of the stimulants over along period of time on fetal heart rate and compromising fetal welfare.

Q. Are there -- are there differences between a live birth and an abortion with respect to the use of uterine stimulants like Pitocin or Misoprostol for the purposes of either inducing or augmenting labor?

A. Yes, and I'll remark that I believe I'm well-qualified to comment on that. My group has published the seminal literature on Misoprostol and uterine contraction, New England Journal of Obstetrics and Gynecology over the years. So it's something that we've paid a lot of attention to.

Q. And can you -- can you describe examples of those differences, why there will be differences in the application of these stimulants in abortion services as opposed to live birth situations?

A. Well, the intent with abortion is to accomplish cervical -- increase cervical compliance and cervical dilation in preparation for -- for a speedy evacuation of the uterus accompanied by evacuation of the cerebral contents. It's not comparable to the situation in which the entire biparietal or occipital frontal diameter has to come through the pelvis. In addition, there's no concern about, as I mentioned, about the effects of the uterine -- uterotonics we call them, in this case Misoprostol and

Oxytocin on placental profusion and fetal well-being. The situations aren't comparable, and there's no sense in which the college meant to apply this Practice Bulletin to the conduct of abortion. This is live births. I will remark, though, that they do permit -- do recognize the need to provide vaginal birth after cesarean delivery outside of a hospital, but they're not talking about abortion.

MR. RUBIN: Let me just have the record reflect he's referring to Practice Bulletin 115.

MR. GOLDBERG: That's right, Exhibit 10. In fact, I'm going to move the admission of Exhibit 10.

MR. RUBIN: No objection.

MR. THOMPSON: All right.

Q. Let's talk specifically about the administration of these uterine stimulants. Let's -- you understand that Dr. Sella applied, administered Misoprostol both vaginally and buccally to ML for the purpose of softening or preparing the cervix with dosage of 100 MCGs, right?

A. Yes.

Q. In your opinion, does that meet the standard -- appropriate standard of care that should be applied in this procedure?

A. Yes, that's exactly what we do in this situation.

Q. By "we" --

A. At San Francisco General.

Q. At San Francisco --

A. The hospital, Women's Options Center.

Q. Including with women with prior C-sections?

A. Yes.

Q. And from your experience, do you -- are you aware that other abortion providers employ -- administer Misoprostol in those dosages for these purposes in third trimester abortions on women with prior C-sections?

A. Yes, they do.

Q. As you -- you've testified that you go around to various hospitals and clinics around the country who provide third trimester abortions, correct?

A. Yes.

Q. And when you are making those reviews, do you review the dosages of Misoprostol that they apply?

A. Yes. I'm not saying that every one of the programs we've created around the country is accomplishing third trimester abortion.

Q. But where they do?

A. It's probably more important at meetings. I speak with Warren Hern, who runs the clinic in Boulder recently, and we talk with one another about what we're doing and also published our protocols. Doesn't mean they're exactly the same in every place, but generally we agree about what the best approach is.

Q. All right. Let's now turn to Dr. Sella's administration of Misoprostol in -- late in the evening of the second day, the 11th of May and early in the morning of the third day for purposes of augmenting the labor that had started at 100 MCGs. Was that appropriate under the standard of care?

A. Yes.

Q. Is that consistent with what you all do at the San Francisco Hospital?

A. Yes.

Q. Including on women with prior C-sections?

A. Yes.

Q. Is that consistent with your understanding of what other abortion providers do around the country in third trimester abortions on women with prior C-sections?

A. Yes.

Q. How about the fact that Dr. Sella applied Pitocin on the early morning -- starting in the early morning of the third day, May 12th, and through the next seven or eight or nine hours.

A. Yes.

Q. First at what she calls a low dose at ten units?

A. Ten units in a liter.

Q. And is that generally considered a low dose among the abortion providers?

A. Yes.
Q. And then she upped that dose to 60 units per liter?
A. Yes.
Q. And are those dose -- first of all, was her administration of Pitocin for these purposes consistent with the standard of care that should be applied by -- in these procedures to a woman like ML?
A. Yes, it was.
Q. And have you -- have you seen that done in the hospitals where you have worked?
A. Yes.
Q. And as you go around the country and observe others and talk to other abortion providers, are you aware that they also apply similar dosages for those purposes?
A. Yes.
Q. Are you aware that the American College of Obstetrics and Gynecology in 115 gives guidance that Misoprostol should not be used with women who have prior C-sections in the TOLAC, that's the trial of labor after cesarean section; or in VBACs, the vaginal births after cesarean section?
A. Yes, I am.
Q. And notwithstanding that they should not be used -- ACOG guides that they should not be used for TOLACs and

VBACs, do you have any doubts that it is appropriate to use them in abortion procedures?
A. No, I do not, and this -- as we've said, this statement is not -- is not directed at abortion procedures.
Q. And is there good reason that they should not be applied in abortion proced- -- strike that. Is there good reason that Misoprostol can be used even with women with prior C-sections in abortion procedures even if they should not be used in TOLACs and VBACs?
A. Yes.
Q. And what are those reasons?
A. The reasons I've mentioned. With regard to the conduct of the procedure, you need to obtain cervical compliance and dilation.
Q. Would you turn to Exhibit 14.
A. I have it.
Q. Okay. I want to get you the right page.
A. ACOG committee opinion?
Q. This is 115, correct?
A. Uh-huh.
Q. Would you turn to the page 6. That bears document control number -- oh, you don't have a document control number on this. Page six of the Bulletin, do you have that in front of you?
A. You mentioned Exhibit 14, and actually --

Q. I said 10. I mean -- I actually mean Exhibit 10.
MR. RUBIN: Exhibit 10 is which?
MR. GOLDBERG: 115.
MR. RUBIN: What page is that?
MR. GOLDBERG: Exhibit 6 -- page 6.
MR. RUBIN: Page 6 of Exhibit 10.
Q. (By Mr. Goldberg.) Do you have that in front of you?
A. Yes.
Q. Would you read into the record the second full sentence starting, "Because."
A. "Because studies have not identified a clear threshold for rupture, an upper limit for Oxytocin doing -- dosing with TOLAC has not been established."
Q. Oxytocin, is that the same as Pitocin?
A. Yes.
Q. Would you turn down to the bottom of that column in the last full paragraph and read into the record the last full sentence starting, "The varying outcomes."
A. "The varying outcomes of available studies in the small, absolute magnitude of the risk reported in those studies support that Oxytocin augmentation may be used in patients undergoing TOLAC."
Q. And do you agree with the observations that are made in 115 as to those points?

A. I do.
Q. And is it your experience that Oxytocin is used with women with prior C-sections in TOLACs and VBACs?
A. Yes.
Q. And is it also your experience that Oxytocin and Pitocin is used as Dr. Sella used it here with third trimester abortion patients with prior C-sections in abortions?
A. Yes.
Q. Was there a time when the American College of Obstetricians and Gynecologists did have a bulletin that said categorically, as Dr. Bullock would have it, that TOLACs and VBACs should only be provided in hospitals?
A. Yes, there was.
Q. Would you look at Sella Exhibit 13.
MR. RUBIN: Mr. Hearing Officer, we are at 12:35.
MR. THOMPSON: Okay.
MR. GOLDBERG: I'm almost --
MR. RUBIN: I think I know what Mr. Goldberg is doing, but I think he needs to be cut off at --
MR. THOMPSON: Well, I'm going to do that. Here's what I'm going to do. We're going to --
MR. GOLDBERG: I'm almost -- I'm actually almost done with direct.
MR. THOMPSON: But I've come to a new conclusion.

MR. GOLDBERG: Okay.
MR. THOMPSON: I am not going to rush expert testimony. We're going to get through direct, we're going to have a reasonable lunch, reasonable, shorter. If Mr. Rubin does not complete with him, we're going to continue, and we'll do it by phone.
MR. GOLDBERG: That's fine.
MR. RUBIN: That's fine.
MR. THOMPSON: That's what we're going to do, because this is too important. We're not going to push anybody's expert. So let's finish direct. We'll have a human lunch.
MR. RUBIN: Okay.
MR. THOMPSON: You will make your plane.
And, Mr. Rubin, if you are not done with your questions at the end, we're going to continue the hearing, and we'll make them present him by phone, and we'll complete cross-examination, okay.
MR. GOLDBERG: If -- if the Hearing Officer will give me five minutes, I may be able to finish direct --
MR. THOMPSON: Okay.
MR. GOLDBERG: -- if I can have five minutes. I can't -- I can't promise.
MR. THOMPSON: Well, that's fine. I want -- I just want -- that's fine. Let's just get done.

Q. (By Mr. Goldberg.) Do you have Exhibit 13 in front of you?
A. I do.
Q. Can you identify Exhibit 13?
A. That's American College of Obstetricians and Gynecologists Practice Bulletin Number 54 dated July 2004.
MR. GOLDBERG: We move the admission of Exhibit 13, Mr. Hearing Officer.
MR. RUBIN: No objection.
MR. THOMPSON: No objection. Was there -- did you move Exhibit 10?
MR. GOLDBERG: I believe I -- I believe I did, Mr. Hearing -- but I will again.
MR. THOMPSON: Okay. Any objection?
MR. RUBIN: No, not to 10.
Q. (By Mr. Goldberg.) Okay. Would you look on the first page of Exhibit 13 at the upper right-hand corner?
A. Yes.
Q. What does it say?
A. "Out of print."
Q. And over to the left, what does it say, the stamp over to the left?
A. "Replaced by number 115 dated August 2010."
Q. So is it your understanding that Exhibit 13, that is the Bulletin of July 2004, was that the bulletin where

ACOG took the position that all VBACs and TOLACs must be in a hospital?
A. Yes.
Q. Was there a reaction within the profession and among the population generally to that?
A. Yes, and the hospitals, which then refused to allow physicians to accomplish vaginal deliveries after cesareans, and the section rate rose in some of those hospitals to 40, even higher than 40 percent. In the United States overall, it rose to 30 percent.
Q. By "section rate", you mean the rate of live births that are done by cesarean section?
A. Yes.
Q. So in this country after Exhibit 13, the ACOG Bulletin, the cesarean rate skyrocketed?
A. Yes.
Q. And what happened?
A. Well, several things happened. In California, for example, we've studied maternal mortality rates, and they are actually rising as a result of the cesarean rate rising.
Q. So there's risks to not having TOLACs?
A. Yes.
Q. Even with people with --
A. That's to say nothing about the opinion of women who felt that they were being denied the chance to have a

vaginal delivery.
Q. Did the National Institutes of Health convene a convocation on that issue?
A. Yes, because of the rising cesarean rate, the Consensus Conference --
Q. Would you turn to Exhibit 11?
A. I didn't participate in that conference, but I was aware of it and aware of its results.
Q. Would you turn to Exhibit 11? Can you identify that document?
A. This is the NIH Consensus Development Conference Statement on Vaginal Births After Cesarean, New Insights.
Q. Is that -- is that the report from the conference that you just mentioned?
A. Yeah, dated March 2010.
MR. GOLDBERG: And we move Exhibit 11, Mr. Hearing Officer.
MR. THOMPSON: Any objection?
MR. RUBIN: No objection.
MR. THOMPSON: Eleven is admitted.
Q. (By Mr. Goldberg.) And was Exhibit 10 already admitted; that is, ACOG Bulletin 115 on which Dr. Bullock relies, was that a response then to Exhibit 11?
A. Yes, only a few months later the College issued a new committee opinion that replaced the old one of 2004.

Q. And is it your understanding that the purpose of 115 was to remove that categorical prohibition?

A. Yes, among other things.

Q. Among other -- and is it your understanding from your experience that that is -- that is the generally accepted understanding of 115 within the discipline?

A. Yes.

MR. GOLDBERG: Thanks. I have no further questions, Mr. Hearing Officer.

MR. THOMPSON: Okay. It's 12:20 -- 12:40, I'm sorry.

MR. RUBIN: Mr. Hearing Officer, I think, given the time constraints -- and by the way, I apologize if I was getting too vituperative there. I think it's a function of us going later than normal. If we're going to take an hour -- have a human lunch, which means an hour to us State employees, I think, why don't we just -- we could start with Dr. Darney or we could just simply do his cross-examination and redirect by telephone.

MR. THOMPSON: It's up to you. Do you want to take a half hour lunch and start it and get as far as we can get?

MR. RUBIN: I'd rather just start it by phone, because I think -- I don't want Dr. Darney to be running to his gate either.

MR. GOLDBERG: Here's -- here's my suggestion: Why don't -- I would actually prefer that we get as much of Dr. Darney in live as we can, and so Dr. Darney is expecting to stay here -- is expecting to stay here until 2:00, 2:30 or so. We can get a good 45 minutes or an hour in over that period of time. That would be my suggestion.

THE WITNESS: I'd prefer that, too, since I haven't set aside time for telephone -- additional telephone discussion.

MR. GOLDBERG: We'll make -- we're going to make Dr. Darney available. I'm not interpreting what he's saying as not --

MR. THOMPSON: Yeah. Okay. So let's take lunch until quarter after. We'll do a 45-minute cross. What time -- what's your drop dead time for --

MR. GOLDBERG: I figured -- I told Dr. Darney 2:30 is probably -- 2:30, 2:40 is what I would call a drop dead time to get him to the airport for a 4:00 o'clock plane.

MR. THOMPSON: Let's reconvene then at quarter after 1:00, and we'll start cross, and we'll -- again, if we've not completed cross by the time he needs to catch his plane, we will continue the hearing and allow the State to continue its cross, okay?

MR. RUBIN: Okay.

MR. THOMPSON: We're off the record.

(Note: Hearing in recess at 12:42 p.m. and reconvened at 1:25 p.m.)

MR. THOMPSON: We're back on the record. We're on cross-examination of Dr. Darney at 1:25 p.m. Go ahead, Mr. Rubin.

MR. RUBIN: Thank you.

CROSS-EXAMINATION

BY MR. RUBIN

Q. Good afternoon, Dr. Darney.

A. Good afternoon.

Q. So you've given a fair amount of testimony as to your background and history with abortions. How long have you been providing abortions?

A. Since 1973.

Q. Do you recall when Roe vs. Wade was decided?

A. Yes, right after Roe -- right after Roe, my chief and mentor, Ken Ryan, established an abortion clinic, and I worked there as a resident.

Q. Okay. So how many -- I believe you said you've done a few third trimester abortions, or how would you -- what was your testimony on that?

A. A few, yes. A dozen, perhaps.

Q. Oh, okay. A dozen. Of those dozen or so third trimester abortions, have any of them involved women presenting with a prior C-section?

A. I don't recall specifically the cases I was involved in, but after we talked, I asked the chief of our Women's Options Center that I founded, and subsequently she -- I appointed her as director of it, how many third trimester procedures we're doing now, and I mentioned that she said about 30, 30 last year in the past year, so -- and some of those would have had previous cesarean. Now, whether I was involved with one that did have a previous cesarean, I don't recall specifically.

Q. Okay. You're saying "we". That means the facility that you're associated with?

A. Our practice group.

Q. But not necessarily you personally?

A. Not necessarily me personally.

Q. And of those dozen or so third trimester abortions, what's the latest in terms of the term of the pregnancy? What's the latest one you've done?

A. That I personally have been involved in?

Q. Yes.

A. Because I asked Eleanor specifically the latest we as a group had done, which was --

Q. Dr. Darney, Eleanor, whoever Eleanor is, I need your testimony. I'm asking about your personal --

A. I would have to guess. I'll say 33 weeks.

Q. Okay. You don't recall exactly when the latest

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one was?
A. The date on which I did it? No, I don't.
Q. No, no.
A. I don't recall when it was.
Q. And you say you're guessing about 33 weeks was the latest term abortion you've performed that you recall and this specific abortion when you're saying 33 weeks, or are you still guessing?
A. No, I'm just estimating from the patients who were sent to us, and I don't know precisely.
Q. Okay. When was the last time you did a third trimester abortion?
A. Would have been several months ago.
Q. Okay. Do you remember the term on that one?
A. No.
Q. Okay. Do you remember if it was more than 30 weeks?
A. I believe it was.
Q. Okay. Is that the one that's refreshing your memory as to 33 weeks?
A. Maybe.
Q. Maybe. Okay. Of these dozen or so third trimester abortions that you've -- that you've personally been involved in, how many of those occurred at a standalone clinic like the one that is at issue in this case?

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A. Well, none of those, because they're all -- they were all done in our hospital-based clinic.
Q. Okay. And of those 12 or so in the hospital-based clinic, correct me if I'm wrong, but is it fair to come up with a dichotomy between the, let's say emergency, the ones that are elective versus the ones that are more necessary and -- am I phrasing that right or --
A. You mean whether the indications were --
Q. Fetal versus --
A. -- maternal or fetal?
Q. Right.
A. The great majority would have been fetal.
Q. Okay. So by fetal, it was essentially an elective procedure, correct?
A. Well, elective in whose perception? Certainly not in the parents' perception.
Q. Well, if a woman seeks an abortion because of fetal indicators, you're saying that there is -- the health of the mother is not at risk, correct, if she has -- if she carries the baby to term and delivers it, right?
A. Well, it may or may not be a term. Depends on the circumstances.
Q. Okay. Well, going back to these 12 or so, you said that some of them, more than half, let's say, were fetal indicators?

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A. Well, more than half, but if we're going to use that dichotomy -- I mentioned earlier that sometimes both exist. If we're going to use that dichotomy that you suggested, then the great majority would have been fetal -- fetal indications, just as this case of ML was. Typical is a sonogram or a genetic study. That's why the number of these procedures is increasing, genetic determinations. Sonography is increasingly sophisticated. So there are more and more diagnosis of deformities like the patient ML had.
Q. Right, macrocephaly, that kind of --
A. Yes.
Q. Okay. Do you consider -- well, going back to the, I guess, in the universe of operations that physicians perform, there's the -- I guess the most elective I could think would be let's say a collagen injection by an actress, and maybe the most necessary one, an emergency tracheotomy in a restaurant. Okay, this procedure, would you -- would you characterize this as more elective or more like the tracheotomy?
A. Well, I think you'd have to look at each individual patient.
Q. Well, looking at this individual patient.
A. ML?
MR. GOLDBERG: By "this", you mean ML?
MR. RUBIN: Yes.

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Q. Was this a case of elective surgery, Dr. Darney?
A. Do you mean could she have continued? I don't think I can make a judgment, because I didn't talk to her about the effects the birth of this severely effected fetus would have had on her mental health, on the health of the child she already had. So without really knowing the patient, I don't think I can slide -- slide a cursor along the scale you're suggesting.
Q. Well, let's go and talk a little bit about TOLACs now. I'm sure we all understand what it stands for right, trial after -- well, what's TOLAC stand for?
A. Trial of labor after cesarean.
Q. Sorry. Sometimes I still miss that. What's your experience with TOLACs? How many have you done?
A. Again, I don't know precisely, but I would estimate hundreds.
Q. Hundreds. Okay. And you've been practicing since 1973, right? I'm sorry you've been doing abortions --
A. Yes.
Q. How long have you been a practicing physician?
A. Well, I was an intern in 1969.
Q. And since 1969 you've done hundreds of TOLACs?
A. Yes, since 1973.
Q. Okay.
A. When I started my OB residency, I didn't do

deliveries as a surgical intern.

Q. Let's just go -- there was some testimony about I believe a report that you read by Dr. Bullock. Do you know what I'm referring to?

A. Exhibit 12?

Q. I believe that's correct. And you've given -- you've given your opinion in this case as to whether the standard of care has been met by Dr. Sella, right?

A. Yes.

Q. What did you base -- what did you base that opinion on that she met the standard of care?

A. I base that on my review of the medical record, on my knowledge of practice around the country with regard to third trimester terminations and my reading of the literature.

Q. And by the literature, you mean at ACOG and NIH literature?

A. No, I mean all that I've read over the course of my career, what I've written myself and what I've reviewed in writing, what I've written in papers that I've reviewed as a peer reviewer.

Q. Okay. Did you base your opinion on anything Dr. Bullock told you in that report?

A. Well, I read his report and deposition, and then I checked the facts. I checked the medical record against

this report and against Dr. Bullock's reports, and in that way, reading Dr. Bullock's report helped me focus on the medical record. So in that sense it was useful.

Q. Okay. Did you base -- your opinion's based on certain facts as you understand them, correct?

A. It was based on what I see in the medical record.

Q. Certain facts --

A. And the tests reviewed.

Q. Certain facts relate to the -- to the mother, the fetus, the clinic, right?

A. Yes.

Q. Are there any facts that are in Dr. Bullock's report that you relied upon that you -- independently of that?

A. Well, as you might expect, I read his report after I'd read the medical record, and reading his report caused me to go back and look at the medical record more carefully. So I think in that way his report enhanced my understanding of medical record, which I have now read several times.

Q. Okay. So going back to my earlier question, which I don't think you've answered yet, you based -- assume that you're basing your opinion on certain facts as you understand them, right?

A. Yes.

Q. What are you basing -- do those facts include the

facts in Dr. Bullock's report or are they -- as well as the facts in the medical records or --

A. Well, I assume in the -- what I'll have to say were misapprehensions and errors of fact in Dr. Bullock's report regarding, for example, sequence of medications and the dose of medications and so on caused me to look more carefully at this report. I thought you were asking me how did I use Dr. Bullock's reports.

Q. That's part of what I was asking you.

A. Uh-huh.

Q. Okay. If you hadn't -- if you hadn't seen Dr. Bullock's report, would you have a different opinion today in any respects?

A. No.

MR. RUBIN: Okay. Let's -- I don't know when there will be a ruling on that exhibit, so -- but I just wanted to ask those questions, Mr. Hearing Officer, to help -- because I think it would be helpful for the Hearing Officer.

Q. Okay. Let's talk about TOLACs as they relate to third trimester abortions. How would you characterize the risks in the third trimester abortion? Would you characterize them, as surgical or obstetric?

MR. GOLDBERG: Object to the form of the question.

Q. Okay. How would you -- I'll take away the second

part of the question.

I think you're right with your objection.

How would you characterize the risks in a third trimester abortion?

A. Do you mean what would I tell a patient the risks are or --

Q. Well, it doesn't necessarily have to be -- I don't have to put you with a patient necessarily. How would you describe them?

A. Do you mean --

Q. Give me an adjective?

A. You mean as moderate, negligible, severe? I don't understand what --

Q. Not in terms -- not in terms of intensity, but would you describe them as obstetric in nature?

A. The risks of a third trimester abortion not in someone who's had a previous cesarean, or in someone who has had a previous cesarean? I'll need more specifics to describe the risks, because the risks as well as the indications, as we've already discussed, are very specific to the individual case.

Q. Okay. So you feel like you can't generalize about risks?

A. Oh, I could make some gross generalizations.

Q. Did you make any during your testimony prior --

previously today?
A. No.
Q. Okay. And you talked generally about -- if I remember your testimony correctly, you were talking about ACOG Practice Bulletin 115. You were generalizing about why these TOLACs do not relate to third trimester abortions, right?
A. Yes.
Q. So that's a generalization?
A. So you want me to restate the -- outline the differences?
Q. Well, let's go through my questioning instead. So we have -- what I think you had said before was that with regard to third trimester abortions with a C-section, the risks are, in fact, obstetrical in nature, right?
A. No. The third trimester abortion is not an obstetrical procedure. You'll recall that I made a clear distinction between the guidelines from the College, which are directed at obstetrical care and the standard of practice for third trimester abortion, and I stated how those ways the risks are very different.
Q. I was asking more specific questions, Dr. Darney. Not all third trimester abortions -- third trimester abortion where there is a prior C-section history, are those more like a TOLAC situation?

A. Well, because there's -- they're more like a TOLAC situation in the sense that in both cases there's been a previous cesarean, of course.
Q. Okay. And with regard to the certain risks such as -- well, not such as, specifically uterine rupture, aren't the risks fairly similar?
A. No.
Q. Okay. Well, let's go through what exactly a TOLAC is, and then we'll talk about abortions. A TOLAC, as I see it, you have a -- it refers to where you have a term pregnancy, which would be about 38 weeks?
A. Yes.
Q. Okay. And the physician is trying to have the baby delivered through the vagina, correct?
A. Yes.
Q. Okay. And that may or may not involve the use of stimulants such as Pitocin, correct?
A. Correct.
Q. Okay. Could it -- and it may or may not involve in your opinion the use of Misoprostol, correct?
A. Yes.
Q. Okay. And so this case, we have a fetus, which was 35 weeks in terms of its gestational age, right?
A. Yes, approximately.
Q. And we have the same C-section history as you

would have with a TOLAC generally, right?
A. Yes.
Q. Okay. And we're trying to get the fetus out through the vagina as with a TOLAC, correct?
A. Yes.
Q. And in this case, we also have the use of prostaglandins and Pitocin, right?
A. Yes.
Q. And so all things equal, if you have the same woman -- in other words, if this particular patient had presented to Dr. Sella and said, "Can you deliver this baby for me, can you do a TOLAC for me," there would still be -- wouldn't we have similar risks of uterine rupture?
A. No.
Q. Okay. Does the status of the fetus influence whether the -- whether the uterus would rupture?
A. Yes.
Q. So if the baby is dead, and I don't know how -- I don't mean to talk crudely. I'm just trying -- and forgive me if I am. I'm not trying. If the baby or fetus is dead and you're still trying to induce it through labor, through the vagina, through stimulants, you're saying that there's a different risk of uterine rupture than if the baby's still alive?
A. Yes.

Q. Why?
A. Because as we discussed when we reviewed these materials earlier and make -- when we're making the point that -- that College guidelines are directed at obstetrical care, not at abortion care, we mentioned that we'd take a much different approach to achieving cervical compliance and cervical dilation prior to the induction, and we went through that with regard to the medical record of ML; that is, Laminaria were inserted, that Misoprostol was used in anticipation that it would be used over a period of three days. You would never do that in an obstetrical procedure. You'd be concerned about the welfare of the fetus, and then we went on to describe -- well, I'll stop there. There are important differences, and we mentioned those.
Q. Well, okay.
A. And those differences would -- this is answering your question --
Q. Finally.
A. -- finally, excuse me. Those differences would I believe change the risk of uterine rupture, and it would be considerably lower in the situation of a pregnancy termination than in the situation of delivering a baby for all the reasons that we mentioned already.
Q. So the fact that Laminaria were used, is that one of the ways that there's a different risk of uterine

rupture?
A. The fact that the cervix is treated for days prior to the induction, the fact that the fetal head can be collapsed --
Q. Well, hold on. Was the fetal head collapsed in this case before there was uterine rupture?
A. No.
Q. Okay. So continue. So we have -- what else is there now?
A. The fact that you can use -- you would use different doses of uterotonics. The two aren't comparable.
Q. Okay. So do you -- let's compare the risk of uterine rupture for a moment. I believe you gave a lot of testimony about third trimester abortions, correct, and what your experience is with them, what the risks are, comparing them to TOLACs. What is a third -- what does a third trimester abortion mean to you in terms of the range of weeks to term, gestation, the gestation of the fetus?
A. It would -- any termination after about 25 weeks.
Q. Okay. Do any of the risks --
A. So, for example, in our clinic, after about 25 weeks, we use an approach quite similar to the one that was discussed with regard to patient ML. Prior to that time, we would use a surgical approach.
Q. Okay. As opposed -- surgical versus obstetrical

approach?
A. No, surgical versus third trimester approach.
Q. Okay.
A. Second trimester versus third trimester.
Q. Okay. So can you -- with regard to the risk of uterine rupture, is the size of the fetus or baby a factor, all things equal?
A. Yes.
Q. The larger the fetus, the more likely the uterine rupture, correct, all other things equal?
A. Yes.
Q. And this case was a 35-week termination, right?
A. Yes.
Q. That's roughly around the time that people would perform a TOLAC as well, right?
A. Well, no, you wouldn't -- certainly wouldn't intentionally deliver a baby at 35 weeks.
Q. Thirty-six weeks?
A. No.
Q. Thirty-eight weeks?
A. Beginning at 38.
Q. Okay. And with regard -- with regard -- let me try to be more specific about the risk factor with regard to the size of the fetus. What's the hardest part of the fetus to deliver?

A. Well, the largest diameter and the earlier in gestation, the relative -- the head is relatively the largest diameter. So the more premature, we'll call it, a fetus is, proportionally the larger the head is in relation to the shoulder, which is the next larger diameter.
Q. So -- and I guess there are some cases where you have some sort of problem with the shoulders coming out, and those can be catastrophic. In other words, when the head is out and the shoulders are still in, that can be catastrophic results, right?
A. Not in the case of a third trimester termination.
Q. Okay. So I think -- could I take your answer to mean that --
A. That would be another example of how third trimester termination --
Q. Dr. Darney, let me -- let me finish my question. So --
MR. GOLDBERG: I'm going to object. I'm going to object to Mr. Rubin interrupting, and I think that he doesn't like where it's going.
MR. RUBIN: No, I think --
MR. THOMPSON: Overruled. I think I've done a few of these, especially with doctors who are so smart they always just need to answer the question he's asked. I know they -- if you don't understand it, just ask him to clarify

rather than form your own answer. I think that's what's going on here, so -- which I've confronted before, so pose your question, please.
Q. (By Mr. Rubin.) So fair to say, fairly speaking, the head is the biggest constraint in terms of how hard the body has to work to deliver the fetus or the child, correct?
A. Yes, that's the largest diameter.
Q. And as I recall in this case, we had a case where the head was unusually large, right?
A. Yes.
Q. I believe -- what was the medical term that was used in the --
A. Macrocephaly.
Q. And referred to a gestation -- it was as -- if that report is correct that Dr. Sella testified to earlier, about 40 weeks. It was as if it had the head of a fetus that would have been gestational at 40 weeks, correct?
A. Yes, as I recall, the PBD was 93.
Q. Right. So fair to say, it was as if you were -- in terms of the stresses, the risk factor for uterine rupture, you were looking at delivering a 40 week old fetus, correct?
A. No.
Q. So the size -- "no" with respect to I'm wrong to think that the 40 week old head is not a risk -- is not a

factor here?
A. Right. You're wrong to think that, because when you effected fetal demise -- in this case Dr. Sella had effected fetal demise days before, softening the fetal head, and she was prepared if it was -- typically what we do in our -- in our practice to collapse the fetal head, so the size of the fetal head would not be a contraindication of proceeding as she did.
Q. Well, again, there was no collapsing of the head in this case, correct?
A. No.
Q. Okay. So that's not really a consideration for this case, is it?
A. Yes, if you're -- we're talking about the practice of third trimester abortion. That's a -- is one of the procedures.
Q. Well, when Dr. Sella agreed to do -- to perform this procedure, you heard her testimony today, she said she -- she read the signed report. She saw that it was -- we're dealing with a fetus with a 40 week old head, for lack of a better term, right?
A. Yes.
Q. So shouldn't she consider that in whether she should perform this procedure?
A. I'm sure she did.

Q. Shouldn't she?
A. Yes.
Q. Because it's important to consider how much -- how difficult the labor would -- the induction would be based upon the size of the head, correct?
A. Yes.
Q. Okay. And, again, a TOLAC, we're dealing with typically -- you said I think a 38 old week head, right?
A. Yes.
Q. And going back to what you said before, it's your testimony that the status of -- putting aside what you can do in each case, but the status of the fetus, itself, is a heartbeat or there's no heartbeat. Does that change the risk factors for uterine rupture just the mere fact if there's a heartbeat, yes or no?
A. Yes.
Q. The mere fact of a heartbeat will make -- will have what effect?
A. Yes, because the fetus is dead, fetal tissue is -- fetal softening occurs very rapidly. In a matter of 24 hours, the tissue begins to soften, and the fetal death makes a tremendous difference both in second and in third trimester abortion procedures.
Q. Well, and I know you're trying to answer my question. The fact that the fetus is alive or dead in and

of itself, if the heart's not beating, does that make it more difficult or less difficult to deliver?
A. Well, it doesn't have anything to do with the heart beating. It has to do with fetal demise.
Q. So what you're saying though is it leads to necrosis, softening of the tissue, correct?
A. Yes.
Q. Is there some literature you can point to that describes how much -- how quickly the size of the head softens -- well, let me ask this question instead. Does the size of the head actually shrink?
A. Yes.
Q. And is there some literature that talks about how quickly that happens?
A. Yes.
Q. Is it before us today?
A. Well, when we talked on the phone, I referred you to what I've written about the use of Degoxin. That would be a good place for to you start.
Q. Well, Degoxin is used to cause the fetal demise, right?
A. Yes.
Q. And I don't recall -- and you're saying that you told me that there's literature that says exactly how quickly the head softens and how -- how it effects the size

of the head in that literature?
A. Well, as I recall, we discussed how fetal demise, in fact, softens the tissue and decreases the maximum diameter and compliance of the fetal head.
Q. By what percentage?
A. We don't know exactly what percent it would decrease.
Q. Okay. One percent?
A. You mean, are there sonographic studies of those changes?
Q. Yes.
A. I'm not aware of any.
Q. And you're -- I'm convinced that you're one of the most preeminent people in your field, and if there was a study, you'd probably be likely to know about it, wouldn't you?
A. There's -- probably would. There's considerable written about the effect of fetal demise on abortion, and I referred you to some of that literature.
Q. So but there's nothing that you can point that says exactly what the effect is after -- I believe one day of -- the Degoxin's administered on 5-10, and on 5-12, by approximately -- by about one o'clock or so, we have the -- we have the rupture, right? So that's about a day and a half, closer to two days of time for the necrosis to take

effect?
A. Yes.
Q. The 10th to 11th, 11th to 12th?
A. Uh-huh. It makes considerable -- makes a considerable difference.
Q. I see, but there's no -- you're not aware of any studies that would actually quantify that, right?
A. No, the studies that examine that, ours and other studies, base that on surgeons' perception of the ease of the procedure.
Q. I see. Okay. And that sounds fairly subjective, doesn't it?
A. Well, you know, it's a likert kind of scale.
Q. Okay. Is it more subjective than, say, holding a fetus in your hand and weighing it and deciding how much it weighs?
A. More subjective, less subjective.
Q. Less subjective, okay.
A. We were talking about randomized trials, and some -- some subjectivity is eliminated through the process of randomization.
Q. Okay. So --
A. That is, physicians who are performing terminations in which Digoxin hadn't been -- hadn't been used would be compared -- those reports would be compared to

physicians using the same scale in which Degoxin had been used. So it's a whole lot different than picking a fetus and --
Q. Would you be willing -- are you willing to say that if we started out -- if she presented with a 40 week old head in regards to the fetus, of course, after two days of necrosis, would be you be able to tell me if it was equal to like a 38 week old head then or a 39 week or how many centimeters or millimeters were lost in that day and a half of necrosis?
A. No, but I would say that head's going to be -- softening of the head will be clinically significant.
Q. Okay. And that's about as far as you can -- you're willing -- you don't want to speculate, and so you don't want to say anything further than that, do you?
A. I don't want to translate it into millimeters, because remember, we -- you referred to two measures, previous questioning of -- of the diameter of the head, the biparietal diameter and the occipitofrontal diameter, OFD. In the head of a live fetus, that gestation, there's not much compliance as those don't -- can't change very much. When the fetus is dead a day or two days, our studies and other observations suggest that there's considerable compliance, so the head would slip through more easily or can very easily be decompressed.

Q. But I thought you said you didn't know any specific studies that quantify this, right?
A. We've just discussed the kind of studies we did to that make quantification, likert scale, randomized trials.
Q. So going back to the risks now for uterine rupture, size of the fetus is a factor. The fact that there's a previous C-section certainly increases the risks of a uterine rupture with either a TOLAC or this type of procedure in this case, right?
A. Repeat the question.
Q. A previous C-section in either your typical TOLAC or the facts of this case increases the risks of uterine rupture, correct?
A. Yes.
Q. Now, with regard to the use of stimulants, do you have in front of you Bulletin 115?
MR. RUBIN: Joseph, if you cannot stack these, it might work better.
MR. GOLDBERG: I wasn't stacking them. I was putting them upright. Do you want me to stack them?
MR. RUBIN: Well, I don't want them upright.
MR. GOLDBERG: I understood what you meant.
A. I have 115. That's Sella Exhibit Number 10.
Q. Okay. And it's also Prosecution Exhibit Number 2. Can you turn to page -- well, before we turn to any

particular page, let me -- was Misoprostol necessary for this procedure in this case?
A. Was it necessary for ML's procedure? Yes. I don't know if it was necessary, but in my view, it was an important clinical adjunct.
Q. Would you have done the same thing?
A. Yes.
Q. You would have used Misoprostol?
A. Yes.
Q. But you can't say whether it was necessary or not?
A. Well, it's hard to make a judgment in clinical treatment whether anything is necessary; I mean, necessary to a successful outcome. It would have been a very important adjunct, I would think, to success.
Q. And you don't want to leave out a very important adjunct to success, do you?
A. No.
Q. Okay. So then let's turn to page six of Practice Bulletin 115. There's two columns, a right and a left column.
A. Yes.
Q. First full paragraph, the last sentence says, "Therefore, Misoprostol should not be used for third trimester cervical ripening or labor induction in patients who have had a cesarean delivery or major uterine surgery."

I'm sure I read that correctly, but did I miss anything there?

A. No, that's what it says.

Q. And if I understand your testimony correctly, this -- this prohibition -- well, is it fair to characterize it as a prohibition?

A. Yes.

Q. Okay. This prohibition applies only to TOLACs, right?

A. You mean, doesn't apply to third trimester abortion?

Q. That's right, any third trimester abortion regardless of the term of the fetus.

A. Right, it was not intended to apply to a third trimester abortion. This is written --

Q. Well, are we getting into the intent or -- okay. So that's your interpretation of this document, right?

A. Yes.

Q. And I think you've already -- you've relied on this ACOG Bulletin, yourself, as part of the basis for your opinion, right?

A. Yes.

Q. It's certainly very authoritative, correct?

A. Yes.

Q. Does ACOG lightly come out with a -- with a strong

statement like this regarding medical treatments, or are they careful about saying something like this?

A. They're careful.

Q. They don't want to give risk to the many of plaintiffs lawyers out there who are looking for something to sue on, right?

MR. GOLDBERG: Object to the form.

MR. RUBIN: I'll withdraw the question.

MR. THOMPSON: No. Well, you withdrew --

MR. RUBIN: I guess I shouldn't have.

MR. THOMPSON: Who knows.

Q. Let's --

A. Well, I --

MR. THOMPSON: He withdrew the question. You don't need to answer.

A. I do know.

Q. Okay.

A. Because I participated in committees and drafted committee opinions for the College, and they take special care to say that they're not setting a standard of care with any of these for the very reason you mentioned.

Q. Okay. And I believe they repeat this prohibition on page 8 at the very bottom, the third bullet. Let me read that into the record, and you can tell me if I've read it incorrectly. "Misoprostol should not be used for third

trimester cervical ripening or labor induction in patients who have had a cesarean deliver or major uterine surgery," correct?

A. That's what it says, yes.

Q. Okay. So let's compare that to the facts of this case for a moment, Dr. Darney. Is this a third trimester cervical ripening? Did this involve a third trimester cervical ripening?

A. This isn't -- yes, but this is not intended to apply to third trimester abortion. It says delivery of a live baby.

Q. So that first phrase, though, we have present in this case, right, third trimester cervical ripening, right?

A. Yes.

Q. Okay. And we have a patient who has had a cesarean delivery previously, correct?

A. Yes.

Q. So they've also said that this Bulletin 115 replaced Bulletin 54 from 2004, correct?

A. Yes.

Q. And you went into a very educated description of why that was. As I understand it, it was motivated by the change in C-section rates for the 2004 opinion, correct?

A. Yes.

Q. Wasn't motivated by changes in uterine rupture

rates, was it? Did it have anything to do with the uterine rupture incidents?

A. Did the change from 2004 to 2010 have anything to do with the rising incidents --

Q. Or lower incidents?

A. -- of uterine rupture? Yes.

Q. Okay. So your answer before when you said it was C-section rates where we had -- we saw a much higher incidence of C-section rates, there was something else at work, also?

A. Yes, the complications that follow rising C-section rates, and I mentioned, for example, rising maternal mortality in California.

Q. You would have decreasing -- well, with a C-section, there's --

A. Because of rising C-section rates.

Q. Well, of course, with a C-section -- with C-sections you don't have the same high incidence of uterine rupture, do you? Is there any incidence of uterine rupture, really?

A. Well, yes, because if you've had a C-section before and you -- this is what this is all about.

Q. No, no, I'm asking you if you do have a C-section? Let me interrupt you.

A. Then you'd subsequently be a risk of uterine

rupture.
MR. THOMPSON: The question was, is there a higher incidence of uterine rupture in C-sections.
MR. RUBIN: Thank you.
MR. THOMPSON: Can you answer that question?
THE WITNESS: You mean if somebody's actually having a C-section?
Q. (By Mr. Rubin.) Yes, not a history, C-sections.
A. Do C-sections reduce the risk of uterine rupture?
Q. Yes.
A. No, they increase the risk of subsequent uterine rupture. So overall, they increase the risk. That's the problem, and they cause even -- even more important problems, abnormalities of placentation and so on. So we wanted to decrease the rate of cesarean delivery to reduce the risk of subsequent placenta accreta, death from hemorrhage and the subsequent, somewhat less important risk of uterine rupture.
Q. Okay. So I believe your testimony also was that you do use Misoprostol in your practice with TOLACs; is that right?
A. Yes, we would sometimes, depending on the situation, use, despite the admonition rather than prohibition here, despite that admonition not to do so, we would occasionally use Misoprostol if we thought it

important to effect delivery.
Q. Okay. Would you ever use Misoprostol in a TOLAC in a case where it was an elective -- strike that.
A. And I mention that we would almost always use it in the case of a third trimester termination.
Q. Regardless of term?
A. Yes.
Q. But, again, you haven't done one in 35 weeks, have you?
A. I'm not aware that I've done one more than 35 weeks.
Q. More than 33 weeks, I believe.
A. I can't -- I can't recall specifically.
Q. You can't. You're not even sure if it's 33, are you?
A. I don't know precisely.
Q. Okay. So let's see if -- I've lost the thread of my own mind here. Let's see. Okay. So with regard to a TOLAC, you said despite this prohibition in the ACOG Bulletin, you would on certain special occasions still use Misoprostol, right?
A. Yes.
Q. What would justify it in your mind?
A. Need for a more rapid -- I'm not thinking of a particular case.

Q. I understand.
A. I know you just asked me to imagine a situation in which that might occur -- might have occurred.
Q. Well, I'm not asking you to imagine anything, Dr. Darney. I'm asking you to rely upon your experience. What justified it in the past for you in your experience?
A. Well, I don't recall a specific case. I simply know that we -- I have used Misoprostol on women who have had previous cesarean delivery in order to effect the rapid vaginally delivery by priming the cervix.
Q. Okay. Was there any need for a rapid vaginal delivery in your view in this case?
A. No, in fact, it -- that's one of the big differences between -- between abortion in the third trimester and delivery as outlined in the Bulletin we're discussing; that is, that you can take a long time to accomplish the abortion, and you can't take that long accomplishing a delivery.
Q. Right. Right.
A. Because it won't be good for the fetus.
Q. And you keep referring to third trimester abortions. Does your opinion differ at all with a 25 week old fetus versus a 35 week old fetus, or is it the same, same analysis for you?
A. In terms of abortion?

Q. Yeah. Same considerations?
A. Well, I said earlier that at about 25 weeks is when we, and I think most practitioners, move from a surgical evacuation of a uterus to a combination of surgical induction evacuation of the uterus.
Q. Okay. Do you remember my question? Okay. Let me ask it again.
A. Are 25 and 35 the same.
Q. Right, and you're saying that they're the same?
A. The approach would generally be about the same, yes.
Q. And with respect to uterine rupture --
A. You picked 25, which is just the margin, so I -- you know, if you said 27, you'd say it's the same.
Q. With regard to uterine rupture, same considerations between a 25 week and a 35?
A. Yes.
Q. Going back to Practice Bulletin Number -- before we go back to that, let me ask one more question about Misoprostol. Would you give a patient Misoprostol, let's say someone who was seeking to effect a TOLAC and send her home for the evening after administering her Misoprostol?
A. Yes.
Q. Would you give her another one to take home with her and have her administer to herself?

A. Yes.
Q. All right. So let's go back to Practice Bulletin Number 115. Can you look at page 8 again for me?
A. Got it.
Q. This section, I believe, correct me if I'm wrong, discusses where a TOLAC should occur; in other words, clinic vis-a-vis a hospital, right?
A. Yes.
Q. Okay. Fair to say the risks of uterine rupture are -- should be -- are much better managed in a hospital than in a clinic, correct?
A. Well, not the risks of uterine rupture but the consequences of uterine rupture.
Q. Okay. So the consequences of uterine rupture, and why is that?
A. If there is bleeding, you have immediate access to a blood bank.
Q. Right.
A. If a laparotomy is required, it may be more available. It depends on the hospital.
Q. Right, but this is about -- okay. Sorry.
A. For example, one of the issues with this statement was that not all hospitals, in fact, a minority of hospitals, a minority in New Mexico can provide immediate blood banking, immediate anesthesia and immediate cesarean

delivery for TOLACs. So requiring that vaginal delivery after cesarean be accomplished in such a hospital would mean that most women wouldn't have access to it, because they'd have to be at the University Hospital or at San Francisco General. One of the motivations was to -- of this was to make VBAC available to more women by restricting. Again, in the case of some clinics, they -- they can have them. I believe -- having visited the clinic, I believe that's true for Southwest Women's Options. They can have better access to an operating room than a hospital can have, because they're right next door as is the Planned Parenthood Clinic in Los Angeles is right next door to L.A. County USC. So similar procedures, and all the patient has to do is go across the street. While if you were at a hospital in a small town, then there's really nobody to open up the operating room. There's no anesthesiologist there all night.
Q. So in this case, I believe there was about a half -- 25 minute to 30 minute difference from when -- a time interval from when this patient -- when Dr. Sella suspected this patient may have uterine rupture to when she was in the hospital, correct?
A. Yes, 24 minutes I think we have calculated. That's fast.
Q. Can that mean life or death with uterine rupture?

A. Probably not.
Q. Okay. So this first sentence here on page 8 says -- and let me know if I'm reading it incorrectly, "Trial of labor after prior cesarean delivery should be undertaken in facilities capable of emergency deliveries." That's what it says, right?
A. Yes.
Q. A clinic is not what they mean by, "A facility capable of emergency deliveries," right?
A. Well, a birth center could be capable of that.
Q. Was this one? Was the one in this case such a facility?
A. Yes, because the patient could be immediately transferred to the hospital.
Q. Okay. And then the first sentence in the next -- in the third paragraph, "Because of the risk" --
A. And, again, we -- the urgency that is conveyed here is not just maternal welfare. The urgency conveyed here is welfare of the baby; that is, uterine rupture is much more likely to kill the baby than it is to kill the mother. So the concern here and that's how this is completely different than third trimester termination, the concern here is for both the welfare of the baby and the welfare of the mother.
Q. Okay. Let me just make sure, I think this third

-- the third paragraph in the first sentence, looking at this as anything different than the first sentence in the first paragraph, "Because of the risks associated with TOLAC and that uterine rupture and other complications may be unpredictable, the College recommends that TOLAC be undertaken in facilities with staff immediately available to provide emergency care." Does it say anything different than the first sentence?
A. Yes.
Q. What is -- how is it different?
A. No, I think -- I agree that you read that sentence correctly.
Q. And does it, again, restate what the first sentence said?
A. I believe it does, yes.
Q. Okay. So let me just make sure I -- I know you listed some distinguishing factors when Mr. Goldberg was examining you, directly examining you between TOLAC and a third trimester abortion. Parental intent you listed, right?
A. Yes.
Q. The effects of the use of stimulants, and what was the other distinguishing -- were there -- was there another distinguishing factor besides that? I want to make sure we're clear.

A. Between protocols for delivery of a baby and protocols for third trimester termination?

Q. Right. Well, with regard -- no, no, with regard to managing the risk of uterine rupture? I believe that is what we were talking about.

A. Yes, another one -- there would be several, and another one would be the possibility of evacuation of the fetal calvarium, the fact that the fetus is always dead and has softened, as we discussed previously, the fact that you can use drugs in a different way, that cervical -- hydrophilic cervical dilators like laminaria are employed.

Q. I thought they can be employed in either case?

A. They could be, but it would be unusual. We have used -- just as we have used Misoprostol to deliver in TOLAC, we have used Laminaria, but that's not typical, while it's almost always done for third trimester termination.

Q. Okay. If I could just have a moment, I'd like to -- we might be able to wrap this up actually and avoid the necessity of telephone if I could just --

MR. THOMPSON: Are you talking about a short break or just a minute to confer with your expert?

MR. RUBIN: Let me have a few minutes; take a short like five-minute break.

MR. THOMPSON: Yeah, and I have one or two questions.

(Note: Hearing in recess at 2:20 p.m. and reconvened at 2:25 p.m.)

MR. THOMPSON: Back on the record of cross-examination.

Q. (By Mr. Rubin.) Dr. Darney, could you quickly turn to Bate stamp page -21.

MR. GOLDBERG: This is in the --

A. Medical record.

Q. The medical records, yes.

MR. GOLDBERG: Okay.

Q. This is the interview notes dated May 10th.

A. Got it.

Q. This is part of what you reviewed, correct?

A. Yes.

Q. Okay. Did this influence your opinion at all as to whether or not the standard of care was met, what was -- what's contained in here, the substance of it?

A. Yes.

Q. In what way?

A. That the physician, Dr. Sella, interviewed the patient and asked critical questions about parental motivation to terminate the pregnancy.

Q. Okay. And so does parental motivation influence whether or not the risks in this case outweigh the benefits, the medical risks outweigh the medical benefits?

A. Yes, and I thought it was reflective -- it was important for me in establishing the standard of care was met and in my opinion, exceeded, because it reflected the kind of care Dr. Sella continued to provide throughout this experience.

Q. And so if it wasn't a finding of -- that this woman would have had substantial irreversible harm to her physical health and mental health, her family health, her safety, well-being, this wasn't part of what you reviewed, there was no finding of this, would your opinion change?

A. About the standard of care being met?

Q. Yes.

A. No, I think this is one component.

Q. Okay. So this isn't -- okay. That doesn't change your opinion. Would it have been unethical for Dr. Sella to refuse to perform this procedure?

A. Well, that's really a --

MR. GOLDBERG: We're presenting him as a medical doctor, not a medical ethicist.

A. But this is -- this is really an interesting question to me, because one of my former residents just wrote a piece in the New England Journal asserting that it was unethical, that --

Q. Well, let's go to what you think.

A. -- that there's an ethical obligation to terminate

a pregnancy for such a patient.

Q. Would you agree with that?

A. That's Dr. Lisa Harris in the New England Journal about a month ago. So it is something I'm really interested in. Ethics are personal, of course, and you can't have -- I can't say for Dr. Sella whether she would have felt as Dr. Harris apparently would have felt that it was unethical to --

Q. I'm asking what you would do.

A. -- refuse. Would I feel it was unethical?

Q. Right.

A. If I had -- she had contacted us, I would have felt it was unethical if I did not refer her, as her own physician thought apparently, it was unethical not to refer her to someplace where she could receive the treatment she needed. So my own personal definition of ethics would require me, if I didn't do this procedure, to refer the patient to someone who would.

Q. And what's your knowledge as to -- I mean, you talked about the availability of late-term, third trimester abortions, right?

A. Yes.

Q. There are only a few places that do them?

A. Right.

Q. If Dr. Sella said no, what would have -- I'm not

asking you to speculate, but what would be the result for that patient?

A. Well, I don't know if -- if Dr. Sella had said no, I don't know if there's --

Q. Was there another option for an abortion?

A. There may have been. She may have been able to go to Boulder, Colorado, perhaps. I don't know.

Q. Okay. If there wasn't another legitimate option, would that influence what she should do in this case in terms of the risks of -- weighing the risks and benefits of the case?

A. You know, you probably have to ask Dr. Sella that, because I would be making an ethical decision for her. I'd be speculating about how she felt about this ethically. I know those of us who provide all kinds of medical care have different definitions of what we consider ethical, especially in regard to abortion, but also, in other choices, you know, a cesarean section for someone who really has to have a cesarean delivery but doesn't want one.

Q. But let me ask this more specifically. I may be -- by phrasing this ethics, I'm getting off track. Does the lack of other options effect whether the standard of care was met in this case?

A. No, the standard of care is more absolute than that.

Q. It's independent of what's out there with other options, correct?

A. (Nods head.)

Q. And the standard of care is independent of the avail- -- overall availability of third trimester abortions generally speaking, right?

A. Well, the standard -- the standard of care is much better defined than the ethics particularly of abortion.

Q. Right. So let me -- so when I asked you about ethics before, I mean, what I was trying to get at was the ethics of adhering to a standard of care.

A. Right. Now, I see what you're trying to get at.

Q. Yes, and that's my fault, not yours.

A. And that, too, is a difficult -- a difficult question. I might speculate that Dr. Sella felt a special obligation to meet the standard of care for a patient -- what I'm trying to say is that her -- her ethical regard for this patient, that her regard -- her consideration of the ethics of this situation is reflected in this interview I think.

Q. Okay.

A. And I don't know, but I bet she felt a special responsibility to care for this patient, because she wouldn't have had many other choices. I know that's how I feel when such patients come to our hospital. Where else

can the patient go?

Q. And I'm not asking you to -- I'm not asking you to opine on --

A. Doesn't mean that I'm going to say, well, you don't have to meet the standard of care here, because she can't go anywhere else, if that's what you're asking?

Q. That is -- what I'm asking is exactly that. Is the standard of care effected by whether she can go anywhere else? In other words, does the risk of uterine rupture change based upon other options? Does the risk -- or the manageability of the risks in a clinic effected by whether there are other options? I'm not asking to you opine on Dr. -- the empathy of Dr. Sella here. I'm asking you to opine the standard of care in the abstract as to whether or not it's effected by these other choices out there based upon whatever political considerations there may be.

A. Well, I've said that without regard to the special situation of this patient, the record shows that the standard of care was met.

MR. RUBIN: Okay. Well, then thank you. I have no further questions.

MR. THOMPSON: Mr. Goldberg?

MR. GOLDBERG: Yeah, actually these last couple of questions, I don't -- just ask you a couple questions.

REDIRECT EXAMINATION

BY MR. GOLDBERG

Q. If the standard of care that Dr. Bullock is asserting here, as you understand it, were, in fact, the standard of care, would third trimester abortions be available to a woman like ML?

A. Probably not.

MR. GOLDBERG: Thank you. No further questions.

EXAMINATION

BY MR. THOMPSON

Q. Two questions, one sort of follows on that point a little more directly, which I think is, is there a circumstance in which a freestanding clinic is an acceptable location or an unacceptable location to conduct one of these procedures? And what does that, if you can -- and maybe you've provided it in your direct, but what are the criteria that either make a freestanding clinic acceptable or unacceptable?

A. Most freestanding -- you know, 90 percent of abortions are done in freestanding clinics around the country. So there are a lot of those clinics. The great majority of them would not be able to provide this kind of care, because they don't have skilled personnel who know how to do it. They don't have adequate -- an adequate facility, you know, where the patient can labor overnight, and probably most importantly, they don't have the kind of

relationship with a hospital where they can effect a rapid transfer as occurred for this patient and occurs in Los Angeles and occurs in Boulder.

Q. Okay.

A. So I'd say the facility, itself, physical facility, personnel, probably the most important thing, and transfer relationship would be three of the factors that make these clinics different than typical freestanding clinics.

Q. Okay. Now, particular with regard to this case and the uterine rupture, I asked the doctor whether it was the change in the position that was the symptom of the uterine rupture. There's some discussion with regard to the mix of -- or the use of the Pitocin and Misoprostol. Do you have -- did you form any opinion about whether or not that combination of those drugs caused or would cause significant contractions that would lead to a uterine rupture? Do you see my question?

A. Yes.

Q. In your review of the record, I'm not clear whether the uterine rupture was caused by the drug or the change in the fetus's station? Were you able to --

A. No, the -- the rupture was caused by uterine contractions. Now, I don't think that you can indict this particular -- a particular dose as a cause of the uterine

rupture, because the same dose would be unlikely to -- uterine ruptures aren't that common, and we use these drugs, Pitocin, frequently without uterine rupture. The change in station, though, was a sign of the uterine rupture, which Dr. Sella detected. It wasn't that the fetus moved into some unusual position.

Q. And caused the --

A. Right, you know, his head down, engaged and about to deliver, and then when the uterus ruptures, the uterus contracts and squeezes what's ever in it out.

Q. Okay. And my last question is on the back and forth with regard to the head size, the head -- is it your testimony, the head size is less of a risk because in a nonviable delivery both the drug softens the tissue, and there is a possibility to -- what's the term with regard to the head, to collapse the head?

A. Yes.

Q. Even though it didn't occur in this case, I know it didn't occur.

A. I think Dr. Sella said that would have been her next step, and that would be typical.

Q. So that -- would that potential for that treatment, the potential for that medical action would lower --

A. Would mitigate the risk of uterine rupture,

because you make the judgment. We've been at this a long time. I don't want to increase the dose, because there's a relationship between dose and uterine rupture.

MR. THOMPSON: Okay. That's all the questions I had. All right. Thank you, sir.

MR. RUBIN: Have a good flight, Dr. Darney.

THE WITNESS: Okay. Thank you.

MR. GOLDBERG: We can excuse the witness?

MR. THOMPSON: We'll take a quick break.

(Note: Hearing in recess at 2:38 p.m. and reconvened at 2:45 p.m.)

MR. THOMPSON: We're back on the record. It's quarter to 3:00, and I'm not quite prepared to rule on Exhibit 12, except I do have one question. Was this exhibit -- was the expert report done prior to the NCA or was the NCA --

MR. RUBIN: Prior to the NCA.

MR. THOMPSON: Okay. And did the Board rely on it to issue the NCA?

MR. RUBIN: The Board -- the Board relied upon the recommendation of the Complaint Committee, which in turn relies upon staff, which looked at the report.

MR. THOMPSON: Okay.

MR. RUBIN: Just give you the facts as they are.

MR. THOMPSON: Okay. Doctor, you ready?

MR. BULLOCK: Yes.

MR. THOMPSON: Court reporter will swear you in.

GERALD LYNN BULLOCK, MD

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

DIRECT EXAMINATION

BY MR. RUBIN

Q. So if we can just have your full name for the record.

A. Gerald Lynn, L-y-n-n, Bullock.

Q. Dr. Bullock, can you describe -- well, how long have you been licensed as a physician?

A. Since '69.

Q. And can you just go into a little background and describe for the Hearing Officer your educational background that lead you to being licensed as a physician?

A. I finished high school in my home town of Dennison, Texas in '61; went to Arlington State College; got a Bachelor of Science in Biology and Chemistry in '65, and then moved to the University of Texas medical branch in Galveston for five years. I did my medical school there; graduated MD in '69 and did a one-year OB/GYN internship after that. Farther, or just to get to the degree?

Q. Well, after you got your degree, what education if there's any that you want to add?

A. Well, I did my residency in OB/GYN in the Air Force at Wilford Hall Air Force Medical Center, San Antonio, Texas.

Q. What were the years that that occurred?

A. That was immediately after the internship, '70 through '74.

Q. Okay. And can you describe your experience as a physician since that time?

A. Well, I spent four years in the Air Force at Offutt Air Force Base in Omaha as Chairman of OB, and I was on the staff of the two medical schools in town; did some teaching while I was there. And then when I got out, I moved to my hometown again and practiced in Dennison for several years; moved into the Dallas area then. It's about 75 miles; practiced there for a while; wanted to try to get back into academic medicine, so I became full-time faculty at University of Texas Medical School in Houston. My job was training the obstetrical and GYN portion of family practice residency program there and worked there two, three years; job kind of got overwhelming hours-wise, so I moved to North Carolina as Interim Director of OB/GYN department, trying to set up a residency program there under the University of North Carolina umbrella. It wasn't working out.

So I came back home. I've been there ever since. That

was about '89, so a little over 20 years I've been back for now. Right now, I'm practicing OB/GYN in partnership with my daughter, who's also an OB/GYN, and we've been there -- she's been at it six years, and I've been there for 25.

Q. Okay. And if you could turn to Prosecution Exhibit Number 3.

A. Okay.

Q. And is this a -- could you identify this exhibit for me?

A. This is my CV or resume.

Q. Okay. And looking through it, is it up to date?

A. I've changed office address since then. We've moved about ten miles south into the Woodlands. I think except for that it's pretty well up to date.

Q. Okay. So what's your -- can you describe your -- the extent of your experience as a physician delivering, just delivering babies first?

A. Well, I've delivered babies in several contexts and levels of responsibility. I've estimated that the total is about 10,000 babies at some level or another, so whether I was faculty or director doing the delivery.

Q. Roughly about 10,000?

A. Uh-huh.

Q. And you're familiar with the term TOLAC, the acronym TOLAC?

A. Yes, I'm familiar.

Q. And what's your role -- can you describe your extensive experience with TOLACs?

A. I've been doing what we call VBAC until a few years ago, since the early '70s and have continued doing that until just recently. I decided I couldn't stay out in the middle of the night all night any more age-wise, but have been a significant proponent of VBAC and TOLAC. I've written one paper and presented at a regional OB/GYN ACOG meeting in '87 on VBAC in private practice. So I have, you know, relatively extensive experience in VBAC. I've done several hundred.

Q. Is that publication listed in your resume?

A. Yes, it is at the bottom of Bates -127. It says, "VBAC private practice experience in Little Rock, Arkansas '87."

Q. Okay. And if I'm understanding your testimony correctly you're saying VBAC was like the precursor in terms of what the nomenclature is to a TOLAC?

A. Yes, I think someone didn't like the terminology, because there was always the term "failed VBAC", and you didn't want to attach failure to it. So they said the VBAC was to birth but the other was the trial of labor, and so they're not completely interchangeable but they, for practical purposes, mean a similar thing.

Q. So now let's turn from birthing to what is your extent of your experience in handling abortions?

A. Well, I've done probably a couple of three a year all through my career. When I was in residency, first year resident at Wilford Hall, our department chairman was trying to push the envelope and do all the abortions from all over the world, Air Force personnel, and so our unit was doing late second trimester and first trimester and even some that were kind of barely into the third trimester range, so I had quite a bit of exposure during that first year. I have taken the approach that if I think medically I should recommend an abortion, then I felt like it was reasonable for me to do it. I haven't done any elective abortions, maybe once in a while, but not to any great extent.

Q. And have you ever done any third trimester abortions?

A. No.

MR. RUBIN: Let me -- I don't know if we stipulated to this, so let me formally tender Dr. Bullock as an expert in obstetrics and gynecology for purposes of rendering an expert opinion.

MR. GOLDBERG: I have no objection.

MR. THOMPSON: Tendered as an exhibit or tendered as an expert?

MR. RUBIN: Okay. So Exhibit 3 was already

admitted into evidence.
MR. GOLDBERG: Correct.
Q. (By Mr. Rubin.) So you were here for the testimony of Dr. Darney, correct?
A. Yes.
Q. Do you agree with him that -- well, let me ask you, what are the -- how would you compare the risks of uterine rupture in TOLACs, the typical TOLAC versus the risk of uterine rupture in a case like this?
A. Well, I can only go on my experience and opinion, because certainly there aren't very many of these 35-week terminations, and so nobody's done any studies. It just -- this may be the first one in the country. I don't know, but it's the first one Dr. Sella has done, and Dr. Darney has never done one like this. I don't know if anybody at the other three places has done a 35 weaker. So there's no research and statistics on that. So that understood, I would say that there are factors in the live birth TOLAC that lead it toward being a safer delivery.
And there are factors in the 35-week abortion that would lead it to be a safer delivery, and those are in the patient in spontaneous labor -- and let's compare 35 to 35, but at 35 weeks, the cervix has been prepared by the normal body's hormones and all that, and quite often tends to be a very rapid labor and then is not subjected generally to

Pitocin or Misoprostol. So there's not any force on accentuating or exaggerating the strength of the uterine contraction, but in the TOLAC -- in the third trimester abortion, just like Dr. Darney said, they're doing things that you would think might decrease the risk of rupture. I think the Laminaria probably does. I can't really agree that the other, the Misoprostol and the Pitocin don't, but then there's -- nobody's done research on these things. We're just guessing.
Q. Okay. What -- you've heard the testimony from Dr. Darney that the size of the fetus influences the risk factors for uterine rupture, correct?
A. That's right.
Q. And you agree with that testimony?
A. Yes, I agree with that.
Q. And what would you -- let's look at ACOG Practice Bulletin 115, which we had as Exhibit 2.
A. Got it.
Q. And you reviewed the facts of this case as much as Dr. Darney has. You reviewed medical records?
A. I think so.
Q. And did you -- what else, other medical records have you reviewed?
A. For the most part, that and these three documents. I read some other things, but I didn't bring them with me to

consider to rely on.
Q. Okay. How is this, Exhibit 2, Practice Bulletin ACOG 115 informative as to what the standard of care should be in this case?
A. In several places this Bulletin makes fairly flat statements that -- the ACOG is a little bit unusual, because they're not -- they don't tend to make flat statements, but the -- they've made statements that are fairly flat that says you should only undertake TOLAC where you've got capability of emergency deliveries and with staff available to provide emergency care. The second thing that they made a flat statement about is simply Misoprostol should not be used for third trimester cervical ripening or labor induction in patients who have had a cesarean delivery or major uterine surgery. Those are -- those are just flat statements on standard of care.
Q. And how does that relate to this case?
A. Because this patient had a previous cesarean section, and she was on the last half of her third trimester.
Q. Okay. And do you agree with Dr. Darney that you could perhaps lump together -- well, let me ask this question instead. If this was a 25 week old fetus, would you still be relying upon this?
A. No, I don't think so. I think there's a continuum

of the risk as the continuum of size goes. There's not really a specific week at which I would say, "Okay. It's okay until then, but it's not okay after that." I probably wouldn't be arguing with 25-week pregnancy or 26, something like that. So I think there's a significant difference.
Q. Okay. I believe you heard the testimony of Dr. Sella regarding what -- what the facts of this -- what actually happened in this case?
A. Yes.
Q. And do you dispute anything that she's -- any of her testimony that --
A. No, it was a difficult medical record to interpret, especially where you've got one set of times here and one set of times here in a different column, and one of my problems was trying to coordinate those columns and especially when you've got erroneously recorded times to have to try to figure out which one was right. So I don't have any dispute. It was just really hard to interpret these records.
Q. Okay. And so the opinion that you're -- do you have an opinion based upon what you've heard today from Dr. Sella as to whether she met the standard of care in this case?
A. Yes.
Q. And --

A. And the --
Q. What would that --
A. I would say that she did not. That's why I'm here.
Q. Okay. And why?
A. Well, I don't -- I take exception to what Dr. Darney said that -- I agree with the ACOG's position that TOLACs or -- and I can't see the major difference in a TOLAC and a 35-week abortion, but I agree that they should only be undertaken when you could rapidly have a cesarean delivery or emergency access, and I agree that Misoprostol should not be used.
Q. Okay. How does the -- well, Dr. Darney confirmed this and Dr. Sella testified to this that the biparietal diameter, the head circumference, was that of a 40-week gestational age. How does that influence your opinion, if it does?
A. Well, from the standpoint of a head getting through, this was not a 35 weaker but a 40 weaker, you know, as far as the size of the head. That's why the termination was being done in the first place, because the head was bigger than it was supposed to be, and I'm aware that Dr. Sella was planning to do a head decompression or evacuation, whatever term you want to use for it, and I've done that. I know how that is, and I realize that that would make

delivery, if it had been done before the rupture, would have made the deliver to be more likely successful and cut the chances of rupture. Unfortunately it was just a little -- a day late and a dollar short.
MR. THOMPSON: What was that last part? I'm sorry.
THE WITNESS: I'm sorry. A day or two -- it was a day late and a dollar short. I'm from Texas. We say things like that.
MR. THOMPSON: Okay.
Q. (By Mr. Rubin.) That's okay. Based upon Dr. Sella's testimony, when did the trial of labor begin?
A. I don't remember by her testimony, but the cervical ripening started on the 10th, in the morning and continued through that day, and it's hard to say exactly when the labor started. Probably when the membranes ruptured.
Q. Would you characterize this as augmentation of labor?
A. This was an induction of labor in a 35-week patient that happened to have a dead baby.
Q. Describe the difference between an induction and an augmentation?
A. An induction of labor is in a woman who is not in labor if you start the labor from scratch, and the

significance is that you may have to use a higher dose of Pitocin, because your uterus is not primed before it yet, where an augmentation of labor is one in which labor has begun but has faltered, and you're trying to get the contractions back to their normal level, and the uterus is still -- is already more sensitized to Oxytocin, and so you start off at a lower dose. I would interpret this entire venture as a -- as an induction of labor. She didn't come in in labor.
Q. Okay. Going back to the Misoprostol, I believe you testified that this Practice Bulletin's prohibition should apply in this case to these facts, correct?
A. Yes.
Q. Is there anything to the combination in this case of Pitocin and Misoprostol that gives you pause or concern?
A. The combination of Pitocin on top of Misoprostol leads to very, very strong contractions, and the College has taken a position that that's the combination that tends to increase uterine rupture, the combination of Misoprostol and Pitocin.
Q. Let me -- can you -- is there some support in an ACOG Bulletin that you have for that position?
A. I will find it. In -- I don't recall which Bulletin but it's Technical Bulletin -- it's Committee Opinion Number 342.

MR. GOLDBERG: Hold on for a second.
A. On page 543, which is actually the second page of the committee opinion --
Q. Okay. Hold on. Let's wait until all counsel get there.
A. Yeah, okay.
MR. GOLDBERG: What exhibit number are we looking for?
MR. RUBIN: Well, I put all the ACOG exhibits together as Exhibit 2, so --
MR. GOLDBERG: All right. So let's see if I can find it.
MR. THOMPSON: It's the committee opinion?
THE WITNESS: Yes.
MR. THOMPSON: It's the last page of 2.
MR. RUBIN: Yeah.
MR. GOLDBERG: I thought this was the document that you said you were withdrawing.
MR. RUBIN: 342, no, I was not. No, I was withdrawing the other one. 107's withdrawn.
MR. GOLDBERG: All right.
Q. (By Mr. Rubin.) Okay. So I'm on page --
MR. GOLDBERG: Okay. I got it. Great.
MR. RUBIN: Are you okay, Mr. Goldberg?
MR. GOLDBERG: I know where I am.

MR. RUBIN: Okay. Good.
Q. (By Mr. Rubin.) So we're on page 343.
A. 543.
Q. 543. Thank you. Okay.
A. Yes, on the right side in the first full paragraph starting with the Rate of Uterine Rupture, down about two inches, it says, "Additionally, sequential use of prostaglandins and Oxytocin may further increase risk," and the paragraph is talking about uterine rupture. And then at the bottom of -- the very bottom of the page, the last six lines, "Selecting women most likely to give birth vaginally and avoiding sequential use of prostaglandins and Oxytocin appear to offer the lowest risks of uterine rupture," and then this Bulletin also reiterates that Misoprostol should not be used in patients who have had cesarean deliveries or major uterine surgery.
Q. Let me ask you this question, have you ever used Misoprostol?
A. Yes, I've used if quite a lot.
Q. Have you used it with a TOLAC?
A. No.
Q. Never?
A. Never.
Q. Okay. In the hospital that you practice at, when you relative -- in your experience have you seen it -- have

you seen it done in hospitals where you've worked?
A. You know, I'm about the only one in my hospital who still does VBACs, and as of this week I quit. So no, I have not seen that. Nobody in my hospital would do that.
Q. Okay. Have you -- so you have seen the use of Misoprostol?
A. Sure.
Q. What context have you?
A. Well, just for cervical ripening and induction of beginning -- induction of labor.
Q. And would you ever send a patient home after giving them a dose of Misoprostol, sending them home or to a hotel with another dose to be taken later on that day if they were in -- okay.
A. No, just the answer's no.
Q. And why not?
A. Well, because the contraction pattern of Misoprostol induced contractions is unpredictable and quite often very powerful. And, of course, what I would be dealing with would be policies at our hospital that require fetal monitoring with Misoprostol use. That wouldn't have applied in this case, but the other reason that we wouldn't would be unpredictable uterine activity, uterine contractions.
Q. Okay. So going back to whether Dr. Sella breached

the standard of care in this case, I believe you said it was the use of Misoprostol, its conjunction -- conjunctive use with Pitocin, the fact that this was conducted in a clinic. How serious -- how extreme was this breach of the standard of care in your mind?
A. I've said that I thought this was gross negligence, knowing the rules and just ignoring them.
Q. Okay. Let me have you look at the medical records. I believe it is -- it's Bates stamp, one moment here, -21.
MR. GOLDBERG: What's that?
MR. RUBIN: Bates stamp -21 of the medical records.
MR. GOLDBERG: Yours or ours?
MR. RUBIN: I thought the Bate stamp was the same.
MR. GOLDBERG: No, no, no. Our medical records are -- Exhibit 8 has SST.
MR. RUBIN: I think if you turn to your Bate stamp -21, you will be where we are.
MR. GOLDBERG: Okay.
Q. (By Mr. Rubin.) It's the interview notes, the -21, interview notes?
A. Page -020, I've got it -21. Okay. I've got it.
Q. Okay. Now, did this -- this notation influence your opinion as to whether there was gross negligence in

this case?
A. I -- it influenced it. It supported the idea, because there's not any documentation, and that's not to say it wasn't done, but there's no documentation in this counseling note that there was a discussion of uterine rupture in particular with using Misoprostol and Oxytocin. Of course, if Dr. Sella didn't believe that that was true, then she had no reason to counsel the patient about that.
Q. Okay. On that point do you think that consent is a consideration in this case?
A. If she tells us that she talked about that -- you know, we don't always write down everything that we've got --
Q. Right.
A. -- that we've talked about. You just don't do that, and if she says that she did, I have no reason to disbelieve it. So in my opinion, with a -- with a -- I suppose a dictated note as detailed as this, she obviously put some time into a consent.
Q. Okay. Based upon your opinion as to the standard of care, could there be consent to this procedure by this patient?
A. Well, my position is that the procedure shouldn't have been done as it was, and I suppose there could be a position that if the procedure shouldn't have been done as

it was, then it's hard to get someone to consent to something that shouldn't have been done. Probably makes -- probably makes very little difference.

Q. Okay. In other words, you can't consent to something that should not --

A. That seems, seems like that's in --

MR. GOLDBERG: Well, there's leading and there's leading. He was actually putting words in the mouth which are inconsistent with what he had just said, and I think this was the latter.

A. I'm not supposed to agree or disagree but --

MR. THOMPSON: Sustained.

Q. Okay. Dr. Bullock --

MR. THOMPSON: Although I am interested in the answer to that general question. Is this something that a patient could consent to, or is it beyond -- I don't even know if this is, in fact, possible. Beyond -- let me ask you generally, can a patient consent to something beyond the standard of care?

THE WITNESS: We don't have a standard of care for patients, but if Dr. Sella truly believed that what she was doing was the right thing to do and then counseled the patient adequately and honestly about the possible risks that she was getting into, then I have no problem with informed consent.

Q. (By Mr. Rubin.) But again -- well, there's the old -- are you familiar with the phrase, "Can you consent -- can you give consent to someone's negligence?" Are you familiar with that phrase, whether --

A. I haven't seen that before, that phrase.

Q. Can someone consent to gross negligence?

MR. GOLDBERG: I'm going to object. This is -- this is a legal question. This is a question that actually, Mr. Hearing Officer, you're going to have to grapple with and the Board's going to have to grapple with and perhaps a court, but I don't think this witness is competence to offer anything that's going to be valuable on this.

MR. RUBIN: I beg to differ. We've already had an opinion as to gross negligence. We've already had opinion as to consent. I think we -- if he can answer the question.

MR. THOMPSON: Overruled.

A. Would you mind repeating it.

Q. Can you consent to someone's -- can you consent to someone committing gross negligence?

A. Okay. If the doctor tells you, "I'm going to do brain surgery, but I'm going to have some cocaine on the way in and it always makes me where my right hand does like this, can I go ahead and do your surgery," and the patient says, "Well, it's okay," I don't know whether you could consent to that. I don't think I can answer the question.

I really don't.

Q. Okay.

A. I just -- I just can't.

Q. Do you think looking at this, at Bate stamp -21 and do you think there was a consideration by Dr. Sella -- can you tell if there was a consideration as to whether she had -- whether not performing this procedure was an option?

A. I would suppose that Dr. Sella, having a different philosophical approach than I do, and each accepting each other -- each other's philosophical difference of opinion, this sounds like she felt like she had to do it. It sounds like that.

Q. And if you have to do something, you only have one choice, right? That's probably a semantics question.

A. There's one choice I thought of, which she hasn't considered, but it would probably be untenable, but I guess that's what it means if you have one -- if you feel like you have to, you have no choice.

Q. Do you weigh the risks if you have no choice?

A. Do you weigh the risks if you have no choice? No. One of the principles of informed consent that I learned a long time ago was informed consent gives you information that you would need in order to change your mind about what's happening. If you have no -- if there's nothing you can do about it and it's going to happen regardless, then

there informed consent becomes pointless.

Q. Okay. Going back to whether -- I believe you testified that this is a case involving gross negligence. What is your understanding of gross negligence?

A. My definition?

Q. Yes.

A. Oh, what I've been told is that it's a willful and wanton disregard of the welfare of the patient.

Q. Going back to the fact that it appears that Dr. Sella, from these notes, felt like she had only one option, how does that relate to whether there was willful disregard of the risks?

A. Well, then it's incompatible. It's incompatible with gross negligence. This certainly doesn't look like someone that they -- who dictated that, who had no concern for the patient's welfare. This doesn't look like that. The basis for my saying that was just knowing -- knowing the rules and knowing the risks and going ahead anyway, but certainly reading this, you wouldn't get the feeling that she didn't give a hoot.

Q. Right. I'm not sure you answered the -- I'm not sure you understood my question.

A. I may not.

Q. So let me ask it again. Given your understanding of gross negligence as the willful or wanton disregard of

risks and it appears that there is only one option to a physician, is there -- are you more likely to weigh the risks and benefits than you would if there's one option?

A. Well, you have to weigh the benefits and the risks in coming to the conclusion that there's only one option. So this -- that would go with the assumption that the risks and benefits have already been evaluated, and the decision was made that with the risks and benefits as there are, there's only one way you can go.

Q. Okay. So I believe you alluded to before that there was perhaps another option?

A. Oh, if one wanted to follow the ACOG guidelines to the letter, I mean as well as to the letter as you could, the portion of the termination which included fetal euthanasia is legal and proper. It's the delivery that is -- that is my concern, and of course, if someone had to do that, one other way, which would be a tough way to do it would be to do the euthanasia of the baby and then say, "Go to the hospital. You'll be wandering in as a -- as a walk-in with a dead baby," and the hospital would be required to take care of her in the best way possible.

Q. Okay. And would that involve the use of -- the risks associated with a clinic versus a hospital? How would that be managed?

A. Well, in a hospital -- in most hospitals, at

least, the suggestion would be a choice between an induction of labor or a repeat cesarean section, and either one could be possible as an option.

Q. Okay. In your view could a C-section have been performed in the clinic?

A. Well, no. My understanding of the clinic is that it's not set up for major surgery. So, no, it couldn't -- couldn't have been --

Q. So you're aware the Degoxin was administered, and she was sent to the hospital. That would present the option of a C-section at the hospital, correct?

A. Yes. Now, I'm sure that that would be an untenable thing to do, because the hospital would probably get really mad. I don't know how that fits in.

MR. RUBIN: Okay. No further questions. Thank you, Dr. Bullock.

MR. THOMPSON: Pass the witness to Mr. Goldberg.

MR. GOLDBERG: Sure. Can I have a minute to set up?

MR. THOMPSON: Sure.

MR. GOLDBERG: It might be worthwhile to take a three- or four-minute break.

MR. THOMPSON: Okay. And we're off the record.

(Note: Hearing in recess at 3:23 p.m. and reconvened at 3:30 p.m.)

MR. THOMPSON: We're back on the record, 3:30 p.m. Cross-examination of Dr. Bullock. Mr. Goldberg.

CROSS-EXAMINATION

By MR. GOLDBERG

Q. Doctor, I'd like to clear up a couple of things and so start out sort of at the end. I was somewhat confused, and if you turn to page -21 of the medical records, which I think are, by our exhibit number, Exhibit 8, do you have -- that was sort of the last line of questioning that Mr. Rubin had. I just -- I just want to see if I can clarify some things here.

A. Okay.

Q. I'd just like to know, it's correct, is it not, that page -21 of these medical records is not a basis for any opinion of yours that Dr. Sella's care of ML fell below the standard of care?

A. No, it's not.

Q. Okay. Great. That's -- then I'm done with page -21 of those records. A few other similar questions that I have to you -- for you. You testified in response to questions from Mr. Rubin that you understood that on that third day, May 12th, in the early afternoon when Dr. Sella went in and that's when she discovered that the -- the head was no longer engaged, it was -- and the -- after she did an ultrasound and saw that the orientation of the baby had

change and determined that that was a significant risk of uterine rupture --

A. Yes.

Q. -- you understood from her testimony that at that time she had gone in to examine ML, because she was intending to do the decompression of the head in order to facilitate the labor and delivery, right?

A. I understand it now. This is the first time I've realized that.

Q. Right. And the term you said was unfortunately that was too little, too late?

A. Yes.

Q. The Texas term that you used, but I want to make sure I understand. You're not -- you're not saying that the timing by Dr. Sella of when she made the determination of seeking to decompress the head was a basis for your opinion that Dr. Sella's standard of care fell -- Dr. Sella's treatment fell below the standard of care?

A. No, the time of rupture is simply a fortuitous thing that there's no way to predict.

Q. Correct, and I just -- again, you understand what I'm doing here. I'm just trying to figure out what we're -- what we're up against here.

A. I understand.

Q. You also said, you made a point that the head was

large, and it had the size -- I can't use those words, but the --
A. PBD.
Q. Yeah, the PBD of a fetus of 40-week gestational age?
A. Yes.
Q. You're not saying that Dr. Sella's determination that this was an appropriate candidate for a third term abortion fell below the standard of care because of this large head, are you?
A. No, I don't -- I don't think I'm making that assumption.
Q. Right, because you could anticipate my next question was you had never said that before today, right?
A. Right.
Q. Okay. Great. Now, but you do say that the use -- the use of Misoprostol with Pitocin is a basis for your opinion that Dr. Sella's care fell below the standard of care?
A. Yes.
Q. And on that, you relied on what is part of Exhibit 2, but for the Hearing Officer I'll say it's our Exhibit 14. That is the committee opinion that bears -- from ACOG that bears Number 342, August 2006. You have that in front of you, right, sir?

A. Yes, sir.
Q. And you read a part from that opinion, correct?
A. Yes, I did.
Q. When you look at the first page of that opinion as it's in that exhibit --
A. Yes.
Q. Do you have it up there?
A. I have it.
Q. Is there anything on that first page that says, "Out of print?"
MR. THOMPSON: I think we're looking at two different --
MR. GOLDBERG: Right. No, right. That's -- we're getting there. I've got to make a record here.
A. Page 342?
Q. Yes. Is there anything up there that says, "Out of print?" It should be -- I'm going to orient you to the top, at the top of the page anything that says, "Out of print?"
A. This doesn't say, "Out of print."
Q. Is there anything out there that says that this committee opinion has been replaced?
A. No, but you wouldn't -- it wouldn't say it on this form.
Q. It would not say it on this form?

A. Would not, because once you replace it, they never print it again.
Q. Sure. They don't -- they don't print it, because they're no longer relying on it, right?
A. Right.
Q. Are you aware --
MR. THOMPSON: Did you get an audible answer? Okay.
Q. It is correct that the reason they put it out of print is because the College no longer relies on it if it's been replaced, right?
A. That's one of the reasons. One of the reasons is just in updating, that reenforces the previous concept.
Q. Were you aware that this Committee Opinion, Number 342 dated 2006, is now out of print and has been replaced and is -- is articulated by the American College of Obstetricians and Gynecologists as having been replaced by Practice Bulletin 115 dated August 2010 as is represented by our version of the committee opinion, which has been admitted as Exhibit 14?
A. I'm aware.
Q. So you're relying on an opinion that has been replaced by the College and is no longer relied on by the College, correct?
A. Yes, I'm relying on these two in tandem in that

sometimes when you look at one that's five or ten years old and you look at another one that's more current, it tells you -- if there wasn't a change in a particular philosophy, it tells you that it was consistent throughout those periods of time.
Q. The language that you rely on -- the language that you relied on in the committee opinion, do you find that language in 115?
A. Well, I find the part about Misoprostol.
Q. The language you relied on was the language that talked about Misoprostol being used with Pitocin?
A. No, I also relied on this other --
Q. I understand, but I'm asking the question about -- the focus of my question was on your opinion that the standard of care was violated because Dr. Sella used Misoprostol with Pitocin. That's the point here. We're going to get to the other point later.
A. Well, both of the Bulletins state that Misoprostol shouldn't be used at all, so you would assume that it's not with Pitocin, too.
Q. That's your assumption?
A. No, that's my direct reading of the document. I'm not assuming anything.
Q. Were you aware -- let's stick with the use of Misoprostol and Pitocin together. For how long in the care

of ML was Misoprostol and Pitocin used together?
A. Okay. Together, I'll have to go back and review that.
Q. Sure. That would be, again, our Exhibit 8? Well, let me help you out a little bit. What is your -- what is your understanding of the medical record --
MR. RUBIN: Hold on. At least have -- is he going to withdraw the question?
MR. GOLDBERG: I withdraw -- I withdraw the question.
Q. (By Mr. Goldberg.) What is your understanding of the medical records now, Dr. Bullock, as to when Pitocin was first given to ML?
A. Let me refresh my memory here.
Q. Sure. This is definitely not a memory test.
A. I think on the 11th at 00:25. That's what it looks like there.
Q. Actually on the 12th at 00:25. The chart says the 11th, because it was started on the night of the 11th, but then -- it starts at 11 --
A. You're right. This is confirmation -- that is correct on the 12th at 00:25.
MR. THOMPSON: Looking at page number 0030?
A. Yes.
Q. That's correct. And that, of course, your opinion

is different now from your -- your understanding now, Dr. Bullock, is different, is it not, from your understanding when you first rendered your opinion --
A. Yes.
Q. -- that the standard -- let me finish my question -- the standard of care -- that the standard of care was breached? When you first rendered your opinion that the standard of care was breached, your understanding from the medical records was -- from your read of the medical records was that the Pitocin was given continuously to ML from the first day she proceeded -- she presented at the clinic until the third day, correct?
MR. RUBIN: Let me object -- let me object on the grounds of relevance. How is it relevant, a previous opinion based upon a previous reading of the medical records when he's testifying today his opinion is based upon what he heard today.
MR. GOLDBERG: Certainly -- it's certainly relevant to the credibility that a fact finder's going to give to the opinions, to the weight that the fact finder's going to give to the opinions as to whether this expert doctor is going -- has a mindset that the standard of care was breached irrespective of what the facts were.
MR. RUBIN: I'm a little confused, because Doctor -- Mr. Goldberg here a while back while we were arguing over

the admissibility of that prior report said it's not about credibility. Now, he's saying it is. I wish --
MR. THOMPSON: Overruled. I think that -- I mean, the question is with regard to has his opinion changed with regard to the standard of care if he now knows the Pitocin was not administered until 00:25 on the --
MR. RUBIN: 12th.
MR. THOMPSON: -- 12th.
Q. (By Mr. Goldberg.) So it is correct, is it not, Dr. Bullock, that when you first formed your opinion that the standard of care was violated by Dr. Sella, your understanding, incorrectly, was that the Pitocin was given continuously to ML from the very first day she presented to the third day while the Misoprostol was administered?
A. No, I've never thought that. I don't know where you got that idea.
Q. You didn't. Well, let's look at -- let's get Exhibit 12 from the -- in front of you.
MR. RUBIN: Okay. So, Mr. Hearing Officer, is there a -- I think at this point it's -- I think it's in or it isn't, because if counsel's going to start using this to cross-examine the witness --
MR. GOLDBERG: Whether it is, whether it isn't --
MR. RUBIN: -- and using basically -- if he's going after the credibility of this witness with some --

with some external -- I forget the exact term, but he's going to credibility with a report that we're not introducing. I'm not sure that -- I do not believe the Rules of Evidence would allow that. I think he's stuck with his answer.
MR. GOLDBERG: Well, first of all, I would like a ruling. I believe that -- I believe that both already from the record and all of the examination has been addressed to Exhibit 12, as well as the law that I cited, Exhibit 12 is well within the Hearing Officer's discretion to accept and, in fact, should accept, and I would like to have it accepted, but I certainly -- whether you accept this as an exhibit or not, I certainly can use his prior, unsworn statement but submitted to the Board as impeachment.
MR. RUBIN: But he's not testifying differently.
MR. GOLDBERG: Well, of course, he is.
MR. THOMPSON: First of all, I'll allow questions with regard to Exhibit 12. I think he's laid the foundation that there's prior inconsistent statement, and he's able to impeach with regard to Exhibit 12.
I will admit Sella Exhibit 12 for purposes -- I do not believe the facts asserted are offered for their truth. In fact, they seem to be offered in some parts for the opposite. I will not take the facts asserted, for example, in the narrative for their truth, because that is pure

hearsay. I do not believe -- I'm not admitting them -- I'm not admitting them for purposes that the expert is an agent of the party, but I do believe it is relevant that this Exhibit 12 was a predicate for or a basis for the NCA, and in that regard, I'm going to -- I'm going to allow -- it's in essence a part of the charging document or is -- it is a statement by a party opponent.

So I'm going to admit, and then I'm going to throw in the catchall. It's certainly information that they can rely on for serious affairs. The Board is going to rely on his testimony. The Board can rely on this report if they wish. Ultimately, the experts in this case are the Board, and I trust them to discern the weight that an earlier report is given as compared to testimony after he's reviewed all of the records. So for those reasons, I'm going to admit Sella Exhibit 12 and permit the question.

THE WITNESS: May I clarify my answer?

MR. THOMPSON: Sure.

THE WITNESS: Okay. I have now read the document that we're talking about, and there's nothing in the document that says I thought she was under Pitocin the entire time from 5-10 to 5-12. So I've never thought that, and it's not in the document. I don't know where you got the idea.

Q. (By Mr. Goldberg.) You haven't read it carefully

enough, Doctor, so let's -- let's do it. Turn to page -- turn to page 120. Let me conduct my examination.

MR. THOMPSON: Okay. But let's not argue with the witness. If there's a prior inconsistent statement, let's show it and --

MR. GOLDBERG: Sure.

Q. But let's turn to -- turn to page 120. That's the second page. This is your report, is it not?

A. Yes, this is my report. Of course.

Q. You submitted it -- you submitted it to the New Mexico Medical Board, correct?

A. Yes.

Q. And this was intended to express your opinions about Dr. Sella's care of ML, correct?

A. Yes.

Q. All right. Turn to the second page of the report. Turn to the first full paragraph. She was CM -- she was 5CM dilated; do you see that?

A. The second paragraph?

Q. Yes, the first -- okay. Whichever. Read the last -- read into the record the last sentence of that paragraph? Read it out loud into the record.

A. "My assumption from the record is that she was receiving the 50 milliunits per minute during all the times that she was also receiving Misoprostol."

Q. And the milligrams you're talking about there is Oxytocin, correct? Look up two lines.

A. This is a typographical error. I never thought that, and --

Q. You did not?

A. And my assumption from the records was that she was receiving that during all the times that she was receiving -- all right. I'm not -- I did not think that. I didn't -- that was not my intent.

Q. It wasn't?

A. And I will retract it, and I've never thought that she had Pitocin going during the whole time.

Q. How about during your deposition, do you remember being deposed and testifying under oath in this case?

A. I remember being deposed, yes.

Q. And you testified under oath in that case, in your deposition, did you not?

A. Yes, deposition -- yes, I testified under oath.

MR. GOLDBERG: Look -- I believe I have a copy if Your Honor wants -- I mean, if Your Honor wants a copy, also. I'm going to use it for impeachment. This is his deposition. I've given a copy to the witness. There's not a lot of room here, and if Your Honor will indulge me -- or the Hearing Officer will indulge me.

Q. (By Mr. Goldberg.) Let's turn to your deposition

transcript at page 110, Doctor. Starting -- I'm going to read to you the questions and answers starting on page 110, line 22:

"QUESTION: You testified that on the 3d -- what your understanding of the medications that were administered on the third day. Let's take it from the time patient L presents in labor. What medications are provided?

"ANSWER: We haven't talked about the various pain medicines.

"QUESTION: That's right. I will get to that in a second.

"ANSWER: So I'm excluding those from this discussion, because it wasn't part of the problem. My understanding was that she continued getting Misoprostol and Pitocin.

"QUESTION: At the same time?

"ANSWER: Yes, at the same time."

Those were the questions and answers, correct?

MR. RUBIN: Let me -- I do not believe Mr. Goldberg read the question and answer correctly on lines 10, and 11 and 12. Line 10:

"QUESTION: And the same, comma, was the low dose Pitocin?

11:

"ANSWER: The same," pause, "I assume. I didn't see anything that indicated change."
That's what it says, not what Mr. Goldberg said.
Q. (By Mr. Goldberg.) That was your testimony then?
A. I'm trying to put this together. Give me just a minute.
Q. Sure.
A. Are you trying to say that I'm saying here that she got it the whole three days?
Q. Uh-huh.
A. Well, that's not what it says.
Q. Well, turn to page 105 of your deposition.
A. That's not what it says.
Q. Turn to page 105 of your deposition. Okay. We're talking on the first day.
"QUESTION: So on the first day she received one insertion of Laminaria and Misoprostol vaginally and Pitocin on the second day -- and Pitocin. On the second day she received one insertion of Laminaria, Misoprostol every two hours -- every two hours vaginally and Pitocin?
"ANSWER: Yes."
Aren't you -- aren't you affirming that she received Pitocin on the first and second days?
A. I don't know what I was interpreting, your

question, but I've never thought that. I mean, it's pretty clear from the record she didn't get any Pitocin the first day and didn't get it until after midnight of the second day, which makes it the third day, and I've never thought that.
Q. Turn -- turn to page --
A. Let's me finish my --
Q. I'm sorry. Go ahead.
A. I have figured out what happened. I'll wait.
Q. Turn to page 10- --
A. I'm not -- I'm not through yet.
Q. Oh, I'm sorry.
A. I'm waiting for you to be quiet. In my report I had figured out what happened there. I'm only talking about that sequence of events on the late night 5-11 and early morning 5-12 when I said that she was getting 50 milliunits per minute during all the time she was receiving Misoprostol. I didn't intend that to back up two more days, but I've known all along she didn't get Pitocin on the first day or until --
Q. You've known that all along, and you didn't testify to the contrary?
MR. RUBIN: Hold on, please. Can the witness finish?
A. I have never -- I have never thought that, and I

may have answered your question incorrectly, but I have never thought that and do not believe it now.
Q. Turn to page 101 of your deposition. Let's read the questions and answers starting on line 3.
MR. RUBIN: What page are we on?
MR. GOLDBERG: 101.
Q. "QUESTION: So what's your understanding as to what medicines were administered by Dr. Sella on day one?
"ANSWER: My understanding is she was given Pitocin and Misoprostol and Laminaria."
Those were the questions and that was the answer; is that correct, sir?
A. That's what it says.
Q. Sure. But let's -- oh, go ahead.
A. I will still aver that I have not at any time thought the patient got Pitocin on the first day. I don't know how I misunderstood the question and answered it wrong, but that's a wrong answer. And so, yes, it's -- it's a conflict with my current testimony.
Q. Let's turn to page 103 of your deposition, Dr. Bullock. Let's read the questions and answers starting on line 21 of page 103 going onto 104.
"QUESTION: What's your understanding of what the medications were on day two?

"ANSWER: My understanding was she was to get Misoprostol 100 micrograms orally every one or two -- every one to two hours, and she was to get the Pitocin infusion constantly."
That was the question, and that was your answer, wasn't it, sir?
A. And I will still stand by that answer. I consider that to be correct.
Q. This is the -- we're talking about the morning -- the context here is we're talking about the morning of day two.
A. It doesn't say morning.
Q. Well, first of all, she didn't get Pitocin on day two, did she, Doctor? She got Pitocin first on day three? So is it your -- I want to make sure --
MR. RUBIN: Hold on. Are you withdrawing that --
MR. GOLDBERG: No, I'm not.
MR. THOMPSON: Yeah, let's ask one question.
Q. It is correct, is it not, Doctor, that she didn't get Pitocin at all on day one, and she didn't get Pitocin at all on day two? The first dose of Pitocin --
MR. RUBIN: Hold on.
Q. -- the first dose of Pitocin was on day three at 12:25?
MR. THOMPSON: Is that your understanding, Doctor?

THE WITNESS: Yes. I considered midnight to be still part of day two, I'm sorry. I recognize that the first dose of Pitocin was at -- just after midnight on day two/three.

Q. (By Mr. Goldberg.) So I want to make sure I understand your testimony here now before the Hearing Officer and the Board, and is it my understanding correctly of your testimony is that your statement in your report that is Exhibit 12 at page 120, that my assumption from the record is that she was receiving 50 MIU per minute during all times, and that's 50 MIU per minute of Pitocin, during all the times that she was receiving Misoprostol, that that was a mistake? You never intended to say that, and that every single reference to the Pitocins on day one and two in your deposition was a mistake by you that you misunderstood the questions?

MR. RUBIN: Objection. That's a compound question, to say the least. I had a hard time following it. Maybe I'm just stupid, but it doesn't seem like it's an easy question to answer. He has to break that down.

THE WITNESS: I can answer it.

MR. THOMPSON: Let's break it down. If you can answer, go ahead, but --

THE WITNESS: I can answer.

MR. THOMPSON: Let's start first with your report.

Are you now saying -- I think you've answered this question. Are you now saying what you've alleged in the report is incorrect?

THE WITNESS: It's worded clumsily. It intent -- it is intended to mean 5-11 and on down, but taken by itself, that sentence is incorrect, and I don't have a good explanation for the deposition, except that I got off on the wrong track with the wrong date in my mind and answered it wrong.

Q. (By Mr. Goldberg.) Okay.

A. And I'm wondering what in the world difference does it make.

Q. You don't see a difference?

A. No, not in regard to my claims of negligence, I don't see a difference.

Q. Now, let's go back to the question I started with. As you understand the record now, Dr. Bullock, for what period of time was ML provided Pitocin and Misoprostol?

A. It looks like from 23:18 on the 11th.

Q. On the 12th? Oh, 23:18. I'm sorry.

A. No, that was just -- that was just on one day. She got Misoprostol 23:18. She was given Pitocin at 00:25, and Misoprostol would still have been on board, so those were given together. It looks like that was the last Misoprostol she got.

Q. No, actually didn't she get Misoprostol around 25 minutes after 12:00 on the third day, on the 12th?

A. Well, I'm including, -- yes, that's correct. So at 00:24, of course, Misoprostol stays around more than a few minutes. So the dose would have gone through probably 4:00 o'clock in the morning or something like that.

Q. Was that -- that was -- that was the last dose?

MR. RUBIN: Hold on, again.

A. It looks like she was given the last dose of Misoprostol at 00:24 on 5-12-11 -- 5-12-10.

Q. And when was -- and when was the Pitocin started?

A. 00:25.

Q. On the 12th?

A. Yes.

Q. So is it correct then -- well, and in fact, that last dose of Misoprostol was the dose that she threw up, correct?

A. Yeah, but she had it in there for half hour or so.

Q. And what's the half life of Misoprostol?

A. I don't know.

Q. It's -- it's a matter of hours, is it not?

A. That has nothing to do with when she threw it up.

Q. No, it doesn't, but it has to do with how long it's going to be in her system, correct?

A. Well, I've already said that I thought it would be

around until about 4:00.

Q. So is it correct then that as you read the record, the maximum period of time that Pitocin and Misoprostol was administered simultaneously was three and a half hours?

A. It looks like that.

Q. Okay. Thank you. Going back to your examination by Mr. Rubin, again, I want to clarify. You are not expressing an opinion that ML did not present an appropriate fetal indicated candidate for a third trimester abortion?

MR. RUBIN: Mr. Hearing Officer, he's asking a question with a double negative in it. I'm not sure --

MR. THOMPSON: I think he -- I think that question was asked and answered, but is the question -- are you opining on whether or not ML presented as a proper candidate for a third trimester abortion? Is that part of your expert opinion?

THE WITNESS: Yes, I can -- yes, yes.

Q. (By Mr. Goldberg.) And what is your -- and you're saying --

A. There's two -- there's two considerations here. One is was there a solid diagnosis of fetal anomaly. No, there was not. So from the standpoint of was there a medical indication for an abortion, there was one that was suspected but not proven. Number two, was the woman physically an appropriate candidate to go through the

procedure of a third trimester abortion? No, she was not. She had a previous cesarean section. She was going to be given Misoprostol and sent to a hotel. So no and no.

Q. Is it your opinion today that you are criticizing the decision to abort?

A. Well, I've said that in both ways, she wasn't an appropriate candidate, so sure I'm criticizing the decision to abort.

Q. Would you turn to your deposition? Turn to page 95, please, Doctor. Question, it's 94, starting at 94, line 15, let's read the question and answer.

"QUESTION: If a patient has presented herself to you with the information that you understood she had as to this fetus, would you have determined that this was a fetal indicated abortion?

"ANSWER: I would have left that up to the patient. I would have gotten her the same thing that the doctor in New York got her, the best consultation available and the best information, and apparently in spite of all of that they just simply weren't able to tell for sure, but we have had that kind of patient who has gone on and been referred to an abortion clinic even recently, but it was not this questionable. It was not, you know, absolutely. The diagnosis was more well-established. I don't criticize the decision to

abort. This was a potentially bad anomaly, and it followed legal guidelines in New Mexico. I don't have any problem with the decision to abort."

Was -- were those your -- was that your answer to the question when your deposition was taken in -- just several weeks ago by the way?

A. Yes, I was intending that to apply to the patient's decision to abort. I don't have any problem with what she decided.

Q. In your Exhibit 12, again, I still am trying to nail down what your opinions are. In page three of your Exhibit 12, your initial report, Bate stamp number -121, you do criticize the medical records for not documenting blood pressure and pulse, correct?

A. At the time that I had what I had did not include that, and subsequently I've seen that and have withdrawn that criticism.

Q. So you're not criticizing the -- that the medical records did not show blood pressure and pulse, correct?

MR. RUBIN: Objection, asked and answered.

A. I'm still not criticizing that.

Q. Okay. And it's correct, is it not, that you actually are not criticizing the medical records at all?

A. I've not been asked to decide that. I found them extremely hard to read and had errors in them, but as we're

normally human beings and we make errors, as I've just shown, no, I'm not criticizing them.

Q. You also criticized Dr. Sella for using preprinted orders and not providing individualized management in your initial report, correct?

A. I didn't criticize her for using preprinted orders. We all use preprinted orders, but I criticized for signing an order sheet that didn't apply to the patient she's taking care of.

MR. RUBIN: Mr. Thompson, I think we've spent well over an hour on the dubious -- on the dubious question of what seems to be most of his credibility. A lot of these questions are being generated by this one report, which isn't his position anyway. I think in the interest of moving this proceeding along, I think we should probably wrap this line of questioning up with this document pretty soon.

MR. THOMPSON: Mr. Goldberg -- you can make that argument in closing. I am curious about the -- perhaps hear in closing with regard to the relevance. I mean, it seems to have changed some of his opinions from the report based on new medical documents. That's true, but Mr. Goldberg's free to ask the questions.

MR. RUBIN: I understand.

Q. (By Mr. Goldberg.) All right. Well, I'll turn to

the opinion that you -- so let me see if I can identify these bases for your opinion that Dr. Sella's care fell below the standard of care by -- and your opinion is gross negligence. It is that she provided Misoprostol?

A. That's one.

Q. That she provided Misoprostol with Pitocin?

A. Yes.

Q. That she provided this third trimester abortion with a woman with a cesarean section in a freestanding clinic?

A. Yes.

Q. Are there any other bases for your opinion?

A. Mixed in with that is sending a patient home with Misoprostol. I suppose that could be included in one of those others or could be an individual criticism.

Q. Did you criticize -- did you criticize Ms. -- Dr. Sella's care for sending the patient home with Misoprostol in Exhibit 12 --

A. No.

Q. -- your earlier report? Did you criticize Dr. Sella for sending the patient home with Misoprostol when your deposition was taken?

A. I truly don't remember. If I had been asked a questioned, I would have.

Q. Well, you were asked the question whether all of

your criticisms -- you were stating all of your criticisms, and you answered that you were stating all of your criticisms; correct?

A. That's correct, but you know, when you ask that kind of question, you've got to think of all other possibilities that are -- you know, it's kind of a hard question to answer. It's not a lie when you come back with another one.

Q. But you also understand that we want to know what -- we want to know what your criticisms are, right, sir?

A. Of course.

Q. Okay. Great. Now, let's turn to -- other than the ACOG Bulletin 115, which is Exhibit 10, and the Committee Opinion 342, which is Exhibit 14, do you rely on any other literature or documentation for your opinion that a third term abortion provided to a woman with a prior cesarean section cannot be accomplished in a standalone clinic?

MR. RUBIN: Hold on. By the term "documentation", does he mean submitting the question to formal publications, or -- "documentation" means -- is a very broad question.

MR. GOLDBERG: Sure. I'll note -- I'll note that the only thing he brought with him was 115 and the committee opinion. I'm entitled to know whether he's relying on anything else. That's why I asked the broad question, and I

want to limit it right now to documentation.

Q. (By Mr. Goldberg.) Are you relying on any other literature or documentation for your opinion that the provision of these abortion services to ML in the standalone clinic fell below the standard of care?

A. I don't remember whether you mentioned all three of the documents I brought or just two of them.

Q. I only mentioned -- I only mentioned -- actually, well, which is the third document? Just tell --

A. Which one did you -- which one is the first, second?

Q. The committee opinion -- the committee opinion, which is 342 and the ACOG report, which is 115, ACOG Bulletin?

A. 115, yes, in addition the ACOG Bulletin Number 54.

Q. That's the 2004 Bulletin?

A. Yes.

Q. And the one that says it's replaced by 115?

A. I don't remember if that's the one that says that or not.

MR. GOLDBERG: Mr. Hearing Officer, that would be 13.

MR. THOMPSON: Thirteen.

A. Yes, I still rely on 54 as well.

Q. Okay. So other than those three do you rely on

any other literature or documentation?

A. I suppose the Williams Obstetrics -- I don't know whether you brought that or we did, but it has documentation, the same things these do. These are the only ones I'm actually -- that I brought with me and the only ones I intended to use for --

Q. Okay. I'm content with that answer. I'm content with that answer. You testified -- you testified that you are unaware of what the actual practices by abortion providers with respect to how -- treating women for third trimester abortion at standalone clinics, right?

A. I don't know what the standard is for lower gestational age and, of course, this is the only one we've ever heard of at 35 weeks. So I don't know what the standard separately for 35 weeks --

Q. I'll get to that in a second, but let's take the lower. Let's say 33 weeks and below as Dr. Darney testified, about 33 weeks. At 33 weeks and below, you have no independent knowledge yourself of what the standard of care is that is actually applied by people who provide abortions to third trimester abortions to women with cesarean sections, correct?

A. I don't think there is one separate from the obstetrical standards, so that's my answer. I don't think there is one.

Q. Right. I'll ask a -- I'll ask a different question. It's correct, is it not, Doctor, that you are unaware of what the abortion providers actually do?

A. No more than anybody else would have an idea about that. I don't have any independent knowledge.

Q. You have no independent knowledge. You haven't gone and visited any abortion clinics?

A. No.

Q. You haven't talked to Dr. Hern or Dr. Carhart or Dr. --

MR. RUBIN: Objection. There's like no foundation. You're asking -- questioning about these particular people for this witness.

MR. THOMPSON: If he doesn't know them, he doesn't know them.

A. I've answered no. So all of the people that that includes, the answer is no.

Q. And you, yourself, don't provide abortions to women with prior C-sections, third trimester abortions?

A. The number of third trimester abortions I've done is probably -- can be counted on my little thumb.

Q. And not to any with a prior C-section?

A. I don't know whether she did or not.

Q. Okay. So as you sit here today, other than the three documents that you brought with you, is there any

other reason why that supports your position that there cannot be third trimester abortions provided to women with prior C-sections in standalone clinics?

MR. RUBIN: Is he asking him to exclude his own personal experience and his own personal judgment from this answer?

MR. GOLDBERG: Well, again, depositions, I would say that's an improper -- that's an improper coaching objection.

MR. THOMPSON: Well --

THE WITNESS: These three documents --

MR. THOMPSON: Hold on a second. I sustain the objection. So I guess --

MR. GOLDBERG: I'll ask it a different way. I'll withdraw the question, ask it a different way.

Q. (By Mr. Goldberg.) Do you have any other reason that you're going to give to the Hearing Officer, to the Board than what you've just testified to?

A. I have no intent.

Q. Okay. Do you have any other reason?

A. I have opinions that don't have any place in this area, but I don't have any other medical opinions.

Q. Well, you find third trimester abortion repugnant, don't you?

A. No, not necessarily. The way -- in Texas you've

got to document a proven, severe anomaly. You don't just have to have a suspicion of an anomaly, and I have gone along with that, and I've complied with and done those abortions.

Q. You stated in your report, Exhibit 12, "Although I find this practice appalling on a moral basis, apparently this is a legal procedure."

A. Well, that wasn't talking about third trimester abortions. That was talking about this particular 35-week abortion at which my -- my reading of the record indicated was seven and a half pound baby, but I was reading a different guess from what the ultrasound was.

Q. What is your understanding today as to the dosages of Misoprostol that were administered to M --

MR. RUBIN: Objection, asked and answered. He's already gone over this with the witness about when the Misoprostol was given.

MR. THOMPSON: The previous question was Misoprostol with the Pitocin.

A. My understanding that the doses were each 100 micrograms.

Q. How many -- how many dosages were administered on the first day, your understanding today?

A. Two.

Q. Were those dosages administered vaginally or

buccally or both?

A. My understanding is the first was administered vaginally, and the record is not clear as to how the second one was administered.

Q. Turn to Exhibit 8, the medical records. Please point out where you come to the conclusion that there were two dosages of Misoprostol that were administered on day one?

A. Which -- which --

Q. It's Exhibit 8, I believe. Exhibit 10, I'm sorry. Exhibit 10.

MS. NOWARA: No, it's 8.

MR. GOLDBERG: Eight? Is it 8? Okay. Exhibit 8.

A. And did you say a page number?

Q. I did not. Do you have the medical records that show what medications were administered on day one in front of you?

A. Yes.

Q. What day -- read the Bates number down below, the last three digits?

A. -22.

Q. -22. How many -- how many dosages were administered? How many administrations of Misoprostol were given on the first day?

A. It says she gave -- someone gave a dose at 15:55,

and I think this is one of the times that someone got their military time mixed up, and it was really 1:55, I think.

Q. How many -- how many times was Misoprostol administered on the first day?

A. Well, give me a minute, will you.

Q. Okay. I'm sorry.

A. All right. On the 11th, May 11th, there was a dose given at 09:15.

Q. Is May 11th the first day?

A. No, May 11th was the second day.

Q. My question to you was the first -- my question to you was how many dosages -- how many times was Misoprostol administered on day one, and you said twice.

A. Okay. That's what I was remembering a few minutes ago. From this document it appears that -- let me think about it a minute. That was given one time.

Q. Not twice.

A. One time is not twice, right.

Q. How about on the second day, how many times was Misoprostol administered?

A. It was given once at 09:15 or a different time if that's not a correct time, and she was discharged sometime later and told -- was given another dose of 100 micrograms to take at 3:00 p.m., and I'm assuming that means buccal, because it says, "Hold for one hour," and that could be

vaginal, but I don't think that it was.
Q. And until -- as you understand the records, until ML presented that evening in labor, did she take -- did she have any other administration of Misoprostol?
A. My understanding is the one that she -- the one that was supposed to take -- I think there was one she was supposed to take but didn't take.
Q. At 9:00 p.m.?
A. The orders on her page 24 are not clear. It just says to take one at 3:00, but I guess she was supposed to take one every six hours later.
Q. Look at page -- look at page 26.
A. It's not clear.
Q. Doctor, look at page 26. Does that clear it up for you?
A. Yeah, that clears it up. I misread this "RTC", because I always thought RTC was "return to clinic", but I'm being told today that's it "round the clock". So she was to take that every six round the clock, but she did not take the 9:00 o'clock one.
Q. Originally you had actually thought that she was instructed to take Misoprostol every one to two hours; is that correct?
A. No, no, I never was under that understanding. Where that came in was when she was in the hospital -- in

the clinic in the middle of the night May 11th/12, that their plan was to give Misoprostol every one to two hours. On the right side of page 30 it says, "Will augment with Misoprostol 100 micrograms, Q1 to 2 hours, will titrate dose," but I never thought she was supposed to take it every two hours.
Q. At the end of your testimony on direct, you indicated that you had a -- I think the word, phrase you used at one point was a third option, and then testified that that option was to administer Degoxin, effect the demise of the fetus and send ML or a patient out to present at a hospital, correct?
A. Yes.
Q. I just want to make sure I understand. You're not testifying that you think that that's a preferable way to proceed than the way Dr. Sella proceeded with ML, are you?
A. Yes.
Q. You are testifying that that would have been preferable?
A. Medically for the patient's benefit it would have been, because the likelihood of ending up with a ruptured uterus would have been much less. It would have been pretty hard for her to do that, unless she was on staff at the hospital and could do it herself.
MR. GOLDBERG: I have no further questions.

MR. THOMPSON: Mr. Rubin.
MR. RUBIN: One quick -- one redirect question.
REDIRECT EXAMINATION
BY MR. RUBIN
Q. Dr. Bullock, in going through your -- I believe during the cross you were -- you were cited to the statement in your deposition where you say you had no problem with the patient's decision to abort. Do you remember that question?
A. No, I never have a problem with a patient's decision to abort. It's just a personal decision, so that's what I meant.
Q. Right, but you draw a distinction between the patient decisions in this case and the doctor's -- physician's decision?
A. Yes.
Q. Dr. Sella's?
A. Yes.
MR. RUBIN: Okay. Thank you. That's all I have.
MR. THOMPSON: I have a couple questions, Doctor.
EXAMINATION
BY MR. THOMPSON
Q. Is every -- is it your opinion that every uterine rupture of an induced birth, a violation of standard of care?
A. No, sir, it's not. If you follow all the rules

and you do it the way you're supposed to and it happens anyway, that's not a violation of the standard of care.
Q. Okay. But it's your opinion it would be -- a uterine rupture that occurs due to or in conjunction with Misoprostol, or would that not be a --
A. If a uterus ruptures under the use of Misoprostol I would say that's below standard, because the standard says -- ACOG says you're not supposed to use that with a prior cesarean.
Q. Okay. If there was an in utero death after -- let's say there's an in utero death of the fetus, fetus wasn't viable after 35 weeks, how -- what options would a physician have to -- other than cesarean, they could remove the fetus through a cesarean?
A. Yes.
Q. Would that be the only option as a matter in order to meet --
A. No, that wouldn't be the only option. Another option would be a general induction of labor, which would mean that Laminaria would be fine to get the cervix to start opening up, putting a balloon inside the cervix, which is kind of a blown up ball about this big around and just putting pressure on it will help the cervix to begin dilating, and opinions vary about whether various doctors will use Pitocin. Some will. Some won't. So you have

those options, and rupture the membranes as soon as you can get in to do that, as soon as you can get to the membranes.

Q. Would it be appropriate to use Misoprostol in that circumstance?

A. No, not according to ACOG's guidelines, Misoprostol after a cesarean.

Q. Do you -- do you read that opinion, what you rely on for those documents or that literature, to caution against it for the purposes of protecting against agitating a live fetus or for the health of the mother, a concern over uterine rupture?

A. Both reasons. If you've got a live fetus, you will have a high risk of getting fetal distress and inadequate oxygen and all that. If you have a dead fetus, then the only concern left is mother's health, and the proscription still applies, because -- because you're still going to have a higher instance of ruptured uterus.

Q. Is it any -- does it change your opinion at all whether the facility can mitigate that risk through the ways the previous expert testified?

A. You mean like being able to do a cesarean right away?

Q. Being able to have a place in which the patient can rest, have access to an emergency facility, some of those things, if you can remember some of those things

Dr. --

A. It makes the -- it makes the -- yeah, it mitigates that, and then if you've got a facility where -- you know, for example, birthing centers that are on campus, they're simply part of the facility, and you just roll -- maybe you roll from one building to the next, but you're still contiguous, and so it does make a difference, your availability to experts.

Q. Okay. Two other things. Did you form an opinion -- and I don't -- did you form an opinion of whether or not the center in which the doctor worked had the capability to mitigate those factors?

A. I didn't know how close they were to a hospital until today.

Q. Okay. Did you form an opinion as to the -- any harm done to ML as a result of the uterine rupture?

A. Yes, the understood harm is going to be another cesarean, a scar that went caddywhompus, the scar that went crossways, not quite like this incision but all the way down to the cervix, which will make it more hazardous. In fact, one of the doctors at UNM said that she should not get pregnant again. I'm not sure what that doctor's level of training was, whether faculty or resident or fellow, but that is going to be a factor. You know, when she gets pregnant again, she'll review these records, the doctor will

or to help decide whether she should get pregnant again.

MR. THOMPSON: Okay. That's all the questions I have.

MR. RUBIN: Okay.

MR. THOMPSON: Release the witness. You're free to stay. Any reason not to release him?

MR. RUBIN: Well, there is the prospect of a rebuttal -- rebuttal case. I'm not sure what we're getting in the Respondent's case in chief other than Dr. Sella. So I don't want to have him released yet.

THE WITNESS: All right. My plan and my arrangement is to stay to tomorrow. So it's not a problem.

MR. THOMPSON: All right. Mr. Rubin, anyone else?

MR. RUBIN: Prosecution rests.

MR. GOLDBERG: Do you want to start now, or do we want to -- we're not going to finish today. So do you want to start now or do you want to start tomorrow morning?

MR. THOMPSON: Do we have any other -- oh, we're going to have Dr. Sella first?

MR. GOLDBERG: We have Dr. Sella. We have Dr. Sella, and then we have -- we have on our witness list Dr. Robinson, one of the counselors, Ms. Douda and then Ms. Tope, but I'm not going -- I'm not going to finish Dr. Sella at 45 minutes or an hour, so --

MR. RUBIN: Well, my thought is that if we had Dr.

Darney testifying that the availability of other facilities and the availability of abortion in general doesn't have any direct impact on what the standard of care is in this case, I believe that's what he testified to, then --

MR. GOLDBERG: The record -- the record is going to be what we get. My recollection is very different.

MR. RUBIN: Okay. Well, then I won't argue that point. It just seemed --

MR. THOMPSON: You can file a motion in limine.

MR. GOLDBERG: Well, I'll tell you right now, I'm not -- right now at least, I'm not planning on -- if you're asking me, am I going to bring back Dr. Darney?

MR. RUBIN: No, if we're not -- I mean, if Ms. Douda's going to testify as to where abortions are available and when, I believe Dr. Darney said that didn't relate to the standard of care.

MR. GOLDBERG: No, actually Ms. Douda is going to testify to whether ML was counseled on the risk of uterine rupture.

MR. RUBIN: Oh, I'm sorry. Then I misunderstood what you --

MR. GOLDBERG: Dr. Robinson is going to -- but is that still an issue in this case?

MR. THOMPSON: And you all can discuss that on recess --

MR. RUBIN: Okay.
MR. THOMPSON: -- whether or not the counseling issue is still accountable.
MR. GOLDBERG: No, this -- I'll tell you right now, Ms. Douda and Dr. Robinson are going to testify about whether ML was adequately counseled on the risk of uterine rupture.
MR. THOMPSON: Okay. So there's no use calling --
MR. GOLDBERG: And Dr. Sella has testimony on that, also. Ms. Tope is going to testify not about the availability of abortions but the availability of VBACs and TOLACs outside of a hospital setting in New Mexico --
MR. THOMPSON: Okay.
MR. GOLDBERG: -- which is relevant to what Dr. Bullock says is the standard of care.
MR. THOMPSON: Okay. So my question for you all, do what you want to do. Do you want to go an hour of direct of Dr. Sella, try and wrap it up and do cross in the morning, or do we want to -- we're going to end up going probably into the early afternoon tomorrow at least.
MR. GOLDBERG: Well, it depends -- actually it depends on -- yeah, it depends on what results from the conversation. Certainly if we have to put on Ms. Douda and Dr. Robinson, we'll go into the early afternoon. If we don't have to put on Ms. Douda and Dr. Robinson, my guess is

that we're going to be done, even if we start Dr. Sella in the morning, and we would be done in the morning if we start -- even if we start Dr. Sella in the morning, which frankly would be my preference is to start her in the morning.
MR. THOMPSON: Mr. Rubin.
MR. RUBIN: I think that's fine.
MR. THOMPSON: Okay. We're in recess.
(Note: Hearing in recess at 4:40 p.m. and reconvened at 4:41 p.m.)
MR. THOMPSON: Back on the record.
MR. GOLDBERG: Off the record, Mr. Rubin and I conferred, and we agreed that the issue of the counseling of ML as to the risk of uterine rupture and the -- and consequently any issue with respect to the consent is no longer an issue in this case, correct?
MR. RUBIN: Yes. Well-stated.
MR. GOLDBERG: Okay. Great. We'll release those witnesses.
MR. THOMPSON: Those witnesses are released. We're off the record.
(Note: Hearing in recess at 4:41 p.m. for the day.)

THE STATE OF NEW MEXICO
COUNTY OF BERNALILLO

BE IT KNOWN that the foregoing transcript of proceedings was taken by me; that I was then and there a Certified Court Reporter and Notary Public in and for the County of Bernalillo, State of New Mexico, and by virtue thereof, authorized to administer an oath; that the witnesses before testifying were duly sworn by me; that the foregoing transcript contains a true and accurate transcript of the proceedings, all to the best of my skill and ability.

I FURTHER CERTIFY that I am neither employed by nor related to nor contracted with (unless excepted by the Rules) any of the parties or attorneys in this case, and that I have no interest whatsoever in the final disposition of this case in any court.

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