Types of Abortion Injury Typically Litigated

- Death of Woman
- Infertility
- Infection
- Incomplete or missed abortion
- Perforation of uterus or bowel
- Cervical, uterine or bladder lacerations
- Undiagnosed ectopic pregnancy
- Scar tissue formation
- Loss of consortium (companionship and sexual relationships)
- Sexual dysfunction
- Emotional trauma

Legal Liability for Physical Injury or Infection Following Induced Abortion

This article describes abortion malpractice cases with an emphasis on physical injury or infection. It is a sequel to previous articles on abortion malpractice. (Research Bulletin, Vol. 9, No. 1, Nov / Dec 1995; Research Bulletin, Vol. 9, No. 2, Jan / Feb 1996.)

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. In order to be successful in an action for medical malpractice, the plaintiff/patient must establish (1) that a legally recognized duty of care was owed to the plaintiff by the defendant health care professional or a person acting in the capacity of a health care professional; (2) that the defendant breached this duty of care by failing to meet the required standard of care; (3) that the plaintiff has suffered a legally recognized injury and has been damaged as a result; and; (4) that the injury was caused by the breach of duty.

Cases were selected which may be frequently encountered. According to the 1992 Hospital Discharge Summary in short-stay, non-Federal U.S. hospitals for females aged 15-44, there were 113,000 hospitalizations for ectopic and tubal pregnancy. According to other studies, nearly 1% of these could be concurrent with an attempted abortion. In addition, there were 27,000 hospitalizations for missed abortion, 8000 hospitalizations for incomplete abortion as well as 14,000 hospitalizations for complications and 7,000 hospitalizations for genital tract and pelvic infections following abortion and ectopic and molar pregnancies. Due to the much larger number of abortions compared to ectopic or molar pregnancies, the vast majority of these complications and infections are likely to be abortion related.

However, there is evidence that many of these potential malpractice cases are not litigated. Despite the fact that approximately 1.5 million abortions occur in the U.S. each year, an analysis of 500 obstetric and gynecological malpractice claims published in 1991 revealed that only 5% were abortion related.

The cases involve negligent diagnosis, unqualified per-
Statutory Based Claim -
Uterine Laceration

The leading case in the area of abortion malpractice liability based upon a violation of a statute or ordinance is Vuitch v. Furr. 482 A.2d 811 DC App (1984). This was an appeal of a denial of the defendant’s motion for a directed verdict after the entry of a jury verdict for the patient plaintiff. In the course of performing an abortion in the District of Columbia, the defendant lacerated the plaintiff’s uterine wall. Defendant attempted to suture the laceration and kept the plaintiff overnight at his abortion clinic despite his knowledge that the act under which the clinic was licensed as an Ambulatory Surgical Treatment Center which under District of Columbia regulations prohibited overnight stays of patients. Violation of the act was punishable by a fine of $300 or imprisonment for not more than 90 days. The plaintiff was discharged after two days and then taken the next day by relatives to a hospital. The hospital examination revealed that a recent, unsutured laceration in the cervix had left a hole leading from the vagina to the abdominal cavity. The plaintiff, as a result of the 2 day retention, had developed peritonitis, which infected the uterus and necessitated a hysterectomy.

A hysterectomy was performed and fetal tissue, which had not been removed during the abortion, was removed from the abdomen. The court held that, under these circumstances, there were reasonable grounds for the jury to find there was medical malpractice.

The court also found that the defendants had violated two provisions of the Ambulatory Surgical Treatment Center Licensure Act, and that the defendants had committed an intentional tort. It further found that the defendant doctor, as well as his wife, were personally liable for the damages, despite the fact that the abortion clinic was incorporated. The doctor’s wife was held personally responsible because she was familiar with the law prohibiting overnight stays without proper licensing, was secretary-treasurer of the corporation, and knew about the clinic’s practice of treating surgical complications and retaining patients overnight. The case contains a detailed discussion of personal liability by the piercing of the corporate veil and has subsequently been frequently cited in that regard.

Comments: The violation of a statute or ordinance, as in this case, was held to be reasonable ground for medical malpractice. The criminal penalties for its violation and the fact that the defendants were found to have committed an intentional tort, provided the basis for defendant’s being held personally liable.

To determine whether or not a particular site where an abortion has occurred is regulated by some government entity, first determine if it is a doctor’s office, outpatient facility, free standing or hospital based ambulatory surgical center, or whether it is a hospital. Different regulations may apply depending upon the type of facility. The American College of Surgeons has also classified ambulatory facilities providing surgical services as Class A, B or C depending upon whether the surgery is considered minor or major and the method of anesthesia used. At least for purposes of malpractice litigation, the regulations appropriate to the specific type of facility may be asserted as the standard, even if the facility is not formally licensed or regulated by the government.

The Guidelines for Women’s Health Care published in 1996 by The American College of Obstetricians and Gynecologists, state that “All legal requirements must be met, and clinicians who perform abortions should be aware of state statutes and regulations regarding abortion services.” They further state that, “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.”

Various other governmental statutes, ordinances or regulations can be very helpful in establishing the duties of a health care professional. Duties and responsibilities of physicians, nurses, counselors, lab technicians, or other health care professionals are frequently found, sometimes in considerable detail. In addition, some governmental authorities may have explicitly recognized by statute the professional standards of specific professional organizations. Malpractice case law of a state may also provide a precedent for establishing the necessary legal duty.

Uterine Perforation—Miscalculation of Gestational Age

In a New York case which settled prior to trial, the plaintiff, a 29 year old mother of 2 children, was in the process of opening a retail clothing boutique, became pregnant and requested that defendant perform an abortion. Defendant performed neither a pregnancy test nor a sonogram. After a vaginal examination, the defendant expressed concern that the pregnancy might be more advanced than the 11 weeks that plaintiff had calculated. Although the defendant was not equipped for second trimester abortions, he agreed to perform a dilation and curettage for an extra $100.00. Defendant commenced the D&C while plaintiff was under general anesthesia. During the procedure the defendant perforated the uterus of the plaintiff. He then attempted to unsuccessfully perform a dilation and evacuation to remove fetal remains. Plaintiff was transferred to a nearby hospital where a laparotomy was performed and as a result, doctors discovered a 10 cm. laceration in the uterus. Fetal parts were consistent with a 14 week gestation. A supercervical hysterectomy and removal of the left ovary and its fallopian tube was performed: Settlement: $500,000 for plaintiff: Delesus v. Moon, N.Y. County Supreme Court (1994), Lawyer’s Weekly USA, June 20, 1994, p. B10.

Comments: Doctors cannot solely rely on a woman’s estimates of gestational age. Women may have erroneous notions of gestation if there is a history of irregular menses, denial of the fact of pregnancy, false beliefs about susceptibility to pregnancy, or bleeding that was interpreted as menses.

A leading text on abortion techniques states that “First trimester patients who are found to be 11-12 weeks gestational size corresponding to the reported menstrual date of 11 to 12 weeks from the last menstrual period should be given an ultrasound examination if there is any doubt in the examiners mind concerning the actual length of pregnancy... It is very easy to mistake a 16 week pregnancy for a 12 week pregnancy at this stage.” Abortion Practice, Warren Hern (1990), p. 69. See also American College of Obstetricians and Gynecologists Technical Bulletin #187 entitled Ultrasonography in Pregnancy, December, 1993 requiring ultrasonography if gestational age is uncertain or needs verification.

In addition to assessing gestational age, the use of ultrasound has been demonstrated to be valuable in reducing uterine perforations, examining the uterine cavity for fluid collection or retained fetal parts, to confirm pregnancy, to locate the gestational sac, placenta or fetus, identify cysts, and other similar uses.

The likelihood of uterine perforation is increased if the doctor is inexperienced; underestimates the length of gestation, uses forcible or rigid dilation by using metal dilators as opposed to laminaria tents, Dilapan or Lamicel, uses general anesthesia, fails to position his fingers to protect against abrupt relaxation of the cervix, or fails to make the correct judgement of the uterine position and size immediately prior to the abortion. Women who are obese, have had one or more children, experienced a recent childbirth, or have an anteflexed or retroflexed uterus, are more likely to experience uterine perforation.

When the method of abortion is changed it is not sufficient to merely agree on the cost, it is also necessary that another informed consent be obtained. The standards of the National Abortion Federation require that “facilities should provide to patients written descriptions
of the abortion procedure..., and the 
risk and benefits involved in the 
particular abortion procedure the 
patient will undergo... Patients 
must be supplied with materials 
that accurately pertain to their cir-
cumstances, (emphasis in original) 
Standards for Abortion Care, 
National Abortion Federation: 

The policies and procedures 
established by the facility where the 
abortion took place may have been 
violated. Many abortion facilities 
limit abortions to the first trimester 
only, but a 14 week gestation is 
clearly in the second trimester. A 
different abortion method is required 
in the second trimester and the facil-
ity may not be equipped or experi-
enced to do so. Thus, in any mal-
practice litigation, it is essential to 
determine the policies and proce-
dures of the facility involved. 

General anesthesia has been 
found to be about twice as likely to 
be associated with uterine perfora-
tion compared with local anesthesia 
for suction curettage abortion of 12 
or fewer weeks gestation. Similarly, 
use of general anesthesia is also 
more likely to result in uterine per-
forations in second trimester dilata-
tion and extraction abortions. Also, 
in recent years the use of general 
anesthesia has become the leading 
cause of abortion related death of 
women. 

**Septic Abortion -** 
**Failure to Follow-Up** 

Plaintiff, identified only 
as S.R., went to Pittsburgh, 
Pennsylvania to have an abor-
tion performed at the Allegheny 
Reproductive Health Center 
(Allegheny Center). At the time 
she was a student at Fairmont 
State College in West Virginia. 
After filling out routine forms, 
she saw Dr. Saroj Wadhwa, an 
ob/gyn who worked at the 
Allegheny Center. Dr. Wadhwa 
had contracted with Allegheny 
Center through Infertility 
Services, a Pennsylvania medical 
professional corporation, to do 
abortions at Allegheny Center 
and was paid by them for doing 
so. The doctor owned all of 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. It also did 
similar advertising and had tele-
phone listings in Wheeling, 
Clarksburg, and Morgantown. 

At the time of the abor-
tion, there was evidence that cer-
tain of the fetal parts had not 
been removed. One of the med-
ical records prepared by the doc-
tor contained the statement: 
"??complete-fetal parts seen". 
When the plaintiff returned to 
Fairmont, she developed cramps, 
vaginal bleeding and a fever. She 
got to Fairmont General 
Hospital, but its personnel were 
apparently unsuccessful in diag-
nosing the exact nature of the 
problem. She went into shock. 
Ultimately she was transferred to 
the West Virginia Medical Center 
where the personnel there were 
able to save her life. However, 
before the undelivered fetal parts 
were removed, the plaintiff 
developed acute renal failure 
aring from the septic abortion. 
The plaintiff, in the absence of a 
kidney transplant, had to rely 
upon ambulatory perennial dial-
lysis as a life support system. 

The plaintiff brought suit 
in a West Virginia court allegations 
medical malpractice against the 
Allegheny Reproductive Health 
Center, Infertility Services, and 
the city of Fairmont. It was 
admitted that the West Virginia 
court had jurisdiction over 
Allegheny Reproductive Health 
Center under its “long-arm 
statute”. As part of her claim the 
plaintiff contended that the doc-
tor knew that the abortion was 
not totally complete, but permit-
ited the plaintiff to return to West 
Virginia without arranging for or 
advise of her proper follow-up 
care. except to call Allegheny 
Center if she had problems. 
However the attorneys for 
Infertility Services contested the 
judisdiction of the West Virginia 
court because it was a 
Pennsylvania corporation and 
and not done business in West 
Virginia. 

Therefore the trial court 
dismissed Infertility Services 
from the suit and the issue was 
appealed. On appeal, the appeals 
court reversed the order which 
had dismissed Infertility Services 
from the suit. The 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. The breach of duty to provide follow-up care causing substantial increased injury and the receipt of a direct economic benefit from solicitations in West Virginia was held to be sufficient for personal jurisdiction under the West Virginia “long-arm” statute. S.R. v. City of Fairmont, 280 S.E2d 712 (W. Va. 1981). See also Stills v. Gratton, 55 C.A. 3d 698;127 Cal Rptr. 652 (1976) (doctor who performed incomplete abortion has a continuing duty of care despite living in different city from patient).

Comments: This case is a good example of the failure of a doctor to refer, to monitor and to provide appropriate aftercare.

The defendants violated the ACOG Guidelines for Women’s Health Care (1996). These provide that “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.”

Negligent Diagnosis of Ectopic Pregnancy: Failure to Read or Properly Interpret Report

In an Alabama case, the plaintiff, Maurine Williams, went to Summit Medical Center to have an abortion. The abortion was performed by the defendant Dr. Ralph Robinson who used the suction method of abortion. After the abortion, the plaintiff was taken to a recovery room where the nurse gave her either a prescription or antibiotics tablets and told her she should not take sit-down baths, or engage in sex for the next three weeks. She was also told to return for a follow-up visit in three weeks. This was the second abortion for the plaintiff.

However, the next morning the plaintiff noticed she was feeling different than after the earlier abortion. She was still having morning sickness and was experiencing cramping and spotting. She also believed that she should have been experiencing heavier bleeding. After 4 days when the symptoms still had not disappeared, the plaintiff called the toll free number for Summit Medical Center which she had been given. 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. The plaintiff described her symptoms and explained that she still felt that she was pregnant. The woman replied that cramping and spotting were normal and as to the morning sickness it was simply a “neurotic reaction” to the abortion.

The symptoms continued and the plaintiff called again 8 days after the abortion. Again she was told that a nurse was not available but another person was called to the phone. This person told the plaintiff again that her symptoms were not abnormal. There was no evidence that the defendant doctor was advised of the calls.

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 with the help of a neighbor and the plaintiff was taken to the hospital. She underwent emergency, lifesaving exploratory surgery which revealed a pregnancy in one of her fallopian tubes.

The plaintiff then filed suit in an Alabama court against the doctor who performed the abortion and Summit Medical Center claiming negligence in advising the plaintiff of the risk of the abortion procedure; failure to provide post-operative care; failure to use the degree of skill and care required; failure to inform her of the dangers of ectopic pregnancy and failure to diagnose an ectopic pregnancy.

The defendant doctor claimed there were two pregnancies, one uterine and the other in her fallopian tube.

The trial court dismissed the plaintiff’s claim although the plaintiff had submitted an affidavit of an expert forensic pathologist that the defendant doctor had violated the appropriate standard of care in failing to diagnose the ectopic pregnancy.
and failing to provide proper follow-up care. The defendants operative report stated that the products of conception were normal and the fetal age was 6 weeks. This however conflicted with the pathology report which showed only compact and spongy decidual endometrium and chorionic villi, and no fetal tissue.

The plaintiffs 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. It was also alleged that the defendant doctor had not read the pathology report where there was no mention of a fetus or embryo. According to the defendant doctor the fetus was microscopic but the plaintiff's expert stated, in reliance upon medical articles on the subject, that the fetus was 22-24 millimeters in size at 6 weeks and could be readily seen. The appeals court reversed the dismissal of the plaintiff's claim as there were genuine issues of material fact. Williams v. Robinson, 512 So2d. 58 (Ala. 1987).

Comments: This case exemplifies the fact that the outcome may very well depend on who has the most knowledgeable expert witness who can assess the evidence and identify the exact nature of the malpractice. It also demonstrates that there can be conflicting points of view among experts as to what actually occurred.

There was evidence of nursing malpractice. If a lay person acts in the capacity of a nurse, that person will be held to the standards of a nurse. The Standards of the American Nurses Association state that "A nurse should not delegate to any member of the nursing team a function for which that person is not prepared or qualified. Employer policies or directives do not relieve the nurse of accountability for making judgments about the delegation of nursing activities." Code for Nurses with Interpretive Statements, American Nurses Association: Washington D. C. (1985) p. 11.

The plaintiff had signed a Consent to Abortion form which contained the following language: "I understand that having an abortion involves some risks to me, including the following... Ectopic pregnancy or pregnancy in the tubes and 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 still may be pregnant." This was not controlling probably because it did not advise the plaintiff of the potentially life threatening nature of an ectopic pregnancy.

Negligent Diagnosis of Ectopic Pregnancy - Nursing Negligence

In an Indiana case, the plaintiff, a 24 year old woman with no children, received a $100,000 settlement after having a hysterectomy necessitated by a failure to diagnose an ectopic pregnancy. The plaintiff had irregular bleeding and pain over a 12-week period. She was seen by nurses at a health maintenance organization. Several pregnancy tests were positive, but ultrasound showed no fetus in the womb. A radiologist's report was equivocal. The nurses failed to report to, or obtain opinions from, any 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. As a result, the plaintiff required an emergency hysterectomy. Plaintiff sued the health maintenance organization, alleging that the defendant's staff were negligent in failing to diagnose the plaintiff's ectopic pregnancy. The case was settled for the defendant's $100,000 policy limits. Baker v. Metro Health, (Indiana Insurance Commission), Indiana, October, 1986

Comments: Nursing standards are determined by state nursing practice acts, professional organizations such as the American Nurses Association, The Association of Women's Health, Obstetric and Neonatal Nurses, institutional standards, and organizations such as the National Abortion Federation. The Standards of the American Nurses Association state that "Nurses 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 qualified nurses."
health professionals, and other appropriate sources." Code for Nurses with Interpretive Statements, American Nurses Association: Washington D.C. (1985) p.11. The defendant was negligent because the nurses employed by the defendant failed to adhere to this standard.

**Negligent Diagnosis of Ectopic Pregnancy - Failure to Convey Results of Pathology Report**

In a Michigan case, the plaintiff suffered the loss of her right ovary and fallopian tube after the defendant physician failed to diagnose an ectopic pregnancy. The plaintiff went to the defendant physician for an abortion. Prior to the abortion, the plaintiff had experienced cramping and bleeding. The defendant diagnosed the plaintiff's symptoms as an incomplete spontaneous abortion and performed a D&C. Two days later, the defendant received a pathology report indicating that the plaintiff had a possible ectopic pregnancy. One month later, the plaintiff's fallopian tube ruptured. The plaintiff sued the defendant alleging medical malpractice and the jury awarded $217,000 to the plaintiff. Lepage v. Ojeda, M.D.; Eastland Women's Clinic, Macomb Co., Michigan, January, 1991.

Comments: The Standards of the National Abortion Federation require that "there must be an appropriate mechanism for contacting the patient and informing her of the significance of the pathology laboratory's report." Standards for Abortion Care, National Abortion Federation: Washington, D.C., (1987). The failure to advise the plaintiff of the results was the evidence of malpractice.

An induced abortion is an opportunity for the diagnosis of an unruptured ectopic pregnancy. However, it appears that it is seldom the case. In a study of 41,753 abortions at two Planned Parenthood facilities over a 4 year period published in 1976, only 2 of 11 unruptured ectopic pregnancies were actually diagnosed. The study noted that as many as 40% of the patients were lost to follow-up and that the number of ectopic pregnancies was probably much higher. The Centers for Disease Control (CDC) reported that between 1970-85 that the estimated rate of ectopic pregnancy concurrent with induced abortion in the U.S. was 1.35 per 1000 abortions. Based upon that estimate, Planned Parenthood should have found about 55 ectopic pregnancies.

In some cases, the failure to identify an ectopic pregnancy at the time of the abortion has resulted in the death of women. In a study published by CDC covering the period 1972-85, 24 women were identified who underwent an attempted induced abortion and died as a result of a ruptured ectopic pregnancy. The failure to diagnose the ectopic pregnancy before the women left the facility was attributed as the cause.

**Uterine and Fallopian Tube Infection - Sterility**

In a Georgia case tried in 1987, the plaintiff, a 29 year old female secretary, was rendered sterile when the defendant surgeon improperly performed an abortion. The plaintiff charged that the defendant's negligence caused an infection in the uterus and fallopian tubes. The jury returned a $20,000 verdict in favor of the plaintiff. Terry L. Wiggins v. James L. Waters, Jr., M.D., Fulton County Georgia, File No. D21147 (1987).

Comments: Uterine injury, such as a perforation or laceration, has been identified as a risk factor for the type of infection described in this case. Infections and Abortion, S. Faro and M. Pearlman (1990) p.43-46.

Possible infectious complications following abortion include endometritis (inflammation of the inner lining of the uterine wall), salpingitis (inflammation of the fallopian tube or the eustachian tube), peritonitis (inflammation of the abdominal cavity) and pelvic inflammatory disease (inflammation of the genital tract) or pelvic infection. These infections can occur from the insertion of instruments including those used in the abortion procedure itself.

The presence of chlamydia or gonorrhea at the time of abortion greatly increases the likelihood of endometritis or pelvic inflammatory disease following abortion to about 15-30% depending on the study. For example, in a Swedish study, women with endocervical chlamydial infections were over 5 times more...
likely than uninfected women to develop PID within 4 weeks after a first-trimester induced abortion. (23.4% v. 4.4%) Teenagers are more likely to be infected compared to older women.

Despite the substantial increased risk of infection following abortion if chlamydia or gonorrhea is present beforehand, many abortion clinics do not test for its possible presence, and if such tests are offered, they are optional and at extra cost. Test results may also not be available until after the abortion is performed. If the presence of chlamydia or gonorrhea can greatly alter the risk of postabortion infection, it also relates to the issue of informed consent, or the lack thereof. Women with a history of multiple sex partners or a sexual partner with multiple contacts, sexual contact with persons of culture-proven sexually transmitted disease, history of repeated episodes of sexually transmitted disease or attendance at clinics for sexually transmitted disease are considered at high risk.

When and how much of an antibiotic is used in connection with an abortion, or indeed whether or not antibiotics are used at all, is controversial. Some abortion clinics routinely provide antibiotics or furnish a prescription to obtain them. Others may do so only if there are indications of a possible infection i.e. fever of 38°C or above. The current level of effectiveness of antibiotics is also uncertain. While antibiotics may help reduce or eliminate infection, sterility may still result. For example, one study reported that despite antibiotic therapy, patients who have at least one episode of salpingitis have a rate of 21% of involuntary infertility as compared to only 3% among a control group.

Conclusions

The cases examined, which resulted in an abortion-related physical injury or infection, involved negligent practice of doctors and nurses as well as 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.

The failure to diagnose a possible ectopic pregnancy at the time of abortion is of particular concern. In 1992, 113,000 women in the U.S. were hospitalized because of an ectopic or tubal pregnancy and death from ectopic pregnancy represents 13% of all maternal deaths.

There are established methods available to reduce the risk of serious injury or death from ectopic pregnancy. In 1988, the first combined sonographic - pathologic method of screening for ectopic pregnancy in women seeking first trimester abortions was reported in the medical literature. This method combines the use of ultrasound diagnosis to determine if the gestational sac is present and a particular level of hCG (the hormone which signifies a woman is pregnant). With this method it is possible to screen for ectopic or tubal pregn-

nancy at the site where the abortion is performed. It reportedly is effective in diagnosing 90% of cases of ectopic pregnancy before rupture. Thus, it may be considered to be malpractice for an abortion facility not to use this ultrasound - hCG method.

The failure to provide adequate follow-up to women who have had abortions is complex. Many women are self-referrals and thus may not provide the name of a regular doctor at the time of the abortion. Also, many find the abortion to be a negative experience and they do not desire to return to the abortion facility for follow-up care. Still others may give fictitious information, or may move shortly after the abortion, so it may be difficult or impossible to locate them. Also, some doctors travel from city to city and may be in a single location only infrequently. Still other women attempt to recontact abortion facilities and receive unsatisfactory or inaccurate response from unqualified personnel.

A considerably greater number of serious abortion-related physical injuries or infections could be the basis of medical malpractice suits.

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