Need for Investigation of Shelley Sella, MD, George R. Tiller, MD, and Women's Health Care Services in the Abortion of Michelle Armesto (Berge)

Narrative:

Michelle Berge, (now Michelle Armesto), received an abortion at Women's Health Care Services (WHCS), an abortion office owned by George R. Tiller, on May 13, 2003, while she was 18 years of age and in her 24th week of pregnancy. Ms. Armesto will be referred to in the narrative below as "the patient."

The patient told an interim legislative committee on September 7, 2007, that she did not want the abortion and only reluctantly went along after days of intense pressure and threats from her mother and father where she was caused to fear the loss of their love and permanent expulsion from their family. She received further pressure to abort from a WHCS employee during a phone call that the patient's mother had arranged.

The patient and her mother became lost on the way to the abortion clinic and arrived approximately one-and-a-half to two hours late for her appointment. Upon arrival, she was placed immediately into a group with several other women also receiving late-term abortions, who were in the process of watching a video about the Tiller abortion legacy.

From there, without having spoken to anyone or signed any paperwork, including a medical history and consent forms, the patient was taken to a room with an ultrasound machine. She asked to see the viewing screen but was prevented from doing so by the clinic worker who performed her ultrasound. At approximately 11:10 AM, Tiller employee abortionist Shelley Sella, using the ultrasound imaging to guide her, administered a digoxin injection through the patient's abdomen that was supposed to go into her baby's heart. The patient was led to believe that the injection immediately killed her child.

After receiving the injection, the patient was sent to the receptionist to fill out her medical history and consent forms, which were signed at 11:50 AM, 40 minutes after the abortion process was begun and drugs administered. There was no effort before the injection to insure that the patient was over 18, or that she suffered from any kind of condition that would meet the legal requirement of "substantial and irreversible impairment," either physically or mentally, for an abortion after 21 weeks. The legal requirements of a 24-hour waiting period and a private meeting with the physician who would be doing her abortion were not met. At no time was she asked medical questions by clinic staff, but was asked questions only of a social nature.

She was given an injection of lidocaine at noon and then her cervix was inserted with laminaria sticks. She was then sent back to her hotel.

The following day, on May 14, 2003, the patient returned to Women's Health Care Services. At around 9:45 fetal heart tones were detected and the patient's abdomen was given a second injection of digoxin with a notation to recheck for fetal heart tones at 1600 hours.

This indicates that the first injection given on the 13th before consent was obtained, was improperly administered since it apparently missed the baby's heart and failed to kill the baby.

The patient had been contacted by her fiancé the evening before. He asked her to change her mind about the abortion. The patient did not believe that was possible because she erroneously believed that at that time, her baby was already dead.

The patient indicated that she told family and the clinic staff that she did not want the abortion, but was coerced into the abortion and signing the consent forms due to pressure from her family and the clinic staff.

In the three to four minutes that she spent with Tiller during her three-day stay, he told her that if one of his children were in her situation, he would have her get an abortion as well. Another clinic worker told the patient that if she had the baby, her life would be over and that she would never be able to go to college.

The patient, a Catholic convert, believes she was given false information at the clinic by a Unity Church minister who told her that abortions were accepted by the Catholic Church, which she later discovered was not true. He told her that God would forgive her for her abortion, but he never asked her questions or even inquired about how she was doing. When the patient later discovered that she had been given false information about the teachings of the Catholic Church on abortion at WHCS, it caused her emotional pain.

The patient delivered at the abortion clinic on the third day of the procedure. She refused to deliver her baby into a toilet bowl, as ordered by clinic workers. She felt that pushing her baby into a toilet was a demeaning and grossly inappropriate thing to ask her to do. Instead she delivered her dead baby on the floor next to the commode, a sight that still haunts her to this day.

The patient's medical records show blanks that require the signature of "nurse witness." These blanks were signed or initialed by Tiller employee Edna Roach, who has no nursing license or any kind of medical license on file with the State of Kansas, and is unqualified to act in the capacity of a nurse. This should be investigated as possible criminal fraud.

None of Tiller's workers hold valid nursing licenses of any type, nor do they hold any other kind of medical licensing in the State of Kansas, with the exception of his three hired out-of-state abortionists, Shelley Sella, LeRoy Carhart, and Susan Robinson. However, the unlicensed medical workers, including Edna Roach, Cathy Reavis, and Stacey Pack appear to pass themselves off as "nurses" and perform the duties of a licensed nurse, even though they were not at that time qualified to do so.

One employee of WHCS, who initialed parts of the patient's medical chart was Stacey Carmen Pack (initials SCP on the charts). Records obtained from the Kansas State Board of Nursing indicate that she was originally licensed as an LPN in Kansas on August 25, 2005. At the time of the patient's abortion on May 13-15, 2003, Pack had no such license. Ms. Pack is no longer employed by WHCS.

Because the patient's mother was set to graduate from college the following day, the patient was released a day earlier than she normally would have been released, with the verbal promise that she would seek follow-up care in one week. However, because of turmoil in her family and embarrassment over her abortion, she did not get follow-up care. She stated that Tiller's office never her called in follow-up to ask how she was or if she had indeed made the follow-up appointment. She received no follow-up care whatsoever from WHCS.

Earlier this year, the patient requested her medical records from Women's Health Care Services and was shocked to learn that her 24-week baby had been diagnosed as "not viable" by Sella. The patient was a healthy 18-year old in perfect health that did not drink, smoke, or do drugs. She had no reason to believe, and had been given no reason to believe, that her baby was anything but healthy. No basis was given on which the determination of non-viability was made.

The patient did not receive a consultation from a second physician as required by law for post-viability abortions, and she was never diagnosed with any condition that would have met the "substantial and irreversible impairment" standard in the law. There is suspicion that a false determination of non-viability was made because of this.

A CD with Michelle Armesto's full testimony before the interim legislative committee on September 7, 2007, is included herein.

Michelle Armesto gave me (Troy Newman) permission to file this complaint and released her medical records to me for the purpose of inclusion in this complaint. A copy of her medical record is also included at her request.

Summary of Allegations:

1. On the document titled "Certification of Informed Consent – Abortion," that is required by the Kansas Department of Health and Environment, in Section I it states: "The following information was presented to me in writing at least 24 hours before the abortion by Shelley Sella, MD…" The patient never saw or spoke to Sella at any time before she was injected with digoxin by her at approximately 11:10 AM on May 13, 2004. The form was not signed by the patient until 11:50 AM on the same day as the procedure, after it had been initiated. This procedure was done without proper consent as required by law and without respect to the 24-hour waiting period (K.S.A. 65-6709b). It violates the law, standard of care, and ethical considerations to abort a woman without first receiving consent.

2. On the document titled "Certification of Informed Consent – Abortion," that is required by the Kansas Department of Health and Environment, in Section III it states: "Prior to the abortion procedure, prior to physical preparation for the abortion and prior to the administration of medication for the abortion, I met privately with the physician who is performing the abortion and such person's staff and I had adequate opportunity in my own language to ask questions and obtain information from the physician concerning the abortion." The patient clearly did not meet privately with Sella at any time before the abortion procedure began, and only signed this form 40 minutes after the abortion had

been initiated and an injection of digoxin administered. This violates the law on informed consent (K.S.A. 65-6709c), standard of care, and medical ethics.

3. Michelle's abortion procedure was begun without having taken a proper medical history. Her medical history was obtained only after a digoxin injection, a potentially dangerous drug, was administered. This violates standard of care and medical ethics by proceeding with a potentially risky medical procedure without a medical history.

4. The digoxin injection was improperly administered by Shelley Sella on May 13, 2003, and required a second injection the following day. This medical error was likely due to negligence and violates the standard of care for this kind of abortion procedure.

5. A second digoxin injection as administered on May 14, 2003, according to notations on the "LAB AND INSERT" page of the patient's medical records. That second injection is initialed by "CR," believed to be Cathy Reavis, an unlicensed employee of WHCS. If Reavis did indeed perform the second digoxin injection, she is not legally qualified to do so. This would be a violation of the law, standard of care, and medical ethics.

6. Michelle was not asked questions of a medical nature during interviews with WHCS Staff. She was only asked questions of a social nature. This violates standard of care for women receiving any kind of invasive medical procedure.

7. The patient believes that she was coerced by her family and by employees at WHCS to have an abortion she did not want and now deeply regrets. Although the patient told at least one clinic worker that she did not want the abortion, WHCS employees only gave her information that was favorable to the choice of abortion, adding substantially to the emotional pressure and stress that she was under to have an abortion.

8. The minister from the Unity Church who spoke with the patient as a part of the "counseling" at WHCS fraudulently represented to her that the Catholic Church allows for abortion. The patient was a recent convert to Catholicism and later found out that the minister at WHCS had misrepresented the teachings of the Catholic Church on abortion. This was unethical and fraudulent, and caused the patient emotional pain.

9. "Nurses" at WHCS are not licensed in any way in the State of Kansas and are unqualified to perform the duties of licensed and/or registered nurses. This violates the law, standard of care, and medical ethics.

10. Unlicensed workers are represented to patients to be "nurses," which could constitute criminal fraud.

11. The patient did not receive a second signature as required by law for abortions past 21 weeks. Her life was not in danger nor was there any determination made of "substantial and irreversible impairment of a major bodily function" as required by K.S.A. 65-6703 for abortions after 21 weeks. The patient's baby was determined to be between 23 weeks, five days, and 24 weeks gestation.

12. The ultrasound documents included in the patient's medical records indicates that her baby was between 593 and 675 grams in weight. It is the standard of care in neonatology that fetuses meeting the 500 gram threshold are viable and have a better than 50% survival rate. Sella's determination that the patient's fetus was not viable was false and violated the standard of care.

13. The patient believes that the false determination of non-viability was reached by the doctor who performed her abortion, Shelley Sella was made in order to avoid having to comply with K.S.A. 65-6703 since the patient was late for her appointment and missed seeing Ann Kristin Neuhaus, who provided the second signature on post-viability abortions for the Tiller clinic at that time. The patient was never informed that her baby had been determined to be non-viable and only discovered that when she obtained her medical records earlier this year. Falsifying medical records is a violation of the law, standard of care, and medical ethics.

14. On the letter on WHCS letter head that begins "Dear Prospective Patient:" George Tiller states in Section 1: "As Medical Director, I am the supervising physician responsible for your care." As such, this makes Tiller personally culpable for ever act of illegal conduct, violation of standard of care, unethical behavior, negligent acts, and any other irregularities that transpired during the patient's experience at WHCS.

Conclusion:

Request is hereby made for a formal investigation of Shelley Sella as attending physician and George Tiller as owner and Chief Medical Director of WHCS for unethical and illegal conduct, a breach of standard of care, possible negligent acts, and criminal violations of K.S.A. 65-6703 as well as any other irregularities, malpractice, or other issues, including criminal violation of any other laws during Michelle Armesto Berge's experience at Women's Health Care Services on May 13-15, 2003.

Because of the egregious nature of the accusations, I am requesting an emergency suspension of the medical licenses and Sella and Tiller pending the outcome of this investigation in the interest of public safety.