BEFORE THE NEW MEXICO MEDICAL BOARD

IN THE MATTER OF)
)
SHELLY SELLA, M.D.)
License No. MD2009-0759) No. 2012-026
)
Respondent.)

MEDICAL BOARD HEARING
VOLUME I
November 29, 2012
9:00 a.m.
NM Medical Society Offices
316 Osuna Road, NE
Albuquerque, New Mexico

TAKEN BEFORE: DAVID K. THOMPSON
HEARING OFFICER

REPORTED BY: B. Julian Serna
Paul Baca Court Reporters
500 Fourth Street, NW - Suite 105
Albuquerque, New Mexico 87102

APPEARANCES
Hearing Officer:
THOMPSON LAW OFFICE, LLC
303 Paseo de Peralta
Santa Fe, New Mexico 87501
505-982-1873
BY: DAVID THOMPSON

For the Prosecution:
NEW MEXICO MEDICAL BOARD
Building 400
2055 S. Pacheco Street
Santa Fe, New Mexico 87505
505-476-7223
BY: DANIEL R. RUBIN
dan.rubin@state.nm.us

For the Respondent:
FREEDMAN, BOYD, HOLLANDER, GOLDBERG, URIAS @ WARD, P.A.
Suite 700
20 First Plaza,
Albuquerque, New Mexico 87102
505-842-9960
BY: JOSEPH GOLDBERG
jg@fbdlaw.com

GARCIA, IVES, NOWARA
Suite 480
201 Third Street, Northwest
Albuquerque, New Mexico 87102
505-899-1030
BY: MOLLY SCHMIDT NOWARA
molly@ginlawfirm.com

Also Present: Deborah Dietrich

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PROSECUTION EXHIBITS

SELLA EXHIBITS

(Note: Hearing in session at 9:13 a.m.)

MR. THOMPSON: This hearing of the New Mexico Medical Board is called to order. The case before the Board today is Shelly Sella, S-e-l-l-a, MD, case number 2012-026. This matter was initiated by Notice of Contemplated Action issued on August 15th, 2012. The Notice was served on September 19th, 2012. Today is Thursday, November 29th, 2012. The hearing is beginning at 9:15 a.m. It's being held at the New Mexico Medical Society, 316 Osuna Road, Northeast, Suite 501.

My name is David Thompson. I'm the designated Hearing Officer in accordance with the Uniform Licensing Act. I'm not a judge. I'm a simple fact finder. As I tell other people, you can call me whatever you want within reason.

The -- this entire proceeding is being transcribed by Paul Baca Court Reporting, Mr. Serna. I will ask counsel identify themselves along with either clients or experts or witnesses in the room present.

MR. GOLDBERG: Hi, I'm Joe Goldberg, Freedman, Boyd, Hollander, Goldberg, Urias and Ward, representing the Respondent, Dr. Shelly Sella.

MS. NOWARA: I'm Molly Schmidt Nowara from Garcia, Ives, Nowara also representing the Respondent, Shelly Sella.

MR. RUBIN: Danny Rubin, I'm prosecutor for the Medical Board, and with me this morning is Dr. Gerald

Bullock who will be my expert, as well as with us today is Debbie Dietrich, Chief Investigator for the Medical Board.

MR. THOMPSON: Okay. I am going to allow a brief opening, hopefully five minutes each side. I will state for the record I was served by email an opening brief by Respondent and objection by Mr. Rubin. Although there is no provision necessarily for an opening brief, that is true, there does not seem to be a prohibition to it. I took it simply as an opening statement and as a road map. I didn't take it as evidence or for any other purpose. I believe it is part of the record. I will entertain a motion to strike that from the record if you would like to place that motion, Mr. Rubin.

MR. RUBIN: Thank you, Mr. --

MR. THOMPSON: And so, you know, I have -- I have read that opening. And as I described previously, what I'm interested in the opening simply is order of witnesses, what they're going to testify to and generally what the issue is and what the defense is to the case. I generally allow a direct, cross, redirect. I ask if it is your witness that you get your direct and cross in at the same time, so we don't have to recall any witnesses. Okay. Any other questions?

MR. GOLDBERG: Can I ask a question on that?

MR. THOMPSON: Yes.

MR. GOLDBERG: I understand that Mr. Rubin's going to call Dr. Sella as the first witness as part of his case. I do not -- I do plan on calling Dr. Sella as a witness in my case, not to do it all at once. Is that all right with you?

MR. THOMPSON: If that's your preference, that's fine.

MR. GOLDBERG: She's going to be here for the whole hearing.

MR. THOMPSON: Okay. That's true. Okay. And I am -- as is normal case in sort of bench trials, I'm a little more lenient on direct questioning.

MR. GOLDBERG: Leading?

MR. THOMPSON: Leading. I don't -- you know, I'm here just to get to the facts and find the facts for the Board. The Board's the ultimate arbitrator. We want to make a very good record, so if there are objections, a lot of times I'm going to allow you to make an offer of proof in that regard just so the record is clear.

Okay. All right. Any other questions? Any other motions to take up before we start opening statements.

MR. RUBIN: Yes, Mr. Thompson. Thank you. I think you've covered in the record the fact that an opening brief was filed by the Respondent over objections of -- over my objections. You've apparently read the opening brief.

At this point I think it would be fair to not include the brief in the record, and the reason, I think it should be very clear, is there's the notion of bolstering, that both -- both sides have the opportunity to make their opening statement. It gets put down. We have a court reporter here that's going to take it down. To have a separate document with a brief in it, it would be bolstering whatever they could say here.

MR. THOMPSON: Okay.

MR. RUBIN: I think that Mr. Goldberg said, "Well, it's not going to be an exhibit." Well, it may not have an exhibit sticker on it, but except for the sticker, it's going to be in the record as a separate document. There's no allowance in the record for this, and I would say that there is a rule of opening briefs, the Medical Board does have a rule of opening briefs, and it makes no mention, it doesn't contemplate a brief before the hearing at all whatsoever. You can say -- I believe you're familiar with the rule, 16-10-624, and it does allow briefs, but it's only 15 days after receipt of the transcript. These are post-hearing briefs in this rule. The exclusion of some is the exclusion of others. I'm not going to try to quote the Latin on that in front of a law professor.

MR. GOLDBERG: Not any more.

MR. RUBIN: Formal law professor. Nonetheless,

this rule says when you can do it. I think it implies that in all situations, you can't. So to minimize the damage the fact that you've read the brief, he could have -- opposing counsel could have just told you what you've read, and I'm going to tell you -- I'm going to give my opening statement as orally, and so I'd like to be on the same footing, and so for that reason I'd ask that what you've read now be discarded. Thank you.

MR. THOMPSON: Ms. Nowara? Who do I look to here as the --

MR. GOLDBERG: Go ahead.

MS. NOWARA: Thank you, sir. Mr. Thompson, as you did note off -- I think we were off the record, but while the rule does discuss closing briefs and the Hearing Officer's opportunity to request closing briefs if he or she so desires, it certainly does not exclude the submission of opening briefs. This was simply as -- as you indicated a road map to layout the issues, and really it's in response to the Notice of Contemplated Action that's been issued. That until we filed the opening brief was the -- really the only narrative, the only operative document that's found in this case, and so it's just simply a road map to respond to that, and so we would ask for it to be part of the record. The Hearing Officer has considered it. As you indicated, you are not taking the argument as fact, simply the fact as

stated as being some guidance for you as we enter into this hearing. So we would ask that it be made part of the record.

MR. THOMPSON: Again, it's -- let me say, the Board rules do not -- that's true, Mr. Rubin is correct, do not contemplate or do not state that there's an opening brief. It does not preclude it. It does include specific reference to post-trial briefs upon request. Again, I viewed the open brief as an opening statement. I will not -- in my findings, you will not see any citations to the opening brief. I will deny the motion. It will be part of the record for the Board's information. They can do what they want with it. It does not -- it will not point to any of my particular findings of fact or conclusions of law but, again, will serve as a simple road map.

Let me state on the record one other matter that I overlooked. There was a Respondent's motion to close the hearing. The Hearing Officer issued an order November 28th, 2012, closing the hearing. I believe the order is sufficient, states sufficient reasons under 61-1-7(B) to close the hearing. I just want to place that on the record in case that is eventually reviewed by the Board or a district court, the ground by which that decision was made. Okay. So any other motions?

MR. RUBIN: Mr. Hearing Officer, not a motion but

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just a point. Your order on closing the hearing spends sometime discussing the concern that I think we all have about patient confidentiality.

MR. THOMPSON: Uh-huh.

MR. RUBIN: The exhibits that I've given you, which are not objected to, 1 through 3, have all had the patient's name redacted.

MR. THOMPSON: Okay.

MR. RUBIN: So I think that's a concern in any case, not just the case involving reproductive rights, that we protect the patient's identity. So we've done that, and the hearing, the transcript I think in support and for the record that no mention should be made of this patient's name -- initials, I suppose -- I'm just going to refer to the patient. I'm going to ask my witnesses to do the same.

MR. GOLDBERG: Yeah, we referred to the patient both in the written, all the written submissions and so far in this case as ML, and I think that that's an appropriate way to refer to her. We did not redact the patient's name from our exhibits. My understanding is the Board -- the Board, itself, does not take redacted documents as part of its practice. I have no idea what their practice is as part of the exhibits in a hearing, but when you deal with the Board as an agency, they will not take redacted documents, and so we did not redact, and we have relatively voluminous

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exhibits, and -- and, of course, some of those exhibits contain the patient's name.

MR. RUBIN: I think that we can deal with it for the purposes of this hearing. Certainly as a matter of investigation, the Board doesn't want to see anything redacted, but for hearings, I think it's incorrect to say that we don't present redacted records as part of a hearing exhibit. So I think the best way to handle this, and Mr. Goldberg can correct me if I'm wrong, is we can proceed to hearing. I think before the exhibits are submitted to the Hearing -- to the court reporter, I would get them redacted, because I anticipate that there might be other parties, third parties out there in the public who are going to request a copy of everything, and if they do that, we're going to have to redact them at some point. I'd rather do that it up front than have any argument made that there is a -- that these were made part of the record before they were redacted.

MR. GOLDBERG: We have no -- we have no problem redacting, subsequent to their introduction, references to the patient to preserve the patient's privacy as long as everybody agrees to it and the Hearing Officer agrees to it and the court reporter understands, but my understanding as in court and in these hearings, once the exhibits are admitted, they sort of belong to the court reporter until

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the record is made. As long as the court reporter understands and everybody agrees, we're happy to take the exhibits after they've been admitted and redact them.

MR. THOMPSON: Yes, and that will be the process I'll request in this case. We'll admit the exhibits. The exhibits will be sealed for purposes of this hearing. A final record will be provided to the court reporter of those same exhibits with the patient's confidentiality information redacted.

MR. RUBIN: Let the record reflect that the court reporter has nodded in agreement.

MR. THOMPSON: Okay. Anything else?

MR. RUBIN: Nothing here except the case, of course.

MR. THOMPSON: State has the burden. Would you like to proceed with your opening?

MR. RUBIN: Thank you, Mr. Thompson.

An opening statement is about what the evidence will show. I think it also should be about what the evidence will not show, and the evidence in this case is going to not go into anything involving reproductive rights, so to speak. This is not a case about reproductive rights. This is not a case about the legality of a particular type of abortion. This is a case about the standard of care and whether it was followed in a particular case, in this particular case, by

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Dr. Sella.

We will submit evidence that Dr. Sella in this case with this patient administered drugs that are contradicted by well-established guidelines, guidelines established by the American College of Obstetrics and Gynecology, unequivocal guidelines that -- and the evidence will also show that the administering of these drugs coupled with other risk factors, which were readily apparent in this case, lead to an unacceptable risk of uterine rupture for the patient.

Third, and this is a separate argument, assuming somehow that these risks of uterine rupture were acceptable and some -- could somehow be acceptable, they would not be acceptable within a clinical setting where the -- this type of risk is very difficult, if not impossible, to manage.

And fourth, as the NCA reflects, we've alleged gross negligence. The evidence is going to show that Dr. Sella willfully disregarded these risks in her choice of what -- again, in choice of what medications were given to the patient and where this procedure was conducted; that she willfully disregarded that. And, of course, the element, any -- any case for negligence including gross negligence does require damages as an element of it. There's no civil lawsuit here, thank you goodness, but the damages we will also prove, because this is the sad and tragic fact, that

the uterine rupture did occur to this patient, and as a result she had to be evacuated to UNMH. So, again, this is a case about what is the standard of care, was it -- was it adhered to, and if not, does it -- does it meet a level of gross negligence.

This is not about abortion rights. This is similar to any other -- most any other cases that I would bring as a prosecutor. If there was a case where a physician should not have performed a knee replacement surgery or not have prescribed a certain pain medication, that is not to say that we should make any kind of knee replacement surgery or pain medication illegal. This Medical Board is about medical ethics, not about legality.

And so the evidence, again, will show the following: We will have Dr. Bullock who is a licensed physician in Texas who will be presenting most of the evidence on behalf of the Prosecution with regard to the opinions that we believe you should follow in this case. We will also present first Dr. Sella who will I believe provide the facts, which I do not believe are going to be in dispute as to -- as to what happened. Thank you.

MR. THOMPSON: That certainly was one of -- obviously one of my questions early on, and it would probably be just as quick as having those facts come out through a witness than through stipulation as it seems. So

okay. So your only witness -- well, two witnesses, Dr. Sella with regard to the facts of the treatment of ML.

MR. RUBIN: Uh-huh.

MR. THOMPSON: And then Dr. Bullock with regard to the standard of care.

MR. RUBIN: That's correct. There's only one expert for each side as I understand with regard to opinions in this case. Thank you.

MR. THOMPSON: All right. For the Respondent, understanding again I've read your opening brief.

MR. GOLDBERG: Thank you, Mr. Thompson. I'm actually going to respond to what I -- what I understood Mr. Rubin to be saying in his opening statement. I agree with Mr. Rubin that central to the hearing and to the findings and conclusions of the Hearing Officer must address and the decision that the Board must make is what is the standard of care that should be applicable here, but I disagree with Mr. Rubin when he says that the issue of the reproductive rights of women and the procedures that are at the heart of this case are irrelevant. They are not.

I also, to address the Hearing Officer's question about whether there are facts in dispute, I don't know the answer to that yet. There certainly have been facts in dispute in this case all the way up to the present. I won't know whether there are facts in dispute until I actually hear Dr.

Bullock's testimony, because as the Hearing Officer knows as we stated in our opening brief, it depends on who's version of the medical records is, in fact, accepted and operates in this case, because Dr. Bullock very seriously and very substantially misread the medical records, and as a consequence came to a series of incorrect, unfounded --

MR. RUBIN: Let me --

MR. GOLDBERG: This is my opening statement -- incorrect and unfounded conclusions that form the basis of his opinion, which form the basis of the Notice of Charge in this case. That's relevant. The issue of the reproductive rights is relevant, because the standard of care that Dr. Bullock applies in this case -- the standard of care that Dr. Bullock applies in this case and which the prosecutor suggests to the Hearing Officer and the Board to be adopted, in fact, needs to be considered in terms of what will happen to the administration of the procedures that are at the heart of this case.

What the evidence is going to show, Mr. Hearing Officer, is that the procedure that was involved in this case was called a third trimester abortion, sometimes called late-term abortion, but a third trimester abortion on a woman of a gestational age of 35 weeks. That means the fetus is 35 weeks developed, which is not term. Term is 40 weeks and above, but who presented for a third trimester

abortion at the clinic that Dr. Sella works in, the clinic here at Albuquerque New Mexico, Southwest Women's Options. We will refer to it as SWOC.

The evidence will show that there -- in the entire United States there are only four clinics that provide late-term abortions; that is, third trimester abortions, to women in this country, Southwest Women's Options here in Albuquerque, a clinic in Los Angeles, a clinic in Boulder, Colorado, and a clinic in Baltimore, Maryland. You'll also hear that while there are some hospitals in this country that provide a few late-term abortions only -- the overwhelming majority of late-term abortions; that is third trimester abortions, are provided in these clinics, and that while the number of third trimester abortions in this country is relatively small compared to the number of total abortions provided in this country, the women who seek third trimester abortions like ML in this case are women who come with desperate need. You're going to hear evidence on all of that.

Now, why am I saying this? Why are these issues with respect to fundamental reproductive rights relevant? And they're relevant for the following purpose: The standard -- that's the practice in this country. The practice in this country --

MR. RUBIN: Let me object here. This is way

getting over the line of arguments.
MR. GOLDBERG: The practice in this country is the practice --
MR. RUBIN: Mr. Hearing Officer?
MR. THOMPSON: Overruled.
MR. GOLDBERG: The practice in this country is that the overwhelming majority of these procedures occur in clinics. What Dr. Bullock is going to tell the Hearing Officer and what Mr. Rubin is going to assert to the Board is that no third trimester abortions on women with prior C-sections, which amount to 20 to 30 percent of the women giving birth in this country, no third trimester abortion can occur in a clinic outside of a hospital setting.
So what the standard of care that is being offered here turns the reality of the practice in this country upside down, on its head, and the Hearing Officer must take that into consideration. The Board must take that into consideration. The Hearing Officer and the Board must take into consideration what actually is being practiced out in the country, in the community. The Board asserts a national standard of care, and we're going to present the national standard of care. The Board -- but the national standard of care that the Board's going to present is going to, in fact, prohibit any woman with a prior C-section from obtaining an abortion outside of a hospital setting, and you will hear

testimony that that will preclude virtually all women with prior C-sections from obtaining a third trimester abortion. You must take that into consideration.
Our witness will be Dr. Sella, who will testify about what actually occurred in her treatment of ML and not what Dr. Bullock misread the medical records as occurring. You will then hear from our expert, Dr. Darney, a world renowned, one of the word's leading experts in obstetrics and gynecology, in maternal health and in terminations of pregnancies; that is, abortion. He's a distinguished professor at the University of California San Francisco School of Medicine -- here is Dr. Darney. He is -- we're going to go through his qualifications, but he is, in fact, one of the world's leading experts in this area, and he's going to testify that, in fact, the standard of care that Dr. Bullock asserts is bogus; that that is not the standard of care that practitioners around the country in clinics and out of clinics adhere to, and he's going to testify to what will be the effect on the administration of this legal in New Mexico and important medical procedure if the standard of care that is asserted by the Board is adopted.
We are also going to introduce through evidence the testimony of Dr. Susan Robinson, who is a colleague of Dr. Sella's at Southwest Women's Options Clinic, who is going to address one of the issues raised in Dr. Bullock's expert

report that was the basis of the charge here if that issue remains live in the case. Doctor -- the issues that are alive in this case are a moving target. Dr. Bullock said that Ms. -- ML was not adequately counseled on the risk of uterine rupture. That was false. That was incorrect, and Dr. Robinson's going to testify to that as is another staff member at Southwest, and that is a woman by the name of Susan Douda, D-o-u-d-a.
And then finally we're going to present evidence through a paralegal in our office, Ms. Tope, who's going to testify that contrary to the interpretation of one of the ACOG Bulletins that Dr. Bullock makes, that his interpretation is not the practice in New Mexico nor actually is it the practice anywhere else, and she's going to do that through testimony of a survey that was taken.
In conclusion, as much as Mr. Rubin would like to artificially disentangle, disentangle the charge in this case from the procedure that is at the heart of this case, it cannot be disentangled, and the proof of that, one of the fundamental proofs of that and of significant concern in this case is that -- is how the charge arose in this case. The charge in this case did not arise because any colleague or any doctor in New Mexico brought a complaint to the Board.
MR. RUBIN: Let me object here. Again, first,

it's argument. Second of all, how is it relevant? We can make a ruling right now, I believe, as to how this case was charged. We have an NCA. That's where the case begins. As to what happened internally, I do not see how that is relevant to the ultimate facts in this case, and we can avoid a lot of testimony that way if we can just have a ruling on that.
MR. THOMPSON: I'm going to overrule the objection. I am curious, though, and will take it, whenever we have the witnesses that discusses this, about the relevance of how the -- I understand how the complaint came in, and I understand the outside forces and those things that are effecting, but how -- how does it change the issue of the standard, whether or not the doctor met the standard of care as to how the complaint came in?
MR. GOLDBERG: It's relevant in two ways, Mr. Hearing Officer, both to the definition of the standard of care and, also, to the extent to which the standard of care was -- if the standard of care was breached. There is no doubt, no one is going to testify -- I believe no one is going to testify in this case that the risk of uterine rupture is not a known risk for these procedures. No one's going to testify to that. Everybody's going to recognize all of the documents, all of the testimony, all of the doctors that are going to be here, in fact, and all the

doctors in this -- everybody recognizes that a risk of uterine rupture is a known risk. It's a known risk of birth. It's a known risk of termination of pregnancies. It's a known risk of birth without induction of labor, spontaneous labor. It's a known risk of labor that is induced. It's a known risk for women with C-sections. It's a known risk for women without C-sections. It's a known risk that -- it is also -- there's going to be no controversy, that risk occurred here.

It's relevant -- it's relevant, one, to Dr. Bullock's assertion from the record that ML was not adequately counseled, that she has made no complaint here. She has made no complaint here. You don't get a complaint from a colleague, from a doctor or from the patient. You know where the complaint came. The complaint came from the foes of abortion. That's how the complaint came here, and that's relevant in terms of both what the standard of care is here and was the standard of care departed. If, in fact, ML had complained to the Board, that would be -- Mr. Rubin would be here, or somebody like Mr. Rubin, saying this is relevant to the standard of care, and this is relevant to the departure. The fact that she has not complained is relevant to the standard of care and to the standard of departure. That's why it's relevant.

MR. THOMPSON: But you're proving it in the -- it

seems to me -- I won't need to press it, but it seems to me then is it required? And it seems if it's going to the counseling issue, is it required that the patient make the complaint in order for a -- will the evidence show that it is required for the patient to complain for a failure of counseling to be met?

MR. GOLDBERG: No. That's not our -- that's not our position.

MR. THOMPSON: Okay.

MR. GOLDBERG: That's not our position. This is -- this is a -- this is a relevant but not -- not conclusive piece of evidence. Not every piece of evidence has to get you passed the victory line. It has to go beyond 50.01 percent. Evidence is -- as the Hearing Officer knows, evidence is relevant if it only provides a piece of the puzzle, and this is a piece of the puzzle.

MR. THOMPSON: Okay. Very good. With openings concluded, is the State prepared to proceed?

MR. RUBIN: Yes, Mr. Hearing Officer.

MR. THOMPSON: Please call your first witness.

MR. RUBIN: Thank you. The State will call Dr. Shelly Sella.

MR. THOMPSON: Do you want this?

MR. RUBIN: Mr. Hearing Officer, that is your copy. You're holding in your hand a copy of the exhibits.

There's a separate copy for the witness.

SHELLY SELLA, MD

after having been first duly sworn under oath, was questioned and testified as follows:

MR. THOMPSON: Witness is sworn, and it is 9:45 a.m. State may proceed with direct.

MR. RUBIN: Thank you.

DIRECT EXAMINATION

BY MR. RUBIN

Q. Good morning, Dr. Sella.

A. Good morning.

Q. Before I get into the specifics of this case, let's go through a little bit of your background, your general experience in the area of pregnancy termination and obstetrics. What portion of your practice would you say has been dedicated to pregnancy termination?

A. Currently or --

Q. Let's -- currently.

A. A hundred percent.

Q. And how long has it been a hundred percent?

A. Since 2000.

Q. Since 2000. Prior to 2000 -- well, let me ask you, are you familiar with what the term, and it's an acronym, TOLAC, T-O-L-A-C?

A. Yes.

Q. And what does that stand for?

A. Trial of labor after cesarean.

Q. Okay. Are you familiar with -- can you explain a little bit what you understand -- what you understand that concept to mean?

A. That refers to a person who's had a prior C-section and is attempting a vaginal delivery in a subsequent pregnancy.

Q. Okay. So after 2000 you dedicated your practice to abortions, pregnancy terminations?

A. Correct.

Q. So there were no -- you did not conduct any TOLACs after that time?

A. TOLACs referring to -- yes, correct -- I'm sorry. Can you repeat the question?

Q. Sure.

A. I'm overreading the question.

Q. That's okay. And I never ask it as well the second time, but that's all right. So you have not -- because you've dedicated your practice since 2000 a hundred percent to pregnancy terminations, you have not done any TOLACs since that time?

A. I've cared for patients who've had prior C-sections requesting terminations.

Q. Okay. Have you -- outside of the context of a

pregnancy termination, have you cared for patients that have had prior C-sections since 2000?
A. No.
Q. So how many -- well, how many abortions -- and abortion, by the word "abortion" I mean pregnancy termination, and if at some point I refer to something shorthand, as a lawyer I'm missing the nuisance of it, please feel free to correct me. So how many abortions have you personally administered in your career?
A. If you count first through third trimester abortions?
Q. Yes.
A. Approximately 10,000.
Q. Okay. Of those 10,000 -- well, how long have you been licensed as a physician to perform this procedure?
A. Well, I was initially licensed as a physician -- is that your question, when was I licensed?
Q. Yes. That's right.
A. 19 -- woah, 198- --
Q. Well, who was president when you were first --
A. Reagan.
Q. Under Reagan?
A. Yes.
Q. Okay. Close enough. That's fine. He was two terms, but that's fine.

A. 1987, I think.
Q. Okay. And so you've done about 10,000 since -- since you were first licensed?
A. Correct.
Q. Of those, how many have been third trimester abortions?
A. It would be an approximation. Approximately 500 to 1,000.
Q. And what's your understanding of what a third trimester abortion is in terms of the term of the fetus?
A. My understanding is that it's a pregnancy of 25 weeks or greater. Some people say 26 weeks or greater.
Q. For you, it's 25 plus?
A. Yes.
Q. Okay. So of those 500 to 1,000 approximately how many of those women presented with a prior C-section?
A. Approximately 75.
Q. And out of those 75 that you've done, the prior C-section, how many of those occurred in a clinical setting versus a hospital setting?
A. All of them.
Q. What is the -- of those 75 or so, can you recall what the latest term was that you dealt with?
MR. GOLDBERG: Gestational age?
Q. (By Mr. Rubin.) When I say "term", I mean

gestational.
Thank you, Mr. Goldberg.
A. Yes, that was ML, 35 weeks.
Q. Have you dealt with any others at 35 weeks?
A. No.
Q. Have you dealt with any at 30?
A. Who had a prior C-section?
Q. That's right. I'm talking about of those 75, Dr. Sella?
A. My best guess is yes. I haven't reviewed all 75 cases. I think so.
Q. Nothing stands -- you can't recall specifically any previous cases like that that were over 30?
A. I don't remember any cases over, aside from ML, over 32 weeks.
Q. Over 32?
A. Yeah.
Q. Okay. Prior to 2000, when you dedicated your career exclusively to pregnancy terminations, how many TOLACs did you perform?
A. I couldn't tell you the number. I worked for an HMO as a permanent employee, and I didn't keep track of the numbers. I was --
Q. Numerous?
A. Numerous, yes.

Q. Hundreds?
A. More than a hundred.
Q. Less than a thousand?
A. Yes.
Q. Okay. Dr. Sella, why don't we -- and I'd like to do this in a way that's most -- as efficient as possible, so the more you could just provide a narrative as opposed to me prompting you, what I'd like you to do is, for the benefit of the Hearing Officer as well, is to walk us through the facts of this case, and if you need to refer to any medical records specific to the case, this is an open-book test so to speak, you have in front of you a copy of Exhibit 1 or some of the medical records that were provided by you and by UNM to the Medical Board. If there's something missing, please let me know, and I believe your counsel may have additional copies.
MR. GOLDBERG: Can I put in front of her our copy of the medical records, which we believe are complete?
MR. RUBIN: Okay.
Q. (By Mr. Rubin.) So why don't you --
MR. GOLDBERG: That would be -- just for the record, Mr. Hearing Officer, that would be Sella Exhibit Number 8, which are, I believe to the extent that they overlap, identical to the State's or the Board's Exhibit 1, although with different Bate stamping numbers.

MR. RUBIN: And I have no objection to the entry at this point of Exhibit 8 for that reason, so you can look at whatever you'd like, Dr. Sella.

THE WITNESS: Okay.

MR. THOMPSON: Let me instruct you, Dr. Sella, because this is transcribed on the record, if you are testifying off a document, if you could do me a favor and just read the last three Bates numbers, it will help me in the record. So if you'd say, "Looking at -001."

Q. (By Mr. Rubin.) So why don't you walk us through what happened and when, and we'll fill in the details as we go.

A. Okay. The first contact that the patient made with the clinic, and this is on -001, was a phone intake on May 5th.

Q. Okay.

MR. GOLDBERG: Year?

THE WITNESS: 2011.

Q. (By Mr. Rubin.) Okay. And who performed the phone intake?

A. Initially MMS are the initials. Should I tell you the complete name?

Q. Yes. There's no -- it's not a patient, is it?

A. No, Molly Mae Serna.

Q. Okay.

A. And she got information about the patient, that she was a 26 year old. On the phone intake it says G2. Actually she was a G3 P1, miscarriage one. She had had a prior C-section.

Q. Okay.

A. She had no medical problems, and she was at 33 weeks gestation.

Q. Is the phone intake the first two pages here of Exhibit 1?

A. Yes.

Q. And so when did you -- when were you apprised of this phone intake and the contents of it?

A. Well, what happened was she explained why she was seeking a termination; that the fetus had severe brain abnormalities. The phone counselor consulted with the physician who was at the clinic that week, which was Dr. Susan Robinson.

Q. Susan?

A. Robinson.

Q. Robinson.

A. Dr. Robinson had numerous conversations with the family, and Dr. Robinson then consulted with me by phone about this case.

Q. Okay. And when did Dr. Robinson consult with you?

A. I don't know the exact date.

Q. Okay. Was it prior to the patient subsequently arriving in Albuquerque?

A. Yes.

Q. And when Dr. Robinson consulted with you, did she -- was there any information that she left out that's on this form?

A. No, she told me about the abnormalities, the brain abnormalities. She told me about the conversations that she had had with the -- with the patient and her family. We discussed the fact that she had had a prior C-section. That is all on -001 and -002.

Q. Okay.

A. As well as -003.

Q. -003 looks like an unlined piece of paper with some handwritten writing on it?

A. Yes.

Q. And it says "Dr. Robinson" at the bottom?

A. Yes.

Q. CSR?

A. Yes.

Q. All right. Then looking through these records, what -- can you tell us what was the next step in this process that involved you?

A. Oh, that involved me?

Q. Uh-huh.

A. The next step was the day that she arrived to the clinic.

Q. Okay. And when was that?

A. And that was on May 10th.

Q. All right. And so could you show me, did you take any notes on May 10th?

A. Yes. On May 10th the patient came in with her mother and her husband.

Q. Okay.

A. She filled out paperwork. She had an ultrasound, met with the counselor.

MR. GOLDBERG: Might be helpful to the Hearing Officer if you give him a page reference.

THE WITNESS: Okay. The medical history is on -012, -013 and then it's followed by consents. When they met with the counselor, risks and complications were discussed, and she signed consents -014 through -017.

MR. RUBIN: Is the Hearing Officer following?

MR. THOMPSON: I am.

MR. RUBIN: If we're going too fast --

MR. THOMPSON: Yes, I'm following.

Q. (By Mr. Rubin.) Okay. If we could just step back for a second, just a few of the pages that we've skipped and getting to the medical history --

A. Yes.

Q. -- I see an obstetrics report here. I believe it's my Bate stamp. My Bate stamping is off, so if you could locate that for me --
A. You're talking about the ultrasound?
Q. It says -- it's titled Obstetrics Report.
A. Yes.
Q. Okay. Is that -- can you get to that page?
A. Sure.
MR. RUBIN: Is the Hearing Officer there?
THE WITNESS: It's -009.
MR. THOMPSON: Got it. Thank you.
Q. (By Mr. Rubin.) This is, as you said, a -- well, what is this?
A. So this is an ultrasound report.
Q. Okay. And when did you receive this report?
A. That was faxed to the clinic after she called.
Q. Okay. Did you have this in hand when you met the patient?
A. Yes.
Q. Okay. And did you review it?
A. Yes, I did.
Q. Okay. Let's go through a little bit of what's on here before we get back to -- before we pick up the narrative. There is different subheadings here. We have Patients Involved, which I believe has been redacted. The

very last one. Can you read that?
A. Where are you?
Q. I'm at the bottom of the Obstetrics Report.
A. Okay. The biometry?
Q. Biometry.
A. Yes.
Q. Okay. What is the first -- what is the first entry there?
A. The BPD.
Q. And what is BPD?
A. The BPD is the biparietal diameter. It's a measurement taken between the two parietal bones.
Q. So that's roughly a measure of the diameter of the fetus's head?
A. Yes.
Q. And it says 96.3 millimeters?
A. Yes.
Q. And then it has, "G.age: 39W2D." Can you explain what that means?
A. That means based on the size of the head it measured 39 weeks, 2 days.
Q. So in other words, if there was -- the typical fetus that would gestate to 39 weeks, 2 days would be expected to have a biparietal diameter of that amount?
A. Correct.

Q. And what's the second entry there?
A. OFD.
Q. And what is OFD?
A. I don't know.
Q. You don't know?
A. It's not a measurement that I use.
Q. Okay. What is the third one?
A. HC is head circumference.
Q. Head circumference. Okay. And what does it say with regard to the gestational age?
A. Forty weeks, four days.
Q. Okay. How does -- is head circumference -- obviously it's a measurement of the size of the head as well, the circumference?
A. Uh-huh.
Q. So the circumference, the diameter, it's like -- roughly like, assuming the head is of this size, a circle or a sphere around it?
A. In this situation, yes.
Q. Okay. And then let's skip to the bottom one here. I see the words, "Estimated FW." What does that stand for?
A. The estimated fetal weight.
Q. And what does it say there?
A. 2,471 grams; 5 pounds, 7 ounces.
Q. Okay. And can you give us a little bit of

background, a little explanation as to how this is estimated, do you know?
A. How is the weight estimated?
Q. That's right.
A. The weight is a composite from the measurements taken.
Q. I see. So the measurements above are then used to come up with that result at the bottom?
A. Yes.
Q. It's not based upon any direct observation?
A. No.
Q. Or any direct weighing either?
A. No.
Q. Okay. And then the next page, the Obstetrics Report continues, correct?
A. Yes.
Q. And at the bottom under the comments, there's a bunch of the bullets at the bottom. Six I believe. It says here, "BPD and H, C90, to 39 to 45 weeks." Is that -- am I reading that correctly?
A. Yes.
Q. And that sort of repeats what we just discussed on the previous page?
A. Yes.
Q. And you reviewed all that prior to meeting with

the patient?
A. Yes.
Q. Okay. So I didn't get you off the narrative too much. I think you were about to then go on with what medical records and what happened once you met with the patient. There was counseling you said?
A. Yes.
Q. Then why don't you tell us what happened after that?
A. After the counseling and after the consents had been signed --
Q. And the ultrasound.
A. And the ultrasound, yes, she and her husband were taken to the procedure room to begin the process --
Q. Okay.
A. -- of cervical preparation.
Q. Okay. The ultrasound evaluation you said was done the first day?
A. Uh-huh, yes.
Q. Is that -- I see an ultrasound evaluation dated 5-10-11 in the medical records here. I believe that's a few pages -- again, my Bate stamps don't seem to be showing up here.
A. If you show me the page -- can I see -- yes.
MR. GOLDBERG: Do you mind? Twenty.

MR. RUBIN: Bate stamp -20. Thank you.
MR. GOLDBERG: I think it's -20.
A. Yes.
Q. If we could just step back from -20 to review what would be -18 and -19.
A. Yes.
Q. These are also part of the medical records for that patient?
A. Yes.
Q. And the records that we're going through, did you -- did you provide these medical records to the Medical Board yourself, do you recall?
A. Did I personally provide them?
Q. Yes.
A. Me, Shelly Sella, hand them to the Medical Board?
Q. Or mailed them or have anything to do with what was provided to the Medical Record in terms of medical records?
A. I didn't personally make the copies. Is that your question, did I make the copies and put them in the mail? I'm not following you.
Q. Okay. Well, did you? I mean, did you --
A. No, I did not.
Q. Okay. Did you see what was given to the Medical Board from your office with regard to medical records?

A. I saw what was given to the lawyers.
Q. Okay.
A. I think, yeah.
Q. And you approved what was given to the lawyers?
A. Yes.
Q. And you felt that was reflective of -- that those were the medical records relevant to this case?
A. Yes.
Q. Okay. So now, going back to -18 and -19, this is entitled Counseling and Medical Records for Standard D&E/Induction, correct?
A. Yes.
Q. That's the -- that's the caption?
A. Yes.
Q. What is a standard D&E/Induction?
A. Well, it's two different procedures actually. A standard D&E is a surgical procedure done in the second trimester.
Q. Right.
A. And induction is done in the third trimester, which consists of cervical preparation and then inducing labor.
Q. Okay. And so is this your handwriting on this page when you fill in some of the -- some of the blanks?
A. My handwriting is -- yes, partly. Would you like

me to point out which is my handwriting?
Q. Yes. Thank you.
A. Where it says, "Present: Sonogram," and it says, "FI," right above it --
Q. Uh-huh.
A. -- "35 week by known conception."
Q. Okay.
A. That's my handwriting. Then Doctor's notes.
Q. Okay. And at the bottom we have Doctor's Orders on this page, correct?
A. Yes.
Q. Okay. And is there -- do these reflect what was administered to the patient on the 10th at least in part?
A. When you -- you mean the Doxycycline, Oxycodone? These are medications that were given to her --
Q. Okay.
A. -- to take.
Q. Okay. And on the next page this is part of the same form, correct?
A. Yes.
Q. Which is Counseling and Medical Record for an Induction, a third trimester abortion?
A. Correct.
Q. And you have your signature on the bottom, correct?

A. Yes.
Q. Okay. Did you -- I see up at the top of the page here, it says Pre-op Orders for Day of Surgery. Were these followed?
A. For this patient?
Q. Yes.
A. No.
Q. Okay. Why not?
A. This was not surgery.
Q. Okay. So are you saying that an induction, third trimester termination is not surgery?
A. Correct.
Q. Okay. How would you characterize it then if it's not surgery?
A. I would characterize it as cervical preparation and then induction.
Q. Step back and let me ask you a question generally about medical records. A lot of medical records are like this one, I suppose, where you have some preprinted part of a form, and then you divert with what's actually -- what actually occurred from what was printed on the form, right?
A. Yes.
Q. Do you ever make a notation as to the preprinted part that was not followed, that it was not followed? Do you make a notation that it was not followed or cross it out

ever in your medical records?
A. I have done that in the past.
Q. Did you do that -- you didn't do that here though, did you?
A. I didn't do that, and I don't routinely do that for inductions.
Q. Okay. So let's go -- I believe we have the next page in the record that I see here is a -- after the ultrasound on the 10th is a typed page signed by you dated May 10th, 2011. It reads, "Time of interview: 20 minutes." And patient name is blanked out. Is this part of -- you've seen this before, correct?
A. Yes.
Q. Okay. Can you describe what this report is?
A. This is -- this is a narrative of the patient's situation and why she came to the clinic and why she requested an abortion.
Q. And can you describe how she -- how this patient presented in terms of her mental state?
A. She was extremely distraught, upset.
Q. Can you put it in the context -- now, you've -- fair to say, you've counseled -- you've counseled many women, thousands, with pregnancy terminations, right?
A. Yes.
Q. You've seen a lot of -- I guess, have you seen a

fair spectrum of reaction -- of emotional states of these women?
A. Yes.
Q. Is this -- this patient, did she present in some way that was beyond -- well, let me ask the question again. You would expect a woman seeking this kind of procedure would be in a -- would be effected by it emotionally, correct?
A. Yes.
Q. You'd expect any woman going through this to be at least somewhat distraught, correct?
A. Yes.
Q. Is there anything with this patient, especially as is reflected in these records, where you saw something that was beyond what you typically see with a distraught patient seeking an abortion?
A. I would say that she was on the more distraught, anxious, tearful spectrum of third trimester patients who already are in a very desperate state of mind.
Q. Okay. Now, I think if I'm reading this, it says -- and I'll read this into the record. It says here, this is the last paragraph, "Based on my evaluation of the patient and taking into account her age and her family situation, it is my professional opinion that being forced to continue the pregnancy will cause substantial and

irreversible harm to her physical health, her mental health, her family health, her safety and well-being." This is -- this is your statement, correct?
A. Yes.
Q. When did you type that up?
A. May 10th, 2011.
Q. This isn't a preprinted form, is it?
A. No.
Q. I don't see in this any reflection that there was any kind of suicidal ideation. Am I missing something in there?
A. No.
Q. And when you say -- you used the term, "Substantial irreversible harm," are you applying that phrase to everything that comes after, "Separately?" In other words, would there be substantial and irreversible harm to her mental health, substantial and irreversible harm to her physical health, separately to her family health, again, substantial and irreversible harm to her safety and well-being?
A. Yes.
Q. So it applies equally to all those different types of aspects of health?
A. I don't know that I would say it applies equally, but I would say that as I wrote, that it would cause

substantial and irreversible harm.

Q. And was this particular language that you used here, was this motivated by any understanding that you may have or may have had with -- with what the laws of New Mexico are?

A. Can you repeat that?

Q. Your choice of words here --

A. Uh-huh.

Q. -- is it -- did you chose these words or make any -- was what you entered here effected at all or motivated at all by some understanding that you may have had with what the law of New Mexico is with regard to pregnancy terminations?

MR. GOLDBERG: I'm going to object to the compound nature of the question. I think it's a compound the way he stated, is it fair, effected or motivated. As a single answer to that question, it is going to be -- is going to be capable of misconstruction.

MR. RUBIN: We'll start with --

MR. GOLDBERG: It's a classic compound question.

MR. THOMPSON: We'll start with "effected".

Q. Can you answer the --

A. Can you repeat the question?

Q. I will try. Third time might be the charm, and I'll try to ask you more succinctly. This last paragraph,

the words you chose here, was this effected at all by some understanding you may have had with the laws of New Mexico or with regard to pregnancy terminations?

A. No.

Q. Is it motivated in --

A. No.

Q. Okay. So then the next I see here, next page after that page is something that is a medical record entitled Digoxin Injection and Dilator Insertion?

A. -022 bates.

Q. -022. I should be writing this down, too. Why don't we, beginning with this page, if you could go through exactly what was administered to the patient and when on the 10th?

A. Okay. So initially the patient was given Fentanyl and Versed. Following that, her physician had requested that we get samples for testing. So following that, I performed an amniocentesis and a fetal blood draw.

Q. Okay.

A. I then did an intrafetal injection of Digoxin to stop the heartbeat and effect demise.

Q. Okay.

A. This was followed by a paracervical block with Lidocaine and Vasopressin. Rosephin was given, which is an antibiotic and Rhogam as well.

Q. Let me make one -- ask you one question here. It says here the time for the Digoxin was 13:45. Are you saying the Lidocaine and Vasopressin was administered after Digoxin?

A. No, that's incorrect.

Q. Okay. So the time here is correct?

A. The Digoxin was administered first.

Q. I see. So this medical record is incorrect, because this has the Digoxin as coming after, does it not?

A. Correct. The Digoxin came first.

Q. Around what time was the Digoxin administered?

A. Right after the Fentanyl and the Versed.

Q. Okay. So everything -- these three medications all -- it says that they all occurred within about a half hour of each other?

A. Yes.

Q. All right. Okay. So we had the Fentanyl, the Digoxin. Then after the Lidocaine and Vasopressin what was then administered?

A. The Rosephin, an antibiotic.

Q. Okay.

A. And Rhogam.

Q. And what is Rhogam? What does that serve?

A. The patient was Rh negative, so she did not have the red cell -- red blood cell antigen, and Rhogam is an

antibody given to prevent her from forming antibodies.

Q. Okay. And then I see the last handwritten entry by you in this chart on Bates -22. Is that Misoprostol?

A. Yes.

Q. And can you tell me what Misoprostol is, what it does and --

A. Yes, but before I inserted the Misoprostol, I inserted Laminaria.

Q. I see. Okay. What would -- could you explain what that is?

A. If you'll notice, I wrote, "Cervix open to #71 prat." I dilated the cervix and inserted Laminaria, which are seaweed sticks that help open the cervix.

Q. Was there -- what was dilation prior -- was there any dilation prior to inserting the Laminaria?

A. I used dilators to open the cervix, and then I inserted the Laminaria.

Q. So it started off closed?

A. Yes.

MR. THOMPSON: The Fentanyl is a pain --

THE WITNESS: Yes, and Versed is anxiolytic like Valium.

Q. (By Mr. Rubin.) Okay. So then I see a notation here after the Laminaria, it looks like Misoprostol. Is that time correct? It looks like 3:55?

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A. No, that's incorrect. It's 13:55.
Q. Ah, okay. So instead of 15:55, it should have read 13:55?
A. Yes.
Q. So, again, I think I keep interrupting. Why don't you tell us about Misoprostol, what it is, why you used it here?
A. Misoprostol is a prostaglandin pge1, and it's used in this setting as part of cervical preparation.
Q. What does it -- what physiologically does it do?
A. Well, what it does to the cervix is it helps soften the cervix. It helps shorten the cervix.
Q. Okay. And it looks like the amount, if I read that correctly, 100 micrograms?
A. Yes.
Q. And the route is per vagina?
A. Yes.
Q. Patient respond well. I see an "okay" there?
A. Uh-huh, yes.
Q. All right. And then I think we have on the next page a sonography report. This would be Bates -23.
A. Yes.
Q. Is this -- did we look at this already, or is this a second one?
A. It's a second one.

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Q. And why did you conduct a second one?
A. We do all of our procedures under ultrasound guidance.
Q. Okay.
A. And the ultrasound that is taken, the photo is to confirm -- and you can't see that because of the quality, but it's to confirm that the dilators, the Laminaria are well-placed.
Q. Okay.
MR. GOLDBERG: Mr. Hearing Officer, if I'm not oldest man in the room, I'm pretty darn close to it.
MR. THOMPSON: Take a break?
MR. GOLDBERG: Yeah.
MR. THOMPSON: Okay. We will take a five-minute break.
MR. GOLDBERG: That would be fine for me.
MR. THOMPSON: It's 10:20. We'll take a break.
(Note: Hearing in recess at 10:20 a.m.
and reconvened at 10:25 a.m.)
MR. THOMPSON: We're back on the record. It's 10:25. We're on direct examination of Dr. Sella. Go ahead.
Q. (By Mr. Rubin.) I believe where we left off, Dr. Sella, you were discussing Misoprostol and how it softens and shortens the cervix?
A. Yes.

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Q. And so you administered one at around 1:55, and then were there any more on the 10th? I don't see any more medical notes here until we get to something on 5-11. So what else happened on the 10th in terms of what you administered to the patient?
A. That was it. She was discharged.
Q. Okay. Was there any more Misoprostol administered to her on the 10th?
A. No.
Q. And then after that sonography report which we briefly discussed, looks like we're on Bate stamp -24; is that right?
A. Yes.
Q. And I see here -- well, let's make sure we've got it right. Are the times for the medications correct as far as you know? Why don't you just double check now.
A. No, they are not correct.
Q. Okay. Where are they erroneous?
A. It starts with Fentanyl, Versed. That is an 8, 08:50, and all the other times are off by an hour.
Q. I see. Okay. So wherever I see a 9, then Misoprostol, it should be at 8:15 instead of 9:15?
A. Yes.
Q. Fentanyl is at 10:00. My military time is lacking.

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A. No, Fentanyl was at 8:50. That is correct. The Fentanyl Versed -- oh, you mean the subsequent one, the one on the bottom?
Q. Correct.
A. That's 9:02, yes.
Q. That one says 9:00.
MR. THOMPSON: Just for the record, the first Fentanyl is at 8:50 a.m.?
THE WITNESS: Yes, the Lidocaine and Vasopressin, at 8:52. The Rosephin was at the same time.
Q. (By Mr. Rubin.) So for -- so for Dr. Bullock's benefit, this would be on Texas time as opposed to New Mexico time?
A. Yes.
Q. I'll allay the jokes.
MR. GOLDBERG: Can we take another break? No.
Q. So Misoprostol here again is 100 micrograms?
A. Yes.
Q. Given on -- at 8:15?
A. That was -- no, I'm sorry. The incorrect times were the Lidocaine, Vasopressin and Rosephin. The Misoprostol is correct. That's at 9:15. The Fentanyl is incorrect.
Q. Okay. So you're familiar with what -- I saw on one of the previous notes there's something called Pitocin,

correct?
A. Yes.
Q. Is there any --
A. By previous notes, which notes?
Q. I believe we discussed that with regard to Bates stamp --
MR. GOLDBERG: Nineteen.
MR. RUBIN: Yeah.
Q. There was a -- we were talking about some of the orders that were not followed for surgery.
A. Oh, correct. Yes.
Q. It mentioned some Pitocin. So there was no Pitocin given at any time up until now, correct?
A. Correct.
Q. So back to 5-11. The Misoprostol administered to the patient at 9:15 --
A. Yes.
Q. And what else happened on that date in terms of the procedure?
A. An ultrasound was done.
Q. Okay.
A. And it confirmed fetal demise.
Q. Is that on the very next page?
A. Oh, the ultrasound?
Q. Yes.

A. Yes.
Q. Okay.
A. The Laminaria were removed. The cervix was open. More Laminaria were inserted. Misoprostol was placed.
Q. Okay. Was this the Misoprostol at 8 -- 9:15?
A. Correct.
Q. All right.
A. And she was instructed to take Misoprostol, 100 micrograms buccally, and that is between the cheek and the jaw, at 3:00 p.m.
Q. Okay. And that's in your handwritten notes here? I see, "100 mcy MSP to take at 3:00 p.m. hold for one hour."
A. Well, no, that's not my handwriting.
Q. Oh.
A. Reinsert at 16:30, so that was also instructions for her to come back in the afternoon to put in more Laminaria. "MSP, Misoprostol, 100 micrograms mcg at 15:00." The nurse or the RN explained that 100 micrograms Misoprostol to take at 3:00 p.m., hold for one hour.
Q. Okay. So at 3:00 p.m. was Misoprostol administered to the patient?
A. She administered it herself.
Q. Okay. And where did she do that?
A. She went back to the hotel at 9:45. She was discharged from the clinic.

Q. Okay. And so this is right after -- shortly after you administered Misoprostol, you sent her -- at 9:15 she was then sent back to her hotel?
A. Correct.
Q. With an additional capsule?
A. It's a tablet.
Q. A tablet to take at 3:00?
A. Correct.
Q. Okay. So this is your handwriting here on the notes where it says on the second line here, "MSP 100 mcg at 15:00?"
A. Yes.
Q. And so the next line --
A. Yes.
Q. -- is that referring to the same dosage?
A. Yes.
Q. Okay. So we had -- who made that entry?
A. That was a nurse at the clinic.
Q. And what was her name?
A. She doesn't work there any more, so KK.
Q. I withdraw the question. It's okay. I withdraw the question. Okay. So we have the patient going back to the hotel on 5-11?
A. Yes.
Q. What is your next contact with this patient?

A. Bates -026 she returned to the clinic at about 5:00 p.m.
Q. Okay. We're on -26. Is that the page entitled Dilator Insertion?
A. Yes.
Q. Okay. So when did she return to the clinic, about 5:00?
A. Yeah, 5:00ish.
Q. 5:00ish. Okay.
A. Yeah. 4:50 is when she actually first came in. The Laminaria were removed.
Q. Okay.
A. Her cervix had not changed. AROM means artificial rupture of membrane with insertion is what is written. The bag of water broke as I was inserting the next set of Laminaria.
Q. And that's the handwritten notes you're referring to on this page --
A. Yes.
Q. -- -26? Okay. Do you know if she took the 3:00 o'clock dosage of Misoprostol?
A. She did.
Q. All right. What else does it say here in these notes?
A. It says, continue MSP, Misoprostol, 100

micrograms, Q6 hours, RTC, round the clock. Next does at 21:00. Reinsert in a.m.

Q. Okay. By "reinsert" do you mean the Laminaria?

A. Yes, I was planning another day of Laminaria.

Q. Okay. So that's on 5-11, and the next page has a Sonography Report reflecting at 5:30 on 5-11; is that right?

A. Correct.

Q. And what did you conduct that report for?

A. That -- again, that is routinely done. Whenever we insert Laminaria, the insertion is done under a continuous ultrasound guidance. The photo confirms that the dilators were correctly placed.

Q. All right. Okay. So she's back in the clinic at 4:50. When is the next -- I see there's a page here. I believe it's Bate stamped -28.

A. Yes.

Q. Who's notes are those?

A. Those are the clinic administrator's, Joan Garbagni.

Q. And then page -29 --

A. Yes.

Q. -- is this your handwriting?

A. Yes.

Q. And this reflects some of the particulars for this patient. Well, why don't you describe what the

Post-Delivery Checklist is?

A. This is something that we offer to all fetal indication patients where there's something very wrong with the baby, and we go over this list with patients. It -- before their delivery, we talk about whether they're interested in viewing the baby, a blessing, all what's written down here, footprints or handprints, photos. We discuss whether they want ashes or making arrangements for burial, medical photos. So this is a conversation that we have before the day of delivery.

Q. Okay. So this conversation you had with her on the 11th?

A. I'm not sure what day that was.

Q. Okay. So this is --

A. But typically, typically that conversation happens on day two.

Q. Okay. So this is undated, but we would expect that -- you would expect that it would have occurred on the 11th?

A. Correct.

Q. Let's flip back to Bate stamp, let's see, -26. So we have -- I see here in the notes -- I don't see any more Misoprostol being administered in the table at the top of Bate stamp -26. I'm not missing that, am I?

A. No.

Q. Okay. So then in the notes is there any mention of Misoprostol?

A. Yeah, excuse me.

Q. Sure. Any time you want a drink, please. I'll do the same.

A. Yes, as I said, the instructions were for her to continue the Misoprostol every six hours round the clock, the next dose at 9:00 p.m.

Q. And was that dosage -- was there a dose administered at 9:00 o'clock?

A. No, there was not.

Q. Okay. Is there any notation to that effect?

A. Yes, there is.

Q. Where is that?

A. On Bates -030,

Q. Thirty. Okay.

A. When the patient came into the clinic, the first note says, "At 22:53, patient presented for increased UCs," so increased contractions. "Last Misoprostol at 15:00."

Q. I see. That was the one she took in the motel?

A. Correct.

Q. So with regard to the Misoprostol, why was the 11:00 o'clock -- the 9:00 o'clock dose not given? I'm not sure why.

A. Uh-huh. So the question is why didn't she take

it? Because she was given several pills. It's actually a pill that's broken in half, and she was instructed to take it every six hours round the clock. However, she was also instructed, as all patients are instructed, that she should not take the pill if she's having contractions. So she did not -- she did not take it, because she was having contractions. She did not take the 9:00 o'clock dose.

Q. Okay. Can you point out where in your -- on Bate stamp -30 where you note the contractions?

A. Patient -- the first -- my first line, "Patient presented for" -- you see the arrow going up?

Q. Yes.

A. So increase -- that's increase --

Q. Increase.

A. -- UCs.

Q. That says UC after the arrow?

A. Yes.

MR. GOLDBERG: It's not Uniform Commercial Code.

THE WITNESS: No.

MR. RUBIN: Pardon me?

MR. GOLDBERG: It's not Uniform Commercial Code.

MR. RUBIN: No. Thank goodness.

A. And the S just didn't get copied.

Q. Okay. All right. Let's go through these notes then. Is it fair to say that on Bate stamp -30, the

right-hand column, this is a narrative of what happened?
A. Yes.
Q. Would you be so kind as to translate that for lack of a better word.
A. Into English?
Q. Yes. Thank you.
A. Okay. So, again, she came in in the middle of the night with contractions, and the last Misoprostol she had taken was at 3:00 p.m. At 23:17, so that's 11:17 p.m, I had removed the Laminaria. The cervix was 5 centimeters, 70 percent. UCs, so uterine contractions, were every four to five minutes.
Q. Okay.
A. Will augment with the Misoprostol, 100 micrograms, Q one to two hours, will titrate dose.
Q. Okay. So does that reflect that any Misoprostol was given after the contractions on the 11th?
A. Misoprostol was given at 23 -- so on the right-hand side is the notes. On the left-hand side are the medications on -030.
Q. So MSP in the right-hand -- or the left-hand side is Misoprostol?
A. Yes.
Q. And 100 micrograms were given at 23:18 on the 11th, and then again at 12:24, 00:24 military time --

A. Yes.
Q. -- on the 12th?
A. Yes.
Q. Okay. So we're back here. It says here I believe in the right-hand column, "Begin low dose Pitocin?"
A. Let me just go back.
Q. Sure.
A. Because there's a line that's missing. At 00:25 it says, "CX," that's cervix, "minimal change." So her cervix had not changed. "Repeat Misoprostol, MSP. Repeat Misoprostol/begin low dose Pitocin."
Q. Okay. So there were contractions at this point, but there was no change in the dilation of her cervix?
A. Correct.
Q. Okay. Now, I thought your testimony earlier, and correct me if I'm wrong, a few minutes ago was that she was told not to take Misoprostol if there were contractions?
A. Correct.
Q. So here there are contractions, but you're administering Misoprostol.
A. Correct.
Q. Okay. Why the difference?
A. The difference was that I gave her the Misoprostol to take -- well, first I inserted the vaginal Misoprostol and then the Misoprostol to take round the clock every six

hours to help prepare the cervix, so that was to soften, to shorten, thin out the cervix. It was not to start labor or augment labor. But then she came into the clinic with contractions already, so the plan changed. The plan was no longer, "Tomorrow let's put in more Laminaria." Here she's already in labor, so the plan is moving toward delivery.
Q. Okay. So then I see an entry for Versed around the same time as the dose of Misoprostol?
A. Yes.
Q. And then I see despite the word there -- what would be your notes on the right-hand side as the low dose Pitocen beginning?
A. Yes.
Q. I see 10 units?
A. Yes.
Q. And 10 units per 1,000?
A. Yes.
Q. And what unit is that, CCs?
A. Boy, I don't know how many units are in a CC, but there's a -- you know, there is a calculation. I don't know that exact number.
Q. Okay. So it's -- what does --
A. It might be one -- I don't know. I'm not sure.
Q. Did you write these -- did you make these entries yourself?

A. The Pitocin, yes, I did.
Q. Okay. So you're telling me -- and I understand, because I write things down where I don't know what the heck I wrote.
A. No, no. I know what I wrote. What I -- what I don't know the answer to is how many CCs equals a unit. That's what I don't know.
Q. I see. So what is the 1,000 unit?
A. It's NA, so an IV was started, and a solution of 1,000 CCs was given. Ten units of Pitocin were placed in the 1,000 CCs. Now, I cannot tell you how many CCs -- what the -- how many CCs equals one unit. I don't know that offhand. It says on the bottle.
Q. Okay. I understand. Okay. So then let's go -- let's pick up the narrative here on the right-hand side then. I believe it says here at 00:52 --
A. Yes.
Q. -- patient threw up Misoprostol?
A. Yes.
Q. So that's after the first Pitocen -- after the drip was started?
A. Yes.
Q. So then Misoprostol was thrown up. Did you -- what was the import of that in your mind?
A. Well, she threw up the Misoprostol, and as I note

also, the contraction pattern was unchanged. So she wasn't tolerating the Misoprostol. The contraction pattern hadn't changed. The cervix was not changing. It was time to try something else.

Q. Okay. So what was -- what was the something else that was tried and when was it tried?

A. So what I wrote here was, "Will switch to therapeutic rest with Versed, Fentanyl, one and one, Q one hour PRN," and I'll explain that dosing. "Continue low dose Pitocin overnight. Reassess in a.m."

Q. Okay. "In a.m.," that would be the following day?

A. Yes, on May 12th.

MR. GOLDBERG: That would be the 12th?

THE WITNESS: Yes.

MR. GOLDBERG: We're already in May 12th?

THE WITNESS: Yes, but what I'm -- "a.m." meaning the start of the usual day, 7:00 in the morning. In other words, sleep over night.

Q. Okay.

A. In the morning, even though it was already morning, but in the metaphorical morning, 7:00, 8:00, we'll reassess and see where she's at.

Q. Okay. So that would have been on the 13th would be the plan?

A. No, no, no, no. I'm sorry. It was about midnight

that she threw up the Misoprostol, and she was on -- and I had already started the low dose Pitocin. The plan was that overnight she would get the low dose Pitocin and rest with the Fentanyl and Versed. So she would basically sleep, maintain the Pitocin. In the morning, 7:00 a.m. --

MR. THOMPSON: Sunday morning.

THE WITNESS: Yes.

MR. THOMPSON: So when you're saying "overnight", you mean the same day's sleeping period?

THE WITNESS: Correct. Yes.

Q. (By Mr. Rubin.) So she threw it up the night of the 11th, and the plan was on the morning of the 12th?

A. Well, she threw it actually right at --

MR. GOLDBERG: For the record, she threw it up at about ten minutes of 1:00 on the morning of the 12th. She got it at about 12:25, and about 25 minutes later she threw it up. That's what the document says.

THE WITNESS: Yeah, she may have thrown it up earlier.

MR. RUBIN: Thank you for your testimony.

A. I'm laughing just that we're discussing her throwing up, but she threw up within that time period. I didn't write the note the second that she threw up, but --

Q. I understand you're not going to do that.

A. So is there a question now still about the -- what

happened overnight?

Q. No, it sounds like after she threw it up, the plan was she would rest overnight?

A. Correct.

Q. And where would -- where would she rest?

A. At the clinic in the gurney room.

Q. Okay. So she's in the gurney room, and then I see here, looks like I have a notation, "Fentanyl and Versed." Can you tell me what time that is? It look like 1:05, or is that --

A. Well, she -- she got Fentanyl and Versed overnight almost continuously.

Q. Okay.

A. Fifty micrograms of Fentanyl and a milligram of Versed. She got it at 11:00 p.m. Then at 1:18 she got Fentanyl. All those times are just overnight medications to help her sleep.

Q. I see. So she was in the gurney room receiving these IVs?

A. Correct.

Q. And looks like the next entry on the left-hand side that doesn't involve Fentanyl or Versed is at 7:30?

A. Correct.

Q. And what is LR?

A. Lactated ringer, a certain IV solution.

Q. Okay. What is that for?

A. She -- when she woke up and I checked her at 7:12, I then increased the Pitocin to 60 units, but it was placed in 1,000 CCs of an IV solution, and that was LR.

Q. Okay. And going back to the right-hand side, can you read me your notes regarding the Pitocin? I think it says, "Excellent progress?"

A. Yes.

Q. And then above that you have a dilation of seven centimeters?

A. Yes.

Q. And have there been any contractions then?

A. There were mild contractions.

Q. Is that noted in the records here?

A. No, no.

Q. But there were mild contractions?

A. Yes.

Q. Okay. Is that something you normally should -- you think you should have noted?

A. No. That's expected with the therapeutic rest.

Q. Okay. So why was the Pitocin -- just am I characterizing by saying you ramped up the Pitocin from 10 to 60?

A. Yes.

Q. Okay. And why was that?

A. She had progressed -- when she first came in at 11:00 p.m., she was five centimeters. Eight hours later she was seven centimeters. In other words, that took a long time to progress two centimeters. At the time that I checked her, her contractions, she still was not in what I would call adequate labor.

Q. Okay.

A. And I increased the Pitocin to facilitate delivery.

Q. I see. Let just do a little summary here. At what point were you -- I think, if I can read this correctly and if I understand your testimony, there was a point at which you had began the Pitocin and you administered Misoprostol at about the same time; is that right?

A. Initially, yes.

Q. Okay. And it was then -- and that's at 12:24, Misoprostol. 12:25 you start the Pitocin. That's not the -- and when was the Misoprostol thrown up?

A. The note is 00:52.

Q. Okay. So shortly after she got the Misoprostol and the Pitocin, she then threw up the Misoprostol?

A. Correct.

Q. Okay. And fair to say there was no more Misoprostol given after that?

A. Correct.

Q. Let's look at Bate stamp -31.

A. Yes.

Q. What's that?

A. Those are medications.

Q. Okay. And is this --

A. It's a continuation of the medications on -30.

Q. Okay. And so I see oxygen, Versed, Versed, Versed, Fentanyl, Lidocaine, Versed, Fentanyl, oxygen, and then what is the one at 13:17?

A. DC Pitocin, so discontinued Pitocin.

Q. Okay. And why was that?

A. At that point I suspected uterine rupture, and I turned off the Pitocin.

Q. Okay. And why did you suspect uterine rupture? What lead you to that situation?

A. When I checked her, I noticed that I could no longer feel the head, which I had been feeling before, and I check with an ultrasound, which we have in the room, and I could see that the fetus was now sideways, transverse.

Q. Okay. What prompted you to bring her into the -- I guess there's a gurney room?

A. Yes.

Q. And there's examination room?

A. Yes.

Q. And so she -- you brought her into the examination room?

A. Correct. It's called a procedure room, but yes.

Q. Procedure?

A. Yes.

Q. Okay. And that's when you made the first -- you had the first observation that this might -- that you should discontinue at Pitocin, and what -- what were you -- what were you thinking at that point about what was happening with this procedure?

A. What I was thinking at that point was that it wasn't happening; that I would have expected her to deliver by this point. So I brought her to the procedure room to see -- to assess if I could do a cranial decompression; in other words, to collapse the head and facilitate the delivery.

Q. Okay. So what prompted you to bring her into the procedure room wasn't anything that she did or said?

A. No.

Q. And that's when you found the transverse lie, you couldn't see the head anymore, and you discontinued the Pitocin?

A. Correct.

Q. Okay. If we could flip back to page Bate stamp -30.

A. Yes.

Q. Let me -- let me read what you -- what I think you've written here at the last five or six lines or so on the right-hand column, Bate stamp -30, "1:15, patient brought to procedure room for examination of cervix."

A. No, no, no, I'm sorry, vertex -- vertices and vertex no longer palpable, and that's the head.

Q. Okay. Got it. And then it says, "Ultrasound indicates now a transverse lie."

A. Yes.

Q. And just describe for the record what a transverse lie is?

A. It's the baby's sideways.

Q. And you would expect the baby in what position if it was --

A. It was head down. You would expect it head down.

Q. Right. And then I see here an A and P with a circle on it. What does that mean?

A. Assessment plan.

Q. "The assessment plan is then to RO" -- means rule out -- "uterine rupture?"

A. Correct.

Q. "Discontinue Pitocin. Transfer to UNM."

A. Yes.

Q. Okay. Did you -- when you say, "Rule out uterine rupture," is that something you were going to do, or is that

something UNM was going to?
A. I strongly suspected it, and they were going to confirm and treat her if they needed to.
Q. Okay. And so once you expected -- once you anticipated that -- well, go -- what is a uterine rupture, and explain a little bit why that would be a concern?
A. Well, uterine rupture is a separation, an opening of the uterus. It's a risk really for any delivery but certainly more common after a prior C-section.
Q. Okay. And so what -- so we have a uterus that rips?
A. Uh-huh, yes.
Q. Is it a very vascularized membrane?
A. The kind of C-section that she had was a low transverse incision. So that is in the lower part of the uterus that develops in the later part of the pregnancy called the lower uterine segment. It is thinned out. It is less vascular, less bloody than a C-section incision that's made in the upper part of the uterus. And remember when we -- I pointed out the diagrams on page -002, the one that goes this way is what she had, the low transverse incision --
Q. Right.
A. -- as opposed to the classical, which goes up and down.

Q. She had the first, the one on the -- the picture on the left, not the picture on the right?
A. No, she -- the patient had the one on the left.
Q. Which is the lower risk one?
A. The lower risk, yes.
Q. Okay. And so what happened -- what is the concern when you have uterine rupture?
A. In a live birth, the concern is damage to the baby and possibly death of the baby. In a -- in this situation where the fetus is not a concern, the concern is damage to the uterus. There can be bleeding, injury -- an injury to the uterus.
Q. Well, you say with a live birth, there is concern about damage to the fetus?
A. And the mother, both.
Q. Right, to the -- so the concern about the uterus being -- there's concern to the mother in both cases, correct?
A. Yes, yes.
Q. The only difference between the live birth and the termination procedure, you're not worried about the fetus anymore?
A. Correct.
Q. But other than that, the risks are the same?
A. Yes.

Q. How -- do you think that a -- that the clinic was at all ready, equipped to handle this case once you suspected uterine rupture?
A. Absolutely.
Q. Okay. And did you feel like if there was a uterine rupture, that it could be handled at the clinic? You could care for her?
A. No, we could not care for a uterine rupture, but we could certain transfer her very quickly, and she could get the care that she needed very rapidly.
Q. Okay. How long did it take to your knowledge for her to be transferred to UNMH to get the care she needed?
A. As far as I know it took minutes, but you might have the records. I don't know exactly. I know that it was extremely quick.
Q. How would you characterize the risk of bleeding to the mother? I mean, I guess on a continuum, maybe a cut finger versus a femoral artery? Like what's the --
A. With a uterine rupture?
Q. Yes.
MR. GOLDBERG: Generally you're talking about? Not with respect to ML?
MR. RUBIN: That's right.
A. Generally, it's very variable, extremely variable from minimal, minimal bleeding to severe bleeding.

Q. Okay. Could you find in the records there, to refresh your recollection when she was taken to UNM, how long it took her to get there?
A. I don't even know where to look.
Q. You can take a few minutes.
A. I would need some help here.
MR. RUBIN: I would have no objection to her counsel -- to her counsel --
MR. GOLDBERG: Actually I can't give her any help.
Q. (By Mr. Rubin.) Do you think it would take you all -- as far as you know, there's nothing in the medical records in the case?
A. I don't know the exact timing.
Q. Okay. So how do you know it was quick?
A. I know because I was following it very carefully, because I know when she left, and I got the call from the hospital or I called the hospital, I can't remember, within moments. I know that it was very quick transfer.
Q. Okay. So you were on the phone with UNMH confirming her acceptance there --
A. Correct.
Q. -- for treatment?
A. Correct.
Q. Okay.
MR. THOMPSON: All right. It's -104. There's --

let's see. -102 has a date of 13:50 -- or time of 13:50.
Q. (By Mr. Rubin.) Can you turn to Bate stamp -100 for me? I don't believe that's -- that particular page is in the copy of the medical records that I have as my Exhibit 1. It is in their Exhibit 8.
A. Thirteen -- I'm sorry. Okay. Go ahead.
Q. I believe it's -- so are you on Bate stamp -100?
A. Yes.
Q. I see here this is a -- this is a form printed by UNM -- UNM Hospitals?
A. Yes.
Q. Okay. I see an arrival time. What does that arrival time say?
A. 13:39.
Q. 13:39. Did you provide her with some Oxycodone? Under Meds, is that --
A. Well, I don't know that she was provided -- maybe she brought that with her. I don't know what that refers to.
Q. So 13:39 is, as far as you know, is that -- is that consistent with what your impression was as to when she arrived there?
A. I couldn't say.
Q. Okay. At least we have in your notes the time that she -- we have 1:15 is when you examined her, correct?

A. Correct.
Q. So this would be one about -- if my math's pretty good, about a half hour later?
A. Yes. A bit less.
Q. Okay. Approximately a half hour?
A. Twenty-four minutes, whatever it is.
Q. Okay. Let's proceed. I think we have Bate stamp page -34, Progress Notes. Are you on that?
A. One moment. Yes.
Q. And is this your handwriting?
A. Yes, it is.
Q. Does this contain any information in addition to what we've already covered?
A. No.
Q. Okay. All right. Same with the next page?
A. Well, it talks about my visits to the hospital, conversations I had.
Q. Okay. So it says here, if I'm reading this correctly, "Thursday" -- and this is Bate stamp -35, "Thursday, 5-12, transferred to UNM." What does that say?
A. Presumed.
Q. "Presumed uterine rupture." You made a telephone call to a Dr. V. Rosenberg. Is that the patient's doctor back east?
A. Yes.

Q. Okay. And then patient's MD, and I see -- is that a "5m" after that?
A. Yes, I don't know what that means. It may be five minutes that got cut off.
Q. Okay. On 5-21 the one-hour visit with the patient and the family, correct?
A. Yes.
Q. How did that -- can you give your impressions as to what happened at that time? Is there some discussions or counseling? What was -- what was your role at that time?
A. My role was to be with them. This was a complication. I was very concerned, and I wanted to be there with them.
Q. Okay. 5-13, again, "One-hour visit with patient's mother. The patient was asleep."
A. Yes.
Q. And then a call to her doctor, five minutes.
A. Uh-huh, yes.
Q. Okay. Saturday the 14th, same thing, another one-hour visit with patient and mother. "Patient discharged."
A. Yes.
Q. All right. On the next page here we have an operative note here, correct?
A. Yes.

Q. Okay. Was this -- is this page -- why is this included in the medical records for this case, this patient?
A. Well, this is just a form that we would have filled out had she delivered.
Q. Okay. And so you wrote over it here, "Transfer to UNM, rule out uterine rupture," correct?
A. Yes.
Q. So that was to indicate that this formally wasn't relevant?
A. It was to indicate that she was transferred.
Q. Right. So this information was not relevant to your medical records?
A. Correct.
Q. Okay. Let's see. We are on Bate stamp -- if you could turn to the letter dated May 15th. I believe it's two pages.
A. What number? Oh, okay, I see.
Q. I'm trying to figure that it out myself.
MR. GOLDBERG: Thirty-eight.
A. And -39.
Q. Thirty-nine?
A. Yes.
Q. Did you write this letter?
A. I did.
Q. Okay. And on page -39 it says, "The rupture was

repaired and blood loss was within normal limits?"
A. Yes.
Q. And what did you rely on for that assessment?
A. That was the report that I had gotten.
Q. From whom?
A. From one of the physicians. I don't remember which.
Q. Was it a written report?
A. No.
Q. Is there any indication here as to the -- any permanent damage to the patient?
A. No.
Q. Okay. So there's nothing either way?
A. Correct.
Q. Is one of the complications of uterine rupture possible infertility in the future?
A. Not that I'm aware of.
Q. Does uterine rupture effect a woman's ability to deliver a full-term baby in the future -- in future conceptions?
A. That depends on the rupture, the size of the rupture and the repair. It can effect her -- well, it certainly would require her to have a C-section in the future.
Q. Okay.

A. And it can effect her ability to go completely to full term.
Q. Okay.
A. The uterus is weaker as it is after one C-section.
MR. RUBIN: Okay. I think we're almost done, Dr. Sella. Appreciate your patience.
If I could just have a moment, Mr. Hearing Officer, I'm looking for a page I thought I had.
MR. GOLDBERG: Maybe I can help you.
MR. RUBIN: I'm looking for Bate stamp -- are we off the record.
MR. THOMPSON: Let's go off the record.
(Note: Hearing in recess at 11:06 a.m.
and reconvened at 11:11 a.m.)
MR. THOMPSON: Back on the record, time of 11:10. Direction examination of Dr. Sella. You may proceed.
Q. (By Mr. Rubin.) If you could look at the very last page of the medical records I've included as Prosecution's Exhibit 1, I believe it's an Operative Report -- are you there, Mr. Goldberg?
MR. GOLDBERG: This is my last.
MR. RUBIN: That's your last page?
THE WITNESS: Yes.
MR. RUBIN: Okay. Let me get you your --
MR. GOLDBERG: If this is your only copy, I --

MR. RUBIN: No, I made two copies.
MR. GOLDBERG: Excellent. Thank you very much.
MR. RUBIN: Okay. Everyone has a copy.
MS. NOWARA: And can I --
MR. GOLDBERG: I lied to you.
MS. NOWARA: Can I say just for the record that I think --
MR. GOLDBERG: I lied to you. It's not this one.
MR. RUBIN: You need to put that on the record, your prevarication.
MR. GOLDBERG: I think it is on the record, because as I say, I lied to you. I do have it.
MR. RUBIN: All right. Okay. Is everyone where I am?
MR. THOMPSON: Do we have -- counsel, you have a question?
MS. NOWARA: No.
Q. (By Mr. Rubin.) Okay. Thank you, Dr. Sella.
A. Yes.
Q. Okay. Here we are again now.
A. Yes.
Q. You have in front of you something titled -- caption in the upper left-hand corner is an Operative Report?
A. Yes.

Q. Okay. And let's -- have you seen this page? Have you seen this?
A. Yes, I have.
Q. When did you first see it?
A. When we got the records from UNM. I don't know when that was.
Q. And you recall meeting with me several weeks ago, correct?
A. Yes.
Q. And do you remember making a statement as to what you thought the birth weight of the -- or the fetal weight was of the fetus?
A. Yes.
Q. Do you recall what you told me then?
A. I'm not sure what I told you, but what I -- I mean, I think what it is, which is under six pounds.
Q. Okay.
A. Is that what I told you?
Q. I think that's -- well, I can't answer that. I'm not allowed to.
A. Okay. That's what I have thought always, so --
Q. Let's go down to the operative findings on this page.
A. Uh-huh.
Q. Last sentence there it says, "Birth weight,

approximately 7.5 pounds." Do you see that?
A. I do.
Q. And so you had this document well before you met with me?
A. Correct.
Q. Does this change your opinion as to what the weight of the fetus was?
A. Not at all.
Q. Okay. The person who made these notes is she an attending surgeon, Lisa Moore, MD?
A. The person who wrote the -- who dictated the chart?
Q. Yes. Can you tell -- can you tell from this document who entered these operative findings?
A. Let's see. I can -- I don't know who dictated this, but I can tell you from my experience that attending surgeons do not dictate op reports. Residents do.
Q. Okay. I see also here under the attending surgeon, "Surgeon: Sarah Woods, MD, R-2 and Lisa Moore."
A. Correct.
Q. "Assistant Surgeon: Sarah Decker, MD."
A. Yes.
Q. Could one of them made this entry regarding the birth weight?
A. Yes.

Q. And if you can -- I'm not asking you to speculate, but how do you -- if you can't tell me without speculating, don't tell me, but how do you think they arrived at this birth weight, approximately 7.5 pounds?
A. I think that they held up the fetus and said, "This feels approximately 7.5 pounds."
Q. Okay. And did you ever -- you never saw the fetus, did you, other than the head?
A. After the delivery, no.
Q. Okay. You never weighed it?
A. No.
Q. So this is -- suffice it, this is the only record that -- so there were no other records that you know of regarding someone actually trying to weigh the -- weigh the fetus other than this one, is there?
A. On the contrary. There's a record showing that the fetus was not weighed.
Q. Okay. And where is that?
MR. GOLDBERG: Our Exhibit 17 is the hospital records.
MR. RUBIN: All right.
MR. GOLDBERG: And if you look to --
MR. RUBIN: To the Bate stamp?
MR. GOLDBERG: Yeah. I believe again --
THE WITNESS: -187.

MR. GOLDBERG: 000187. With your permission, I'm going to give this to --
MR. RUBIN: That's fine.
THE WITNESS: Is this for me or for him?
MR. GOLDBERG: The Hearing Officer has all these.
THE WITNESS: Okay.
Q. (By Mr. Rubin.) So where on 000187 does it say what you say, that the fetus was not weighed?
A. Yes, it does.
Q. Can you point that out to me?
A. Yes. Okay. So on the right-hand side, it says, "Gross Anomalies." Nothing is recorded. "Resuscitation," not recorded. "Neonatal," dah, dah, dah, dah, dah. Birth Weight, blank.
Q. It's blank.
A. "Male/female," blank.
Q. Okay. So this in your mind reflects that there was no actual weight taken?
A. Correct.
Q. Would it be reasonable to rely upon whatever -- rely upon this report as a reasonable assessment of what the birth weight was?
A. No.
Q. So it would not be reasonable for whichever one of these surgeons or doctors held the fetus, it would not be

reasonable for them to say based upon just holding it, that it was approximately 7.5 pounds?
A. Correct. It would not be reasonable.
Q. So then they should not have entered this here, should they?
A. Correct.
Q. And so you would not -- you would not rely upon this?
A. No.
Q. "This" meaning that weight?
A. The weight, yes, I would not.
MR. RUBIN: Okay. If I could just have a moment. Okay. I have no further questions. Thank you, Dr. Sella.
MR. THOMPSON: One moment, Doctor.
THE WITNESS: Yes.
MR. THOMPSON: Can we admit Exhibit 17 or at least -00187.
MR. GOLDBERG: I'm going to move -- I'm going to all of Exhibit 17.
MR. RUBIN: Yeah, I would have no objection to Exhibit 17 provided that it is nothing more than the medical records of UNM.
MR. GOLDBERG: I'll represent that -- my understanding is that these are the medical records provided by UNM to the Medical Board.

MR. RUBIN: No objection. Again, we need to take care if these are not redacted.

MR. GOLDBERG: All of our exhibits, I'll affirm again, we will take care of the redactions before these -- these become formal records.

MR. THOMPSON: Okay. Mr. Goldberg, do you -- you care to take her on direct. So I assume you don't have any questions --

MR. GOLDBERG: I'm sorry.

MR. THOMPSON: -- for the doctor at this point? You want to wait for your case-in-chief?

MR. GOLDBERG: Actually what I'd like to do is I'd like to cross-examine her on one item, on one matter and then do my direct of her when I plan on doing my direct.

MR. THOMPSON: So long as you make your very best efforts not to be duplicative.

MR. GOLDBERG: Yes. I actually -- I want to do this, because I want to tie up this matter.

CROSS-EXAMINATION

BY MR. GOLDBERG

Q. And that's, Dr. Sella, I want to talk about the last matter you talked about with Mr. Rubin in your testimony, and that is the weight of the baby. To your knowledge nobody weighed the fetus; is that correct?

A. Correct.

Q. You didn't weigh the fetus, because it was in the womb for -- at all times when ML was in your care?

A. Correct.

Q. And as you testified, no one at the hospital weighed the fetus, correct?

A. Correct.

Q. But you -- and you testified that you don't believe that the estimate of the medical resident who, as you expect basically held up the fetus after it was delivered --

MR. RUBIN: Objection to the medical reference -- medical resident. There's no foundation for that.

MR. GOLDBERG: Well, the record will --

MR. THOMPSON: Overruled. She -- I mean, she's speculating. She's speculating it was a resident, speculation.

Q. (By Mr. Goldberg.) Holding it up and saying, "This weighs seven and a half pounds," you wouldn't rely on that?

A. No.

Q. And you don't have any reason to rely on that?

A. No.

Q. In your opinion are there -- is there information in the medical records that you think does give you a reasonable basis to estimate what the weight of this fetus

was at birth?

A. Yes.

Q. Let me go back to Exhibit 8, Dr. Sella, and if you'll turn to that sonogram report that was found at -- I think it was -8 or maybe -9.

A. -009.

Q. -009. And Mr. Rubin went over a bunch of things with you. On that -009, if you go back to the estimated fetal weight at the bottom on -- just to get a repeat for the record, what was the estimated fetal weight as of the -- this would be what date, Doctor, 5 --

A. May 2d, 2011.

Q. May 2d. And what was the weight?

A. Five --

Q. And this was an estimated weight, right?

A. Correct.

Q. Five pounds, seven ounces?

A. Yes.

Q. From your experience and from your knowledge as a fellow of obstetrics and gynecology is that within the range of a fetal weight you would expect for a fetus at that gestational age?

A. Yes.

Q. Is there generally understood approximately how much weight a fetus gains in utero during this time of

gestation?

A. Yes.

Q. Approximately how much weight do you expect a fetus to gain in utero by week during this time of gestation?

A. At this stage of pregnancy, about half a pound a week.

Q. Half a pound a week. What is the interval between May 2d when this report was done and when you effected the demise of the fetus, so that you would not expect any further weight gain?

A. It was one week and one day.

Q. Eight days?

A. Yes.

Q. So what would you -- employing then the baseline here on -009 and the generally accepted understanding in the discipline of the weight gain, what would you anticipate the weight gain of the fetus to be at the time of birth?

A. What would I expect the weight to be?

Q. The weight, yes.

A. To be under six --

MR. RUBIN: Let me object to the term "at birth". I don't think there's a foundation for the term "at birth".

Q. (By Mr. Goldberg.) At the time that the fetus was delivered at UNM Hospital, because we've already established

that the fetus stops gaining weight when the fetal demise is effected.

MR. RUBIN: Right. Okay. I'm sorry.

A. Okay. So under 6 pounds; 5 pounds, 13 ounces.

Q. Would that be -- would that be a weight that is consistent with a fetus in the 35th week of pregnancy, a gestational age of 35 weeks?

A. Yes.

MR. GOLDBERG: Thank you. I have no further questions at this time.

MR. THOMPSON: Okay. I've got a couple questions.

THE WITNESS: Yes.

EXAMINATION

BY MR. THOMPSON

Q. On -0002 when you talked about the two types of cesareans, you used the term "risk". Is that a different risk cesarean or different risk with regard to your procedure after the cesareans are done?

A. It's a different risk of -- the risk of uterine rupture is increased with the classical C-section.

Q. Okay. So the C-section she had presented a lower risk for uterine rupture?

A. Correct.

Q. The symptom where you first thought there was a possible uterine rupture, the symptom of that was the change

in station?

A. Correct.

Q. And I just want to make sure I understand the timeline. I apologize. You all understand it better than I, but I think for the record -0030 --

MR. GOLDBERG: That's the night of the 11th and the morning of the 12th.

Q. (By Mr. Thompson.) So following about a quarter down to 11:20 --

A. Yes.

Q. That is 11:20 a.m. on the --

A. It's 11:20 p.m.

Q. P.m. on the --

MR. GOLDBERG: Night of the 11th. On the night of the -- if you think of the --

MR. RUBIN: Let me object here. Let's have the doctor --

MR. GOLDBERG: But if you think of it as -- if you think of it as the -- if you think of it as the first day, second day, third day, it probably is helpful.

Q. (By Mr. Thompson.) Okay. So either in the context of first, second or third or the actual day, that is the 11:20 p.m. on --

A. Day two.

Q. -- day two, and the actual date would be?

A. The actual date, May 11th.

Q. May 11th?

A. Yeah.

Q. Okay. And she was given -- she did not take the -- wasn't Pitocin --

A. Misoprostol.

Q. Misoprostol on day one, the 10th?

A. On day one she was given -- I administered the Misoprostol vaginally. She was not given any buccally. On day two she was given Misoprostol vaginally, and she took one dose buccally at 3:00 p.m.

Q. And then did not take the second does at --

A. Nine p.m.

Q. -- nine p.m.?

A. Correct.

Q. On day two?

A. The 11th.

MR. THOMPSON: The 11th. Okay. That's all the questions I have. You remain under oath, because you're going to be recalled by your counsel, but you're free to step aside now. It's 11:30.

MR. RUBIN: Well, it's --

MR. THOMPSON: And we have to call someone out of order. I'll check on procedure. We can go off the record for this.

(Note: A discussion held off the record.)

MR. THOMPSON: Back on the record.

MR. DARNEY: May I request that the heat be turned down a little bit.

MR. THOMPSON: Absolutely. You can request it.

PHILIP D. DARNEY, MD

after having been first duly sworn under oath, was questioned and testified as follows:

MR. THOMPSON: Let the record reflect it is 11:30 a.m. Respondent is going to call their expert, Dr. Darney, out of order.

You may proceed, Mr. Goldberg.

EXAMINATION

BY MR. GOLDBERG

Q. Good morning. Would you state your name, please.

A. Philip Darney.

Q. Dr. Darney, where are you employed?

A. University of California San Francisco.

Q. Which department?

A. Obstetrics, Gynecology and Reproductive Sciences.

Q. And is that in the School of Medicine?

A. Yes.

Q. And University of San Francisco -- University of California San Francisco is a stand along health sciences -- standalone health sciences center; is that correct?

A. Yes, no undergraduates.
Q. No undergraduates, and all the graduate or professional courses are related to the health sciences?
A. Yes.
Q. What is your position? What position do you presently hold at --
A. I'm Distinguished Professor, Distinguished Professor of Obstetrics, Gynecology and Reproductive Sciences and of Health Policy.
MR. RUBIN: May I ask? We could save some time if we agree to stipulate, both sides.
MR. GOLDBERG: No, I'm going to -- no, I'm going to -- I don't want to stipulate to Dr. Darney's experience. I want to go through it. I think it's important for the Hearing Officer, and it's important for the record.
MR. THOMPSON: If he wants to produce it for the record, that's fine.
MR. RUBIN: That's fine.
Q. (By Mr. Goldberg.) How long have you been at the Medical School at UCSF?
A. Since January 1981.
Q. That's more than 30 years?
A. Yes.
Q. What does it mean to be Distinguished Professor at UCSF?

A. It means through academic achievement, publications and research and -- research grants and publications, you achieve a highest tenure track level possible at the University of California.
Q. Before I turn to your educational and professional background, I want to ask you a few questions about the medical school at UCSF. Have you heard of US News and World Report rankings for higher educational institutions?
A. Yes.
Q. What is UCSF Medical School's US News ranking for this academic year among all medical schools in this country?
A. I haven't read it for this academic year, but it's consistently ranked in the top five medical schools in the country.
Q. What is UCSF's Medical School's US ranking among all medical schools with respect to women's health?
A. We're generally ranked about number two behind Bringham Women's Hospital.
Q. Let me now turn to your background. Please tell the Hearing Officer about your college and professional education?
A. I was undergraduate in experimental psychology, University of California Berkley; medical student at UCSF, state surgical intern at the US Public -- US Public Health

Service Hospital; did my public service commitment as an epidemic intelligence service officer at the Centers for Disease Control, assigned to the Alabama State Health Department. I trained under William Brass, London School of Hygiene and Tropical Medicine and medical demography. I returned to the CDC; worked as a demographer and completed my preventative medicine residency; passed the preventative medicine boards.
I returned to clinical training at Bringham Women's Hospital in Boston; completed my residency in obstetrics and gynecology there; worked as faculty member at Harvard Medical School for two years; moved as an Associate Professor to the Oregon Health Sciences Center -- Health Science University, excuse me, in Portland, Oregon; worked there for two years and then returned to UCSF where I've been for 30 years.
Q. And you testified that you hold the title of Distinguish Professor. Do you hold any other academic positions at UCSF?
A. I've been Chief of Obstetrics and Gynecology at San Francisco General Hospital for 15 years. I'm the founding director of the Bixby Center for Global Reproductive Health. That's my current position.
Q. Explain briefly in general to the Hearing Officer what is the Bixby Center of Reproductive Health?

A. Research and Training Institute of the University of California focused on contraceptive development, contraceptive clinical trials, evaluation of family planning programs, training in family planning. We focus research on the relationship between contraceptive use and HIV disease, in prevention of HIV transmission and have permanent research and training installations in Harare and Zimbabwe and Kazimba and Pina, Kathmandu and Nepal, truly a global, global organization.
Q. How many professionals?
A. About 20 faculty, and about half of them are physicians. The other half are demographers, anthropologists, psychologists.
Q. I'm going to -- I'm going to move over there so the Hearing Officer can see something other than the back of your head.
A. Okay.
MR. THOMPSON: I was going to suggest that. It's probably appropriate.
Q. Are you one of founders of the Bixby Center?
A. Yes, it was founded 13 years ago by -- by epidemiologist Nancy Padian and myself.
Q. On top of this -- I put all of the exhibits in front of you, but on the top, I put Exhibit 9. Do you see that in front of you?

A. Yes.
Q. Can you identify Exhibit 9?
A. That's my curriculum vitae or resume.
MR. GOLDBERG: Let me move Exhibit 9, Mr. Hearing Officer.
MR. THOMPSON: Any objection?
MR. RUBIN: No objection.
MR. THOMPSON: Exhibit 9 is admitted.
Q. Make reference to Exhibit 9 if you want. I'm going to turn to some of your academic work, first to your publications. Have you authored or coauthored any books on medicine?
A. I've written or co-written five textbooks on ambulatory gynecologic surgery, contraception, women's health, two of them in their 13th and 5th editions respectively.
Q. And are they currently in print in -- those last two, in print and adopted at various universities and medical schools around the country?
A. Yes, I believe they're the most widely used text of their kind in the world.
Q. Approximately how many peer reviewed publications have you authored or coauthored?
A. I think just short of 200.
Q. Two hundred separate peer reviewed publications,

articles?
A. Hopefully.
Q. Explain what it means for an article to be peer reviewed; that is, published peer reviewed publications?
A. Usually concerns original research or original reviews, which are submitted to a scholarly journal. The journal sends them out to reviewers who evaluate them for scientific integrity and determine whether they should be published or not or whether they should be revised before publication.
Q. Is it generally understood in the discipline of medicine that when an article is published in a peer review journal that it passes muster among the peers in that discipline?
A. Yes.
Q. Have you authored or coauthored chapters in other books? You've described the five books of medicine that you, yourself, authored or coauthored. How about chapters in other books?
A. Yes, dozens of chapters in other -- in colleagues' textbooks.
Q. Have you served as an editor or on the editorial board of any peer review publications?
A. I was on the editorial board of obstetrics and gynecology, the principal journal of our specialty. I'm on

the editorial board, senior editor of the Journal of Contraception. I'm a regular reviewer for many journals, including the New England Journal, Lancet, and editorialist for both of those journals.
Q. Is that an honorary -- is that an honorific position? Does it involve work?
A. No, it involves prompt response to the journals request for scientific review.
Q. Let's turn to your research, Dr. Darney. Are you currently a principal investigator, not just one of the investigators, but a principal investigator on any research grants currently?
A. Yes, on five or six related to contraceptive development and evaluation for the most part.
Q. Over the course of your career, approximately how many research grants have you been the principal investigator?
A. I haven't counted, but I would say about a hundred from various sources, national institutes of health, centers for disease control, pharmaceutical companies, private foundations.
Q. Finally, I want to turn to your honors and awards, Doctor. I say this with all experts I put on, this is not -- sometimes for people it's hard to talk about their own honors and awards, but I'm going to ask you. Have you

received any honors and awards that you consider to be distinguished honors and awards?
A. Yes.
Q. Give some examples to the Hearing Officer?
A. In 2003 I was elected to the Institute of Medicine of the National Academies.
Q. Can you describe what the National Academies are?
A. It's a panel of experts in various disciplines, engineering; in my case, medicine.
Q. How many obstet- --
A. In science --
Q. How many obstet- --
MR. RUBIN: Let me object here. I don't think the witness is being allowed to finish his answer.
A. I was going to say that there are approximately 20 obstetrician gynecologists that have been elected to National Institutes of Medicine and --
Q. Any -- I'm sorry. Go ahead.
A. I recently received the -- my wife and I for our work in training sex and gynecology residents and fellows, received the Margaret Sanger Award, Planned Parenthood Federation of America for lifetime achievements in reproductive health. I received the Society of Family Planning's award for lifetime contributions to contraceptive research. I received the American Public Health

Association's award for outstanding achievement in reproductive health, public reproductive health, and my own institution I received the Chancellor's Award for the Advancement of Women. I received the public service award of the Chancellor at UCSF. Those are examples.

Q. In addition to all of your academic work, your clinical work, your research work, your prodigious publications, do you engage in public service activities?

A. Yes.

Q. Will you describe to the Hearing Officer some of the public service activities that you have engaged in?

A. One I'm particularly proud of is founding the New Generation Health Center in San Francisco, which serves poor teens in the City not far from my hospital. I also help to found the Saint James Infirmary, which cares for the health needs of commercial sex workers who are often disenfranchised in the city of San Francisco. I've long been a volunteer for Planned Parenthood as a board member physician.

Q. Turning to your academic work, within the discipline of medicine and the subdiscipline of obstetrics and gynecology, are there particular -- is there a particular fellowship or fellowships that address the training of people who provide abortion services?

A. Yes. I think it's particularly relevant to this

discussion we're having here. I founded a training program at UCSF in 1991, and we now have similar programs at 26 major medical schools around the country. We started one two years ago at the University of New Mexico, for example.

Q. What is it called?

A. The Fellowship in Family Planning.

Q. Is that a recognized fellowship now within obstetrics and gynecology?

A. Yes.

Q. And typically how long is that fellowship? And that comes after -- after a medical student graduates from medical school, does a four-year fellowship in obstetrics?

A. Does a residency.

Q. Four-year residency?

A. And the fellowship is two to three years, and the objective of the fellowship is training in research related to contraception and abortion, aspects of those disciplines and clinical skills related to those two fields, and we now have about 220 active graduated fellows working mostly in academic institutions all around the country.

Q. And did you have a role in the founding of the very first fellowship?

A. Yes.

Q. And have you --

A. And the fellowship program is now based at the

Bixby Center. In addition to the fellowship program, we established in honor of my mentor at the Harvard Medical School, Kenneth J. Ryan, the Ryan Residency Program in which we help residency programs develop training, specifically for family planning for their residents, and we have those programs at 76 leading medical schools around the country, and the University of New Mexico is, for example, one of -- is one of those programs.

Q. In your clinical work, Dr. Darney, do you provide abortion services?

A. Yes.

Q. You provide abortion procedure?

A. Yes.

Q. In your experience, approximately how many total abortion procedures have you administered?

A. Dr. Sella was asked that question. I estimated that I provided about the same number of abortions.

Q. Of those abortions, approximately how many of those were third trimester abortions?

A. A small fraction. As you're aware, the third trimester, even the second trimester abortions are a small portion, about 5 percent of all pregnancy terminations.

Q. Where do you provide -- presently where do you provide abortion services?

A. I provide them in the Women's Option Center in San

Francisco General Hospital.

Q. Is that -- is that a clinic?

A. Yes, it's a clinic associated with the hospital.

Q. But it's not a freestanding clinic like Southwest Women's Options?

A. No. It is the sister clinic to the university hospital or the largest abortion providers in the Bay Area.

Q. Among -- from within the universe of the third trimester, small number of third trimester abortions that you have provided, were any of those on women with prior C-sections?

A. Yes.

Q. Do you consider yourself as having expertise in the area of obstetrics and gynecology, including the standards of care for providing obstetrical services including VBACs and TOLACs?

A. Yes.

Q. Do you consider yourself as having expertise in the area of providing medical abortion services including the national standards of care in providing abortion procedures?

A. Yes.

Q. I want to turn now to your assignment in this case, Dr. Darney. Can you describe to the Hearing Officer what you were asked to do in the case?

A. Review the medical records of the care of the patient we're calling ML. The records were just -- just reviewed to determine if the care was within the standard of -- the national standard of care, to review the Board's expert, Dr. Bullock's review of these records, and in addition, I reviewed his deposition, and in making these reviews, I relied on my lifelong review of the medical literature, my own and others' writings about these topics.

Q. In that -- in that package of material in front of you, would you pull out Sella Exhibit Number 8, which has already been admitted. You have a copy in front of you right there.

A. This is the medical record.

Q. Sure. Have you seen that before?

A. Yes.

Q. Are these the medical records that you reviewed?

A. Yes.

Q. Before we turn to your -- your opinions, I want to ask you a few questions about Southwest Women's Option Clinic. Were you familiar with the Southwest Women's Options Clinic before you were engaged to be an expert consultant in this case?

A. Yes.

Q. Would you explain how you were aware of Southwest Women's Options Clinic?

A. Well, I actually visited, because it was one of the -- still is one of the training sites for the resident and fellowship programs that we established at the University of New Mexico, and we make site visits to determine the adequacy of the training at every one of those -- one of those universities.

Q. When you make those site visits, do you make them for the purposes of evaluating the standard of care that is provided at those clinics?

A. Yes, to make sure that our residents and fellows would be well-trained.

Q. Did you reach -- do you have any opinions generally about the standard of care with respect to the abortion services that are applied at Southwest Women's Options clinic?

A. The care there was exemplary, and we provide good training for our residents and fellows.

Q. Now, I want to turn, again, before we go to your opinions just specifically what you did in your investigation in this case in order to reach your opinions. You said you reviewed the medical records. What else did you do?

A. I reviewed Dr. Sella's curriculum vitae. I reviewed the opinions of Dr. Bullock, and I reviewed the deposition of Dr. Bullock in regard to this case.

Q. Did you talk with Dr. Sella about this case in your investigation?

A. Yes, I did talk with her about this case.

Q. You were here this morning and heard all or mostly all the testimony of Dr. Sella?

A. Yes.

Q. And you heard her description of the procedure that was administered to ML; is that correct?

A. Yes.

Q. So instead of going back over that, was that -- was that testimony consistent with your understanding of the procedure as you went through the medical records?

A. Yes, it was.

Q. Okay. So let's turn to your opinions. First, do you have an opinion as to whether ML was an appropriate candidate for a third trimester abortion under the circumstances presented in this case?

A. Yes, I believe she was.

Q. First, before we -- well, first, explain to the Hearing Officer what kind of considerations go into determining whether somebody is a good candidate for a third trimester abortion?

A. Well, the circumstances of the pregnancy, whether the pregnancy is first a threat to the life or health of the pregnant woman and then the circumstances of the fetus,

whether the fetus has a reasonable chance of a meaningful existence in the -- in the view of, first, the parents and an assessment of medical experts, neonatologists, perinatologists.

Q. Within the discipline, is it generally understood that appropriate third trimester abortions fall into one of two categories, fetal indicated or maternal indicated?

A. Yes. It's possible you could have both indications.

Q. This abortion, the abortion on ML, which category did this fall within?

A. Fetal indications, severely compromised cerebral condition and high probability of condition incompatible with meaningful life.

Q. I want to turn to another opinion. Do you have an opinion about whether Dr. Sella's treatment of ML comported with the applicable standard of care?

A. I do, and it did.

Q. Let's break down that opinion somewhat. First, what is the appropriate standard of care to apply in this case; that is, the administration of a third trimester abortion to a woman like ML?

A. The practice around the country, there are very few of -- of those procedures are done. There are very few practitioners capable of doing them. So a national standard

is more appropriate than, say, a state or local standard.

Q. You're familiar from your work and experience with the provision of third trimester abortions around the country?

A. Yes, I am. We provide third trimester abortions at our clinic. I have actually asked the clinic director who I appointed to that position about our own experience when we're doing more of those procedures recently. She said that we'd done about 30 in the past year. I would have been involved in just a few of those.

Q. How many --

A. So we and just a few other places are -- would be responsible for the bulk of the third trimester procedures done around the country.

Q. And that's what I was going to ask. How many -- how many locations are there in this country where third trimester abortions are regularly provided?

A. Less than a dozen.

Q. How many -- set the hospital set -- hospitals aside, how many freestanding clinics provide third trimester abortions in this country?

A. I'm aware of only four.

Q. And where are they?

A. Here, in Albuquerque --

Q. And that's the Southwest Women's Options Clinic that Dr. Sella works?

A. Uh-huh.

Q. Go ahead.

A. New York, Maryland, Boulder, Colorado.

Q. You said New York. New York or Los Angeles.

A. Los Angeles, excuse me.

Q. Big city. Okay. And then you said that maybe your hospital provides around 30 a year?

A. Yes, recently.

Q. And are there obstacles to providing third trimester abortions in a hospital that you would not expect to see when it's -- they're provided in a clinic setting?

A. Yes. A typical hospital that's accomplishing deliveries, for example, would not have someone who's expert in -- in perhaps not in second trimester abortions, certainly not in third trimester abortion. I know that from all the hospitals I visit. I've lectured, for example, at a hospital from which ML was referred on Long Island, and they wouldn't have anyone there to provide this service. Other obstacles are hospital policy, the skilled personnel, both nurses and physicians, hospital policies, state laws, the right equipment, access to the right drugs and so on, a number of obstacles.

Q. Let's talk about where you provide abortion services in San Francisco. When you want to provide a third trimester abortion at the hospital in San Francisco, do you have to go to a committee first?

A. Yes.

Q. And what does that committee do?

A. The committee judges whether or not the termination meets the two criteria we discussed, which is a threat to the life or health of the pregnant woman or is the fetal condition incompatible with meaningful life.

Q. And from your experience are there hospitals where the policies of the hospitals make it difficult for committees or doctors to accept third trimester abortions?

A. Certainly are.

Q. From your experience, also -- well, let me, before we get to this, the nursing staff in a large hospital is pretty -- is pretty sizable, correct?

A. Yes.

Q. Large number of nurses. Pretty heterogeneous generally?

A. Yes.

Q. From your experience has the large size in heterogeneity of nursing staffs in a hospital posed obstacles to providing late-term; that is, third trimester abortions in hospitals?

A. Yes, as well as second -- sometimes any kind of abortion.

Q. Can you explain that to the Hearing Officer? How does -- why does that happen? How does it happen?

A. Well, you might find that nurses -- if you're not specialized, nurses aren't -- first, may not be trained to provide a specialized service, or they may not want to do it based on their religious or political attitude toward abortion.

Q. And is that a problem that you see in these freestanding abortion clinics that --

A. No, because if you specialized, then the freestanding clinic can hire people who specifically want to do this work. At our clinic in San Francisco General Hospital, we hired people who work there who really want to do this work, have a lot of experience at it and provide excellent patient care and excellent support for the -- for one another and for the physicians.

Q. To your knowledge does the University of New Mexico Hospital provide third trimester abortions?

A. No. In fact, the University of New Mexico Department has established its own freestanding abortion clinic where the training that I described is accomplished. It's not done in the hospital. It's done in a freestanding clinic. Sometimes -- I don't know the particular circumstances in New Mexico. I did at one time. Sometimes in a publicly owned hospital, a state hospital situation,

give you Arizona, for example, the university hospital is forbidden by statute from providing an abortion.

Q. And so the Medical Board's expert consultant, Dr. Bullock, says that the appropriate standard of care --

MR. RUBIN: Objection. Where's the foundation? Dr. Bullock hasn't testified yet.

MR. GOLDBERG: I'll lay -- I'll lay a foundation for this.

Q. Did you read Dr. Bullock's report in this case?

A. Yes.

MR. RUBIN: I'll object to that.

Q. Did you read --

MR. RUBIN: Hold on. Let me object to that, because the report is not in evidence. He's not going to get it in this way. We need to discuss whether -- the propriety of having this, Dr. Bullock's report, as an exhibit before we go any further.

MR. GOLDBERG: I haven't -- I haven't -- I'm going to offer it by the way as an exhibit. This is one of the exhibits that's at issue here, Mr. Hearing Officer, but first of all, I'm going to lay the foundation first. I'm not going to -- I'm not going to ask him the substance of the report.

MR. RUBIN: I thought he already -- I thought he was going into that just now.

MR. THOMPSON: First of all, I think he can -- I mean, if he's read the report in preparation of his exert testimony, he's able to testify about that just from reading the report.

MR. GOLDBERG: But I'm going to ask -- I'm actually -- through him I'm going to move the exhibit, and we'll do that, but I want to lay -- I want to lay a foundation for all of this. I'm entitled to lay a foundation. I understand where Mr. Rubin's coming from, but I haven't asked him any substantive questions yet about the report. I'm going to do that, but I am going to do that.

MR. THOMPSON: And I understand that, and I also think I do understand that this is partially probably rebuttal testimony for the State's expert, and so we're going to -- we're going to -- I'm going to allow it.

MR. RUBIN: Well --

MR. GOLDBERG: Let me lay my foundation, and I'm telling you I'm going to move, so you're going to have your opportunity to make the argument, and we'll let the Hearing Officer decide, but I want to lay the foundation.

MR. RUBIN: Exactly. One thing at a time.

Q. (By Mr. Goldberg.) All right. Did you read Dr. Bullock's deposition in prepar- -- in reaching your opinions?

A. Yes.

Q. Okay. Now, let me -- would you pull out from the stack Exhibit 12?

A. I have it.

Q. Is that the report of Dr. Bullock that you reviewed in preparation for -- in your investigation and preparation for your opinions?

A. Yes.

MR. GOLDBERG: I'm going to move Exhibit 12. I believe Mr. Rubin has said he objects on hearsay grounds. We're prepared to argue.

MR. RUBIN: I object on several grounds, and I think I need to voir dire this witness. If Dr. Darney is saying that he rendered his opinion in this case based upon what Dr. Bullock said, I'd like to question him on that, because I don't think that's true. I think he certainly reviewed it, but if Dr. Darney is testifying that he was able to determine whether the standard of care was met in this case based on what Dr. Bullock said, that's not -- I don't think that's the case at all. In other words, if Dr. Bullock never submitted his report, how would his case be any different? He needs to establish -- I mean, experts can rely on other outside material as a basis for their opinion. Mr. Goldberg here is -- I think it's almost by slight of hand, he's trying to just get it under that umbrella, but that's -- for him to say that he's looked at it is one

thing. For him to say that's part of what he used to rely upon for his opinion is something totally different, and so that is why it is not appropriate. There's no foundation.

Second, the way the ULA works is I sent a request for exhibits. I never got a response to that. That was months ago. You have that in the record, Mr. Hearing Officer. Last couple of days I've gotten a few -- a few exhibits except for -- with some exceptions. I have never -- they've never asked me for my exhibits. I've never -- I'm not presenting this as my exhibit. This is a report I provided to them as a courtesy it turns out.

Now, that does not elevate it to anything more than that, and as you know, a report of an expert in district court is hearsay, because it's not -- and Professor can correct -- former Professor can correct me if I'm wrong, but what Dr. Bullock says there, it's not a sworn statement. He may contradict what's in his deposition. They have the deposition for that, but his report isn't a prior sworn statement and consistent with anything. So there's no foundation that he's relied upon it, I think, and there's nothing -- there's no rule that would allow it.

MR. GOLDBERG: I'm not --

MR. RUBIN: And it's not my exhibit. Thank you.

MR. GOLDBERG: All right. I'm not offering it on the basis that he relied on it. He can testify about it --

about it -- he can testify about it, because he relied on it, but I'm offering it actually -- I'm offering it for its -- for itself. All right. Okay. That's number one.

Number two, I'm going to let Ms. Schmidt Nowara discussed the -- the issues with respect to the request for exhibits and the exchange of exhibits and whatever, because I don't think that what Mr. Rubin said was accurate, but Dr. Darney testified in his -- in his engagement in this case was, one, to opine about the standard of care that was done and to respond to Dr. Bullock's opinions. Well, as I've said to you, Dr. Bullock's opinions have been a moving target. They have been a moving target and -- but his opinions at one point --

MR. RUBIN: We don't have an opinion yet in the record of Dr. Bullock.

MR. THOMPSON: Well, we have an opinion. It's whether or not we have an evidentiary piece of paper, which is his expert report. We have an opinion that's been disclosed. The question is do we have Exhibit 12 as an exhibit.

MR. GOLDBERG: That's correct, and Dr. Darney's out -- he's out of turn, and so he's not going to be around to respond to whatever new opinions Dr. Bullock may provide here, but the big issue in this case is whether this obstetric standard of care that Dr. Bullock is promoting or

an abortion standard of care is going to be applicable. I want to deal with this, and in order to deal with this productively, we need to get -- we need to get some information in the record through Dr. Bullock's report on what he is providing here. So let's turn -- let's turn to the basis of the objection, which is, is it hearsay.

MR. THOMPSON: Hearsay.

MR. GOLDBERG: It is not hearsay. It is incorrect to say that all expert reports are hearsay. All right. First of all, the -- an expert report of your own expert is hearsay, because it is an out-of-court statement that is -- would be offered for the truth of that statement, but the expert report of the opposing party's expert is not hearsay. It is not hearsay, because first of all, the basic definition of hearsay --

MR. RUBIN: We'll have to take a look.

MR. GOLDBERG: Sure. The basic definition of hearsay says that --

MR. RUBIN: May I look over --

MR. GOLDBERG: Sure. You may. 11-801, definitions, defines hearsay, and then it says statements which are not hearsay. All right. That is -801(D)(2), "Admission by a party opponent," D -- let me finish -- "Statement by the party's agent or servant concerning a matter within the scope of the agency." Case after case

after case recognizes that a disclosed -- a disclosed expert falls within that category. This is a statement, because the statement becomes the admission of the party. All right. So, one, it's not hearsay under -801(D). It's also not hearsay, because it does not -- because it does not -- for the purposes that we are using it for, it does not fall within the definition of hearsay.

The definition of hearsay is a statement other than one made by declarant while testifying at trial offered in evidence to prove the truth of the matter asserted. Well, we are not seeking to offer Exhibit 12, Dr. Bullock's statement, for the truth of his opinions. We contest his opinions. We are offering this as a typical -- the fact that he made the statement. We want to get in the record the fact that he has said that the standard of care is what he says the standard of care is and why. We are not offering it for the truth, and again, the cases support that.

MR. THOMPSON: But you're offering it that it is his opinion.

MR. GOLDBERG: No, no, actually we're -- I don't -- I don't know what his opinion is.

MR. RUBIN: Is it to his credibility?

MR. GOLDBERG: No, no. It's to -- it's to lay the foundation for Dr. Darney's opinions. Okay. That's number

one. I'm not quite done yet with my -- with my -- I have three bases --

MR. THOMPSON: All right.

MR. GOLDBERG: -- as to why it's not hearsay. One, it's an admission of a party opponent under -801(D)(2)(d) -- I mean -801(D)(2)(d). Two, it's not hearsay under the definition, and three, it's not hearsay because we're also offering it as for the fact it is the basis for the Board's charge here, and we're offering it for the fact of the basis for the Board's charge here.

Finally, of course, all of this can be beside the point, because the rules that govern this hearing explicitly authorize the Hearing Officer to admit hearsay evidence when that evidence is the type of evidence -- let me get the language of the statute.

MR. RUBIN: The type of evidence that people rely upon in the conduct of serious affairs.

MR. GOLDBERG: That's right. People rely on in the conduct of serious affairs. Now, certainly Mr. Rubin and the Board are precluded to say that they -- that they -- that what is in their own expert's report is not something that they are relying on in the conduct of their serious affairs. So for all of those reasons, one, it's not hearsay. Two, the Board -- for the three reasons that I've given, and two, because the Hearing Officer not only is

allowed to, but as I read the New Mexico cases, should admit hearsay if it is the type of information that people rely on in the conduct of their serious affairs, and the Board cannot say that they are not relying on Dr. Bullock's report in the conduct of this serious affair.

MR. RUBIN: Mr. Thompson, I think I actually just said that. We are not relying upon Dr. Bullock's report in the conduct of this affair.

MR. GOLDBERG: He did.

MR. RUBIN: If he is going to rely upon it, I think this goes to the point before about the charging document. Once we have an NCA, I think we proceed. That's when this case begins. It's a Board complaint. Now, Mr. Thompson, if you feel like I will -- Mr. Goldberg is correct in that you have discretion. We do not strictly apply these rules here, but I think Mr. Goldberg is incorrect in reading that hearsay rule. If there is some case that says that somehow this man, Dr. Bullock, is the party opponent, I'd like to see it. He seems very well prepared. Yet, I didn't see any citation to the actual case that says that, and if I'm wrong -- if there's a case that says that, I will withdraw my objection, but he's not a party opponent.

MR. GOLDBERG: I said he's an agent. The language of the statute, the rule is an agent of a party opponent. Clearly the Medical Board is the party opponent here, and it

doesn't take -- it doesn't take a lot of court decisions to say that a disclosed expert is not an agent of the party opponent.

MR. RUBIN: So are there court decisions or not?

MR. THOMPSON: Here's what I'm going to do, I'm going to -- I'm going to permit the questioning regarding Exhibit 12. Let me --

MR. RUBIN: Sure.

MR. THOMPSON: -- rule on the admissibility of that exhibit after lunch, so I can -- I can formulate a coherent response for the record. I will say that it appears there's a report by the State's expert that Respondent's expert has relied on for his opinion. So I'll permit questions as to -- as to the report, and I will decide whether to admit Exhibit 12 afterwards.

MR. RUBIN: On that point, just about lunch, what -- what is your pleasure, Mr. Hearing Officer? It is past 12:00.

MR. THOMPSON: Mr. Goldberg, I don't know when the flight is, and I don't know --

MR. GOLDBERG: Yeah, ultimately, we have to get Dr. Darney out of here by, 2:00, 2:15 or so, 2:30. I am --

MR. RUBIN: It's not fair.

MR. THOMPSON: Tell me how you want --

MR. GOLDBERG: Yeah, I am slightly more than

halfway done with my direct.

MR. RUBIN: Well, so if I understand what Mr. Goldberg is saying, we have to have today's -- he spent about a half hour on his qualifications, which I would have stipulated to, and this man has to leave at 2:00 o'clock, and we haven't had lunch yet. Maybe I'm getting angry because I haven't eaten lunch yet, but I get like what, 40 minutes without eating to cross-examine this man, and he's their most important witness? That is not fair, and if that -- and this is not a criminal proceeding. If Mr. Goldberg was incompetent in scheduling this -- Mr. Darney, that's nothing we can use for Dr. Sella. This is not fair at all.

MR. GOLDBERG: Well, we were --

MR. RUBIN: Either he can take another flight or we can continue this.

MR. GOLDBERG: We actually were prepared to put on Dr. Darney first. Mr. Rubin wanted to put on Dr. Sella first, and it's his case. I couldn't argue, but we -- we've told Mr. Rubin for a number of weeks that Dr. Darney had to get out of town this afternoon.

MR. RUBIN: I was told 4:00 o'clock.

MR. GOLDBERG: That's his plane. His plane is at 4:00 o'clock. He's going to have to leave here around 2:30. That's what I said, between 2:00 and 2:30. His plane's at 4:00 o'clock.

MR. THOMPSON: Let's do this. So how much more -- halfway done. How much more on direct do we have?

MR. GOLDBERG: Probably another 15, 20 minutes.

MR. THOMPSON: Okay. So that takes us to 12:30.

MR. RUBIN: Okay.

MR. THOMPSON: We can have lunch until 1:15.

MR. RUBIN: 1:15.

MR. THOMPSON: That gives you an hour and 15 minutes of cross.

MR. RUBIN: Okay. So at 12:30 we stop?

MR. THOMPSON: Mr. Goldberg?

MR. GOLDBERG: I'll try. I'll try. I mean --

MR. RUBIN: Please do try for me. Thank you.

MR. THOMPSON: Let's do -- let's do 20 more minutes of direct and decide at that point whether we have to cut lunch. I do want to give -- we're going to have enough for lunch, but I do want to give enough time for cross, so --

MR. GOLDBERG: I'm not seeking to -- I'm not seeking to constrain Mr. Rubin's cross-examination.

MR. THOMPSON: Okay. I understand that. I'm just trying to build it in in the period. So it's 12:15. Let's proceed to 20 to 1:00.

MR. GOLDBERG: All right.

MR. THOMPSON: Okay. We were on -- discussing

Sella Exhibit 12.
Q. (By Mr. Goldberg.) Do you have Exhibit 12 in front of you?
A. Yes.
Q. What is your understanding, Dr. Darney, as to the standard of care that Dr. Bullock asserts should be applied in this case?
A. Well, based on his statement, deposition and this information and briefly stated, his opinion is that this care should have been provided in a hospital.
Q. Would you turn to the third page of Dr. Bullock's report, Exhibit 12, Bate stamped -121.
A. And you're not -- you're not asking for other opinions about this report?
Q. No. No. Just right now, I'm just talking about the -- and would you read into the record the first full sentence on page -121.
MR. RUBIN: Let me state -- hold on. Let me just make my objection for the record. He's reading things into the record that hasn't been admitted.
MR. THOMPSON: Standing. If I, in fact, deny admission of 12, I'll strike the reading of the paragraph, but let's go ahead and do that.
MR. RUBIN: Thank you.
A. "Freestanding clinic is an unacceptable location

for a labor in a patient with a prior cesarean section much less an induction with no uterine monitoring and excessive dose of uterine stimulants."
Q. And from your review of Dr. Bullock's deposition, what was your understanding as the basis for Dr. Bullock's opinion that the standard of care was that a third trimester abortion on a woman with a prior C-section had to occur in a hospital?
A. Risk of uterine rupture.
Q. And what literature did Dr. Bullock rely on?
A. I believe he relied on the ACOG Practice Bulletins.
Q. Was it 115?
A. 115 and an earlier one.
Q. Would you look at Exhibit 10?
A. I've got it. That's 115.
Q. Now, do you have an opinion as to whether an -- does 115 set out an obstetric standard of care?
A. Yes.
Q. What is it?
A. The tenets of this is to accomplish a live delivery.
Q. You have an opinion about whether an obstetric standard of care is an appropriate standard of care to apply to third trimester abortions generally?

A. No, it's not.
Q. To third trimester abortions performed on woman who has had a prior C-section?
A. No, it's not.
Q. To ML in particular?
A. No.
Q. Are there differences -- strike that. In your review of Dr. Bullock's deposition, did you understand that Dr. Bullock saw an equivalence between providing a third trimester abortion to a woman like ML and a delivery of a stillborn baby near term?
A. Yes. He didn't distinguish on the types of care, specialized procedures and so on without regard to this particular case.
Q. Now, I want to ask you, from your experience, you -- you testified that you have special expertise in obstetrics, which is the delivery of live babies, right?
A. Yes.
Q. And you also testified that you have specialized expertise in the delivery of -- termination of pregnancy services, abortions?
A. Yes.
Q. From your experience is there an equivalence between the -- an abortion procedure and the delivery of a live baby?

A. No.
Q. And for purposes of applying a standard of care, can you describe to the Hearing Officer the pertinent differences, why you would expect a different standard of care?
A. Well, clearly the most important difference is the intent to deliver a healthy, live baby. That's the parental expectation. It's exactly the opposite in the case of a termination.
Q. And does that govern -- does that -- does that effect the way then a doctor performs his or her services?
A. Yes, for example, one would certainly not drain the fetal calvarium in order to accomplish the delivery when -- except in extreme circumstances to save the life of the woman, of the laboring woman. You wouldn't do that in the case of obstetrical delivery, while as Dr. Sella described that's -- that's routine in accomplishing a third trimester abortion.
Q. How about specifically with respect to the application of uterine stimulants for the purpose of preparing or softening the uterus, are there pertinent differences between an abortion and a live birth?
A. Very different, because we're talking in this -- in this particular case and all third trimester abortions about a dead fetus. You're not concerned about the effects