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## Tanya Williamson, Abortion Death

### Tanya was not adequately monitored in the recovery room

Tanya Williamson is referred to as "Patient A" in medical board documents pertaining to her abortionist, **Moshe Hachamovitch**. By cross-matching details with outside sources, I was able to identify her by name.

Tanya had laminaria inserted at Hachamovitch's facility on September 6, 1996, for an early second-trimester abortion. Hachamovitch estimated that she was almost 14 weeks pregnant. He instructed Tanya to return the next day for her abortion.

Tanya returned on September 7, as instructed. According to medical board documents, "At or about 11:00 a.m. Patient A was given Valium 10 mg." This medication was not noted on clinic documents that were given to Certified Registered Nurse Anesthetist (CRNA) Gori, who then administered 150 mg. of Brevital at about 1:50 p.m., whereupon Hachamovitch performed the abortion.

The medical board then notes, "150 mg. of Brevital causes loss of consciousness and also potentially decreases the patient's respiratory rate and blood pressure. The amount of Brevital administered to this patient would cause respiratory depression for approximately 30 minutes. The majority of that time Patient A was in the recovery room. The level of respiratory depression is tied into the amount of stimulation of the patient. Surgery is a very strong stimulus, once that is removed the respiratory depression increases."

Records are conflicting as to who administered Pitocin and Methergine to Tanya, and what the dose was and what the route was. Either that, or she got double dosed.

"When Patient A was transferred from the operating room table to the gurney for transfer to the recovery room she was still anesthetized," noted the medical board. "She was unable to move herself from the operating table to the gurney. Patient A never responded verbally to the CRNA. Shortly after Patient A was transferred to the recovery room, her pulse and oxygen saturation levels were taken and *the pulse oximeter was removed from her finger.*" (emphasis mine)

A pulse oximeter monitors both the patient's pulse, and the patient's oxygen level in her blood. By removing the pulse oximeter, the staff eliminated a vital source of information about Tanya's well-being as she came out of anesthesia.

The medical board notes that at 2 p.m., after 5 minutes in recovery, Tanya's blood pressure was 96/80, and her pulse 68. This is within normal limits. At 15 minutes (2:10 p.m.), Tanya's blood pressure had fallen to 60/40, her pulse to 52, and her respirations were shallow. Such a sharp fall in blood pressure is an alarming sign that the patient might be going into shock or suffering other life-threatening problems. The falling blood pressure is especially alarming in combination with shallow breathing.

At 2:11 p.m., Tanya's pulse was noted as "thready," which means weak and erratic. Her blood pressure was so low that it could not be measured with a cuff.

The medical board noted, "At this point, a patient without an obtainable blood pressure and a barely palpable pulse was functionally in cardiac arrest. Respondent was notified of the problem with Patient A at approximately 2:15 p.m."

Hachamovitch examined Tanya in recovery, started a new IV with D5W and Ephedrine, then told the recovery room nurse to do CPR, and somebody to call Emergency Medical Services (EMS).

EMS Advanced Cardiac Life Support (ACLS) was dispatched at 2:40 and arrived at 2:41 to find Tanya "cyanotic, non-responsive, pulseless, apneic and her pupils were fixed and dilated."

ACLS took Tanya's vital signs, attached a cardiac monitor, and properly placed a breathing tube to help get oxygen into Tanya's lungs.

One ACLS team member "then hooked up the Respondent's equipment which the CRNA had been using to ventilate the patient to the intubation tube. He checked for lung sounds and abdominal sounds.

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There were not lung sounds nor were there any abdominal sounds. By that time the EMTs arrived and one came over with the EMS BVM [bag-valve mask, a device for pumping oxygen into a patient's lungs]."

The ACLS team member switched over to the EMT's ventilation unit, and was able to hear oxygen being moved in and out of both of Tanya's lungs. This indicates that Hachamovitch's CRNA had been using useless, broken equipment on Tanya.

The medical board said, "When respondent arrived in the recovery room, he should have immediately ascertained the patient's pulse, blood pressure, and if there was vaginal bleeding. This should have taken between 20 seconds and, at the outside, two to three minutes. He should have realized that the patient was in cardiac arrest and started ACLS. The cause of the arrest was not relevant at that point; the immediate treatment was the same. Given the clinical picture of this patient at 2:15 p.m. when Respondent was called to the recovery room EMS should have been called immediately and the patient intubated. Even if Patient A were only in a near arrest situation Respondent should have immediately call EMS and instituted the rest of ACLS protocol. Advanced Cardiac Life Support consists of immediate call to EMS for transfer to hospital, intubation, EKG monitoring so that if the patient requires defibrillation, the rhythm and appropriate ACLS drugs are known. This patient's condition had to be treated in a hospital setting, the sooner the patient were to get to the hospital, the better her chances of survival."

Despite the fact that Hachamovitch had the equipment to put a breathing tube into Tanya, she was being given oxygen with a face mask. There was no note that Hachamovitch had even inserted an airway, which is a small device that keeps the patient's tongue from blocking air from getting into the lungs.

The medical board noted, "Epinephrine and Atropine were the appropriate ACLS drugs to administer. These drugs help to restore cardiac function. Respondent had these drugs in his office but failed to give them to Patient A. Respondent instead administered Ephedrine. Ephedrine is not sufficient to restore cardiac function."

"At no time during Patient A's stay in the recovery room did Respondent or any of his staff monitor the patient with an EKG. Respondent had an EKG and a cardiac defibrillator available, which he never used on Patient A," the board further noted. "Such a failure deviated from accepted medical standards."

The board also noted that the reading from the pulse oximeter, taken just as Tanya was being moved to recovery, was not credible given her condition, and that Hachamovitch should not have relied upon a pulse oximeter reading given Tanya's obvious distress. (The board didn't bother to chew him out for taking the pulse oximeter off her finger, when even an EMT would have left it in place.)

"According to the chart, Patient A was responsive when she entered the recovery room and at 2:00 p.m. she was stable. By 2:10 p.m., the patient developed hypotension, bradycardia [abnormally slow pulse] and probably respiratory depression." Appropriate treatment, the board said, would have been "endotracheal intubation and administration of supplemental oxygen."

"A physician who performs surgical procedures, i.e. abortion, under general anesthesia in free standing outpatient facilities, has an obligation to recognize when a patient is in cardiac arrest and to know how to resuscitate the patient. Respondent did not recognize that Patient A was in cardiac arrest. Respondent did not carry out generally recognized resuscitation measures in this patient."

"For patients following general anesthesia, monitoring in a recovery room consists of the following: electrocardiogram monitoring and pulse oximeter for the initial stage of recovery "the initial period where the patient is not yet fully responsive to stimuli, or when the patient is not completely awake. It may be in that initial period that the patient, when questioned, or when stimulated, will be responsive. But during the initial period, if the patient is not stimulated, they may become more depressed and have depressed respiratory function. Each patient, in the primary stages of recovery from general anesthesia should have available in individual EKG, a pulse oximeter and a blood pressure cuff. The vital signs must be documented every five minutes until the patient is fully responsive to stimuli and the patient must be observed by staff for respiratory rate and effort, cardiac rate and rhythm, as well as color. The recovery room should be staffed by nurses and other medical personnel who have specific training in recovery room cases."

On Saturday, September 7, 1996, the day Tanya died, Hachamovitch had one R.N. in the recovery room, along with a medical assistant, a sonographer and a receptionist from the front who went to the recovery room to help when the recovery room was busy. The sonographer was not trained to observe patients recovering from anesthesia. The receptionist had taken a medical secretary course, and did not have any special training in caring for patients covering from general anesthesia.

At the time Tanya was brought into the recovery room, there were nine other patients in the room, and yet another patient was brought in a few minutes after Tanya. One of those nine patients already in the recovery room was shaking and almost convulsing.

The board noted that Hachamovitch's recovery room was not sufficiently staffed to adequately monitor patients recovering from general anesthesia.

The board also noted, "Respondent's medical record did not accurately reflect the care and treatment rendered to patient A."

"The Committee was particularly troubled by the testimony of CRNA Gori. The Committee found particularly incredible her testimony that she held the patient's nose and listened for breath sounds. .... Monitoring of patients recovering from general anesthesia should consist of electrocardiogram monitoring and a pulse oximeter for the initial stage of recovery and these patients should be stimulated during the initial stage of recovery. There was no evidence presented on the Respondent's behalf that this was done. To the contrary, the evidence establishes that the Respondent did not follow this protocol. Specifically,

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the patient was not observed other than at five-minute intervals to take vital signs. There is no evidence that the Respondent ever attempted to stimulate the patient."

"The Committee also found that the Respondent failed to run a continuous IV line in Patient A's arm until she was free of the effects of the anesthesia. The Respondent's own testimony indicates that he had to run another IV line in order to give the patient the medications more rapidly. This testimony establishes that the patient did not have a patent [in-place, functioning] IV line that was sufficient for the administration of the medications that would have been required in an emergency, such as the instant situation."

"The Respondent's recovery room lacked an individual EKG machine for each patient recovering from general anesthesia as well as an individual pulse oximeter and blood pressure cuff for each recovering patient." The board suspended Hachamovitch's license, and added probationary requirements that he was to be supervised by an anesthesiologist who had no conflict of interest, that Hachamovitch maintain ACLS certification, and that he maintain at least one staffer in recovery who is ACLS certified.

Sources: State of New York Department of Health Decision and Order SPMC-99-261; New York State Department of Health Statement of Charges December 1, 1998; "A Woman's Right, A Woman's Risk," ABC News, March 8, 1999

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