CHOICE SUX

back

Abortion and Anesthesia

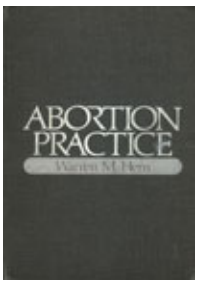
" On the issue of Anesthesia in general, all medications used in anesthesia have the potential for serious risk. Anesthesia complications are an increasing proportion of total abortion morbidity and mortality. "

2006 Clinical Policy Guidelines, National Abortion Federation

NATIONAL ABORTION FEDERATION

Complications and risks of general anesthesia include but are not limited to: difficulties with the lung, heart, liver or nerve functions. Serious illness, additional surgery and even death may result from the complications of general anesthesia.

Abortion clinic website



"CDC investigators found a two to four times greater risk of death associated with the use of general anesthesia. In another study, general anesthesia was found twice as likely to be associated with uterine perforation and cervical injury. " (PG 35)

" The degree of bleeding experienced under general anesthesia is greater, the risk of perforation is greater, and the risk of death due to aspiration of vomitus, among other things, appear to be greater. I

believe it is preferable to have a patient who is uncomfortable but able to tell me what she is feeling and if she feels a strange abdominal pain than to have a patient who is quite comfortable because she is dead." (PG 119)

Abortion Practice by: Warren Hern

Abortion hospital did not monitor patients

The Inglewood Women's Hospital, an abortion facility, was inspected by the state and in 1987. The state report released noted that doctors at the hospital did not adequately monitor patients under anesthesia, according to the July 30,1989 Los Angeles Times article, *Doctor accused in abortion suit testifies*.

Some patients were **"encouraged to leave the facility before they felt comfortable doing so,"** and some were not examined by doctors after surgery although the physicians signed discharge papers, according to the report.

Family sues, daughter dead after abortion

In September of 1992, 13-year-old Deanna Bell of Chicago died after an abortion she received at an Illinois abortion clinic, Family Planning Associates Medical Group.

Being six months pregnant at the time Deanna was schedule to have her three-day procedure top begin at 7:40 am on September 3rd. She was getting a common procedure known as a Dilation and Extraction of “D & E.”

On September 4, Bell went to the Elston Avenue clinic to have additional laminaria inserted by a nurse practitioner. However, the nurse practitioner was unable to remove the laminaria because the dilating devices were too tight, Bell's cervix was immature, and Bell was unable to cooperate by lying still. Bell was sent to the Washington Boulevard facility, where abortionist, Stephen Lichtenberg was working that day, to have the procedure performed under general anesthesia.

In an approximately 20-minute procedure, Dr. Lichtenberg removed the laminaria that had been inserted the day before and inserted new ones. Certified registered nurse anesthetist Larry Hill administered the anesthesia for the procedure.

Bell was told to return to the Elston Avenue clinic at 6:30 a.m. the following day to complete the D&E procedure. When she arrived at the clinic the next day Bell was given anesthesia at 7:40 a.m. and Dr. Lichtenberg performed the procedure and CRNA Goode administered the anesthesia.

CRNA Goode decided to use a higher level of anesthesia than was used the day before because Bell appeared nervous and because the extraction procedure is more painful than the insertion and removal of laminaria.

During the procedure, CRNA Goode administered 200 mg of Brevital as an induction dose and subsequent maintenance doses totaling 200 mg over the course of the 11-minute procedure. CRNA Goode administered supplemental oxygen only by waving an oxygen mask near Bell's face. A pulse oximeter attached to Bell's finger registered that she had a blood oxygen saturation of 97% throughout the procedure, which is within the normal range. Bell breathed spontaneously throughout the procedure and her blood pressure was steady. At the conclusion of the procedure, Dr. Lichtenberg noted on an a health maintenance organization form that Bell's abortion was uneventful, then he left the room to prepare for the next patient's procedure.

Bell was disconnected from the monitoring equipment and CRNA Goode and a

medical assistant, Elizabeth Sturm, placed Bell on a gurney to be transferred from the operating room to the recovery room. While Sturm was referred to as a medical assistant, she had never received any type of formal medical education. CRNA Goode placed his hand next to Bell's mouth so he could feel her breath during the transfer. CRNA Goode testified that he saw Bell's chest moving, and he felt and saw that Bell was breathing spontaneously and smoothly. After Bell was in the recovery room, Sturm put a pulse oximeter on Bell's finger and a blood pressure cuff on Bell's arm, then CRNA Goode went into another operating room.

Before obtaining a reading from either of Bell's monitoring devices in the recovery room, Sturm began to write on Bell's medical chart the vital signs Sturm expected to find, rather than Bell's actual vital signs. This practice is called "precharting." While Sturm was precharting, the pulse oximeter beeped, indicating that it was not getting a reading. Sturm removed the device from Bell's finger and checked its operation by making sure the light inside the device was on. Sturm then placed the device on another of Bell's fingers, but still did not receive a reading. Sturm looked at Bell's appearance for evidence of a problem, but she noticed only that Bell was "a black girl." When Sturm was still unable to get a reading on the pulse oximeter, she summoned the nurse, Dolly Barnett.

Barnett looked at Bell and saw that she was pale. She performed a jaw thrust to open Bell's airway and saw that Bell was not breathing. Barnett listened and felt for a heartbeat and breathing, but neither was present. Barnett told Sturm to bring CRNA Goode, and Barnett began administering CPR. Sturm went into the second operating room and told CRNA Goode that he was needed in the recovery room immediately.

Upon entering the recovery room, CRNA Goode began assisting Barnett with cardio pulmonary resuscitation (CPR). CRNA Goode picked up the Ambu bag, a portable mechanical ventilator attached to a tube of pure oxygen, placed it over Bell's nose and mouth, and squeezed the bag to force air into her lungs. The bag compressed smoothly, and CRNA Goode saw Bell's chest rising, which indicated that the oxygen was going into her lungs. Barnett continued administering chest compressions, while CRNA Goode ventilated Bell with the Ambu bag.

At approximately 8 a.m., after finishing another patient's procedure, Dr. Lichtenberg came into the recovery room. Dr. Lichtenberg took over the external chest compressions and continued them for the duration of the resuscitation effort. CRNA Goode attached electrocardiogram (EKG) cables to Bell and attached her to the EKG machine to monitor her cardiac activity. The EKG readout displayed a terminal pattern. At approximately 8:15 a.m., CRNA Goode intubated Bell with an endotracheal tube.

Two hours after the abortion began, lying in a recovery room of the abortion clinic, and after approximately an hour of resuscitative attempts, Bell was pronounced dead at 8:52 am. Doctors at the clinic said the death was the result of an amniotic fluid embolism, but a lawsuit filed in Cook County Circuit Court claims anesthetic problems were the cause of death.

David Myers, one of the lawyers who filed the suit on behalf of the dead girl's mother, said the girl was given an anesthetic twice within 15 or 16 hours and might have suffered from what amounted to an overdose.

The complaint charged that the defendants: owner and abortion doctors Edward Allred and Stephen Lichtenberg -- as well as nurse anesthetist Arthur Goode and three other clinic employees:

> **"departed from accepted medical practice by negligently permitting a non- M.D. personnel to perform laminaria insertion and removal on a 13-year-old patient with an immature cervix and a 20.5 week pregnancy, and improperly administer anesthesia."**

It also charged, **"Failure to monitor her recovery, failure to resuscitate her and failure to transport her to a fully equipped hospital"**

Experts for the family testified that defendants breached the standard of care by failing to inform Bell or plaintiff of the risk of death from general anesthesia.

Abortionist Marilyn Frederiksen testified for the defense that the consent form given to Bell conformed to the standard of care. She also opined that Bell's transportation to and care within the recovery room conformed to the standard of care. She stated that the staffing of the recovery room was proper and that 911 should not have been called because the patient was never stabilized.

The family argued that that there was evidence of an **"assembly line"** approach to general anesthesia in abortion procedures at the abortion clinic. This evidence consisted of the number of such procedures scheduled for September 5, 1992, and a newspaper article from 1980 in which defendant Allred admitted to having an "assembly line" approach to these procedures.

The medical examiner listed the cause of death on Bell's death certificate as "undetermined" and the manner of death as "expired after abortion."

Information regarding this case was taking from case No. 1-98-2583, Appellate court of Illinois, First District, Fifth Division, 315 Ill. App. 3d 533; 733 N.E.2d 766; 2000 Ill, and the Chicago Tribune article, Mom sues abortion clinic after 13-year-old girl dies, 5-5-1994.

Abortion death, no qualified anesthesiologist

According to the reports filed by the Department of Health and Human Services Departmental Appeals Board, Civil Remedies Division, case of: Gideon M. Kioko, M.D., Vs. The Inspector General, Docket No. C-92-115, Decision No. CR256: 4-13-1993, Abortionist Gideon M. Kioko was charged by the Maryland state medical board with negligence while he was medical director at Cygma Health Center in Kensington.

Kioko worked at Cygma after he left Hillview another abortion facility where a woman was left severely paralyzed and brain damage, unable to talk,swallow or move her arms and legs after her abortion.

According to the board's documents, Kioko performed an abortion in July 1989 on Debra Gray, 34, who had been given the anesthetic Brevital. Minutes into the abortion, Gray began having breathing problems, but Kioko continued the operation.

News reports state that after Gray went into full cardiac arrest, another doctor who had been working elsewhere in the clinic administered CPR. Gray was taken by ambulance to the Malcolm Grow Medical Center where she was declared brain dead and was removed from life support systems three days later.

According to the Associated Press, the board found that Kioko performed abortions during which an anesthetic was used without a qualified physician or anesthesiologist present to monitor patients.

On December 3, 1991, Kioko agreed to surrender his license in order to avoid facing formal disciplinary proceedings, which had been initiated against him.

According to reports, those proceedings involved charges that implicated Kioko's

professional competence and performance. On May 8,1997 the board reinstatement Kioko's license and placed him on probation for three years.

Then on November 1, 2005 the State Board determined that the investigative facts regarding the Kioko's office conditions and procedures, and his care and treatment of 2 patients, constituted extraordinary circumstances requiring immediate suspension of the his license.

Healthy abortion patient now paralyzed

Susanne Logan went to the Hillview Women's Medical Surgical Center**,** an abortion clinic in Suitland, Maryland, for what she thought would be a safe, simple abortion.

Susanne's tragedy was documented in an April 21,1991 60 Minutes story entitled, *Substandard abortion clinics in the US causing controversy.*

60 Minutes reports that, Susanne was given general anesthesia during the abortion attempt, but minutes later, according to her attorney, Patrick Malone, she stopped breathing,

"Apparently about halfway through the procedure, the nurse looked at the patient's face and noticed that the lips were turning blue, Susanne's lips. Then all hell broke loose."

During the 911 call the clinic acknowledges that they could not get Susanne to breathe:

Unidentified Woman #1: Fire and rescue.
Unidentified Woman #2: Yes, this is Hillview Women's Medical Surgical Center at 5408 Silver Hill Road. We have a patient in the exam room who has--no, we can't get any pulse or respiration.

60 Minutes host, Meredith Vieira said, "**County paramedics who responded to the 911 call reported the clinic in chaos. Hillview workers lacked the right medicine to reverse the effect of the anesthesia. Their emergency equipment was broken, causing Susanne's brain to go without oxygen for 12 minutes."**

Susanne entered the clinic for a safe abortion and left brain damaged and paralyzed. She survived for three years, dying in 1992 at the age of 24.

Abortion doc did not know CPR, patient dead

In 2005, The Board of Medicine disciplined abortionist Mi Yong Kim, prohibiting her from administering conscious sedation, deep sedation, or general anesthesia and requiring her to compile and keep better patient records reports the Richmond Times Dispatch, in their May 22, 2005 article entitled, *Regulations have made office-based anesthesia safer*.

The Times Dispatch states that the hearing centered around a 2002 case in which a patient died after an abortion Kim performed on her. Kim gave the patient 25 milligrams of Versed, a sedative. She stopped breathing. Medical board records indicate Kim did not know cardio-pulmonary resuscitation (CPR), nor did any of her medical staff.

An ambulance was called, and the doctor gave the patient a drug that is used to reverse the effects of the sedative. By the time the 26-year-old patient, was taken by ambulance to Inova Alexandria Hospital, it was too late. She died just more than an hour after the abortion procedure began.

News reports state that Kim didn't have the proper equipment or training to resuscitate a patient whose heart stopped, nor was the doctor adequately trained in administering the type of sedation she gave to the patient, the Virginia Board of Medicine concluded in the case.

An autopsy noted the cause of death as **"probable air embolism."**

Teen dies, no one cries

The Philadelphia Daily News (*Undaunted*: 8/11/1994) reported that in 1990, a Manhattan jury awarded $1.2 million to the family of a 13-year-old girl Dawn Ravenell who died after a failed second-trimester abortion at a New York clinic. Abortionist Allen J. Kline was a defendant in the suit, along with a Long Island nurse, Robert Augente.

In the September 20,1996, New York State Education Department, Office of the Professions', *Summaries of Regents Actions on Professional Misconduct and Discipline*, newsletter it was reported that nurse, Robert Augente, of East Williston, NY received a 2 year suspension, (execution of suspension stayed), with 2 years probation after being found guilty of charges of administering anesthesia to a patient without having first performed a pre-anesthetic assessment of the patient, failing to intubate patient prior to the commencement of an abortion, and failing to prepare a proper anesthetic record contemporaneously with his administration of anesthesia to the patient.

The patient was 13-year-old girl, Dawn Ravenell, an honor student and daughter of two Pentecostal ministers, who was 21 weeks pregnant at the time of the 1985 abortion procedure. Augente gave her general anesthesia, and Kline was halfway through the abortion when Ravenell began to waken, vomit and choke, court records showed. Kline and Augente inserted a breathing tube in her mouth and moved her to a recovery room. There, Ravenell was left unsupervised, according to the court records cited in the report, and began choking again. By the time staff checked on her, she had suffered a massive heart attack and went into a coma before an ambulance arrived. She died at the hospital three weeks later without regaining consciousness.

Dawn's mother, Ruth Ravenell, said in a phone interview with Newsday (*Abortion Team Told to Pay $ 1.2M In Teen's Death*: 12/11/1990) that neither she nor her husband, was aware that their daughter was pregnant. "I know that she was fearful in that we are a religious family," said her mother, **"I think that she felt that for me to see her as less than perfect would have been too much."**

According to court records, the clinic's staff told the girl that if she requested confidentiality, her parents would not be notified.

The Philadelphia Daily News reported that at one time, Kline was part of a group of a group of doctors who owned Cherry Hill Women's Center and Northeast Women's Center. But at the time of the article he performed abortions in Einstein. Kline also opened a clinic in Atlantic City.

In addition the paper noted that Kline has been traveling to fill a position left vacant by the March 1993 murder of abortionist David Gunn. Kline traveled to Florida, where he performed abortions at the Pensacola Women's Medical Services. Administrator Sandy Sheldon made no mention of Dawn's death when she stated

of Kline that, **"He believes that women have the right to choose, and he has the guts to put his money where his mouth is."**

Dayle Steinberg, 1994 associate executive director of Planned Parenthood of Southeastern Pennsylvania said this when asked if this incident would cause them not to refer clients to Kline any longer, **"Absolutely not, the quality of his care has been excellent,"** calling him an **"excellent doctor."** and said that the quality of his care has been excellent.

After the death of Dawn Ravenell, Dr. Bernard Nathanson, one-time abortionist turned pro-life champion, interviewed her parents who live in Brooklyn. It was clear that the parents of the thirteen-year-old black child, who entered Eastern Women's Center in New York and signed the surgical consent for an abortion (New York State has no provision for parental notice or consent), should have been notified their daughter was about to undergo a surgical procedure. The journal, *First Things*, posted the interview:

Dr. Nathanson: Your first notification was that this daughter of yours was in Roosevelt Hospital in a coma.

Mr. Ravenell: Right-she's fighting for her life. That's what they told me. They told me I had to come in right away, that Dawn is here at that hospital fighting for her life.

Dr. Nathanson: Those are the words they used?

Mr. Ravenell: That's what they said. I was going-how could she be fighting for her life-she left this morning, going to school, looking healthy, never been sick.

Dr. Nathanson: She told you she was going to school that day?

Mrs. Ravenell: She had never been sick. We couldn't understand how she was in Manhattan fighting for her life.

Dr. Nathanson: So you were stricken, literally staggered by the news?

Mrs. Ravenell: I had to constantly while I was in the hospital sitting there-they were running tests-I had to keep my hand over my mouth to keep from screaming in horror.

I could not believe this was happening. I said this is a bad dream, I'm going to wake up and this would not have happened. How can people intrude themselves into my life, make decisions for my child, and then tell me to come pick up the pieces after you've made a mess. This is what you're saying to me: you have nothing to do with the decision that was made, but now we're finished, so you come and pick up the pieces-there are no pieces left to pick up-you have killed a perfectly beautiful lady, and for what?

I kept asking the doctor, how could this happen, how could they do this to my child without my knowledge, and he said to me, **"Mrs. Ravenell, I'm not an attorney, I'm trying to do everything I can for your daughter medically, but you have to look into those avenues on your own."**

Dr. Nathanson reflects: It is odd-and utterly inexplicable to us-how Americans can act so swiftly and decisively to protect their young in circumstances which pose only a minor, rather remote threat to their lives, but virtually neglect them in other much more hazardous settings. According to figures released by the Consumer Product Safety Commission, from October 1989 through September 1990, more than 200 items (toys, rattles, clothing, blankets) were recalled because they were judged to be dangerous for use by children-yet a thirteen-year-old girl is allowed by law literally to sign her life away when confronted by a formidable surgical procedure such as late abortion.

Inappropriate methods of anesthesia in abortion

In 1996, the New York State Board for Professional Medical Conduct voted

unanimously to revoke the medical license of abortion provider Herbert Schwarz on grounds of **"negligence and incompetence."** The board found the Manhattan doctor had endangered 11 patients between 1994 and 1995 by **"failing to perform necessary diagnostic test before performing abortions,"** among other things.

New York's Daily News (*State Yanks abortion doc's license*: 10/2/1996) reported that abortionist Herbert Schwarz mishandled abortions on 11 women, including one who was rushed to a hospital bleeding badly. Schwarz, trail of alleged professional misconduct dates back 18 years, **"placed his patients' lives at risk,"** saying that the board upheld 19 of 29 misconduct charges filed by State Health Commissioner Barbara Ann DeBuono.

"We cannot allow a physician to remain in practice who constitutes a danger to his patients," the panel said.

Schwarz was found guilty of using inappropriate methods of anesthesia on abortion patients, failing to check the women's vital signs and having no oxygen equipment on hand in case of emergency.

Abortion doc fails to monitor vitals

The Daily Collegian (*State: doctor loses license*: 9/14/2006) reported that in 2002, Pennsylvania abortionist Harvey Brookman performed an abortion on a 17-year-old girl in the King of Prussia area, and he allegedly took on the role of an anesthesiologist for the procedure but neglected to monitor the girl's vital signs. The documents also said Brookman did not perform the surgery correctly, causing the girl to be rushed to another hospital for surgery.