Q. I'm sorry. I want to go back to the morning. When you released ML, did you release her with any uterine agent medications?
A. Yes.
Q. What did you release her with?
A. I gave hear Misoprostol, 100 micrograms and instructed her to put it in buccally between the cheek and the jaw at 3:00 p.m.
Q. You were here when Dr. Bullock testified?
A. Yes.
Q. And you heard Dr. Bullock criticize you for giving Misoprostol to ML to take outside of the clinic?
A. Yes.
Q. When you got the Notice of Charge, do you remember anything in the Notice of Charge telling you that providing a patient with Misoprostol to take outside the clinic was a basis of that charge?
A. No.
Q. When you went through your lawyers, you received the information, the backup information. Did you read Dr. Bullock's report?
A. Yes.
Q. Do you remember Dr. Bullock criticizing that in his report?
A. I don't.

Q. So is the first time you heard that criticism yesterday?
A. Yes.
Q. All right. Now, let me ask you, in all -- when you were in Wichita, Kansas and you were providing abortion services, did you provide to your patients Misoprostol to take buccally --
A. Yes.
Q. -- outside the clinic? Are you aware of any third party abortion provider that does not provide Misoprostol to patients to take outside the clinic?
A. No.
MR. RUBIN: Objection, relevance. We're not talking about all third trimester abortion patients here. We're talking about late-term C-section histories. I think the relevance -- maybe it's already been slightly relevant, but I don't think it is at this point based upon the testimony we've heard.
MR. GOLDBERG: Well, that wasn't -- that wasn't by the way either Dr. Bullock's testimony or the basis of his testimony. His testimony wasn't limited on this criticism. His testimony wasn't limited. He gave a somewhat extravagant characterization. He just said he would never have Misoprostol -- apply Misoprostol -- give somebody Misoprostol to take outside.

MR. THOMPSON: That was my understanding of his testimony. Objection's overruled. Question was -- and on cross, you can be more definitive with regard to -- to the -- to the issuance of the drugs. Overruled.
Q. (By Mr. Goldberg.) When you gave the Misoprostol to ML, what were your instructions to her?
A. The instructions to her and to all patients who I give Misoprostol to take at home is that if they start contracting, not to take the next dose.
Q. Again, just so the Hearing Officer understands let's describe a little bit what it means to take a tablet like Misoprostol buccally. Where is it inserted?
A. It's like chewing tobacco, right between the cheek and the jaw.
Q. And how long typically does it remain there?
A. It doesn't dissolve -- it sometimes doesn't dissolve completely. Actually it can just sit there.
Q. So it's not like taking a small, you know, breath mint and sticking it there, and then 45 seconds or a minute it dissolves?
A. I've never tried that, but I'll take your word for that.
Q. It can be there for an extended period of time?
A. Yes, yes.
Q. Okay. Was there anything else to the procedures

that you administered to ML that morning of the second day?
A. No.
Q. When did she return to the clinic approximately?
A. She came back in the afternoon at about 5:00 in the evening.
Q. And I think I asked this. Going back to the morning, did you apply Pitocin?
A. No.
Q. In the afternoon, describe the procedures that you administered to ML?
A. I removed the Laminaria. I checked her cervix. It had not changed. The bag of water broke with me inserting the Laminaria, and I instructed her to continue the Misoprostol every six hours round the clock. The next dose at 9:00 p.m. The plan was for her to come back the next day for more Laminaria.
Q. Did you administer any Pitocin to ML that afternoon?
A. No.
Q. What was the dosage that you gave -- first of all, what was the dosage that you gave ML to take buccally that afternoon?
A. A hundred micrograms.
Q. Okay. So how many times did you apply Misoprostol vaginally to ML?

A. Total of the two days, twice.
Q. Once the first day and once the second day?
A. Correct.
Q. It would be incorrect to read these records to say that Misoprostol was applied vaginally twice the second day?
A. Correct.
Q. When ML returned the third day -- I mean, the third time on day two, describe to me what the procedures were that you administered?
A. She came in the middle of the night contracting. I removed the Laminaria, and I checked her. I checked her cervix. She was contracting every four to five minutes.
Q. What medications did you give her?
A. I gave her Misoprostol.
Q. At what dosage?
A. A hundred micrograms.
Q. And then later on that evening or the early morning of the 12th, what medications did you apply?
A. I repeated the Misoprostol.
Q. That was approximately an hour later?
A. Yes.
Q. At what dosage?
A. A hundred micrograms.
Q. And each time, what was -- what was the means of delivery?

A. Buccally.
Q. Okay. What happened to the second dosage of Misoprostol?
A. She threw it up within half an hour.
Q. When did you administer -- did you administer any Pitocin to ML that night, the morning of the third day, May 12th?
A. Yes.
Q. When did it start?
A. It started when I gave the second dose of Misoprostol.
Q. When did you give the second dose of Misoprostol?
A. At 00:25.
Q. And when did she throw up -- or when did you -- when did you put in the record that she had thrown up the Misoprostol?
A. I wrote that she threw up at 00:52.
Q. So that's approximately 25, 27 minutes later?
A. Yes.
Q. So for what period of time did she have Misoprostol in her mouth that you were also applying Pitocin?
A. Twenty-seven minutes.
Q. What's about -- what's the half life approximately of Misoprostol?

A. It's about 20 to 40 minutes.
Q. And so when would you expect -- you heard Dr. Bullock's testimony. When would you expect Misoprostol basically to be out of the system?
A. Basically out at four hours, even at three hours, not a whole lot left.
Q. Okay. Thanks. Did you -- after that second dosage of Misoprostol the night of the second day and the morning of the third day, the one that she threw up, did you ever apply Misoprostol to -- administer Misoprostol to ML again?
A. No.
Q. Did she continue with the Pitocin throughout the night?
A. Yes, she did.
Q. And the dosage of the Pitocin was?
A. Was 10 units in 1,000 CCs.
Q. And in the morning, did you change that dosage?
A. Yes.
Q. And you changed it to what?
A. Sixty.
Q. Again 60 --
A. Sixty units in 1,000 CCs, yes.
Q. Explain to the Hearing Officer why you upped the dosage of Pitocin?

A. I upped the dosage of Pitocin to facilitate delivery. When she -- when I checked her in the morning, she still was not in what I would call active labor. She had progressed two centimeters from 11:00 p.m. to 7:00 a.m. That's eight hours, and I thought that the -- the safest thing to do would be to encourage contractions at that dose, which is my protocol.
Q. Okay. Is there anything else about your treatment of ML that you -- that I haven't covered that you would like to state for the record.
A. No.
Q. Okay. I have one more area to cover on my direct examination, but this would be -- for me, this would be a good time to take a break.
MR. RUBIN: For me as well.
MR. THOMPSON: Okay. Take a five-minute break.
(Note: Hearing in recess at 10:44 a.m.
and reconvened at 10:52 a.m.)
MR. THOMPSON: Okay. We're back on the record, completing direct examination of Dr. Sella. Go ahead, Mr. Goldberg.
Q. (By Mr. Goldberg.) Dr. Sella, I want to turn to the criticisms that Dr. Bullock has made with respect to the care you provided to ML.
MR. RUBIN: Hold on. I think a good time just to

state a general objection, there's only one expert per issue. This comes up quite a bit in the prosecutions I do, and certainly it's within the rights of a physician to have someone else opine on their behalf on the expert issues, but -- and I was very careful with Dr. Sella. I just asked her for the facts. Sounds like Mr. Goldberg is getting into what her opinion is as an expert on the standard of care when we've already had Dr. Darney speak to that, and there's no -- they don't get two experts on the same issue. So I don't want to -- I think that's probably -- if there's agreement on that, I think we can proceed. If not, we should probably reach a ruling on that, because I don't want to interrupt him during the whole -- during his questioning.

MR. GOLDBERG: Sure. I'll tell you it's been a long time since I -- I have done proceedings before the Medical Board before. This is not my first, but it's been a long time, but it was never my experience that a one-expert understanding precluded having the Respondent respond to the charges. This is really responding to the charges. If the Hearing Officer is going to rule that Dr. Sella doesn't get an opportunity to say -- to respond to this, that's -- that will be the ruling of the Hearing Officer, but I would say fundamental fairness suggests that Dr. Sella, who's -- it's her license that's at stake here. She ought to have the opportunity to say whether she thinks Dr. Bullock's

criticisms are good or bad, and I would think you would want to hear that.

MR. RUBIN: And I thought that's what Dr. Darney was here -- she chose to have Dr. Darney speak for her.

MR. GOLDBERG: Sure. I wouldn't have missed the opportunity to have Dr. Darney here. Any lawyer would want to have somebody besides the person who's being charged respond, but I'm not thinking -- I don't think in this case I wouldn't put up Dr. Sella as an expert. An expert is somebody who doesn't have a dog in the fight. An expert is neutral. She's the one who is being charged. I'm giving her the opportunity to say what she wants to say about the charges.

MR. THOMPSON: Objection overruled; admitted for that purpose. I think she's entitled to -- confronted with a charge that she did not meet the standard of care, that she's able to rebut that. She's able to rebut that with her understanding of what the standard of care was and what she did. So you may proceed.

Q. (By Mr. Goldberg.) You heard Dr. Bullock criticize your performance of this late-term abortion procedure, this third trimester abortion procedure on a woman with a prior C-section in the freestanding clinic.

A. Yes.

Q. And not in the hospital setting?

A. Yes.

Q. And that his opinion was that that was improper?

A. Yes.

Q. How do you respond?

A. I disagree.

Q. Tell the Hearing Officer all the reasons why?

A. Well, I think providing this service in an outpatient setting with excellent backup, which is what we have, is very safe and a good setting for women who are seeking a third trimester abortion.

Q. Do you -- do you have -- if, in fact, you could not provide abortion services in the third trimester to women with prior C-sections in the clinic here on Lomas, is there any place in New Mexico where a woman with a prior C-section could get a third trimester abortion?

A. Not that I know of.

Q. If, in fact, the standard of care were that no woman with a prior C-section could get a third trimester abortion in a standalone clinic, would that have an impact on the ability of women with prior C-sections to get third term abortions in the United States?

A. Yes.

Q. What would be the impact?

A. The impact would be that they would, because of that restriction, would essentially be forced to carry a

pregnancy to term.

Q. Does carrying a pregnancy to term have risks?

A. Yes.

Q. Are some of those risks greater than the risks of -- strike that. Are some of those risks serious risks like the risks attendant to providing an abortion on a woman -- a third trimester abortion on a woman with a prior C-section?

A. Can you repeat that question?

Q. It was a bad question. The risks of carrying a fetus to term, are some of those risks as serious as the risk of a uterine rupture here?

A. Yes.

Q. You heard Dr. Bullock's testimony that he relied on ACOG Bulletin 115 for his opinion on the standard of care?

A. Yes.

Q. You testified today that you are a fellow -- if they still call them fellows -- a fellow in ACOG, College of Obstetricians and Gynecologists?

A. Yes.

Q. And is part of that, maintaining that, you have to remain current, right, in the practice?

A. Yes.

Q. Including obstetrics and gynecology?

A. Yes.

Q. Not just abortion?
A. Yes.
Q. And you have stayed current; is that correct?
A. Yes.
Q. I want you to explain to the Hearing Officer your understanding of the proper application of ACOG Bulletin 115? And ACOG Bulletin 115 is in -- is an admitted exhibit in that book. It is Exhibit 10, Dr. Sella.
A. My understanding of this Bulletin is that it is geared towards term live births; as well, it's a guideline.
Q. Did you understand ACOG Bulletin Number 115 to be establishing a categorical prohibition of administering TOLACs or VBACs outside of a hospital setting to -- outside of a hospital setting?
A. No.
Q. Prior to the publication in 2010 of ACOG Bulletin 115, did you understand the previous ACOG guideline as a establishing such a categorical prohibition?
A. Yes.
Q. And do you have an understanding as to why the ACOG changed its guidelines?
A. Yes.
Q. And explain to the Hearing Officer what your understanding is?
A. My understanding is that the first bulletin was

very restrictive, and consequently many facilities that used to offer -- it was then called VBACs -- stopped offering them, and the C-section rate, which was rising anyway, rose even more, and the number of women, the percent of women who could have a VBAC plummeted. So the C-section rate rose for many reasons, but that certainly was one of the big reasons that it was no longer available. The rising C-section rate is a concern. It was a national concern. The NIH, the National Institute of Health convened a consensus conference on vaginal birth after cesarean in March 2010, and they looked at many things, but one of them was what were the barriers for women seeking -- that was called TOLAC. What were the barriers for women seeking TOLAC, and one of them was this -- the prior bulletin. In response, ACOG issued 115. That's my understanding.
Q. To your knowledge do any of the providers of abortion services in the third trimester, Dr. Hern -- outside of a hospital, Dr. Hern, Dr. Seletz, yourself, Dr. Robinson and Dr. Carhart, do any of them look to ACOG Bulletin Number 115 as establishing a standard of care as to how you're going to apply third trimester abortions to women with prior C-sections?
A. No.
Q. Are -- is the matter of how abortion providers like yourself who provided abortions in the third trimester,

how you do it, is that a matter that you discuss among yourselves all the time?
A. Yes.
Q. You've never seen Dr. Bullock at any of those meetings?
A. No.
Q. Dr. Bullock criticizes -- you heard Dr. Bullock criticizing you for administering Pitocin at the same time that you administered Misoprostol. Do you remember that?
A. Yes.
Q. How do you respond to that criticism?
A. Well, two ways. One is that in the third trimester abortion practice, that is part of the standard of care, and the second is, in fact, she didn't have Misoprostol and Pitocin at the same time for very long. Maximum given when she threw up and when it was administered, approximately three hours after the Pitocin was given, the Misoprostol was no longer in her system.
Q. When you -- finally, you heard Dr. -- I shouldn't say finally, next to finally -- you heard Dr. Bullock criticize you for administering Misoprostol at all. Do you remember that?
A. Yes.
Q. And you heard him say that he interpreted ACOG Bulletin 115 as prohibiting the administration of

Misoprostol even in third trimester abortions?
A. Correct.
Q. How do you respond to that criticism?
A. I disagree.
Q. Can you explain to the Hearing Officer why?
A. Again, this is -- I believe that third trimester abortion is distinct from an obstetric procedure. Although some of the risks are similar, it is not the same. So the standard of care is not the same. The standard of care for third trimester abortions are -- may have some similarities but are distinct from the standard of care for obstetrics.
Q. Are you aware of any provider of third trimester abortions that does not use Misoprostol as an agent for softening the cervix?
A. We all do.
Q. Not one?
A. No.
Q. And, finally, you heard Dr. Bullock criticize you for giving Misoprostol to ML to take back with her to the motel.
A. Yes.
Q. And I think we covered this before, but I'm going to give you the -- how do you respond to that criticism?
A. Again, I disagree with him. This is a practice that -- that we use, that I have used in Wichita. We have

close follow-up with our patients, and it has not been a problem, and it was not.

Q. I'm actually done with the questions, but as I do almost all the time in situations like this before I pass the witness, is there anything else that you would like to say to the Hearing Officer or put into the record before I pass you to cross-examination?

A. Yes, I'd like to say that I deeply regret that ML had a uterine rupture. It is a bad complication, and I recognize that, and my -- my goal when I see patients is that they go home physically well and emotionally at least moving towards recovery, because it's not realistic to think that emotionally they'll be fine at the end of the week, and this didn't happen with ML, and I regret that.

Q. And I'm going to make myself a liar. I'm going to ask a couple of follow-ups.

MR. RUBIN: Objection.

MR. THOMPSON: That he's a liar?

Q. You testified yesterday that you visited ML everyday that she was in the hospital?

A. Yes.

Q. Did she ever complain to you or blame you for the uterine rupture?

A. Not at all.

Q. In the, what, more than a year since that

occurred, just about almost a year and a half now since that occurred has she ever picked up the phone and called you to blame you for that uterine rupture?

A. Never.

Q. Have you ever gotten any report from anybody that she blames you for that uterine rupture?

A. On the contrary.

MR. GOLDBERG: Thank you. I pass the witness.

MR. RUBIN: If I can just have a few moments.

MR. GOLDBERG: Oh, is the Court going to rule on --

MR. THOMPSON: I'm going to rule on -- this may help you on your redirect -- I mean, on your cross.

MR. RUBIN: So we should put that ruling on before my cross?

MR. THOMPSON: Yes.

MR. RUBIN: Okay. Good. If I could just have a few moments.

MR. THOMPSON: Okay. We'll go off the record.

(Note: A short recess was taken.)

MR. THOMPSON: Okay. Back on the record. Hearing Officer's reviewed the affidavits provided, Exhibits 5, 6, 7; has read the Young v. Board of -- 81 NM, 5, 1969, involves a legal residuum rule, which interestingly enough is usually applied in -- in the reverse, and the question

is, legal residuum is that reliable evidence? Was the evidence reliable that the State used to revoke the -- or attempt to revoke a board of pharmacy license. Here we sort of have -- have the reverse. Is the evidence certainly permissible in an administrative proceeding but reliable in a court of competent jurisdiction.

I am not going to admit those exhibits for the following reasons. I do believe they're hearsay. I don't believe there's an exception to them. Although certainly I understand these witnesses' unavailability issue, doctors are --

MR. GOLDBERG: I think the word is notorious.

MR. THOMPSON: -- notoriously difficult to reach, and so if there's -- I entirely understand that. That's really not the -- and I believe the affidavits, in fact, are probably trustworthy. There's no reason to not believe the statements in there. The problem I have with them is that -- is whether the truth in the affidavit could be probed. I believe the State has some right to probe that truth and that they were not able to exercise that right in a timely manner, so I'm not sure it's reliable.

I also believe reading them that it somewhat borders on expert testimony with regard to the standard of care. I think there's been sufficient evidence on that. So I think some of that evidence is duplicative with regard to the

expert and the Respondent's testimony. I believe it is consistent with what has been provided previously. I will reserve ruling, however, if on rebuttal these issues are gone into. I'm -- I will at that point decide whether a rebuttal expert can be crossed on those affidavits. So for the purpose of their offer, I'm going to exclude 5, 6 and 7.

Okay. We're off the record for about four minutes.

(Note: Hearing in recess at 11:12 a.m.
and reconvened at 11:15 a.m.)

MR. THOMPSON: Back on the record. Number 2012-026, 11:15, cross of Dr. Sella.

CROSS-EXAMINATION

By MR. RUBIN

Q. Good morning, Dr. Sella.

A. Morning.

Q. Let me first start with a question about your testimony with regard to whether this was an augmentation procedure on day one, which I believe was 5-10, correct?

A. Yes.

Q. That's when on 5-10 ML first presented to you. Was she -- did she have any contractions on 5-10?

A. No.

Q. Was she dilated?

A. No.

Q. So on 5-10, fair to say, there was -- it would be

an induction of labor, correct?
A. No. You mean what I did with the procedures that I did on 5-10?
Q. No. When there's no labor, there's no dilation, are you still contending that you induced labor on 5 -- began induction of labor on 5-10?
A. I did not.
Q. You said you augmented labor on 5-10?
A. I did not.
Q. When you gave Misoprostol on 5-10, I believe your testimony was that a -- that it acts in part as a stimulant for contractions?
A. Was that a question?
Q. Yes.
A. That was not the purpose that it was used for.
Q. Can -- does Misoprostol, one of the things it does is to stimulate contractions, correct?
A. It can. It was not used for that in this purpose.
Q. Okay. And, of course, Misoprostol doesn't know -- doesn't know what you're using it for. It just acts the way it's going to act, right?
A. No.
Q. Just common sense, right?
A. No, that's not correct.
Q. Okay. Why not?

A. At that dose, in my experience giving that dose vaginally helps prepare the cervix, and it is part of cervical preparation. It is not part of inducing labor.
Q. So you're saying that dose would not stimulate labor?
A. Commonly not.
Q. Okay. So in your mind this was an augmentation of labor, not an induction of labor, because labor had already started to some extent by the time you presented --
MR. GOLDBERG: Object to -- object to the form of the question. It's contrary to the testimony.
Q. (By Mr. Rubin.) Well, I want to make sure I understand the testimony correctly. It's partly my fault. Was -- it's your contention today that you served not to induce labor but to augment labor?
MR. GOLDBERG: Same objection.
MR. THOMPSON: Overruled. I do have a question, the same question actually because I'm not clear. I think you testified that when ML came in, it was -- it was induction that went to augmentation. So my --
MR. RUBIN: That's what I thought, too.
THE WITNESS: May I clarify that? The first two days, day one and day two were to prepare the cervix.
MR. THOMPSON: Right.
THE WITNESS: That was neither induction nor

augmentation. She then went into spontaneous labor, presented at about 10:53 p.m. on day two. At that point I induced labor -- excuse me, I augmented labor. She was already in labor. She was already contracting every four to five minutes, so she was already having contractions. I augmented the labor.
Q. (By Mr. Rubin.) Okay. So let's go a little bit into the -- your testimony regarding the protocols that you typically use and that were used in this case. Is it your testimony that you differed in this case from your usual protocols for third trimester abortions with regard to the -- with regard to the counseling you gave ML? And if -- if you're confused by the question --
A. I am confused.
Q. Let me be more specific. What I'm asking you about is how you differ here from other cases that didn't -- third trimester abortion cases that don't involve a C-section. Did you -- I believe your testimony was that you differed in how you counseled ML from the typical third trimester abortion patient with regard to her C-section?
A. Well, every patient is different, and every patient has different issues, and routinely I discuss the specific issues that that patient faces.
Q. Okay.
A. So routinely when a patient has a C-section, I

discuss the additional risks.
Q. Okay. Now, with regard to the dosage, the doses of Misoprostol --
MR. GOLDBERG: I almost made you say that.
MR. RUBIN: You almost made me say "dosages".
Q. The dose of Misoprostol, how did you in this case depart from the protocol that you use for third trimester abortions?
A. Again, every case is different. It's not a cook book.
Q. That's why I'm asking the question. How did you depart from your cook book, if you will, with regard to Misoprostol in this case from your standard protocol for third trimester abortions?
A. In this case I gave her the Misoprostol buccally and instructed her to take it every six hours.
Q. Okay. And with the typical third trimester abortion protocol, you do not have them take it buccally?
A. It's hard to say the typical, because every one is different. Sometimes I do -- I give that, and sometimes I don't. I can't really say typically. But everytime, I don't always give it. I don't always omit it.
Q. Okay.
A. It depends on the situation.
Q. Okay. So when you were testifying earlier today

about what you typically do for third trimester abortions, there's -- there's no real cut and dry protocol that you follow?

A. There is guidelines, and then, again, every patient is different.

Q. Right. How did you differ -- well, on the Misoprostol, did you give more or less Misoprostol than you give the typical third trimester abortion patient?

A. When I've given Misoprostol round the clock I have at times given more.

Q. So the typical patient -- so, again, keeping in mind that every case is slightly different, but if -- if you could generalize, and tell me if you can't, generally you give less Misoprostol than you would give in this case?

A. I wouldn't say that.

Q. Okay. Thank you. What about Pitocin, same question?

A. Can you repeat the question, please.

Q. Sure. To the extent you can generalize about what you generally do with third trimester abortions, did you give more or less Pitocin to this patient in this case compared to those others cases?

A. Neither more nor less. Can you ask that question again?

Q. No, no. I think that will be -- I'm not trying to

be rude, but I think that would be Mr. Goldberg's job.

A. Okay.

Q. Let me ask you a question or two about -- about consent and about consulting with patients. If you felt that this procedure for ML was not appropriate for you to do, do you believe that there would be any issue with getting any consent? Would you still -- do you think consent would be relevant in such a situation?

A. Can you explain that? I don't understand your question.

Q. Okay. If let's say hypothetically ML presented with whatever conditions where you felt that you could not provide her with the abortion service, is consent relevant at that point? I think it's an easy question.

A. I don't think it's an easy question, because it wouldn't happen. If I felt that a patient -- that I could not care for a patient --

Q. Right.

A. -- I would not begin the consent process.

Q. Right. So when I ask you if it's not relevant, I think you're saying, yes, it's not relevant.

MR. GOLDBERG: Object -- I'm going to object to that. Not only -- he wants to say not starting the process is the same thing as relevance, because he wants -- it's clear he wants to use this for a particular purpose. That's

improper.

MR. THOMPSON: Overruled.

A. I still don't understand the question. I'm sorry. I really don't understand what you're getting at.

Q. Okay. Then I'll move on. Now, your -- you understand that -- you've testified as to what you think the standard of care is in this case, right?

A. Yes.

Q. And it's fair to say the standard of care is driven by the medical issues that would apply to this case?

A. Yes.

Q. Now, your attorney made a statement before, and I found it interesting. I want to know if you agree with it, and I think I'm quoting him fairly close to verbatim, but correct me if I'm wrong, that politics and the availability of abortions influence the medical necessities. Do you agree with that?

A. I can't speak for him. He would have to speak for himself.

Q. I'm asking if you --

MR. THOMPSON: Do you agree with that statement --

Mr. RUBIN: Right.

MR. THOMPSON: -- putting Mr. Goldberg aside?

A. Can you repeat that? Politics --

Q. Sure. I believe you used the term politics,

whether that dictates, influences the medical necessities?

A. I would want to ask him to elaborate on that comment, because I would want to flesh it out. What exactly does that mean? And I guess I can't ask him that, so I can't answer that question.

Q. Let's pretend he didn't say it. Let me ask you the question as if I'm saying it and ask you to agree with me then. Put Mr. Goldberg aside. Do politics influence the medical necessities in a given case?

A. The medical necessities, and what do you mean by that?

Q. Standard of care?

A. So do politics -- you're asking -- you're asking me if the political climate influences how we take care of a patient --

Q. Uh-huh.

A. -- day-to-day, whether we give -- insert Laminaria or -- I mean, is that what you're talking about?

Q. That's right. I'm talking about the procedures, themselves, what you administer to a patient, how you treat a patient, what happens -- and I can put it a different way if you'd like. How does what outside the clinic influence what you do -- what you do with a patient in the clinic?

A. I would say that the politics outside the clinic influence the patient's state of mind when she comes to the

clinic, and that effects the counseling and the emotional care of the patient. I think that has a very big impact. The actual technical part of the procedure to me is distinct from the politics. I would be interested in having a conversation with Mr. Goldberg about that, but that is my -- my view.

Q. Okay. Does the standard of care that applied in this case, is that effected at all by the availability of this procedure to ML elsewhere?

A. Let me see if I understand. You're asking if the care that she received or the care that I followed --.

Q. The standard of care.

A. The standard of care was influenced by the politics.

Q. Should it be?

A. Should it be?

Q. Should it be influenced by -- I'm trying to ask the more specific question, not just politics generally, but the availability of third trimester abortions, does that influence the standard of care in this case? Because we've heard a lot of evidence about it.

A. About the standard of care?

Q. About both, about the availability of third trimester abortions elsewhere as well as the standard of care. I'm wondering, the standard of care in this case

given this patient presenting with what she had, is that influenced by the availability of abortions, third trimester abortions elsewhere?

A. Okay. I understand now what you're asking.

Q. Okay.

A. What is effected by the availability is that she had to travel from New York to Albuquerque. That's -- that's the politics of it. Once she's seeing us, we're a clinic. Our job is to take care of her. It's not about the politics.

Q. Right. So what you administered to her, what you insert in her, what you do to her surgically speaking has nothing to do with whether abortions are available elsewhere to her, correct?

A. Not for me.

Q. Okay. Thank you. Let me ask you a few questions about the ACOG Bulletins, and you testified that you are a fellow at ACOG?

A. Yes.

Q. And so you're familiar with 54 and 115?

A. Yes.

Q. All right. Do you have 54 in front of you?

MS. NOWARA: It's 13.

MR. RUBIN: Thank you.

MS. NOWARA: Do you have it?

A. I have this one, yes.

Q. Okay. If you could turn to the summary of recommendations in Number 54, and I believe there's a recommendation that they characterize as level C on that page, the first one.

A. Yes.

Q. Are you with me?

A. Uh-huh, yes.

Q. Let me read it. "Because uterine rupture may be catastrophic, VBACs should be attempted at institutions equipped to respond to emergencies with physicians immediately available to provide emergency care." I'm reading that correctly, right?

A. Yes.

Q. Let's compare that for a moment. Maybe keep your finger on that page and then look at 115 and have you turn to -- try to keep your finger there as well -- page 8 of 115, and let me -- on the third paragraph that begins with the word "because".

A. Yes.

Q. "Because the risks associated with TOLAC and that uterine rupture and other complications may be unpredictable, the staff recommends that TOLAC be undertaken at facilities with staff immediately available to provide emergency care." I'm reading that correctly, too, right?

A. Yes.

Q. Are you saying that's a significantly different statement from the one I just -- we just read in 54?

A. If you read just those two sentences, they're comparable, but if you continue to read, you'll see that there is a difference.

Q. Okay.

A. Shall we read the next sentence?

Q. Well, let me move on to my next question. Your attorney has the chance to give you redirect on that.

A. Okay. Sorry.

Q. Now, you understand that 115 provides -- gives a very strong recommendation, if you will, against using Misoprostol with TOLACs, right?

A. Yes.

Q. Would you say it's -- you say it's a guideline, right?

A. Yes.

Q. Does it give -- does it elucidate any specific circumstances where you would give Misoprostol in a TOLAC? Does it mention any situations there?

A. It does not.

Q. Okay. And 54, if you could turn back to that. I'm sorry. Do you have 342 in front of you? We need to switch to 342 for a minute.

A. Yes.
Q. Is 342 in your mind still relevant?
A. 342 is out of print and has been replaced by number 115.
Q. Okay. So both -- both of these previous ones were replaced by 115, correct?
A. Yes.
Q. And on page 343 -- oh, wait. Now, on page --
MR. GOLDBERG: That's number 14, Mr. Hearing Officer.
Q. On page 2 --
A. Where are we now?
Q. Exhibit 14, 342, and I believe you were here for Dr. Bullock's testimony. He cited a few statements in 342 that were against the mixing of prostaglandins and Oxytocin, right?
A. Yes.
Q. And Misoprostol is a prostaglandin, right?
A. Yes.
Q. Okay. So correct me if I'm wrong, but it seems like the evolution from 54 to 115 was that in 54 they said you don't mix them. In 115 they say you don't use Misoprostol, right?
A. Yes.
Q. So the fact that it doesn't mention -- 115, that

you shouldn't mix the two, why would they mention that you shouldn't mix them if they're saying you should use one? Does that make -- would you expect them to say not to mix them?
A. I'm not going to -- to comment on how ACOG wrote the Bulletin. I can't do that.
Q. Okay. That's fine. Let's go -- before I ask another question about this, I just want to go back to the video that we watched. I was hoping you would do this with Mr. Goldberg. Where did the patient stay during -- and maybe you covered part of it. Did -- or let me -- strike that. Let me ask it this way. I believe the video included a depiction of an annex room, right?
A. Yes.
Q. And that was for patients that required special attention, correct?
A. Yes, in recovery, yes.
Q. Okay. And that was set aside from the other patients? And maybe it's because it was a poor made video, so maybe if you could just explain for me, I thought I heard where the room that certain patients would go to depend upon their level of risk?
A. No.
Q. Okay. All patients were sent through the same rooms regardless of risk?

A. The annex room is part the recovery room.
Q. Okay. And is the annex room set aside from the recovery room because of any risk assessment?
A. The annex room is designed -- and it's right off of the recovery room. It is, for example, if someone comes with a partner and they want to be together, they want sometime together, we put them there.
Q. Okay. And so this patient, to the extent there were other patients in the facility, she would be in the same room as the rest of the patients, correct?
A. At which point?
Q. Except for when the procedure's being -- well, there was a room with -- the room with the lighting adjustments with the stirrups was where the procedure -- that's the procedure room, correct?
A. Correct.
Q. Other than that room, the other rooms are for all the patients. You don't differentiate among them, correct?
A. Again, as I explained with the annex room, there are patients who go there, and there are other -- but that's for recovery. Is that what you're talking about, the recovery period or which period are you referring to?
Q. I'm talking about when they go into the clinic from the outset?
A. From the outset they go to the waiting room.

Q. Okay. And maybe you could just answer this without me trying to be specific about rooms. Is there a different procedure for where patients go depending upon what trimester they're in?
A. Is there a different part of the clinic that they go?
Q. Sure, different rooms, different part of the clinic.
A. Okay. The video showed the gurney room. That was the laboring room, so that is for women in labor. First and second trimester patients are not there.
Q. Okay. And with regard to this patient, did she -- did you have her set up in any way different than other third trimester patients?
A. In terms of?
Q. In terms of where she sat, what was provided for her, any preparations? Was anything done differently for this patient than your typical third trimester patient?
A. The only difference was that she came in in the middle of the night, and so she was our patient at night.
Q. Okay. But -- okay. Going back to ACOG then, I understand you differ with Dr. Bullock about whether the standards as expressed in 115 should apply in this case, correct?
A. Correct.

Q. And you do not believe they should apply to any third trimester abortions, correct?
A. Correct.
Q. I'm going to give you a hypothetical, and witnesses hate hypotheticals, but it's going to hopefully give me an answer. Assuming Dr. Bullock is right that ACOG -- that this ACOG 115 should apply in this case, do you feel you followed 115?
A. I'm not going to make that assumption, because I don't believe that to be correct.
Q. Well, that's why I was trying to make light of the fact that witnesses don't like hypotheticals, because it can be uncomfortable, but I'm going to ask you to answer the question.
A. And I can't.
MR. RUBIN: Mr. Thompson, would you ask the witness to answer the question, please? I'm giving her a hypothetical that I think is very relevant and very helpful to the Board, because in the event that Mr. Bullock is correct regarding 115, we would like to know what she thinks about how it applied in this case.
MR. THOMPSON: Doctor, if you're able to answer if 115 were the standard of care applied to third trimester --
MR. RUBIN: No, to this case, not to third trimester abortions.

MR. THOMPSON: If 115 were considered the standard of care.
THE WITNESS: I would say -- I actually like your question a whole lot better. If this Bulletin was for third trimester providers --
MR. RUBIN: Let me object to the answer.
THE WITNESS: -- and these were the guidelines --
MR. RUBIN: Let me object to the answer, because that wasn't the question. You may have liked his question better, but Mr. Thompson I believe was trying to ask my question. Assuming the ACOG Bulletin applies to the facts of this -- the standard espoused in this -- facts in this case, did you follow it?
MR. THOMPSON: And we know you don't assume that.
THE WITNESS: Okay.
Q. (By Mr. Rubin.) Right. Please, I'm not trying to put words in your mouth. I'm not saying you -- so you understand, it's hypothetical.
A. If I was an obstetrician/gynecologist taking care of obstetric patients and I did not follow this, I was not following the ACOG Bulletin. Yet, these are guidelines. So this is not -- the Practice Bulletins are not the standard of care, and that's -- that's clearly stated by ACOG. They are guidelines.
Q. So you're stating 115 is not evidence of this --

is not relevant to the standard of care in this case as discussed by ACOG?
MR. GOLDBERG: She's -- she's not an expert here anyway. She's the Respondent, and she's not a lawyer. Dr. Bullock actually is a lawyer. She's not a lawyer. Relevance is a legal issue. She's already -- she's already stated what she does know as a -- as a fact. She can testify as to facts.
MR. THOMPSON: Let me try, and I'll try to explore the point, which I think he's getting at, which is in a -- in a statewide where they derived the standard of care for a patient like ML, and they took the standard of care from Bulletin 115 whether they should have or shouldn't have or not, that's the state we're at and you're in that state, do you believe that you met the --
MR. RUBIN: Guidelines.
MR. THOMPSON: -- the guidelines of 115?
THE WITNESS: Okay.
MR. THOMPSON: Is that any better?
THE WITNESS: Yes, it is, because the difference is that you're saying these guidelines are no longer guidelines. These are the standard of care in this community.
MR. THOMPSON: Yes, in community X.
THE WITNESS: So if that was the standard then and

I had -- then I would not have met the standard.
MR. RUBIN: Okay. Thank you. Thank you to both of you. If I could just have a moment. All right. That's it. Thank you very much, Dr. Sella.
MR. GOLDBERG: I have some questions.
REDIRECT EXAMINATION
BY MR. GOLDBERG
Q. 115, the last line of questions, when you say you did not meet the standard of care under 115 in providing the care, it's not because you did it in a clinic setting, is it? Because 115 doesn't require this to be done in a hospital?
A. Correct.
Q. What way do you think you did not meet the standard of care?
A. And, again, that would be if it was determined that 115 was the standard of care.
Q. Sure.
A. I want to be very clear about that, because it is not determined. The issue is Misoprostol.
Q. Only with respect to the Misoprostol?
A. Correct.
Q. But, of course, you were not applying the Misoprostol -- 115 is written for TOLAC, the trial of labor, correct?

A. Correct.
Q. And VBAC, vaginal birth after cesarean?
A. Yes.
Q. VBAC -- VBAC is a successful TOLAC, correct?
A. Yes.
Q. So as you understand 115, was 115 addressing Misoprostol for the purpose that you were using the Misoprostol as to ML; that is, for preparing the cervix over a long period of time?
A. No, it was not.
Q. So if somebody was asking you in this hypothetical community -- somebody was asking you in this hypothetical community, is this the standard of care that applies to this particular thing, what -- as to Misoprostol, what would you say to them?
A. I'm sorry?
Q. I'll make that argument in the brief.
A. Thank you.
Q. But as long as we're on 115 and for -- I'm not going to spend a lot of time on this, this politics stuff, the record will be what the record is as far as what I've said, but this notion that the standard of care is driven exclusively by the science, do you believe that the standard of care that is applicable in this country to physicians is driven exclusive by scientific concerns to your knowledge?

A. No, of course not.
Q. And ACOG doesn't believe that does it. Would you read the first page. Let's turn to the first page of 115, and please read into the record under Backgrounds, the sentence -- the sentences starting with in the right-hand column, "In part (these reports)." They're talking -- here they're talking about the fact that VBACs and TOLACs have plummeted since 54, right?
A. Yes.
Q. Okay. Now, continue to read.
A. "In part" --
Q. Yes.
A. "In part these reports and the professional liability pressures" --
Q. "Professional liability pressures", let me stop you there. Let me stop you there. You've been a doctor for a long time. Do professional liability pressures effect how doctors perform their jobs?
A. Yes.
Q. Do they -- do they have -- have they -- you've heard the phrase "preventative medicine"?
A. Yes.
Q. What's preventative medicine?
A. Preventing -- preventing --
Q. Lawsuits?

A. Yes, most definitely do.
Q. Is it not correct, Doctor, that doctors routinely in this country, they bemoan the point, but routinely in this country administer tests, comport their services in some part, because they're seeking to avoid what they consider to be unfounded liability?
A. Yes.
Q. That's not driven by science, is it?
A. No.
Q. Thanks. As long as we have 115 in front of us, let's go to the area where Mr. Rubin did not want you to clarify, and do you remember where you were?
A. No. Page 8.
Q. Yes. It's on page 8.
A. The next sentence?
Q. Sure. Put it in context. Do you remember the context?
A. Dr. Rubin had me read --
Q. Mr. Rubin.
MR. RUBIN: That's okay. I called him Dr. Goldberg.
A. Mr. Rubin had me read the sentence that was duplicated and then outdated, either bulletin -- yeah, I think it was the bulletin. He had me read --
Q. And that was actually the -- yeah, it was the

bulletin. But go ahead. Read the sentence that he -- that he was addressing.
A. The sentence that I read was, "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."
Q. Now, go ahead and read what you wanted to read.
A. "When resources for immediate cesarean delivery are not available, the College recommends that healthcare providers and patients considering TOLAC discuss the hospital's resources and availability of obstetric, pediatric, anesthetic and operating room staffs."
Q. If you want -- if you want to have recourse to ACOG Bulletin 54, go ahead. That's the out-of-date replaced bulletin, but is that language in 54?
A. I did not see that.
MR. GOLDBERG: Okay. Thank you. I have no further questions.

EXAMINATION

BY MR. THOMPSON

Q. Doctor, I have actually just one question with regard to the -- to these journals and the protocols that were established in the Kansas clinic by Dr. --
A. Tiller.

Q. -- Tiller. Are those -- part of the previous experts testified that University of New Mexico has this fellowship on family -- it's a family planning fellowship, and that fellowship involves abortion services?

A. Yes.

Q. Are there protocols as part of that fellowship with regard to implementing what Dr. Tilman (sic) initiated in Kansas?

A. No. And the reason is that those fellowships deal with first and second trimester abortion, and I don't know of any that are involved in third trimester abortion.

Q. And when did Dr. Tilman develop these protocols?

A. That was over time. He started providing abortions in the -- I think in the '70s.

Q. Okay. And I want to focus specifically on third trimester, post-cesarean.

A. Yes.

Q. Did he develop protocols -- well, I think you testified your protocols were bourne of his, what he developed for those procedures?

A. Yes.

Q. When did he develop these protocols?

A. I couldn't tell you the exact date. It was over time.

Q. Was it before these Bulletins?

MR. GOLDBERG: 115?

MR. THOMPSON: Yeah.

A. Yeah, because he was dead, and that one -- yes, it was before 2004. Is that the year?

MR. GOLDBERG: 115 is 2010.

THE WITNESS: Oh, well, 2010 he was not alive.

Q. (By Mr. Thompson.) Great.

A. He was providing abortion -- third trimester abortions for patients with C-section using Misoprostol and Pitocin in 2004.

Q. And prior?

A. And prior to that, yes.

MR. GOLDBERG: And after?

THE WITNESS: Yes.

Q. And I guess my general -- I think you testified to this and the expert testified to this as well, but we have these Bulletins which appear to apply to obstetric, which is live birth.

A. Yes.

Q. But there's no practice bulletin like this with regard to the procedure that was applied to ML?

A. Correct.

MR. THOMPSON: That's all the questions I had.

MR. RUBIN: Mr. Thompson, I was intending on calling Dr. Sella for rebuttal, but I realized -- if I could

-- I could ask her one more question, then I --

MR. GOLDBERG: I have no objection.

MR. THOMPSON: Okay. That's fine. Let me just complete that.

Q. (By Mr. Thompson.) Oh, there's been a lot of discussion about this being a 35 week. When does the -- what is the time period for the third trimester?

A. It starts at either 25, 26 weeks through 40 weeks.

Q. Is there any significance in your mind if a patient presents at 32, 33, 34 weeks as compared to 35?

A. No.

Q. Okay. In your practice did you do live births where you -- were you -- at one point of your practice did you do -- did you have an obstetric practice?

A. Yes.

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

RECROSS-EXAMINATION

BY MR. RUBIN

Q. One last question. Dr. Sella, in this case, do you consider the procedures you performed on behalf of the patient to be elective?

A. How do you define "elective"?

Q. How would you define "elective"?

MR. THOMPSON: Do you know what elective surgery is?

THE WITNESS: Yes, so as opposed to non-emergency.

Q. That's -- well, as -- how would you define elective?

A. Elective would be someone electing to have a procedure.

Q. Choosing to do a procedure?

A. Choosing to do a procedure.

Q. And I think you were here for the testimony yesterday where there are some procedures that are way up on the other scale as not being elective, someone has to do an emergency tracheotomy, okay. Is this case a case of elective surgery?

A. It's elective in the sense that the patient comes requesting a procedure, yes. For her, for the patient I don't think that she saw it as elective, but that's a different story.

Q. Okay. Did you see it as elective?

A. Yes.

MR. RUBIN: Okay. That's -- no more questions.

MR. THOMPSON: Okay.

MR. GOLDBERG: I'm sure you're not going to allow rereredirect.

MR. THOMPSON: Thank you, doctor.

MR. GOLDBERG: I won't even ask.

MR. THOMPSON: Okay. Mr. Goldberg.

MR. GOLDBERG: Actually it's Ms. Schmidt Nowara who's going to put on Ms. Tope.
MS. NOWARA: I need to do something. Do we want to a -- it's 12:00. I don't know. Ms. Tope's testimony is going to be very short.
MR. THOMPSON: I'd just as soon get through it.
MS. NOWARA: Okay.
MR. RUBIN: By "short", do you mean like half an hour?
MS. NOWARA: By short, I mean maybe ten minutes.
MR. GOLDBERG: Her "short" is a lot better than my "short".
MS. NOWARA: My "short" is a lot better than everyone else's "short". Trust me.
MR. THOMPSON: Ms. Tope.
THE WITNESS: This is the hot seat, right?
MS. NOWARA: Good morning.
MR. THOMPSON: Let's swear in -- the court reporter swear her in, please.

DEBORAH R. TOPE

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

DIRECT EXAMINATION

BY MS. NOWARA

Q. Good morning. Ms. Tope.

A. Good morning.
Q. Can you please state your name and spell it for the court reporter.
A. Debbie Tope, T-o-p-e.
Q. Ms. Tope, where do you work?
A. I'm employed with Freedman, Boyd, Hollander, Goldberger, Urias and Ward.
Q. Well pronounced. How long -- what is your job title there?
A. I'm a paralegal.
Q. And how long have you worked at the Freedman Law Firm?
A. A little over ten years.
Q. Do you work with Mr. Goldberg?
A. Yes.
Q. I'm going to turn to this case specifically. Are you familiar with the case at hand?
A. Yes.
Q. And did Mr. -- are you the paralegal assigned to this case?
A. Yes.
Q. Okay. And did Mr. Goldberg give you an assignment related to this case?
A. Yes.
Q. And what was that that you were asked to do?

A. To conduct a survey related to the availability of VBACs in New Mexico?
Q. Okay.
A. Excuse me. Let me clarify, in a non-hospital setting.
Q. So in a non-hospital setting, that includes clinics, birthing centers?
A. Yes.
Q. And did you do anything to identify non-hospital based clinics or birthing centers in New Mexico?
A. Yes, I searched the internet using the Google search mechanism to identify --
Q. Google?
A. -- to identify birthing centers.
Q. And approximately how many birthing centers or non-hospital based clinics did you identify?
A. About eight.
Q. Okay. Did you come up with a fact pattern to give to the clinics?
A. Yes, I -- I constructed a fact pattern to present to the birthing centers as follows: That I am a 32 year old married woman who is interested in finding a location to have a -- the birth of my second child. I had a previous cesarean section -- previous cesarean section. I had other fact patterns doing it, the other portions of the fact

pattern to answer if I was asked questions. Initially what I just stated is the information that I gave when they answered the phone.
Q. Okay. And as part of this assignment after identifying the birthing centers, did you call the birthing centers?
A. Yes, I called them, and I either spoke to someone at the time or left a message, and they called me back.
Q. And did you speak to someone at all approximately eight of these birthing centers that you located?
A. No. One center did not call me back.
Q. Okay. I'm going to hand you -- or actually in front of you is what's been marked Sella Exhibit Number 16. Do you recognize Exhibit 16?
A. Yes, this is the chart I prepared as I was doing the survey.
Q. Okay. Did you create this document?
A. Yes.
Q. And please explain what the chart describes?
A. The chart lists the locations and contact information for the centers that I called along with any questions that I was asked by the center, my responses to any questions, and their -- their statements to me as to the availability.
Q. Let's walk through the -- let's walk through the

chart. Listed is -- the first clinic listed or birth center listed is Northern New Mexico Birth Center?
A. Yes.
Q. Where is that located?
A. In Taos.
Q. And were you able to speak so someone at the Northern New Mexico Birth Center?
A. Yes.
Q. And did you give your scenario to the person you spoke with?
A. I did.
Q. And what did they indicate as to whether they would do a VBAC?
A. They said, yes, depending on my medical history, they could do a VBAC. They offered me a free half-hour consultation to come in and discuss this with one of the midwives. I declined that on the basis that I was still in the preliminary process and had not yet made a decision.
Q. And is it your understanding that the New Mexico -- Northern New Mexico Birth Center is a freestanding clinic?
A. Yes.
Q. Not in a hospital?
A. Oh, correct.
Q. Let's move on to the second center listed, Dar a

Luz Birth and Health Center. Where is that located?
A. That's in Los Ranchos, New Mexico.
Q. And did you -- were you able to speak to someone at that clinic?
A. I did.
Q. And were you able to ascertain whether they performed VBACs?
A. Yes, they indicated that they can do VBACs. They -- the questions I was asked by the individual at that center was if I had had just the one cesarean section, and I answered yes. The other question they asked was which way does the scar go, horizontal or vertical, and I answered horizontal.
Q. And did they indicate that they could care for you, the hypothetical patient?
A. Yes.
Q. Let's move to number three, Natural Birth Center. Where is that located?
A. That is -- this person, this provider does not have her own birthing center, but she indicated that she and other midwives use a birthing center located in Nob Hill.
Q. Okay. And did they -- did the woman you spoke with indicate whether they do VBACs, they can do VBACs?
A. Yes. She volunteered that all midwives can do VBACs, and they believe in them, and she indicated that she

could do that for me.
Q. Now, I don't think I actually made this clear. When we -- when you're talking about VBAC, that's an acronym that there's a lot of testimony on the record about what that stands for, but what is your understanding of what that stands for?
A. I understand VBAC to mean a vaginal birth after cesarean section.
Q. Thank you. Let's move to the fourth clinic, Empowered Women, Empowered Births, LLC, or Service. Did you contact someone from that service?
A. Yes, I spoke to someone at that location, and she indicated that -- well, she does not have a birthing center of her own. She initially when I had expressed an interest in locating a birthing center, in response to that she offered the names of the Dar a Luz or the Rio Grande Midwifery as locations that have their own birthing centers. She indicated that she could do a birthing center birth by renting a location on Wellesley, and that she also does home births.
Q. And did she indicate that she -- so she indicated that she could do a VBAC?
A. Yes, she indicated that we could do a natural birth or a VBAC with her.
Q. Let's move to Inspire -- I'm sorry. Go ahead.

A. She did ask a couple of questions. She asked me why had I had a cesarean with the first baby, and I responded, and how did I feel about that, and I responded that as part the scenario that I had constructed that -- that I had been in labor for 12 hours and had pushed for one hour, and labor had not progressed beyond that.
Q. And why did you give that part of the scenario?
A. I had constructed that part of the scenario to make it as similar as possible to the case at hand.
Q. To ML's case?
A. Yes.
Q. As you -- the facts as you understood them?
A. Yes.
Q. Let's move to Inspired Birth and Families. What is Inspired Birth and Families?
A. I found out that this is not a birth center; that they do birthing classes, and the individual I spoke to said that she could offer me names of midwives who do do VBACs, and she volunteered that if a woman is low risk in every other area, midwives can certainly handle VBACs, and if a problem arises, that person could be transported to a local hospital.
Q. And then finally Rio Grande Midwifery?
A. This location only does home births, and she said we could certainly do VBACs as home births, and she also

asked why I had a C-section before. She volunteered that she had a patient do a VBAC in April, and that everything was fine with that birth.

Q. And is Sella Exhibit Number 16 an accurate reflection of your survey results?

A. Yes.

Q. And what you've just testified to?

A. Yes.

MS. NOWARA: I'm going to move to admit Sella Exhibit 16 into evidence.

MR. RUBIN: I'm going to object. Certainly a witness can testify based on -- refresh their own recollection based upon their notes. It would be improper bolstering, however, for her to then have as an exhibit what she just put in the record. That's why we have a court reporter. She said essentially what's on here, but I don't see how she gets -- how the Respondent gets to have a separate exhibit saying what she just said into the record. I don't print out Dr. Bullock's testimony, submit that as an exhibit. I mean, that's just not how we do things here.

MS. NOWARA: Can I respond?

MR. THOMPSON: Uh-huh.

MS. NOWARA: As the Hearing Officer has said in this hearing, in these administrative type procedures there is a more flexible standard as to what goes into the record.

This is going to be reviewed by both the Medical Board, possibly district court, and even all the way up to the Supreme Court. We'd ask for this to be a part of the record, because I think it will just make the record clearer as to what the testimony was. It just augments.

MR. RUBIN: Bolsters.

MS. NOWARA: Pardon the --

MR. THOMPSON: Hearing Officer is going to admit Exhibit 16 as a summary of the witness's testimony, summary survey.

MS. NOWARA: Thank you. I have no further questions.

MR. RUBIN: I have no questions.

MR. THOMPSON: You're released.

Mr. Goldberg, any more witnesses?

MR. GOLDBERG: We do not. Relying on the stipulation we entered into yesterday, the other two witnesses we had were addressing a matter that is now removed from the consideration.

MR. THOMPSON: Anything else from Respondent?

MR. GOLDBERG: No.

MR. RUBIN: If we could take a lunch break, I will have some questions for Dr. Bullock on my rebuttal.

MR. THOMPSON: Okay. How long do we know with Dr. Bullock?

MR. RUBIN: I would say 45 minutes.

MR. THOMPSON: All right. How's everybody's schedule? You want to come back at 1:00?

MR. GOLDBERG: That would be fine.

MR. THOMPSON: We're in recess.

(Note: Hearing in recess at 12:07 a.m. and reconvened at 12:58 a.m.)

MR. THOMPSON: Okay. We're back on the record. 1:00 p.m., 2012-026, matter of Dr. Sella. The witness was sworn previously. Doctor, you're still under oath.

DIRECT EXAMINATION

BY MR. RUBIN

Q. Good afternoon, Dr. Bullock.

A. Hello.

Q. You were here for I believe most of the testimony of Dr. Sella, correct?

A. Yes.

Q. And you heard her testimony regarding whether or not the ACOG standards in Bulletin 115 should be applied to the facts in this case?

A. Yes.

Q. And do you agree or disagree with her opinion and why?

A. I disagree, because there's nothing in there that says this doesn't apply to dead babies. This just applies

to babies, and there's -- if they wanted something to -- to disapply to near term babies with fetal demise, they would have said it, and this was -- there's no difference in an abortion, 35-week baby with fetal demise induced versus a mother who simply comes in and says, "It's quit moving," and you find out it's dead. They're the same, and the standards apply to both of those patients.

Q. Okay. I believe Dr. Sella's testimony earlier today was that she characterized the risks in a third trimester as being somewhat obstetric or partially obstetric, and pardon me if your memory is different. How would you characterize the concerns and the risks in a third trimester? Is it obstetric or not?

A. Yes, they're obstetric, but it is a continuum, and while the risks at beginning of third trimester, give or take 25 weeks, they're not as extreme as the risks at -- at when at the time the baby is at its full size, which in this case it was. There's a continuum. I can't really say at which point it becomes obstetric and which -- when it stays I guess surgical.

Q. Uh-huh. So on that point are you offering any opinion today with regard to the standard of care that should apply to all third trimester abortions?

A. No, because the ones that are much earlier, it hasn't been established what the standards are at which

specific levels of pregnancy.
Q. And do you think this case is like a typical third trimester abortion?
A. No, this is one of, at the very most, a handful of cases like this, this far along that have been done in the entire country. It may be the first, in fact. So certainly most of the -- all of the other third trimester abortions are earlier, and the majority, much earlier than this.
Q. Okay. Did you look for any published standard for a third trimester abortion?
A. Yes.
Q. Did you find any?
A. I didn't find any.
Q. Okay. Now, you were here for -- I believe for Ms. Tope's, Ms. Tope's testimony?
A. Yes.
Q. And I believe she was talking -- she gave some testimony regarding her investigation into the availability of TOLACs or VBACs for -- that midwives provide, right?
A. Yes.
Q. Outside of a hospital setting?
A. Yes.
Q. In your experience in obstetrics and gynecology, do you have any knowledge as to any kind of national standards or national associations regarding midwives and

what they do?
A. The American College of Nurse Midwifery is the national certifying organization for nurse midwives, and you can make a general assumption that midwives who advertise -- that birthing centers, most of these are going to be certified nurse midwives, and the American College of Nurse Midwifery has standards and rules that prohibit VBAC in a freestanding birthing center.
MR. RUBIN: Okay. So if you could just help me out, Mr. Goldberg, which is the exhibit that we have with Ms. Tope? I --
MR. GOLDBERG: Sixteen.
MR. RUBIN: Can I see 16 for a second?
MR. GOLDBERG: Here, we have copies.
MR. RUBIN: Thank you. I appreciate it.
Q. (By Mr. Rubin.) So looking at Exhibit 16, what's your -- what's your thoughts on this?
A. These are all nurse midwives who are breaking the rules of American College of Nurse Midwives and are offering a product that is below the national standard.
Q. Okay. Now, there's been -- during your previous testimony and, again, during Dr. Sella's testimony, we talked about whether it's good or bad to mix Misoprostol and Pitocin, and I believe Dr. Sella's testimony was that there were maybe a few hours at most when the two were being

administered concurrently. Do you think that's -- given that's the understanding of what happened, what are your thoughts on that, and how would you relate that to what the ACOG Bulletin says?
A. Well, the Bulletin says not only together but in sequence, and the reason behind that is Misoprostol is not something that just works this minute while it's in your bloodstream, but it -- more or less you can think of it as priming the myometrium, the muscle in the uterus, and so it's -- one of the issues is sequential use of Misoprostol and Pitocin, so it doesn't say in the standards you can use it a little bit. It says don't do it.
Q. Right. So if -- okay. And your testimony regarding whether you would send a patient home with Misoprostol, with a tablet to take home to take buccally, I think there might have been some confusion as was characterized. You said you would never do that? Is that what your testimony was, or why don't you clarify it if you think that is --
A. Well, Misoprostol is a drug that you can use for various things. One thing you can use it for is what they call peptic ulcer disease. I don't treat that initially, but certainly I'd send someone home with it then, and if I were trying to induce a first trimester abortion, I wouldn't feel bad about sending the patient home. I never have.

They've always been hospitalized, but I wouldn't -- I wouldn't feel bad about sending someone home with it in the first trimester.
Q. But so what were you saying then in your testimony yesterday about Misoprostol with this patient?
A. Oh, with this patient; never would have sent her home with Misoprostol.
Q. Okay. Now, I believe Dr. Sella testified that Misoprostol that she gave on the first day was not intended to stimulate contractions or somehow initiate labor.
A. Right.
Q. Do you think she was correct in characterizing her use of Misoprostol that way?
A. Well, yeah, I would agree that she probably intended to soften the cervix, but whether you intended to induce labor or not, that's what it did, and the lady came back in the second day in the late evening in active labor, and you can't call that spontaneous labor. This was Misoprostol-induced labor. If the lady had stayed at home and hadn't been at the clinic, she would have never gone into labor that day. Spontaneous labor means you're sitting around and you start contracting and you're in labor. This was an induced labor by Misoprostol.
Q. And as to -- I believe Dr. Sella was talking about the dosage. She used 100 micrograms. What kind of dosage

do you use and how would you relate that to your intent with regard to Misoprostol?

A. The routine dosage that I use and most of the people where I am is 50 micrograms by mouth every four or five hours.

Q. And that would be the amount that you would use to induce labor?

A. Yes.

Q. And so this would be twice that amount?

A. Yes.

Q. Now, what are your -- I believe you heard Dr. Sella's testimony that the protocols that she generally follows for the typical third trimester abortion with respect to the Misoprostol and Pitocin in those protocols, she didn't deviate from that in this case. Does that raise any concerns for you?

A. Well, the protocols as I understand them were written for third trimester abortions, but the majority of those are in the intermediate level or 25 to 28, 30 weeks, and they're not dealing with babies with full-term sized heads and --

MR. THOMPSON: Can I interrupt. I have a question about this full-term sized head. It's continuing to bother me.

THE WITNESS: Okay.

MR. THOMPSON: The illness that the baby was suffering was a large head.

THE WITNESS: Yes.

MR. THOMPSON: So are you saying that in terms of -- you're saying it's -- did that illness have any impact on how you're defining the statement you just made?

THE WITNESS: Yes, the size of the head is the primary factor in whether you're going to rupture the uterus or not. In a 35-week sized head is a centimeter or so less diameter and two or three centimeters less circumference, and this was, as far as the cervix goes, was a full-term baby, because it was a full-term head.

MR. THOMPSON: Head.

THE WITNESS: And the head coming down the birth canal and stretching the scar is what causes the rupture eventually.

MR. THOMPSON: But it's not necessarily true that that baby was 35 weeks gestational period, because the head was larger than the gestational period?

THE WITNESS: Yes.

MR. THOMPSON: Is that true or not?

THE WITNESS: Yes, that's true. It was a 35-week baby by pretty well-documented dates but had a full-term sized head.

MR. THOMPSON: Okay. I see. Thank you.

Q. (By Mr. Rubin.) Well, I think there's been a lot of testimony from the doctors in the room and the rest about 115. Is there anything else you want to add about the propriety of performing a TOLAC in a clinic as stated in 115?

A. Well, I understand that the testimony has been that ACOG took 54 and decided to water it down and fix it so that you could have TOLACs in birthing centers, but I don't read it that way. The proscription against TOLACs outside hospitals, they're word-for-word the same, you know. So I don't find in 115 where it's made a big difference and has said you can now deliver VBACs outside the hospital. They're worded the same. They've got a lot of other wording along with them, but the actual recommendations they wrote are -- you know, are not different.

Q. In you experience in Texas, do you encounter VBACs or TOLACs outside of a hospital setting?

A. Oh, yes.

Q. And what's your thoughts on those?

A. I think, as we had a midwife bring a patient in one night who was doing home birth TOLACs, I talked with her. I said, "You know, if she has a catastrophe in the hospital and I'm following the rules and I'm in the building with her, I know how to fix it, and I've got people that will help me fix it and facilities and blood and stuff." I

said, "What in the world are you going to do if she ruptures in your clinic?"

Q. What did she say?

A. And she said, "We're going to call 911."

But I said, "Yes, but in the meantime while they're getting there and you're trying get them to the hospital and they're calling an obstetrician, the baby's going to either die or be brain damaged, high likelihood, and if you don't -- if you don't succeed in your timeline any better than sometimes we do, you might lose the mother." I said, "What in the world will you do if you lose a baby or you get a brain-dead baby or brain-damaged cerebral palsy baby? What are you going to do with yourself the rest of your life?" And I didn't get an answer, but I wasn't expecting an answer, but --

Q. Right. Of course, concerns about the fetal or baby aren't present in this case.

A. That's true.

Q. But what about with regard to the mother?

A. Well, you know, everybody was really lucky this time, because quite often, particularly the way this rupture went, it was a thousand wonders that it didn't extend another centimeter into the uterine arteries, which would have had a horrendous bleeding episode if that had happened. So the patient did well, except for what's already been

stated in testimony, and the patient's not mad at anybody. That's great. She may not even know there's a complaint. I don't know, but everybody's really lucky this time not to have a major rupture.

The two ruptures that I've dealt with in my long practice have been hemorrhage catastrophic ruptures, and we really had to work fast to get things done. If we'd been in a birthing center, we'd have been in real trouble.

MR. RUBIN: Okay. Thank you. That's all I have.

MR. THOMPSON: Mr. Goldberg.

MR. RUBIN: Mr. Goldberg, you want --

MR. GOLDBERG: If the Hearing Officer doesn't mind, I only have a question or two I believe of Dr. Bullock.

CROSS-EXAMINATION

BY MR. GOLDBERG

Q. Did I hear you correctly state that the size of the head of this fetus is the primary factor causing the rupture?

A. No. Contractions with the size of the head without --

Q. That's what you meant when you testified in direct examination?

A. What I meant when I said that was of the baby, the head is the most important factor. Certainly you don't

rupture a uterus without contractions though.

MR. GOLDBERG: Thanks. I have no further questions.

MR. THOMPSON: No questions.

MR. RUBIN: None whatsoever. Well, that's the Prosecution's rebuttal.

MR. THOMPSON: Okay. Thank you, Doctor.

MR. BULLOCK: You're welcome.

MR. GOLDBERG: Mr. Hearing Officer, we would recommend in lieu of closing arguments, closing briefs. I think, given the number of exhibits here, the nature of the testimony, the length of the hearing, closing briefs would be more helpful to you and probably would be a better way for us to present a summary, and that would be our recommendation.

MR. RUBIN: Mr. Hearing Officer, I would prefer -- and I've learned this with enough experience with the Medical Board, albeit six months, that it is good to put a closing argument on the record, and I will be -- I will be brief, but I think that's -- the record is what the Board members like to rely upon first and foremost as opposed to separate standalone briefs, and we do -- you can ask for closing -- proposed findings and conclusion, which I always like to have serve as my formal closing to the Hearing Officer for posterity sake as well, so if I could just give

a five- or ten-minute closing argument, I would be much obliged.

MR. THOMPSON: Okay. We'll do that, and I will order -- I will order closing briefs with proposed conclusions and findings at the same time.

MR. GOLDBERG: We have no problem -- we have no problem with providing a brief closing argument also, again, if that's helpful to you, but I just want to make it clear that we think that in this case, proposed findings and conclusions accompanied by a closing brief make sense.

MR. THOMPSON: Okay. So let's do that. The thing that comes up a lot is 30 days to -- from the time the hearing adjourns to produce findings. So after the meeting, if you all want to extend that, that gives enough time for the transcript to be done.

MR. RUBIN: Uh-huh.

MR. THOMPSON: Because I do like citations to the transcript and the record proper. T for transcript; RP, record proper, and I'd like those in Word form.

MR. GOLDBERG: Word.

MR. THOMPSON: You can submit them in .pdf to the Board if you'd like. I'd like them in Word form.

MR. RUBIN: May I ask a question? What would be the reason be on -- there's no pending legal issues. Findings and conclusions would cover what we think.

MR. THOMPSON: I will tell you what I -- it can be on whatever you would like. If we could have a limit or as short you could. I think the issue of standard of care, how you view that I think would be helpful to the Board, because you're going to have -- there's certainly a lot of factual testimony. I think the briefing -- and you can put it in -- these are suggestions of issues that have come to my mind. One of those would be applying the facts to -- to the standard of care and what the testimony said about that.

MR. RUBIN: Okay.

MS. TOPE: Did you actually give a date, or are you saying 30 days --

MR. GOLDBERG: Actually I heard the Hearing Officer, and I agree, suggesting that we at least -- counsel confer about whether we want to extend the date, the limitation on the Hearing Officer's ability and definitely we'll -- we will talk about that, and I assume that if we do reach such an agreement, we can have an extension of time to file the findings and conclusions and the brief.

MR. THOMPSON: You can stipulate with counsel about that, and just send me an order.

MR. RUBIN: Okay. So finding and conclusions are due when?

MR. GOLDBERG: Isn't it under the statute?

MS. NOWARA: It's supposed to be 15 days.

MR. GOLDBERG: I think under the statute, as I recollect it, it's 15 days and then 30 -- you have 15 days after that.

MR. THOMPSON: I have 30 from the adjournment.

MR. GOLDBERG: Right. We have 15 from the adjournment to get the finding and conclusions in and --

MR. RUBIN: We do?

MR. GOLDBERG: I think so. Isn't that what it is?

MR. RUBIN: Is that Board rule or is that the ULA?

MS. NOWARA: No, I think it's Board.

MR. RUBIN: Under 62-10-624, it doesn't say when. It says, "The Board of Hearing Officer may require all parties to submit proposed findings of fact and conclusions of law. The Board of Hearing Officer shall determine the time for submission."

MR. GOLDBERG: Okay. Great.

MR. RUBIN: So I think we can work that around getting the transcript then fairly easily. So we should probably set it for a certain amount of days after the transcript's available.

MR. GOLDBERG: Why don't you and I confer after the closing arguments.

MR. RUBIN: Sure. That's good.

MR. GOLDBERG: And then we'll communicate our proposal to you. Fair enough?

MR. THOMPSON: Yup. Fair enough.

Mr. Rubin.

MR. RUBIN: Thank you. So I think in closing what we have here is a case with very few disputed facts. In fact, I don't think there are any disputed facts. There's been much to do about the facts as initially understood by one or more of the experts, but I think that all kind of washes out in the end, and I'll be perfectly frank that if the standard to be applied to the facts of this case is a third trimester abortion standard, we have no -- we don't -- we don't have any -- we don't win. We have nothing -- we have no case then, because that's not the case as we see it, and that's not the standard of care as we see it.

Dr. Bullock was very clear in his testimony that it is an obstetrical case at this point at this -- with these 35 weeks gestational age. You can factor in the additional microceph- that caused the head to be different and with a C-section. The only applicable guideline that someone can reasonably provide is the TOLAC guideline, and that is in ACOG 115. There are no national standards otherwise that would apply to this highly unusual case.

And sometimes, like with law, good cases make bad law. This is an unusual case. I'm not sure what kind of -- we're not looking to set standards for third trimester abortions with this case. A lot of the testimony you've heard, a lot

of the evidence you've heard has been, "Well, what about the" -- has been generalizing, characterizing our case as one about third trimester abortions. This is such a tiny fraction of those cases, and we're not looking to change availability of abortions on any large scope because of this case. That's not what this is about.

So I think this case comes down to the credibility of the experts, and Respondent has -- the Respondent, herself, I will stipulate to any laudatory adjective they want to assign to her experience with abortions. Same with Dr. Darney. They are among the best, but this is not a case about abortions with regard to the standard of care, and Dr. Bullock has done more TOLACs than either of them by a significant margin. He has -- that is what he did. He has extensive experience with TOLACs, and sure, there is -- we spent about an hour with how he had -- there was a report submitted that somehow was attempted to discredit him. Bottom line is that he was correct in his report that said you don't mix Misoprostol and Pitocin in cases like this, and it was done, and you don't even give Misoprostol in cases like this.

And as to where it was performed, I think that you -- certainly the Board could read ACOG different ways, but Dr. Bullock's way I think is the way that you err on the side of caution. And in erring on the side of caution, you don't

want to bring in these notions, and I guess I'll call it politics, or for whatever reason if a certain procedure's not available, readily available somewhere else, that should not change the medical issues and the standard of care in this case, and the more evidence that we've seen of what goes on in the world and in this country unfortunately with -- with these type of procedures, the more they're trying to make that part of the case. The more it proves my point that what they're arguing, the standard of care is being influenced by -- not by the -- not by the medicals but by whether this patient could get this procedure -- get these procedures somewhere else.

It's not a defense. It's not a defense to the argument that something shouldn't have been done, that they couldn't have gotten it done elsewhere. That doesn't even make sense logically, does it.

So finally, the standard that we have to prove to you and prove to the Board is gross negligence. And, again, I believe that when Dr. Sella has a hard time saying whether she felt this was truly elected or not, Dr. Darney wasn't even willing to say it was elected, there's no choice that whatever the risks are, you just willfully disregard them, and I think that the progress notes are clear about that. I mean, they -- they officially disavowed that their position that -- I mean, Dr. Darney disavowed his position that his

opinion wasn't formed by those findings regarding this patient's health on I believe it's page 21 of the medical records, but everything else he said was consistent with the notion that this patient needed this procedure done or else, and they were going to do it and regardless of what happen -- what the -- what the fetus was presenting with or what the mother was presenting with, and it was an unfortunate outcome.

We certainly proved the damages. There was a uterine rupture, and Dr. Bullock was very clear that this patient was very lucky. I don't know if this is the kind of case that would come up on a regular basis. I hope it would not, but I think it needs to be on the record as to what should have been done in this case. Thank you.

MR. THOMPSON: Okay. Thank you.

Ms. Nowara.

MS. NOWARA: Thank you. We want to thank everyone for allowing Dr. Sella to have this hearing. We want to thank you, Mr. Thompson, for listening carefully to the evidence and for helping us make a record in this case.

This case is important to Dr. Sella personally. As I think you could tell, she's a serious person. She's someone who's a thoughtful and careful expert in her field and provides exemplary care to her patients, including ML in this case.

The Medical Board is asking you to make a recommendation of a finding -- to recommend a finding that Dr. Sella was grossly negligent, and the Board asks you to rely exclusively on the word of Dr. Bullock, its expert, really that was the Board's entire case, who is neither an expert in abortion services or family planning medicine. Dr. Bullock is an OB/GYN. Dr. Bullock has no expertise in these types of procedures. This is, of course, in contrast to Dr. Darney who is a world expert in the provision of abortion services, including third trimester abortion services.

Dr. Bullock is also someone who provided advice to the Board to issue an NCA in this case based on grave errors in his reading of the record, and I respectfully disagree with Mr. Rubin. That does matter. That, of course, matters. It matters that Dr. Bullock's understanding of this case was very different when he read the -- when he read the records and issued a report to the Board, and for now for the Board to come in and say, "Well, these errors don't matter," is simply an attempt I think to salvage his testimony, but they can't.

The Board's also asking you in making -- in their request for you to make this recommendation, they're asking you to disregard the compelling evidence presented by Dr. Darney, who, as we said, is a -- is a leading expert in

the world with regard to family planning medicine, and Dr. Sella's own testimony and the various documentary evidence that we've introduced in this case.

The facts, as Mr. Rubin said, are undisputed at this point in this case. It seems that everyone's on the same page. ML was a fetal indication patient. She had one prior C-section, and she was treated by Dr. Sella in approximately the 35th week of her pregnancy, and she sought a third trimester abortion because the fetus that she carried was likely to suffer from terribly anomalies that would substantially impact the quality of life. Dr. Darney testified clearly to you that Dr. Sella's plan followed the national standard of care with regard to these procedures.

I believe that the injection of ACOG 115 and the other outdated ACOG Bulletins really are a red herring here, because those are, first of all, not the standard of care. In fact, the guidelines themselves very exclusively say that they're not to be considered a standard of care. They're simply guidelines. That's very -- there's a very explicit reason for that, which Dr. Darney testified to, which is that ACOG does not intend for these to measure whether there was negligence in a case.

It's also a red herring because these are obstetric -- these are obstetrical guidelines, and this, as Dr. Darney and Dr. Sella compellingly testified, both, this is not an

obstetric procedure. This is an abortion procedure.

Dr. Sella effected fetal demise on the first day, and she administered one dose of Misoprostol at 100 micrograms. This was part of her plan to prepare the patient's cervix over the course of a number of days and to eventually on the fourth day induce labor. In addition to administering the Misoprostol, she inserted Laminaria to dilate the cervix or to prepare the cervix, to thin it out, to ripen it.

The next day, so the one dose of Misoprostol, no doses of Pitocin, just Misoprostol, and it's very clear from both Dr. Darney and Dr. Sella that the Misoprostol in this instance, it was meant to ripen the cervix, and that this is the protocol followed by abortion providers who provide these types of procedure, these third term abortions, that this is -- this is the protocol that is followed generally.

On the second day, ML was administered -- was at the clinic twice, was given two doses of Misoprostol and then appeared at the clinic late in the evening hours of the second day, 5-11, when -- and appeared in labor. Dr. Sella then changed the plan, because remember the plan was to prepare the cervix over a three-day period and then induce labor.

This very fact that the plan changed, that Dr. Sella was responsive to the patient shows that she was careful and exact really in her treatment of this patient. She was not

just following some -- reflexively following some protocol. Instead she was responding to the needs of the patient. On that -- when the patient came back to the clinic, she was then admitted to the clinic, and she was given one dose of Misoprostol at approximately 11:18 p.m., another 100 micrograms, and then another dose of Misoprostol at approximately 12:24 a.m., so this is now into the third day.

And the purpose of this, you see the purpose of this administration of Misoprostol, it's to augment labor, because at this point the patient was in labor. This is very different than the administration of the Misoprostol before, which was over a much longer span of time, because that was about cervical preparation.

The patient was then placed on therapeutic rest, which included -- well, she was placed on a low dose of Pitocin, 10 units per 1,000 CCs. She threw up the 100 micrograms of the last dose of Misoprostol she was given about -- within half an hour of receiving it. Dr. Sella placed her on therapeutic rest, again, being responsive to the particular needs of this patient and what issues the patient was presenting. She was given Fentanyl and Versed and was maintained on that low dose of Pitocin. It -- around 7:30 a.m. Dr. Sella then increased the dose of Pitocin to 60 units.

Now, after that last dose of Pitocin at 12 --

approximately 12:30 a.m., she received no more Misoprostol. She was only receiving Pitocin and then these other medications, and that does need to be clear for the record.

The patient continued to be monitored, and you heard compelling testimony about this, also, that the patient has -- there's a one-to-one ratio between the patient and clinic staff. Dr. Sella was constantly monitoring the patient. You can see from the records in Sella Exhibit Number 8 that the vital -- her vital signs were continuously being monitored and documented, contrary to what Dr. Bullock had initially opined, and around 1:00 p.m. Dr. Sella took the patient into the exam room to determine what was going on, to decompress the cranium, to again be responsive to the needs of this patient, because she was not -- Dr. Sella had thought that she would have delivered it by this point and she had not, and it was at that point that Dr. Sella recognized the signs of what she believed was a uterine rupture, and the patient was immediately transferred to UNMH where she was treated without incident and returned back to New York after three days.

Dr. Darney testified that the standard of care here includes -- for one of these procedures to take place in a clinic setting requires that the clinic have experienced staff, that it have the medications and equipment on hand, and that it has access and a relationship to emergency

services, and that's exactly what happened in this case. In this case -- and that's exactly what is true of Southwest Women's Options. Southwest Women's Options Clinic has experienced staff. It has the equipment and medication to handle these procedures, and in the event of an emergency, in the rare event of an emergency, as happened here, they were immediately able to transfer this patient to a tertiary care hospital, UNMH, which is just minutes away from the clinic.

Dr. Darney has visited clinics and hospitals around this country. And so he is really in the best position to determine what is the standard of care for the provision of these types of procedures, and he testified clearly that Dr. Sella, Southwest Women's Options fell within the standard of care and, in fact, exceeded the standard of care.

Dr. Bullock has testified that this is an obstetrical procedure. Again, Dr. Bullock is not an expert in the area of family planning medicine or abortion services. You've heard from everyone else that this is not an obstetrical procedure. This is an abortion. While Dr. Sella may have said that there were some obstetrical risks or type -- obstetrical type risks, that's not saying that this is an obstetrical procedure, and that needs to be very clear. This is not.

Second, Dr. Bullock has opined that VBACs cannot be

done in a clinic setting, and there's been a lot of testimony about this, and the Hearing Officer, obviously you'll have to make your decision based on your examination of the record and of the exhibits, but it's very clear from Dr. Darney's testimony and from a clear reading of the exhibits that we presented to you that at one point ACOG was recommending in its guidelines that there not be VBACs in a clinical setting, and that they dialed back from that, and that there's a very clear reason for that that's expressed in NIH document, and that is because there was a growing concern of an escalating rate of C-sections and the complications that stem from that, and so for that reason, ACOG 115 replaced the previous ACOG, ACOG 54, and dialed back that language, so that it was not an absolute recommendation but that, in fact, instead if there were going to be VBACs, if a patient wanted a VBAC in a clinical setting, as long as they were properly consented, they understood what the risks were and the clinic could take care of the patient, that it could be done in a clinic setting.

Dr. Bullock has expressed the opinion that the administration of Misoprostol was categorically grossly negligent, but the Hearing Officer has heard much more credible testimony, with all due respect, that contradicts -- directly contradicts that opinion. Dr. Darney testified

that the administration of Misoprostol in this case was within the standard of care, and that really Dr. Bullock's opinion as to that is based solely on his understanding of the standard of care in an obstetrics case.

I think his redirect was very telling about that when he was discussing his concerns. This was in regards to his concerns about VBACs in a clinic setting. Notice that his immediate focus was on fetal health. It was on whether there would be -- if there was a uterine rupture, whether there would be a problem with the fetus. That's because and that's why -- that's one of the major distinguishing factors between an obstetrics case and an abortion case. You don't have that fetal concern in a case like this, because the fetus has been demised.

As Dr. Darney explained, there are other significant differences between obstetrics and care in abortion care with regard to the administration of Misoprostol. One of those is that the preparation of the cervix in an abortion -- in a third trimester abortion under these circumstances can take place over a period of a few days, and that you need the Misoprostol, or the Misoprostol is a -- is a useful tool in that cervical preparation. That is very different than an obstetrics case.

But Dr. Darney also clarified that ACOG 115 is not a standard of care. It's a guideline, and that even in some

obstetric cases, they do administer Misoprostol to VBAC patients. So even, even on the outer limits, that that -- that Misoprostol is sometimes administered to VBAC patients in an obstetrics case, let alone in an abortion case.

Dr. Bullock then has also opined that the use of Pitocin and Misoprostol together was grossly negligent. This may be a relic of Dr. Bullock's fundamental misreading of the records. He had initially thought that the Pitocin and Misoprostol were being administered simultaneously. That was his -- that was a fundamental error on his part. In fact, the Misoprostol and Pitocin were only administered together for a very short period of time, at most the testimony I think even by Dr. Bullock's admission, at most three and a half to four hours.

And again, Dr. Darney, the expert in this area, testified that this use of Misoprostol and Pitocin and then Pitocin after the administration of Misoprostol certainly fell within the standard of care for these procedures.

Finally, Dr. Bullock has testified that it was grossly negligent for Dr. Sella to give the patient Misoprostol to take back to her hotel. He has not cited any authority for this proposition. He maintains it was grossly negligent, because Misoprostol can cause unpredictable contractions, but as Dr. Sella testified, as Dr. Darney has confirmed, the Misoprostol in this instance was not being used to induce

labor. The patient did go into labor, and at the time she went into labor, she stopped taking the Misoprostol per the advice of Dr. Sella, and I want to make that very clear for the record that the patient was advised to stop taking Misoprostol if she did start contractions, which is what she did do.

Whether Dr. Bullock formed his opinion due to his own disapprobation of third trimester abortion procedures or simply because he doesn't understand the standard of care for third trimester abortion procedures is unclear, but it is clear from the testimony and the great weight of the evidence that's been introduced in this hearing that his opinion is wrong.

The Board has made much of the fact in this hearing that this is a unique procedure, that they're not trying to establish some general guideline for third trimester procedures, third trimester abortion procedures or even third trimester abortion procedures for a woman with a prior C-section. They're attempting to say that this is -- as I understand it, the argument is that this is a unique case. It doesn't make sense then if you're applying the standard that the Board must meet, that there is gross negligence in this case then. Gross negligence shows -- requires a showing that there was a willful or wanton disregard of a standard of care. So by the Board's own argument and -- its

own argument shows where its logic fails.

The Board -- for the Board to win, and it is the Board's burden. It must prove by a preponderance of evidence that there was gross negligence for you to recommend a finding of gross negligence. As we talked about in our opening brief, as I'm sure we will address in our findings of fact and conclusions of law, gross negligence is an elevated negligence standard. It's not simple -- simple negligence, and there's a reason for that. The Medical Board's job is not to throw itself into every case where there is some claim of simple negligence, and that's why there's this elevated standard.

Gross negligence means wanton, reckless indifference towards patient care, and I would submit to you that the evidence, the overwhelming evidence here shows that Dr. Sella was extremely careful about this patient and that Dr. Sella is an extremely careful physician when it comes to all of her patients. The Board is trying to make the argument that Dr. Sella would have done this abortion no matter what, because this patient was desperate to have an abortion, but we know that isn't true. One, Dr. Sella has said if she felt she couldn't care for this patient, she would have turned her away. Dr. Sella has turned patients away and does turn patients away if she believes that she and the clinic cannot adequately care for these patients. Dr. Sella

applied her considerable expertise in this case and decided that this case -- that this patient was an appropriate patient for the clinic.

Yes, there was a bad outcome, and as Dr. Sella said, she regrets that there was a bad outcome, but that does not -- from that does not flow that there was negligence or gross negligence. In fact, there wasn't. There was exceptional care in this case.

The Board issued this NCA on the basis of an erroneous report. Thanks to the due process guarantees that are outlined in the ULA and the Medical Practice Act, that initial finding of the issuance or that there was enough evidence to issue an NCA can be remedied by you and in favor of exonerating Dr. Sella, and we ask you to look at the facts of this case, the science and the expert opinions issued by Dr. Darney, and we ask that you recommend that Dr. Sella be exonerated.

MR. THOMPSON: Thank you.

Mr. Rubin, anything else?

MR. RUBIN: Oh, no, nothing further.

MR. THOMPSON: Okay. Well, I want to thank both sides for their presentation. This is a neat case in lot of respects and difficult in a lot of ways. I think it was very professionally presented, and that needs to be acknowledged by both sides. So I appreciate the time you

took into preparation and presentation of the matter.

In the matter of Shelly Sella, MD, license 92-62 2012-026, the evidence is closed, and argument is closed in this case. I will await word from the parties how they want to proceed on extending the time period for the Hearing Officer to submit findings and conclusions. If I do not hear otherwise, I will have it calendared for 30 days for my requirement under the rule. Okay. Anything further?

MR. RUBIN: Nothing from the Prosecution.

MR. THOMPSON: Okay. We're in recess. Thank you.

(Note: Hearing adjourned at 1:45 p.m.)

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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