Legal Aspects of Obstetric Sonography

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Whereas diagnosis was the radiologist’s sole concern in the past, the current political and social milieu demands an understanding of ethical, moral, and legal issues that are now intimately related to daily practice. This requirement has been further magnified by the boom in newer imaging techniques and the increase in public awareness about imaging and medicolegal issues. Sonography, in particular, is an area in which technologic innovation has become the standard of care in a relatively short time. Clinicians now rely heavily on sonography to assess fetal growth and development. The link of new technology (sonography) and a high-risk specialty (obstetrics) has increased the potential for significant liability [1, 2].

The Roe v. Wade decision has added further import to obstetric sonography. This landmark case held that a woman has the right to terminate her pregnancy until the end of the second trimester on the basis of her right to privacy [3]. The decision to abort sometimes is made primarily on the basis of a sonographic diagnosis of fetal anomalies. Lapses in this assessment result in multiple legal actions and a variety of damages. These are grouped under the general theory of tort. It is essential that all those who perform sonographic examinations be familiar with these concepts, because more than 80% of sonography-related litigation arises from obstetric cases [4].

Tort litigation attempts to compensate one whose interests have been harmed. A plaintiff must prove several elements by a preponderance of the evidence. First, the defendant must owe the plaintiff a legal duty that has been breached. Next, damages to the plaintiff must have been incurred. Finally, the breach must be the proximate cause (legal cause) and the cause-in-fact (actual cause) of the damages.

Historically, no action could be brought by or on behalf of a fetus for damages that occurred prenatally. Courts did not recognize the fetus as a separate living or legal entity; it was considered merely a part of the mother. Concern over fraudulent claims, fear of suits brought by a child against the mother, and difficulty in showing proximate causation justified the courts’ rulings on a public-policy basis [5]. Slowly, courts began to create a right to sue on behalf of the dead fetus under states’ survival statutes or wrongful-death statutes. Currently, every American jurisdiction recognizes possible liability for prenatal injuries.

Courts have based such claims solely on the strict definition of negligence. Plaintiffs claim that the physician’s act or failure to act has caused them injury. These misdeeds or nondeeds include failed sterilization procedures, failure to perform diagnostic tests, laboratory errors, missed diagnosis of pregnancy, and failed abortion. Many courts, however, have been bothered by the tenuous link between the negligence of the physician and the ensuing damages [6, 7]. One cannot argue that the radiologist caused the fetal anomaly that was overlooked. These are legally difficult concepts grouped under the category of preconception torts. However, when the radiologist negligently performs sonography, conception has already occurred. Unlike cases involving failed sterilization or defective genetic counseling, damages have been incurred by a living being with legal rights—the fetus.
Wrongful Pregnancy

Claims of wrongful pregnancy arise most commonly after a failed sterilization procedure or unsuccessful abortion that has resulted in the birth of a normal child. These claims are brought by the parent(s), who allege that the negligence of the physician has resulted in the birth of an unplanned, albeit healthy, child [8]. The application to obstetric sonography is clear. If a pregnancy (or a twin pregnancy) is overlooked, the radiologist may be liable under this theory, provided the couple would have terminated the pregnancy with the correct information before the third trimester. Wrongful pregnancy has gained widespread acceptance in American jurisdictions [9].

The damages awarded for these claims have been inconsistent [10]. In the earliest cases (and some recent ones as well) monetary compensation was denied under the "blessing's rule," whereby the birth of a child is viewed as "God's gift" [11, 12] to the parents. Recently, a few courts have followed the "burden rule," asserting that an unwanted child is an unnecessary stress and, as such, the parents should be awarded costs of pregnancy, emotional distress, and costs of child-rearing [13, 14]. One court even awarded general damages to the parents, not specifying the exact breakdown, but awarding an amount far in excess of medical costs, possibly to compensate for intangible emotional injuries [15].

Virtually all courts, however, deny costs of child-rearing, but award pregnancy and childbirth costs in an attempt to integrate the cost-benefit ratio [16–19]. In most jurisdictions, this is the current limit of liability to a radiologist for missing a pregnancy. As a missed twin involves no additional pregnancy and delivery costs, damages are not likely to be awarded.

Wrongful Birth

Wrongful-birth claims are also brought by the parents and are similar to those of wrongful pregnancy with one exception: the infant is born defective. The parents do not claim that the defect was caused by the physician's negligence. Rather, because the parents were not given the option to terminate the pregnancy, it is the birth itself that is wrongful [10].

These actions usually arise from negligent genetic counseling. The parents assert that they were not informed that the risk of having an afflicted child existed, and if they had been so informed, they would have opted for an abortion. One recent case was brought by the parents of a child with autosomal recessive polycystic kidney disease. When their first child died from the disease, they were advised wrongly that there was virtually no risk of having a second affected child. A wrongful-birth claim was successfully brought [20]. A case with even wider ramifications involved the lack of counseling about the efficacy of prenatal diagnostic tests and the increased risk of Down syndrome in the fetus of a 37-year-old woman. When the baby was born defective, the parents sued and were awarded damages [21].

One basic purpose of the fetal survey is to exclude fetal malformations. When such anomalies are diagnosable but overlooked on examination, claims of wrongful birth may arise against the radiologist. The parents must show that had they known of the deformity, they would have terminated the pregnancy. This "openness to abortion" is exceedingly difficult to prove. In some of the wrongful pregnancy cases, the act of attempting to obtain sterilization or an abortion is, in itself, definitive proof of such openness. This, however, does not exist in most wrongful-birth cases or in wrongful-pregnancy claims in which a pregnancy has been overlooked. Therefore, a significant burden of proof exists on the plaintiff's part.

Nonetheless, a vast majority of jurisdictions recognize these claims, awarding the cost of pregnancy, extraordinary medical costs, and, occasionally, costs of child-rearing. At this time, however, courts are split as to whether parents also may recover for associated mental distress [10]. A few courts have denied medical costs if mental distress awards are granted [6]. Finally, a small minority of states have denied these actions entirely via statute, possibly representing a new trend in jurisprudence [22, 23].

Wrongful Life

Wrongful-life claims are closely related to those of wrongful birth, but are brought by the defective child and not by the parents. These claims have met with far less judicial and legislative acceptance, primarily because of public-policy concerns and difficulty in accurately determining damages. The cases that created this concept did not involve medical negligence. Instead, a child sued his father for having been born into an imperfect life, that is, illegitimate. Although the court recognized that a child has a right to be born "unencumbered" and, as such, recognized the validity of the cause of action, damages were not awarded. They believed the public-policy concerns were too far-reaching, and, as such, should be left to the legislature [24]. Similar claims are now referred to as "dissatisfied life" [10, 25].

The so-called diminished life suits, the second category of wrongful life, involve impaired infants [19]. These claims, often brought simultaneously with wrongful-birth claims, are brought by the child [25]. It is alleged that, if not for the negligence of the physician, the defective child would have never been born [2]. Once again, the physician is not alleged to have caused the anomaly; it is the life itself that is construed as a burden [27]. These decisions have received a great deal of press because of the large amount of damages sought.

A great majority of American courts (and British, as well) are bothered by a complex ethical and philosophical question: Is an impaired existence better than no existence at all? Most courts have responded yes, relying on various reasonings [26]. Some base this determination solely on the "sanctity of human life" at any level [21]. As such, birth can never be an injury in the eyes of the law. This concept has been somewhat undermined by the legalization of abortion, the acceptance of "do not resuscitate" orders in terminally ill patients, and the rights of patients to discontinue medical treatment under certain circumstances. In some cases, it has been decided that there may be times when the cost-benefit ratio of a life is so imbalanced that nonlife becomes preferable [28]. Other courts choose not to deal with the philosophical issue. Instead, they rely on the inability to determine the amount of damages accurately to deny recovery. What compensation is appropriate for one who claims he would rather not have been born? Clearly, the formula should weigh the value of
deformed existence against the value of nonexistence [20]. As one court stated, this “is a mystery more properly to be left to the philosophers and the theologians” [21].

The courts also examine public-policy concerns, to assess whether it would be of benefit or detrimental to society as a whole to rule one way or the other. Some courts fear that an award of damages for wrongful life would lead to an onslaught of litigation. Also, if these claims could be brought against physicians, they might also be brought against mothers who chose not to abort defective fetuses. Ultimately, some fear compulsory abortions for mothers of afflicted fetuses and the practice of defensive medicine to avoid wrongful-life suits [29]. Nonetheless, a few courts have accepted these wrongful-life claims. One early case, Curlender v. Bioscience Laboratories [30], involved laboratory error in Tay Sachs screening. After the parents were told that they were not carriers, an afflicted child was born. The court summarily ignored the social and philosophical arguments in ruling in favor of the child. Even more curious, this same court felt that parents should be liable for a defective child if they refused abortion [30]. (Later the state of this jurisdiction, California, passed a statute outlawing wrongful-life claims brought against parents [31].) In Turpin v. Sortini [28], the court awarded only special damages for the child, denying general damages for emotional distress and impaired childhood. They asserted that impaired life was not always preferable to nonlife, and that public policy dictated the importance of the individual deciding the value of his own life [28]. Thus, in jurisdictions permitting wrongful-life claims, damages usually are limited to the more tangible costs of pregnancy and extraordinary medical costs during infancy and childhood: the less tangible general damages for emotional distress or impaired childhood are denied as being too difficult to assess [28, 32]. Presently, only high courts in California [28], Washington [32], and New Jersey [33] and intermediate courts in Colorado [34] recognize these claims [6]. In fact, many states are now passing legislation to preclude these actions entirely: Pennsylvania was the most recent in April 1988 [23].

The implications for the radiologist are in many ways similar to those of wrongful birth. If an anomaly is diagnosable on sonography but is overlooked, and the parents would have aborted the fetus with this knowledge, claims for wrongful life (in addition to wrongful birth) may arise, provided these are not precluded by legislation.

Wrongful-life claims may also arise in another situation. Recent technologic advances have given physicians the ability to perform interventional procedures and invasive testing (including amniocentesis and chorionic villus sampling) in utero. Insertion of shunts under sonographic guidance into the hydrocephalic or hydronephrotic fetus may improve or prolong life, but may also result in significant additional medical expenses throughout life. If the procedure is successful, the fetus may claim, “But for the procedure, I would never have been born,” and yield a wrongful-life claim. Wrongful-birth claims are less likely in this situation because informed consent is obtained from the parents before the procedure [35, 36]. Since the Canterbury v. Spence [37] decision in 1972, patients must be informed of the risks, benefits, and alternatives to the intervention in order to yield a valid consent.

As these innovative radical therapies become more routine, a boom in litigation may ensue.

Wrongful Death

When negligence has resulted in death, claims of wrongful death may ensue. Early statutory law did not create a cause of action on behalf of a fetus [2, 5]. However, since Roe v. Wade, the fetus fatally injured in utero may make a wrongful-death claim provided it was viable at the time of insult [4]. Courts are largely undecided about damages. Some will award medical and funeral costs and, occasionally, even pain and suffering. Most deny claims for loss of earnings as these are too difficult to assess [38]. A few jurisdictions have enacted statutes to prevent these actions entirely [2]. If an anomaly is erroneously diagnosed when in fact the fetus is normal, and the parents choose an elective abortion, a wrongful-death claim may arise. If sonographically guided therapy is unsuccessful or leads to the death of the fetus, the radiologist may be liable.

Agency Law

It is essential that all practitioners of sonography understand the relationship between the radiologist (physician) and the sonographer (technologist). In the private office, the technologist is an agent, working for and under the control and direct supervision of the physician. Any reasonable act committed by the technologist within the scope of employment yields concomitant liability for the physician, under the “borrowed servant” rule. For example, if a technologist takes a patient hostage, the physician is not likely to be liable (unless the physician had prior knowledge of the technologist’s predisposition) because the action is outside the scope of employment. On the other hand, if a technologist overlooks an anomaly, the physician would be found liable as this omission occurred within the scope of employment. Many physicians do not rescan patients or rescan only selectively after the technologist’s examination. Physicians are as liable for misdiagnosis or nondiagnosis in these cases as they would be if they had scanned the patient themselves [35, 36]. In the hospital-based practice, the radiologist would probably share liability with the hospital depending on the degree of technologist supervision.

Recommendations

Seven suggestions aimed at improving protection from potential claims related to obstetric sonography follow. These recommendations are by no means exhaustive; they represent a baseline of prudent practice.

1. Follow the American College of Radiology (ACR) guidelines for fetal surveys. (These guidelines are printed on pp. 1256–1257.) When a malpractice claim of any type arises, it must be shown that the physician deviated from the standard of care. The courts originally looked to the community in which the physician practiced to determine this standard. Presently, the determination is made on the basis of a nationwide level of minimal acceptable performance, often determined by professional society guidelines. In 1985, the ACR
approved such recommendations for fetal surveys, detailing the structures that should be visualized during each trimester [39]. Although the guidelines are not conclusive, noncompliance represents strong evidence of deviation from the standard of care and bodes poorly for the radiologist in a malpractice action.

2. If an abnormality is identified or suspected, obtain a second opinion and/or a follow-up study. Rescanning by an unbiased second radiologist is helpful to confirm a possible fetal anomaly. Although this may seem excessive, it is helpful to minimize the risk of an “imagined” anomaly resulting in an elective abortion and a wrongful-death suit. Any question about fetal structures or measurements, amniotic fluid, and placental or fetal position should be confirmed on a follow-up study or by a second opinion preferably before submission of a final report.

3. Detail which fetal structures were normal in a written record. Merely stating “the fetus appears normal” is inadequate. Each fetal structure and its measurements should be noted in the written record. This is strong evidence of the content and quality of the examination and also aids the radiologist’s memory if called to testify. Also note which structures were identified suboptimally.

4. Be familiar with your jurisdiction’s case law and legislation. This basic knowledge is acquired easily from newspapers and local bar associations. It gives the radiologist an edge in dealing with counsel and prospective litigants should the need arise.

5. Rescan patients thoroughly after the technologist’s examination. The physician is liable for any reasonable activity of the technologist performed in the scope of employment, under the theory of agency law. The physician is thus responsible whether or not the physician personally has scanned the patient. Double-checking the technologist’s examination is important to minimize potential liability.

6. Give prompt verbal and written reports, especially if an abnormality is discovered. Prompt and precise communication between radiologist and clinician is essential for optimal care of patients. Reporting should always be prompt; this becomes even more important in the event of an abnormality, because the patient may opt to abort. A significant delay may result in claims for wrongful birth and wrongful life if the patient is denied the opportunity for elective abortion.

7. Document the study. The best defense to any malpractice action is documentation. If the study is normal, representative images of the normal fetal structures, fetal position, placenta, and amniotic fluid volume should be taken. Video is an excellent permanent record of fetal heart activity. If the results of the study are abnormal, obtain multiple images of the abnormality. Note when and to whom written and verbal reports were delivered.

Conclusions

The changing social climate dictates that every physician be familiar with current legal and ethical issues. The radiologist who performs obstetric sonography is no exception. Application of basic negligence law to the unborn child has resulted in the innovative legal theories of wrongful pregnancy, wrongful birth, and wrongful life. These claims may arise during the routine fetal survey or in the course of sonographically guided interventions or invasive tests.

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