affiliation, increased isolation, lessened ability to get along with others, paranoid ideation, sleep disturbances, increased rate of psychiatric hospital admissions, increased likelihood of depression, more suicide attempts, more grief reactions, higher incidence of smoking, increased illicit drug use, shorter and less stable relationships with men, higher rate of divorce, and a greater likelihood of being unhappy in marriage.⁴⁴⁷

Various risk factors for negative psychological reactions have been identified by several psychologists, all of whom support legalized abortion.⁴⁴⁸ One article states that negative reactions may arise from ambivalence or conflict at the time of the abortion:

Abortion: A Special Case of Anniversary Reaction, 68 PEDIATRICS 670 (1981).

439. Leslie M. Butterfield, *Incidence of Complicated Grief and Post-Traumatic Stress in a Post-Abortion Population*, 49, DISSERTATION ABSTRACTS INT'L 3431-B (1988). Gail Barger Williams, *Induced Elective Abortion and Perinatal Grief*, 53 DISSERTATION ABSTRACTS INT'L 1296-B (1992).

440. Anne C. Speckhard & Vincent M. Rue, *Post-Abortion Syndrome: An Emerging Public Health Concern*, 48 J. SOC. ISSUES 95, 95 (1992).

441. Rif S-El Mallakh & Allan Tasman, *Recurrent Abortions in a Bulimic: Implications Regarding Patho Genesis* 10 INT'L J. EATING DISORDERS 215, 215 (1991).

442. Nancy Horowitz, *Adolescent Mourning Reactions to Infant and Fetal Loss*, SOC. CASEWORK 551 (1978).

443. See generally David H. Sherman et al., *The Abortion Experience in Private Practice*, WOMEN AND LOSS PSYCHOBIOLOGICAL PERSP. 98 (William F. Finn et al. eds., 1985) (33% of couples who were married or in long-term relationships felt that abortion negatively affected their sexual life to some degree); See also Joseph A. Cancelmo et al., *Psychodynamic Aspects of Delayed Abortion Decisions*, 65 BR. J. OF MEDICAL PSYCHOLOGY 333 (1992).

444. K. Franco, *Psychological Profile of Dysphoric Women Post-Abortion*, 44 J. AM. MED. WOMEN'S ASS'N, 113, 114 (1989).

445. *Id.*

446. DAVID REARDON, *ABORTED WOMEN: SILENT NO MORE* 23 (1987).

447. Thomas Strahan, *Women's Health and Abortion I. Deterioration of Health Among Women Repeating Induced Abortion*, NEWSLETTER (Ass'n for Interdisciplinary Research in Values and Social Change, Washington, D.C.) Winter 1993, at 1.

448. See generally N. E. Adler et al., *Psychological Factors in Abortion. A Review*, 47 AM. PSYCHOL. 1194 (1992); N. E. Adler et al., *Psychological Responses After Abortion*, 248 SCIENCE 41 (1990).

“[a]mbivalence may engender a sense of loss. Conflict about the meaning of abortion and its relationship to deeply held values or beliefs, perceived social stigma, or lack of social support may induce negative reaction.”⁴⁴⁹ The second article states that the following women risk psychological problems after abortion: those women undergoing second trimester abortions, younger and unmarried women without children, and women whose culture or religion prohibits abortion.⁴⁵⁰

Long-term negative psychological reactions have also been identified. Since 1987, information on the subject has been published which includes: several books, data-based studies on long-term negative psychological effects, several articles in medical or social journals, four doctoral dissertations, and at least two presentations made to professional organizations. For example, the Medical College of Ohio studied women who were one to fifteen years post-abortion and reported difficulty in assimilating their abortion experience. A majority of these women were found to suffer from anxiety, somatoform disorders, and dysthymia. Forty-eight percent had undergone psychotherapy after their abortion and a significant number had dealt with suicidal thoughts or attempts after their abortion. Anniversary reactions were reported by 42 percent of the group. Those women with multiple abortions evidenced more severe pathology than women with a single abortion.⁴⁵¹ Another study limited itself to women with only one abortion and no identifiable trauma within five years. This study showed a wide range of grief reactions. Specifically, the study indicated that many women suffered

449. N. E. Adler et al., *Psychological Responses After Abortion*, 248 *SCIENCE* at 42.

450. *Id.* at 42; N. E. Adler et al., *Psychological Factors in Abortion*, 47 *AM. PSYCHOL.* at 1200.

451. K. Franco et al., *Psychological Profile of Dysphoric Women Postabortion*, 44 *J. AM. MED. WOMEN'S ASS'N* 113, 114 (1989); *See also* N. D. Campbell et al., *Abortion in Adolescence*, *ADOLESCENCE* 813 (1988) (finding differences between adolescents and adults in perceptions of coercion, preabortion suicidal ideation, and postabortion nightmares. Antisocial and paranoid personalities as well as drug abuse and psychotic delusions were found to be significantly higher among those who aborted as teenagers); K. Franco et al., *Anniversary Reactions and Due Date Responses Following Abortion*, 52 *PSYCHOTHERAPY & PSYCHOSOMATICS* 151, 152 (1989) (increased depression and more physical symptoms, including abdominal pain, dyspareunia, headaches and chest pain were reported by women reporting anniversary reactions).

from severe grief an average of eleven years post-abortion.⁴⁵² Post-traumatic stress disorder (PTSD) based upon DSM-III-R criteria which is attributable to abortion—has been found in at least 18.8 percent of women three to five years post-abortion.⁴⁵³ Severe, long-lasting anniversary reactions, painful emotional fantasies, and prolonged grieving have been reported in narratives of post-abortion women.⁴⁵⁴ Other studies found long-term guilt, anger, stress trauma, suicidal impulse, and other long-term negative psychological effects.⁴⁵⁵ In addition, other theoretical articles attribute psychological problems to induced abortion.⁴⁵⁶ Based on these various studies, it appears women who have second trimester abortions or coerced abortions are at particular risk for long-term negative psychological effects.

E. Exemplary or Punitive Damages

Exemplary damages are proper when the act which creates actual damages imports insult or outrage, and is committed with a view to oppress or is done in contempt of plaintiff's rights. Punitive damages

452. Gail Barger Williams, *Induced Elective Abortion and Perinatal Grief*, 53 DISSERTATION ABSTRACTS INT'L 1296-B, 1296-B (1992).

453. Catherine A. Barnard, *The Long-term Psychosocial Effects of Abortion*, (Institute for Pregnancy Loss, Portsmouth, N.H.) 1990, at 54.

454. Douglas Brown, et al., *Prolonged Grieving after Abortion: A Descriptive Study*, 4 J. CLINICAL ETHICS 118 (1993).

455. See e.g., ANNE SPECKHARD, PSYCHO-SOCIAL STRESS FOLLOWING INDUCED ABORTION (1987); JEANETTE VOUGHT, POST-ABORTION TRAUMA: 9 STEPS TO RECOVERY (1991); D.A. Bagarozzi, *Post-Traumatic Stress Disorders in Women Following Abortion: Some Considerations and Implications for Marital/Couple Therapy*, 1 INT'L FAMILY AND MARRIAGE 51 (1993); Lee Gsellman, *Physical and Psychological Injury Following Abortion: Akron Pregnancy Services Survey*, NEWSLETTER (Ass'n for Interdisciplinary Research in Values and Social Change, Washington, D.C.) Sept.-Oct. 1993, at 1; David C. Reardon, *A Survey of Post-Abortion Reactions*, (Elliot Institute, Springfield, Ill.) 1987, at 1; Vaughan, *supra* note 432; David C Hanley et al., *Women Outpatients Reporting Continuing Post-Abortion Distress: A Preliminary Inquiry*, Oct. 23, 1992, presented at Poster Session at the 8th Annual Meeting of the International Society for Traumatic Stress Studies, Los Angeles.

456. See generally Joel Brende, *Fragmentation of the Personality Associated with Post-Abortion Trauma*, NEWSLETTER (Ass'n for Interdisciplinary Research in Values and Social Change, Washington, D.C.) July-Aug. 1994, at 1. Joel Brende, *Post-Trauma Following Abortion*, NEWSLETTER (Ass'n for Interdisciplinary Research in Values and Social Change, Washington, D.C.) July-Aug. 1994, at 1; Robert C. Erikson, *Abortion Trauma: Application of a Conflict Model*, 8 PRE-AND PERINATAL PSYCHOL. J. 33 (1993); Speckhard & Rue, *supra* note 440; Anne Speckhard & Vincent Rue, *Complicated Mourning: Dynamics of Impacted Post-abortion Grief*, 8 PRE-AND PERINATAL PSYCHOL. J. 5 (1993).

may be awarded when the act is done with reckless indifference or bad motives.⁴⁵⁷ For example, in *Rodriguez v. Hennon*⁴⁵⁸ the jury awarded the plaintiff \$250,000 in exemplary damages after the negligent diagnosis of an ectopic pregnancy. The plaintiff's fallopian tubes later erupted because the doctor had failed to submit scanty tissue to a pathology laboratory after a D&C.⁴⁵⁹ In the case of *Kidd v. Tucker*,⁴⁶⁰ an Alabama court entered a ten million dollar judgment in favor of the estate of a woman who died from an induced abortion. This judgment was entered despite a statutory cap of one million dollars for medical malpractice awards.⁴⁶¹ The court held that punitive and exemplary damages were awarded because there was clear and convincing evidence of the defendant's abandonment and neglect.⁴⁶² Additionally, the court found that defendant's conduct was willful, wanton and malicious in its intentional infliction of a series of acts performed solely in the defendant's interests.⁴⁶³ The court based their reasoning on: (1) defendant's performance of a second trimester abortion which was contradicted by unqualified personnel, (2) the disengagement of monitors and alarms, (3) the administering of improper medication over a period of time, and (4) the abandonment of a critically ill patient.⁴⁶⁴ In contrast, in *Shirk v. Kelsey*,⁴⁶⁵ when the defendant was negligent in not repeating a pregnancy test or performing ultrasound, an appellate court overturned a punitive damage award.⁴⁶⁶ Even though the doctor's negligence resulted in a missed abortion, the court held that the defendant had not acted willfully or with wanton disregard of the plaintiff's rights.⁴⁶⁷

457. Linda L. Schlueter, Kenneth R. Redden, 1 PUNITIVE DAMAGES 35 (3rd Ed. 1995).

458. Case No. 91-22697 (Harris County District Court, TX, January 11, 1993).

459. *Id.*

460. *Kidd v. Tucker*, Case No. 93-0632 (Circuit Court of Jefferson County, AL December 2, 1996).

461. ALA. CODE §6-5-547 (1975).

462. *Kidd*, *supra* note 460.

463. *Id.*

464. *Id.*

465. 617 N.E.2d 152 (Ill. App. Ct. 1993).

466. *Id.* at 160.

467. *Id.* at 159.

V. CONCLUSION

In the cases which resulted in abortion-related physical injury, infection, or reproductive injury, negligence was found to be committed by doctors, nurses, and lay persons acting in the capacity of health care professionals. Diagnostic errors, sub-standard abortion techniques, and failure to follow-up were the primary areas of negligence resulting in serious life-threatening infection. In a number of cases, the failure to diagnose an ectopic pregnancy at the time of the attempted abortion resulted in serious injury. These injuries appeared to be preventable, but occurred because of diagnostic errors, lack of prompt pathology testing, and failure to communicate results to the patient. Improved diagnostic technology, which utilizes the ultrasound-hCG method of on-site testing, offers an improved screening method for possible ectopic pregnancies. If abortion facilities do not use these devices, it may signal a case for medical malpractice.

Recovery for emotional distress was made in cases when the woman felt coerced, compromised, or fearful to a significant degree. The types of coercion ranged from abortions performed against her will and without her consent to abortions performed due to back sprain. Coerced abortion is a known risk factor for psychological problems following abortion, and the cases confirm it. Also, in some cases, abortions occurred for a suspected genetic reason, i.e., fetal anomaly. This is also a known risk factor for emotional injury following abortion. In two cases, women were traumatized when they saw the intact body of parts of their aborted child.

The cases demonstrate that disregard or indifference to the life or health of the child in the womb is not limited to abortionists. In a number of instances, there appeared to be a disregard for life in the womb by various professionals. The principle theoretically found in medical practice that the fetus is also a patient, or that a physician should do no harm was not put into practice.

As the cases indicate there is no particular type or kind of mental anguish or emotional distress required for liability, provided it is related to the abortion injury. In order to prevail, the services of a licensed psychiatrist or psychologist, knowledgeable about abortion

related emotional injury, will be required as a expert witness with some limited exceptions. During my research, it was disturbing that some of the monetary recoveries, particularly for emotional injury, appeared to be too low. It is likely that increased knowledge among lawyers litigating these cases regarding physical and emotional injury will increase the amount of recovery. This should result in an improved client interview process, better selection of knowledgeable expert witnesses, better case presentations in court, and larger jury awards or settlements.