BEFORE THE NEW MEXICO MEDICAL BOARD

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

MEDICAL BOARD HEARING
VOLUME II
November 30, 2012
9:00 a.m.
NM Medical Society Offices
316 Osuna Road, NE
Albuquerque, New Mexico

TAKEN BEFORE: DAVID K. THOMPSON
HEARING OFFICER

REPORTED BY: B. Julian Serna
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SELLA EXHIBITS

(Note: Hearing in session at 9:01 a.m.)

MR. THOMPSON: We're back on the record. It's 9:01 a.m., Friday, November 30th. We're on the second day in the matter of Shelly Sella, MD, license number 92-62, number 2012-026. State has rested. We are on direct examination by Mr. Goldberg of Dr. Sella. Dr. Sella, you remain under oath.

THE WITNESS: Yes.

MR. THOMPSON: Remember that?

THE WITNESS: Yes.

MR. THOMPSON: Go ahead, Mr. Goldberg.

DIRECT EXAMINATION

BY MR. GOLDBERG

Q. Dr. Sella, you've testified before, so you testified that you work at Southwest Women's Options. Where do you live?

A. In Oakland, California.

Q. Can you explain to the Hearing Officer how it is that you work here in Albuquerque, New Mexico, but you live in Oakland, California?

A. I share the practice with Dr. Susan Robinson, and we work a week at a time. So I work for a week, and she's home, and then she works for a week, and I go home to California.

Q. And as you explained in your testimony as part of

the Board's case that you're a medical doctor, can you explain in your words what it is that you do, how you view your job at Southwest? What is it that you do as a medical doctor?

A. I provide first through third trimester abortions.

Q. Let's turn to your background, Dr. Sella. Where were you born and raised?

A. I was born in Israel, and I was raised in New York.

Q. Can you describe briefly and generally your college and professional education?

A. Yes, I went to -- undergraduate at University of Wisconsin-Madison. My degree was independent major in women and health.

Q. And then your professional education.

A. Oh, okay. I went to medical school at Sackler School of Medicine in Israel. I did an internship in family practice in Madison, Wisconsin followed by a residency in OB/GYN in Oakland, California.

Q. And where is the Sackler School of Medicine?

A. Tel-Aviv, Israel.

Q. And it might help a little bit if you just slow down.

A. Okay. I will, yes.

A. Tel-Aviv, Israel.

Q. Why did you want to become a doctor?
A. One summer when I was in undergraduate at University of Wisconsin, I worked for a summer at a women's clinic in Los Angeles. It was a clinic that provided abortions, and that experience had a deep impact on me, and I decided I wanted to learn how to do abortions and to provide them. So when I went back to Madison, Wisconsin, I started a premedical course of study. The rest is history, and here I am today, but that was the original impetuous, that summer working -- working at an abortion clinic.
Q. Are you board certified, Dr. Sella?
A. I am.
Q. In what congress or college?
A. In obstetrics and gynecology.
Q. What does it mean to be "board certified", to be a fellow of the American Congress of Obstetrics -- Obstetricians and Gynecologists?
A. What it means is that you've passed a written and oral exam and that you maintain certification yearly.
Q. As part of your training in obstetrics and gynecology, did you learn about providing abortion services?
A. When I was a resident, it was not an integral part of the OB/GYN residency to train OB/GYNs in abortion, and it has changed, and Dr. Darney talked about that. So I had to work very hard to get that training and to arrange special

training at that point.
Q. Can you describe again briefly and generally your professional experience after you finished your residency in OB/GYN?
A. So initially I worked at the La Clinica de La Raza, which is a clinic in Oakland, California as well as working for Kaiser Permanente in the medical center.
Q. And let's put a time frame on that. From what periods of time to what period of time?
A. La Clinica was from 1994 to '96, and Kaiser was from '93 to 2001.
Q. You have a stack of exhibits in front of you, Dr. Sella. I'm going to be making reference to them.
A. Yes.
Q. Will you take a look at Exhibit 1, which is labeled Sella Exhibit 1. Can you identify this document?
A. Yes.
Q. What is Sella Exhibit Number 1?
A. It's my resume.
MR. GOLDBERG: We move Sella Exhibit Number 1, Mr. Hearing Officer.
MR. THOMPSON: Any objection?
MR. RUBIN: No objection.
MR. THOMPSON: One is admitted.
Q. (By Mr. Goldberg.) When did you start providing

abortion services exclusively?
A. In the fall of 2000.
Q. Where were you providing abortion services at that time?
A. At that time it was at multiple clinics in the Bay Area, California.
Q. And did there come a time when you started working with Dr. George Tiller in Wichita, Kansas?
A. Yes.
Q. When was that approximately?
A. In 2002.
Q. Can you describe how it came about that you went to work for Dr. Tiller?
A. We met at a post-graduate seminar sponsored by the National Abortion Federation in 2000 -- in the fall of 2001, and I heard him speak. I was very impressed with his philosophy and approach to patients, and we -- I visited his clinic, and I started working with him in June of 2002.
Q. At that time in 2002 did Dr. Tiller have a reputation among the professionals who provide medical abortion procedures?
A. Yes.
Q. And what was that reputation as you understood it?
A. His reputation was he was the leading provider of third trimester abortions in the US and in the world.

Q. Was the clinic where you went to work with Dr. Tiller, was this a hospital-based or a non-hospital-based clinic?
A. It was non-hospital based.
Q. Did Dr. Tiller provide abortion services beside third trimester abortion services?
A. Yes.
Q. First and second trimester abortions?
A. Correct.
Q. Were there other doctors who practiced at the clinic with you in addition to you and Dr. Tiller?
A. Yes. There were two other physicians who rotated. There was Dr. Susan Robinson and Dr. Lee Carhart and I and Dr. Tiller, so the three physicians would rotate with Dr. Tiller one week at a time. Is that clear?
Q. Sure. The Susan Robinson that worked with you in Wichita, is that the same Dr. Robinson that works with you now at Southwest?
A. Yes.
Q. And where -- is Dr. Carhart still providing medical abortion services?
A. Yes.
Q. Where?
A. He is providing abortions in Germantown, Maryland.
Q. And is that clinic in Maryland one of the clinics

that provides third trimester abortion services?
A. Yes.
Q. How long did you work with Dr. Tiller?
A. For nine years.
Q. While you were working with Dr. Tiller, did you provide first, second and third trimester abortion services?
A. Yes, I did.
Q. Was Dr. Tiller recognized in the profession as one of the leading practitioners of abortion services?
A. Absolutely.
Q. Same question with respect to the late-term abortion services, was he considered one of the leading practitioner's in terms of late-term abortion services, third trimester?
A. Yes, I would say he was considered the leading of them, of third trimester abortion.
Q. When you worked with Dr. Tiller, did his clinic in Wichita use standard protocols in providing abortion services?
A. Yes.
Q. Before we turn to your description of the protocols you learned there, I want to ask you some preliminary questions. Are abortion services the same irrespective of the gestational age of the woman who seeking the abortion?

A. No.
Q. So are there different abortion services that are provided in the first trimester from the those that are provided in the second trimester from those that are provided in the third trimester?
A. Yes.
Q. Okay. Can you briefly describe to the Hearing Officer those differences?
A. In the first trimester, so that's up to 12 to 14 weeks, it's a one-day either a surgical or medical procedure. If it's surgical, it's done in the clinic. If it's medical, that is with Methopristone R846 and Misoprostol and that's offered up to seven to nine weeks depending on the clinic.
Q. And "that" meaning the medical?
A. The medical abortion, which is an abortion where the woman miscarries at home. And the second --
Q. Can you describe the surgical procedure?
A. The first trimester surgical procedure --
Q. Yes.
A. -- involves dilating the cervix and then using gentle suction to remove the pregnancy at its absolute simplest description.
MR. THOMPSON: That's 12 to 14 weeks?
THE WITNESS: Up to, so from 5 to 12 to 14 weeks

is in one day dilating the cervix using instruments to dilate the cervix and then using suction to empty the contents of the uterus.
MR. THOMPSON: Is Misoprostol used in that procedure?
THE WITNESS: Yes -- no, I'm sorry.
MR. THOMPSON: Just in the medical?
THE WITNESS: In the medical, yes.
Q. (By Mr. Goldberg.) Can you describe the second trimester procedure? Is that medical or surgical or both?
A. The -- in the second trimester, the cervix is prepared depending on the gestation; in other words, depending how far along the pregnancy is, over one to two days followed by the extraction on either the second or third day. Again, that depends on how far along the pregnancy is.
Q. Is that procedure a surgical procedure, or is it a medical procedure?
A. That is a surgical procedure.
Q. And so is it correct that in the second trimester the only procedure that is employed is a surgical procedure?
A. Correct.
Q. Does that procedure have a commonly recognized name or characterization?
A. It's called a D&E, which stands to dilatation and

extraction. Some people think the E stands for evacuation, but either one.
Q. And, again, I don't want to belabor the second trimester procedure, but in that procedure, is the cervix prepared?
A. Yes, it is.
Q. And is Misoprostol employed as one the preparatory agents?
A. Sometimes it is in the preparatory phase when the patient comes in for the Laminaria, and it's routinely given on the day of the extraction before the extraction.
MR. THOMPSON: Are there dose -- particular dosages with regard to these protocols?
THE WITNESS: Of which?
MR. THOMPSON: Misoprostol.
THE WITNESS: The Misoprostol? If it's given with the Laminaria, usually the dose is between 100 to 200 micrograms.
MR. THOMPSON: Okay.
THE WITNESS: And on the day of the extraction, it's 400 micrograms.
Q. (By Mr. Goldberg.) But this case involves the third trimester, and we're going to focus on the third trimester, and is the procedure that you described in your testimony at the beginning of this case, again, for the

record, is that a surgical procedure, or is it a medical procedure?

A. It's a medical procedure.

Q. And normally -- and, again, focusing on the protocols that you employed, you learned and employed at Wichita, can you describe normally a third trimester abortion procedure? How many days did it go, generally what you did?

A. Okay. From the beginning, from the phone -- there was extensive phone counseling, determination whether the patient could be seen or not in the clinic. Once the patient arrived, the counseling continued. Consents, of course, were obtained. The --

Q. Doing this, will you break it down into day one, day two, et cetera.

A. Yes, day one, counseling, consents and ultrasound, Degoxin injection to effect fetal demise, and the cervix was -- the cervical preparation was begun with Laminaria and Misoprostol at times. On the second day, Laminaria were removed, and the cervix was continued to be modified. On the third or fourth day, depending on the condition of the cervix or the patient's history, the induction was begun using Misoprostol and Pitocin.

Q. This procedure that you described and you employed while you were at Wichita, this is not what is sometimes

referred to as a partial birth abortion, is it?

A. No, no.

Q. Is it correct that Dr. Tiller was the physician who actually first developed this abortion procedure that you described?

A. Yes, as far as I know.

Q. And he's generally recognized in the profession as the person who developed this third trimester abortion procedure?

A. Yes.

Q. I want to go and -- while you worked with Dr. Tiller in Wichita, did you provide late-term abortion services to women with prior C-sections?

A. Yes.

Q. When a woman with a prior C-section presented herself for abortion services there, were there special considerations?

A. The difference with patients with a prior C-section is that they were counseled that the procedure would take longer; that we would prepare the cervix generally over three days, rather than the more typical two days.

Q. And were they counseled about any particular risks that are attendant to abortion services on women who had prior C-sections?

A. Yes.

Q. And what were the risks that were counseled?

A. Well, they were counseled on all the risks of a third trimester abortion, including the risk specifically for them of uterine rupture.

Q. And are there other specific risks, unique risks to women with prior C-sections that they were counseled on?

A. Yes.

Q. And so we have a record, are there -- are there placental risks that are associated with having an abortion after a prior C-section?

A. Yes, there are.

Q. Will you explain that to the Hearing Officer?

A. Yes. If a woman has had a prior C-section, there's greater risk for the placenta to overlie the cervix, and that's called a placenta previa. With each successive C-section there's more and more risk of that. With a placenta previa, there is higher risk of the placenta growing into the uterus, but even without a placenta previa, a woman who has had a C-section scar is at risk for the placenta growing into the scar, so that is called an accreta. If it goes through the muscle layer it's a percreta, and if goes all the way through, it's an increta. So every woman with a C-section is at risk for that -- for the placenta accreta if the placenta is anterior, so if the

placenta is on top. So imagine, the placenta can be any place. It can be on top, on the bottom. This -- let's see. Okay.

MR. GOLDBERG: Dr. Sella's a visual person by the way.

MR. THOMPSON: That's fine.

A. The placenta can be here fundal, so it's at the very top. The scar is down here. Actually this is perfect, because it shows the little indentations let's say is the scar. If the placenta is anterior, so if it's attached here, there's concern that it's growing into the scar. If the placenta is posterior, well, the scar's up on here, on top here, so it's not a worry. If the placenta covers the cervix, and we'll say this is the cervix, but it's on the inside, that's the previa that I was talking about.

MR. RUBIN: Can we just have the record reflect that the witness is using a water bottle to demonstrate what she was trying to -- ah, I don't need that.

MR. GOLDBERG: So you have -- so you have a good record. Thank you, Danny.

THE WITNESS: What's that?

MR. THOMPSON: Yeah, I just wonder, so -- and that's -- that risk is the same with either C-section? We talked about those two different C-sections.

Q. (By Mr. Goldberg.) The low lateral or the --

A. Right, or a classical -- yes, any scar is a site for the placenta to possibly grow into.

Q. Why don't you use the bottle again and just describe to the Hearing Officer the low transverse versus the classic incisions?

A. Okay. This is actually good, because this we can imagine as the cervix, although usually the cervix is longer.

MR. RUBIN: The bottle cap?

THE WITNESS: The bottle cap. Sorry. The bottle cap is the cervix, but imagine that it's longer. This is the top of the uterus. This is the bottom part.

Q. Got it.

A. Okay. You got it. The low transverse incision is here. It's low. It's transverse; in other words, it's sideways. A classical C-section scar is a vertical incision, and it goes up here in the active -- it's called the active segment of the uterus. It's more muscular. This part is thinned out later in the pregnancy.

Q. And while -- while the vertical scar going into the muscle, working muscle area is called "classical", is it correct that most C-sections in today are done with the low transverse incision?

A. Yes.

Q. That's the -- that's the preferable way to do it?

A. Yes.

Q. Again, we're still talking about while you were working in Wichita with Dr. Tiller. Did the protocols that you learned with Dr. Tiller change when a woman who was seeking a third trimester abortion service had a prior C-section?

A. Just what I mentioned about --

(Note: Cell phone ringing.)

Q. Oh, I'm sorry. Terrible mistake.

A. Just what I mentioned with the counseling.

MR. GOLDBERG: It actually happened once in a recent trial.

MR. THOMPSON: Art Encinas.

MR. GOLDBERG: Oh, yeah. You could go to jail with Judge Encinas.

A. So just what I mentioned, that the counseling was different, because the patient was informed that we would expect that the process would take longer, would take more time.

Q. Other than that, the protocols were the same?

A. Correct.

Q. In the protocols that you learned at Dr. Tiller's, was Misoprostol an agent that was employed to help prepare the cervix?

A. Yes.

Q. On the first day?

A. Yes.

Q. On the second day?

A. Yes.

Q. Throughout?

A. Yup.

Q. What were the dosages that you learned to apply of Misoprostol in the exercise of these protocols?

A. For cervical preparation, 100 micrograms vaginally and buccally every six hours as needed. In labor? You're talking about an actual induction of labor as opposed to an augmentation?

Q. Let's start with an induction of labor.

A. Okay. So that would be on the fourth day, and she would get 400 micrograms of Misoprostol every two hours.

Q. Before we go onto the augmentation, explain for the record what is the difference between an induction of labor as opposed to an augmentation of labor?

A. An induction of labor is start -- if the woman is not contracting, using medication to start the labor. So we're going from zero to labor. That's inducing. Augmentation is there is already labor. There are some contractions, but the contractions are not efficient or effective enough. So it's giving her more medication -- it's giving her medication to augment what already is there.

Q. So is it correct then that Misoprostol can be used for the preparation of the cervix; is that correct?

A. Yes.

Q. And is it also correct that Misoprostol can be used as either an induction or augmentation agent for inducting -- or inducing or augmenting labor?

A. Yes.

Q. But those are different purposes; is that correct?

A. Preparation, induction --

Q. Preparation versus --

A. -- augmentation, yes.

Q. And they may have different dosages?

A. Correct.

MR. THOMPSON: And ML was -- ML was in an induction?

THE WITNESS: I --

MR. GOLDBERG: If you allow me?

MR. THOMPSON: Sure.

Q. (By Mr. Goldberg.) When you start -- in your initial plan for ML, was that a plan for an induction of labor?

A. Yes, it was.

Q. When she actually presented -- when she actually presented the night of the second day at around 11:00 o'clock and was in labor, did you consider that then an

induction of labor, or did the plan change?
A. The plan changed.
Q. And it changed to what?
A. At that point it was an augmentation.
Q. So did you -- did you consider when ML presented in the evening of the second day, did you consider that you had successfully induced labor, or did you consider this to be a spontaneous labor?
A. I considered it spontaneous.
Q. And even though you had been prescribing Misoprostol to ML; is that correct?
A. Correct.
Q. And why do you draw the distinction that this should be considered a spontaneous labor as opposed to an induced labor?
A. My purpose in giving the Misoprostol on the first two days was to prepare the cervix and not to start contractions.
Q. And were there specific aspects of your orders or instructions to ML and the nursing Staff there about the use of Misoprostol that made it clear that you were using it exclusively as a preparatory agent and not an inducing or augmentation agent?
A. Yes.
Q. And what was that?

A. When she was given the Misoprostol to take every six hours round the clock, the instructions were and always are that if you start contracting, do not take the next dose.
Q. And that occurred in this case, did it not?
A. It did.
Q. That is, the ML case?
A. Yes.
Q. And you had -- you had instructed her to take the Misoprostol per your instructions at 9:00 p.m. the night of the second day, correct?
A. Correct.
Q. And she didn't?
A. That's right.
Q. Let's go back to Wichita.
A. Okay.
Q. Were the protocols -- I'm sorry. I want -- I talked about Misoprostol. When you were at Wichita, as to the Misoprostol, did you use the Misoprostol with women in third trimester abortions who also had prior C-sections?
A. Yes.
Q. Did the dosage change?
A. No.
Q. Now, I want to turn to Pitocin. Is Pitocin an agent that you generally employ for preparing the cervix?

A. No.
Q. Why?
A. Pitocin causes contractions, but in the beginning of the process, you don't need contractions. You need the cervix to get ready. The cervix needs to be prepared, and Pitocin is not effective at cervical preparation.
Q. So what do you use the Pitocin for? And here I'm talking generally at Wichita. What do you use the Pitocin for in your protocols that you employed for third trimester abortion?
A. Pitocin was used for contractions.
Q. So would it -- so would it then be that the Pitocin was first used when you were at the induction of labor stage rather than the preparation of the cervix portion?
A. Yes.
Q. And what was the dosage that you generally employed of Pitocin at that time?
A. To induce labor?
Q. Yes.
A. Sixty units in 1,000 CCs.
Q. And that was not called a low dose?
A. No.
Q. But in the protocols that you used in Wichita that you learned from Dr. Tiller, did you from time to time use

low doses of Pitocin?
A. Yes.
Q. And for what purposes?
A. We used them for a therapeutic rest where someone came in the middle of the night, they were not progressing, and they were then -- and they were given medication to help them rest, Fentanyl and Versed, and low dose of Pitocin, low enough that it would -- it would hopefully cause some changes but not enough that she couldn't get rest. So it wasn't used to induce the labor at that point. It was different.
Q. Let me see if I -- let me see if I can understand this as a lay person.
A. Okay.
Q. Is it correct then that while you wanted the patient to rest; that is, to sleep --
A. Yes.
Q. -- you didn't want the contractions to stop completely. You wanted them, the contractions, to continue but in a -- in a -- I'm trying to find the right word -- in a weaker form?
A. Yes.
Q. Okay. And did the dosages that you've described, either the low dose or the normal dose --
A. Yes.

Q. -- were those dosages applied to women in third trimester abortion services who had had prior C-sections?
A. Yes.
Q. The protocols, did Dr. Tiller essentially develop those protocols?
A. Yes.
Q. Did those protocols become the protocols that were generally used around the country by the clinicians that performed third trimester abortion services?
A. Dr. Carhart, who is one of the third trimester providers, worked with Dr. Tiller. So, yes. Dr. Hern started providing third party trimester abortions at about the same time as Dr. Tiller. There was a cross-pollenation between the two, I'm sure, and Dr. Seletz as well was influenced by Dr. Tiller.
Q. Are there individualized variations among the different clinics that provide third trimester abortion services with respect to the protocols?
A. Of course.
Q. Do those individualized variations change the basic protocols?
A. I don't think so.
Q. Are the protocols that you learned at Dr. Tiller's and employed there consistent with the protocols that you employ here in Albuquerque at Southwest Women's Options?

A. Yes.
Q. Why did you stop working for Dr. Tiller?
A. He was assassinated.
Q. Did the clinic continue after Dr. Tiller's assassination?
A. No.
Q. While you worked -- while you worked for Dr. Tiller were abortion foes a concern?
A. Yes.
Q. This is difficult, but can you explain to the Hearing Officer what kind of concerns are caused by medical doctors providing these services by abortion foes?
A. Before I started working for him, there had been an assassination attempt, and the clinic had been bombed. While I was working for him, there was constant harassment. There were always people outside yelling at patients and at the staff as we would go in and out of the clinic. There was a guy who would come every Wednesday with a bullhorn and get on a fence and yell to patient's partners, "Daddy, daddy," and that was nonstop every Wednesday. You knew the day of the week by this guy. There was a campaign that would point to send inflammatory postcards to the neighbors of all of the staff, and that included me in California. There was a truck that had defamatory photos, a big truck, on it, and that went through neighbors -- neighborhoods as

well and, in fact, one time there was an ACOG conference in San Francisco and the truck went through my neighborhood in Oakland dropping off leaflets about me and my work.
There was vandalism. Somehow someone got into the clinic and got a hose in there and flooded the clinic. There was a boycott of businesses that the clinic frequented. For example, the garbage service stopped providing service to the clinic, because they were threatened with loss of business and that campaign of outing them, that they supplied us with their garbage services. The cab companies in town refused to take care of our patients, and quite a few were coming from out of town. They would refuse to pick them up from the airport. So we had one cab company that would agree, and we would tell patients, "Make sure that you use that cab company."
Fed Ex refused to come by the clinic and pick up our packages. Even Dr. Tiller's wife's dry cleaner was harassed and targeted, and finally he was killed.
Q. Did that harassment stop for you personally when you moved to Albuquerque?
A. No.
Q. In that -- in that pile of exhibits will you look at -- take out Exhibits 3 and 4, and can you identify those documents?
A. This is a picture of me smiling, but this is from

Operation Rescue website.
Q. And the second one?
A. The same.
Q. They're different --
A. I'm sorry. This one is -- number 3 is Operation Rescue, and number 4 is --
Q. If you look at them, they're two different -- they're actually two different --
A. Yes, I see that they're two different things, but are they both from the same website? Yes.
MR. GOLDBERG: And, again, I'm going -- I'm going to move for these admissions, but I had a conversation with Mr. Rubin, Mr. Hearing Officer, before the -- we're not introducing these in any way to suggest that the Board is an instrument of the abortion providers. That's not our intent at all. All we are seeking to do is to create a record here, because we think it will be helpful to the Hearing Officer and the Board in making the decisions in this case to understand the full context in which these professionals are exercising their professional services. So we're going to move the admission of Exhibits 3 and 4.
MR. RUBIN: Mr. Hearing Officer, I would oppose the admission of these exhibits. I did allow some latitude during the direct examination of Dr. Sella. There was some background, but I fail to see the relevance of introducing

these, quite frankly, inflammatory perhaps even and I would say offensive documents into Medical Board's record. I fail to see how the standard of care changes or is influenced whatsoever by these type of incidents. What we're dealing with in this case are medical issues. Medical issues drive the standard of care. I'm sure Dr. Sella would answer it that way if I asked her, and I may have to. The medical issues dictate what the standard of care should be. Political issues don't enter into that.

MR. GOLDBERG: And, again --

MR. RUBIN: I'm not -- I'm not saying that -- I mean, it is obvious -- I think it is apparent to anyone that knows anything about this issue that it is highly charged. I'm not doubting for a second that what Dr. Sella is saying is not true, what she deals with either, but I don't believe it has a place as evidence in this case. Thank you.

MR. GOLDBERG: Do you want a response from me?

MR. THOMPSON: Yes, please.

MR. GOLDBERG: Sure. I'll make it very specific, Mr. Hearing Officer. As we indicated in our opening statements and I believe as testimony and evidence says, Dr. Bullock's standard of care as Dr. Darney testified would mean that all third trimester abortions for -- all third trimester abortions for women with prior C-sections would have to occur in a hospital. You also have evidence in the

record about a hospital being a large and complicated social institution with a huge nursing and other attending staff that is very heterogeneous. In a clinic like Southwest Women's Options there's no doubt that the people who work there are dedicated people. You see it in the witnesses that have come before you. If -- the Board and the Hearing Officer need to understand, need to understand what kind of pressures and what kind of context the application of a standard of care would be, and the application of a standard of care that requires that all abortions occur in a hospital setting where there will clearly be nurses and other staff who will not respond to this type of intimidation and pressure the way that the staff at a clinic, standalone clinic respond to it is something that the Board and the Hearing Officer needs to take into consideration.

It is this context, and it is not correct to say that standards of care are driven exclusively by scientific medical risks. Everybody knows that standards of care apply the medical knowledge in the context in which it is being applied, and this is an important part of the context. That's our purpose here.

MR. RUBIN: Mr. Thompson, one point.

MR. THOMPSON: Sure.

MR. RUBIN: Thank you for your indulgence. I believe Mr. Goldberg is mischaracterizing the testimony of

Dr. Bullock. Dr. Bullock was very clear. He is not talking about all third trimester abortions, and I think there's been a real effort in this case to make it seems as if we are making a case about third trimester abortions. This is a 35-week term, which she characterized as the term "pregnancy". His testimony was very specific that the risks change from 25 weeks to 35 weeks, so even so if the Medical Board does accept his testimony, which I think it should, it would not have the global implication anywhere on what Mr. Goldberg is saying. Thank you.

MR. GOLDBERG: Well, we'll argue about his testimony, but he clearly said that the ACOG standard said no third trimester -- no abortion services should be -- I'll take that back, no TOLAC or VBAC should occur with a woman with a third -- prior C-section outside of a hospital setting. That's what his testimony was, but we'll argue that. We'll argue that later.

MR. THOMPSON: Yeah.

MR. GOLDBERG: And but I'm explaining to you -- again, this is not to infuse this with the political issue of abortions. I don't need to do that. All you have to do is walk out in the parking lot here to know that, and all you have to do is know how this matter came before the Board. What I'm trying to do is create a record that I think will be helpful to you and the Board in understanding

what happens with these procedures, where they -- not only who's doing them and where they're doing them, but the context in which they're doing them, and the Board and the Hearing Officer needs to know that to determine what is the proper standard.

MR. THOMPSON: Okay. Exhibit 3 and 4, let me tell you as a matter of practice I'm a very reluctant gatekeeper of documentary evidence. Generally I'm very liberal in the admission of documentary evidence for a couple reasons. One is this is in essence a bench trial. Eventually it is the Board and perhaps a district court, court of appeals that's going to make the ultimate decisions. Having had experience as a Hearing Officer, and this is with the State, I'm inclined to have a record as complete as possible. People can argue either through direct or cross as to the weight these exhibits should be given and their relevance.

I will say I -- I did review these previously. I had some concerns about the relevance as to what my job specifically is with regard to the NCA. That seems to have been removed; meaning, as Hearing Officer I take the NCAs as they come. I don't take judgment. It's not a grand jury. So the Board, through a complaint committee takes whatever information from whatever complainant. It's undisputed in this case that these complaints came through a third party. So originally I did have some real concerns about the

relevance as to that issue, and that seems to be mitigated by Mr. Goldberg in his statement today.

As an abundance of caution, I am going to admit 3 and 4 to provide the record for all parties as these proceedings go forward, and their content and their purpose is the weight applied either by the Hearing Officer, Board or appellate court. Okay. So 3 and 4 are admitted.

MR. GOLDBERG: And we will -- we will move on.

THE WITNESS: May I add just one thing about the list of harassments was the multiple complaints to the Medical Board of Kansas.

Q. That happened in Kansas?

A. Yes, from Operation Rescue.

Q. How did you feel after Dr. Tiller was assassinated?

A. Bereft.

Q. Why did you continue to provide abortion services?

A. Well, I never -- I never thought of stopping, very committed to this work. Everyday that I go to work renews my commitment.

Q. I want to turn now to your coming to Albuquerque, to Southwest Women's Options. How did it come about that you came to Southwest Women's Options?

A. Dr. Curtis Boyd, who has a clinic here in Albuquerque, felt that it was important to continue offering

third trimester abortions. So he invited my colleague in Wichita, Dr. Susan Robinson and I, to start a third trimester practice. Up to then, he had been providing first and second trimester abortions.

Q. Is Southwest Women's Options, the clinic here in Albuquerque, is it a non-hospital-based facility?

A. Yes.

Q. Can you describe generally who works at Southwest Women's Options now?

A. So there's Dr. Robinson and I. We are -- we have just started training a third physician, Dr. Carmen Landau. There are RNs on staff, counselors, medical assistants and administrators and a clinic manager.

Q. Approximately how many staff are there counting everybody at Southwest Women's Options?

A. About 15.

Q. Does Dr. Boyd regularly provide abortion services now at Southwest?

A. Not at this point.

Q. So was it -- at least when you and Dr. Robinson came, who were the doctors who were providing abortion services?

A. Before we came or --

Q. No, at the time -- at the time -- at the time you and Dr. Robinson came?

A. It's the two of us.

Q. And presently today as an example --

A. Yes.

Q. -- is it you -- are you and Dr. Robinson -- well, you are here, but are you and Dr. Robinson providing abortion services?

A. Yes.

Q. Is there a third doctor who's coming on board?

A. Yes, Dr. Landau.

Q. In preparation for your testimony in this hearing did we prepare a video to provide a visual representation of the Southwest Clinic?

A. Yes.

Q. And do you know who made that video?

A. That was a videographer.

Q. And were you there when the video was being made?

A. Yes.

Q. And there's a voice on the video; is that correct?

A. Yes.

Q. Is that your voice?

A. No.

Q. Who's voice is it?

A. That is Joan Garbagni, the clinic manager.

Q. And have you reviewed the video?

A. Yes.

Q. And you were there when it was taken?

A. Yes.

Q. Is the video an accurate depiction of the facility?

A. Yes.

Q. And was it an accurate -- is it an accurate depiction of the facility as it existed when ML was there?

A. Yes.

Q. Is it an accurate depiction of the facility now?

A. Yes.

MR. GOLDBERG: We're going to move the admission, and we're going to play the video, Mr. Hearing Officer, and we have copies, and we're going to move the admission of the video.

MR. RUBIN: No objection.

MR. GOLDBERG: Great. So let's watch the video. It's a short video. It's four minutes or so.

MR. THOMPSON: What exhibit is the video?

MR. GOLDBERG: The video is Number 2.

MR. THOMPSON: Okay.

(Note: Playing Exhibit 2.)

MR. GOLDBERG: That's the video.

MR. THOMPSON: Exhibit 2 is admitted.

Q. I'm pretty sure I asked this, but I'm going to do it again to make the record clear, the protocols

specifically with reference to third trimester abortion services, protocols that you learned and employed in Wichita, are they similar to the protocols that you employed here at Southwest?

A. Yes.

Q. And are they consistent with the protocols that you employed -- excuse me, with respect to the services provided to patient ML?

A. Yes.

Q. Do you have some water?

A. I can use some more.

Q. You were here yesterday when Dr. Darney testified?

A. Yes.

Q. Do you recall him testifying about where third trimester abortions are presently provided in the United States?

A. Yes.

Q. Do you recall him testifying that about 90 percent of third trimester abortions were provided in four clinics around the country?

A. Yes.

Q. About ten percent in hospitals?

A. Yes.

Q. Is that consistent with your experience?

A. Yes.

Q. Can you identify the sites and the doctors associated with the four clinics?

A. Warren Hern in Boulder Colorado, Josepha Seletz in Los Angeles, Lee Carhart in Maryland.

Q. And the fourth site is?

A. Southwest Women's Options.

Q. Here in Albuquerque?

A. Yes.

Q. Let me. On that list can you look at Exhibits 5, 6 and 7? Can you identify those documents?

A. Yes.

Q. And, again, in preparation for this hearing did you talk to Dr. Hern, Dr. Seletz and Dr. Carhart about providing testimony by affidavit about the protocols that they employed in their clinics?

A. Yes.

Q. And are these exhibits a result of those conversations?

A. Yes.

MR. GOLDBERG: We move the admission, Mr. Hearing Officer, of Exhibits 5, 6 and 7.

MR. RUBIN: Mr. Hearing Officer, mindful of the fact that you are liberal and you will -- and I think it is a good thing that you tend to error on the side of inclusion with exhibits, but I -- when I make objections to exhibits,

I like to think I'm the same way. To start with, I know that we have a Uniform Licensing Act, and it requires that all parties are entitled to have advanced notice of exhibits and witnesses. What we have here -- I don't know if Mr. Goldberg wants to characterize it as exhibits or as witnesses, because what they're doing is they are testifying, and I can't cross-examine them at all.

The witness list, which was provided many, many weeks after I sent my request, demand for discovery which you have in the record there -- in fact, I received the witness list I believe about a week and a half ago.

MS. NOWARA: That's not right.

MR. RUBIN: Let me check. Let's just make a record, because I don't want to say -- I have a witness list from -- I received from Molly Schmidt Nowara, November 12th is the date of her witness list; lists Dr. Shelly Sella, Dr. Philip Darney, Dr. Susan Robinson, Susan Douda, Deborah Tope, Dr. Stephanie Headstrom. Doesn't list these three folks.

The exhibit list which I received after that doesn't -- you know, listed these, but I don't -- I didn't have the actual affidavits when they listed it. Let me -- I sent on September 14th my demand for discovery, and so I'm a bit put off by -- and it should be on the record that prehearing procedures, I was in contact with the Ms. Schmidt Nowara,

and we had a certain amount of informal understandings involving what we could and couldn't do, but I think this is beyond the pale, so to speak, to try to present these witnesses, doctors, and I realize that you could argue that it's purely factual. However, I think the import is that what these doctors are saying reflects the standard of care, and that's their opinion.

And, of course, Mr. Thompson, this is hearsay. These are out-of-court statements taken to prove the truth of the matter asserted. They have not satisfied the requirements to show that these declarants are unavailable. That's one exception to hearsay. So I know we're not in district court either, but if the ULA says no and the rules of evidence say no -- and I think Mr. Goldberg yesterday was very clear that he doesn't like having a moving target. I know he's talked to me, he doesn't like -- he feels that there shouldn't be any ambush, and this is way too close. If I had gotten these a month or two ago, I could have accounted for them, but we're not in a criminal proceeding, and I am entitled to a certain amount of due process as well, and so I object. Thank you.

MR. GOLDBERG: I'm going to start the response, but I'm going to ask the Hearing Officer to indulge me if you will also to allow Ms. Schmidt Nowara to explain the communications that she had since she's here, and she's the

one that did the communications.
MR. THOMPSON: Okay.
MR. GOLDBERG: But I'm going -- I'm going to start out by saying we have no quarrel with the conduct of Mr. Rubin prehearing. He has been fulsome. He has provided us information as I would have expected any professional lawyer to do, and we have no quarrel whatsoever with respect to that.
As you have -- Mr. Hearing Officer, I'm sure you can tell, I was not immediately involved in the day-to-day communications between Ms. Schmidt Nowara and Mr. Rubin, although I will take full and ultimate responsibility for them, but I do want Ms. Schmidt Nowara to explain since she's much more knowledgeable about the communications, and then I will explain to you why I believe these documents are relevant and should be admitted under the Act.
MS. NOWARA: Thank you, Mr. Hearing Officer. So we -- and I agree with Mr. Goldberg. Obviously we've had -- and with what Mr. Rubin said, that we have been in close contact about this case. We had a conversation. We received the -- the initial discovery production in -- at the -- in the sort of middle, like the third week of September. This is a case that's been pending in front of the Medical Board for a year. And so this was the first time that we had seen the Medical Board's discovery. We had

seen -- this is the first time we'd seen Dr. Bullock's report, and Mr. Rubin and I had a conversation about the fact that it would be impossible for us to comply with the -- that ten-day request for information, because this was -- essentially, we were starting from, if not scratch, nearly from scratch to answer these specific allegations that were made in Dr. Bullock's report.
MR. THOMPSON: When did you take Dr. Bullock's deposition?
MS. NOWARA: In -- I think it was October 18th.
MR. RUBIN: October 18th.
MR. THOMPSON: 2012?
MS. NOWARA: 2012, yes.
MR. THOMPSON: And when did you get his expert -- or that draft report, Exhibit 12, that I've admitted?
MS. NOWARA: I believe it was September 20th.
MR. THOMPSON: Of?
MS. NOWARA: 2012.
MR. GOLDBERG: 2012.
MS. NOWARA: Yes, these are -- I will say that these affidavits were -- ultimately were produced this week, and that is later than I would have wanted, but what I can represent to the Hearing Officer is that I've done everything in my power to herd these physicians to get us these affidavits, signed affidavits as quickly as possible.

It was -- it involved coordinating speaking with them, making sure that things were accurate and ultimately getting them to review them and to sign them and to get them back to us, and I do apologize for -- to the extent that they are late in that sense, but it was always our understanding, I believe, at least my understanding, that there was flexibility in this case with the delivery of evidence, because again, we were -- we're talking about a two-month window that we've had essentially since we've had the Board's discovery versus the Board's entire year to investigate this case. So we did produce these exhibits this week.
I had talked to Mr. Rubin about -- we spoke on -- about the fact that we were going to be producing affidavits, and so that's an explanation of our understanding and our obligations, and ultimately if -- and if the Hearing Officer determines that it's untimely, I don't believe that it's untimely under our understanding. I think these are important exhibits that should be admitted, but this was a reflection of really the timing of the case.
MR. GOLDBERG: As to the merits, the statute clearly and correctly recognizes the -- given the nature and purpose of these hearings that reliable hearsay information can and should be admitted. That's number one.
Number two, these doctors are unavailable. They're not

subject to the subpoena power here. They are all over the country, and everybody around this table, every lawyer around this table and every doctor around this table knows about the difficulties of getting doctors, busy doctors to come to a hearing like this. I can -- I can tell you as an officer of the law, the difficulties in this case of just getting doctors here in the City of Albuquerque to deal with us with respect to this case.
The information that is provided is clearly pertinent. The Hearing Officer has to determine what the standard of care is, but the Hearing Officer clearly is going to be assisted in that by knowing first -- from firsthand declarations what the protocols are of the three only other providers of third trimester abortion services in the entire country and how those protocols that they employ are consistent with the protocols that are employed at Southwest and were employed on ML.
So to me -- to me this is precisely the type of hearsay -- and I agree. This is hearsay information. We're introducing this, we're asserting this for the truth of those assertions, but it's reliable. These people have no reason not to provide you with reliable information.
MR. THOMPSON: I think it's reliable. I think the problem I see is that -- I mean, affidavit was done the 28th of November after deposition of the expert, after the

report. I mean, I guess I'd like you to address or my view, if not Mr. Rubin's, the prejudice that there's no real ability to rebut -- I think it's reliable, I suppose, but as to the ultimate issue of fact, there's -- there's no ability to either cross this individual on this. There's no -- no ability for the State's expert to rebut this. The other thing is I think the doc -- the Respondent has or could testify that, "The protocols I employed, if this is, in fact, true are consistent with those I have of other colleagues that I've discussed," based on her personal knowledge.

MR. GOLDBERG: She has. As to Dr. -- I have already elicited that from her. She has, as I elicited from Dr. Darney and without objection, without objection.

MR. THOMPSON: Well, and I think that's proper evidence. My question is, is it at that point just duplicative? And now, I'm allowing hearsay unrebutted --

MR. RUBIN: Duplicative.

MR. THOMPSON: Possibly duplicative. So that's my concern.

MR. GOLDBERG: Well, you'll excuse me for being a lawyer, but it cannot be, Mr. Hearing Officer, that any lawyer, with all due respect including a Hearing Officer, wouldn't want in addition to Dr. Sella and even as distinguished a person as Dr. Darney's testimony, yes, I

know that these procedures at Southwest are consistent with the procedures at Warren Hern and Josepha Seletz and Dr. Carhart apply in Maryland, Colorado and California, that's great evidence, but it cannot be that I wouldn't want and you wouldn't want to have those words also out of the mouths of the individuals.

We can't have -- this is not a stretch. For all practical purposes we couldn't possibly get them to come down here. They -- they wouldn't do it, and we couldn't get them to come down here. That's number one.

Number two, if there's any real prejudice here, I will tell you -- this is on the record, but I will tell you, I don't think there's any prejudice whatsoever with respect to Dr. Bullock. Mr. Rubin has had this since yesterday. Dr. Bullock has been here. He actually still is here. If he wants to comment on that, he has the opportunity to comment on that. Mr. Rubin has a rebuttal case. He has the opportunity to comment on that. If Mr. Rubin believes that there is some real prejudice from the timing of the presentation of these affidavits, I certainly am open to -- to allowing some relief from that prejudice, to dealing with that prejudice.

So as an example, if Mr. Rubin were to say, "I want to have the opportunity to call up Dr. Carhart and see if he'll give me a counter affidavit, and I want to be able to submit

that in the record," I would say, "Sure. Go ahead and do that." Or if you want to get some counter affidavit from somebody else, I would say, "Sure. Go ahead and do that." But -- but I actually don't think there's any real prejudice there.

I understand how the timing of all this might lead to a perception of prejudice, but I will tell you with all due respect to Dr. Bullock -- and I don't think there's any doubt in the record or by anybody around this table about my view about Dr. Bullock, but with all due respect to Dr. Bullock, he -- there's no prejudice with respect to him. He can respond to that if he has a response to it. If there's any real prejudice to Mr. Rubin, we're prepared to accommodate that.

MR. RUBIN: I think one point that needs to be made -- well, first of all, Mr. Goldberg obviously, strenuously wants this in the record. The fact that lawyers want it isn't really a valid argument. Also, as he may be well aware, there is the opportunity to have people appear by telephone, and they seemed to have missed that.

MR. GOLDBERG: No.

MR. RUBIN: And third -- well, being outside the subpoena power of the Board is not -- does not meet the definition of -1104, declarant unavailable. I don't know what else to tell you, except if you're going to let this

in, I don't know why I'm going to bother in the future. I mean, it's -- there's like eight reasons that I've given you why this is not appropriate, and Dr. Bullock is arriving late this morning. He's compromised by -- I'm going to have to show him these things, and he's going to have to come up with something very quickly, and yeah, I didn't even have the opportunity to telephone these people.

And we do need some closure on this hearing, and the offer that I can somehow -- we continue this and I can call these folks at some point, it took me long enough just to arrange phone conversations, interviews with Dr. Sella and Dr. Darney, which were not very effective in some respects. Maybe that's partly my fault, but I -- my objection still stands.

MR. THOMPSON: Okay.

MR. GOLDBERG: Can I add -- can I add one other thing?

MR. THOMPSON: Yes.

MR. GOLDBERG: We did not ignore that we could provide witness testimony by telephone. I'm telling you, and it cannot be a surprise to you, I'm telling you that these -- these doctors were not available. They weren't going to come down here. They're not going to testify by telephone.

MR. RUBIN: So I could tell the -- so I'll have a

chance to then --
MR. GOLDBERG: Pardon?
MR. RUBIN: Forget it. Enough said. Enough said. I think we've talked enough.
MR. GOLDBERG: But again, I'm prepared -- I'm prepared to accommodate any real prejudice here if there's any real prejudice. I don't think there is, but I'm prepared to accommodate that.
MR. THOMPSON: Okay. Let's -- I'll look at the issue at the break. Other than admitting these, do you have another category of direct?
MR. GOLDBERG: Oh, sure. I'll proceed -- I'll proceed with direct. You don't -- you don't want me to cite to you the cases that apply the statute here as to why -- or do you want me to?
MR. THOMPSON: For the record, you may want to do that.
MR. GOLDBERG: Sure. Let me just do that. I'll site to Young vs. Board of Pharmacy.
MR. THOMPSON: What's the citation?
MR. GOLDBERG: Oh, I'm sorry, 81 New Mexico, 5, Chief Judge Moise, 1969.
MR. THOMPSON: Take a break in about 15 minutes?
MR. GOLDBERG: Sure.
Q. (By Mr. Goldberg.) I think before I asked you to

identify Exhibits 5, 6 and 7, we had talked about whether the protocols that you employ here in Albuquerque and with ML were consistent with the protocols at Wichita. I believe I asked you whether they were consistent with the protocols of these other clinics, but I'll ask it again. In the protocols that you employed in Wichita and that you employ here in Albuquerque in the third trimester abortion procedures including the one that you applied with ML, are they consistent with the protocols as you understand them that are employed by Dr. Seletz, Dr. Hern, Dr. Carhart, the other three abortion -- late third trimester abortion providers in this country?
A. Yes.
Q. In your testimony yesterday, you described in some great detail a procedure that you employed and that you employed with ML; is that correct?
A. Yes.
Q. And I don't want to repeat that, but I do have some follow-up areas, a couple of follow-up areas that I want to cover with you about that. First, I'd like to address further the intake procedure for third trimester abortion procedures. Are there criteria that the Southwest employs for accepting women for third trimester abortions?
A. Yes.
Q. And what are those criteria?

A. They are maternal indications, fetal indications and whether we think that we can complete the procedure.
Q. And what do you mean when you say, "Whether we think we can complete the procedure?"
A. It means, do I think that this -- the third trimester abortion will safely be performed in the clinic without needing to transfer the patient. If I think there's a high likelihood that the patient would need to be transferred, then I would not accept her to start with.
Q. Can you estimate for the Hearing Officer approximately how many applicants who meet one or both of the other two criteria, that is a fetal indicated or a maternal indicated abortion, are turned down because of this third criteria, and that is, that you don't feel like you can safely complete the process?
A. I would say about 15 percent.
Q. And can you give one or two examples, specific examples without revealing the details, but specific examples of the type of people that are turned down and why?
A. For example, there was a patient who was a maternal indications patient who was morbidly obese, had uncontrolled diabetes and uncontrolled hypertension, and I thought that there were too many medical risks to do this procedure in an outpatient clinic. There was another patient who had had a traumatic brain injury, and in talking

with her, the phone intake, it seemed that she just could not -- we would not be able to take care of her safely in the procedure. She was angry, argumentative and unstable, and that did not seem safe for her or for the staff, and we could not serve her in the outpatient setting either.
Q. I wanted to follow up now on a second area, and that is, you described yesterday in your testimony and I believe Dr. Darney also described the process, the procedure at Southwest if something goes wrong. I'll call it the "transfer procedure". What happens when something goes wrong and the patient needs to be transferred to another setting, a hospital? Does Southwest have an established procedure for that?
A. Yes.
Q. What is it, and what does it involve?
A. If a patient needs to be transferred, we contact our backup physicians. Those are Dr. Tony Ogburn, Dr. Eve Espey and Dr. Rameet Singh at UNM.
Q. And are there established relationships with these doctors? They know that they are what you call backup physicians, that you're going to be calling them for these purposes?
A. Yes, it's a well-established relationship.
Q. And how long has that relationship been established?

A. Before I was there. I don't know how many years, well -- well-established.

Q. Let me follow up a little bit. Dr. Espey, Dr. Eve Espey is she on the faculty at the Medical School at UNM?

A. Yes.

Q. What does she do -- what are her clinical responsibilities at UNM Hospital?

A. Well, in addition to teaching and being an OB/GYN, she also, with Dr. -- with the other two physicians run the abortion clinic, the outpatient clinic associated with the hospital as well as the fellowship program as far as I understand.

Q. That's a family --

A. Planning.

Q. -- planning fellowship program?

A. Yes.

Q. Let me ask a couple questions about the UNM abortion clinic.

A. Uh-huh.

Q. Is that a hospital-based clinic?

A. It's outpatient.

Q. It's outpatient. But it's not physically in a hospital?

A. No.

Q. And it's not -- and it's not part of the hospital

facility as such? It's different from the abortions that are provided by Dr. Darney and his colleagues at San Francisco Hospital?

A. Yes.

Q. All right. Where is the clinic physically located?

A. It's off site, and I don't know the exact address.

Q. And do you know why the university of New Mexico Health Sciences Center, which runs one of the largest hospitals in the State of New Mexico, in fact, the only trauma center and tertiary -- you know, biggest tertiary care center, why they don't have a hospital-based abortion service?

A. I don't know.

Q. You had described that you then call the three consulting doctors?

A. Yes.

Q. Do you call the consulting doctors before or after you call somebody to transport the patient?

A. Well, we call 911, and we call them.

Q. That's first?

A. Yes, of course.

Q. Let me ask a question. Why -- why do you call 911 as opposed to calling the private ambulance service in Albuquerque, the Presbyterian Ambulance Service?

A. It's fastest.

Q. Are there downsides to calling 911?

A. Yes.

Q. What's the chief downside?

A. The downside is that -- that this is public record, and so Operation Rescue can get a hold of the records of 911 calls as they do around the whole country and then lodge complaints to Medical Boards here and around the country based on the 911 calls.

Q. So now we've covered that you call 911, and typically how long a period of time is it before you get a response by the Albuquerque Fire Department EMTs?

A. Until they arrive at the clinic, moments.

Q. By "moments", are you talking minutes or hours?

A. Minutes, minutes.

Q. And then you call Dr. Espey or one of her colleagues, one of -- you call the consulting or backup physicians?

A. Yes.

Q. And what is the purpose of that call?

A. To -- to let them know that we have a complication. We're sending someone, so that they can take care of the patient, period.

Q. So they can be ready for the patient to come?

A. Yes.

Q. And then is there any other aspects of the protocol? After you call 911, you call the consulting physician, do you -- do you call the referring physician?

A. I always call the referring physician. I may not call right in the moment, but always within that time period I do call the referring physician.

Q. Why?

A. I think that's an important relationship to have. It's -- part of the care of the patient is communication with the referring physician. Often that's someone who I've talked to before, and I always talk to routinely afterwards. It's important that they know what is going on with the patient. They are concerned, and I'm concerned.

Q. Again, the care that has been -- that was provided to ML was gone -- has been gone over in pretty great detail, so I'm not going to cover everything, but I do want to cover certain aspects of that care to follow up. So I'm going to do that. First, I want to focus on why ML presented herself to the clinic? What were -- what was your understanding of the problems that caused her to seek an abortion?

A. Well, her baby had severe brain abnormalities.

Q. What were those -- well, first, when were -- to your understanding when were those abnormal- -- and by the way, you can make reference to Exhibit 8, which are the medical records. When were those abnormalities first

detected?
A. At 33 weeks.
Q. And when was it -- what was the gestational age when she presented at Southwest?
A. Thirty-five.
Q. And what were the abnormalities that were detected?
A. There was macrocrania, which means the head was large. Megalencephaly --
Q. And what is megalencephaly?
A. It's a large head with usually an abnormal functioning brain. There was polymicrogyria, and what that is, is you know, in the brain there's enfolding of the brain. Brain kind of looks like a walnut, and those are gyri. Microgyri is that that -- those enfoldings are smaller than usual. Polymicrogyri means that there's a lot of these very small enfoldings. The pohymicrogyri can be focal; in other words, it can be just in one area, or it could be generalized with the prognosis worse if it's generalized, and that's what this baby had.
Q. And how was these -- how were these -- how were these abnormalities detected?
A. The initial abnormality was the large head size on ultrasound, but subsequent to that, she had an MRI, which was able to give much more detailed information, and then

she had another ultrasound, which was not -- which is -- not was but ultrasound is not as precise as MRI for detecting these abnormalities.
Q. Was --
A. Can I --
Q. Sure. Please go ahead.
MR. THOMPSON: Wasn't that same ultrasound -- kind of look -- just point me to the one that's in the record.
MR. GOLDBERG: If you look at --
MR. THOMPSON: With all the measurements in it.
MR. GOLDBERG: I think it's -- sure, it's 11 --
MR. RUBIN: Eight and ten.
MR. GOLDBERG: Ten and eleven.
MR. RUBIN: Am I right? Is it on 10?
MS. NOWARA: I think it's on 9.
MR. RUBIN: It's 9 and 10.
THE WITNESS: Yes, 10. Well, the ultrasound begins on 9, but the MRI report -- yes, the MRI and echo is on 10. It's in the common section, "Subsequent fetal MRI and echo."
MR. THOMPSON: Can I ask one other question. Just occurred to me, so if the head is large and there's these calculations on 9 --
THE WITNESS: Yes.
MR. THOMPSON: -- which the weight is an aggregate

of these calculations --
THE WITNESS: Correct.
MR. THOMPSON: -- would that -- does that distort the weight of the baby?
THE WITNESS: Yes. Yes.
MR. THOMPSON: Of the fetus.
Q. (By Mr. Goldberg.) So without -- without the enlarged head, you would expect a somewhat smaller weight; is that correct?
A. Yes.
Q. So but as you interpret on page 9 of Exhibit 8, as you interpret the estimated fetal weight, which is at the bottom of the biometry at five pounds, seven ounces that includes the enlarged head?
A. Yes.
Q. And so if there were no enlarged head, you would expect that estimated weight to be smaller?
A. Yes.
Q. And, in fact, the estimation shows that it's at a high -- one of the high percentiles; right?
A. Correct.
Q. It's at the 80th percentile?
A. Correct.
Q. But let's turn to -- so there was an ultrasound done, and that was only going to show basically an enlarged

head?
A. The initial ultrasound.
Q. Right. And so the MRI -- first for the record describe where the MRI report is reported?
A. In the Comments Section of the Obstetrics Report on Bates -10.
Q. Would you read the comment starting at, "Subsequent fetal MRI?"
A. Okay. "Subsequent fetal MRI and echo were done on April 28th, 2011 at Hudson Valley Radiology and reported by Dr. Daniel Cohen. Reported findings include macrocephaly with megalencephaly, generalized polymicrogyria, sagital craniostenosis, frontal bossing and a normal corpus collosum."
Q. Taking those as a whole, what -- from your experience, what would be the portent for the fetus if born alive?
A. You never know 100 percent, but based on these findings, this fetus had a very poor prognosis.
Q. Did -- did ML on the advice of her MFM, her maternal fetal medicine doctor in Long Island, did she do further consultation after the MRI was performed?
A. Yes.
Q. Describe to the Hearing Officer what was recommended and what she did?

A. She went to consult with a pediatric neuroradiologist.
Q. Is that Dr. Timor?
A. Dr. Ilan Timor.
Q. Do you have an understanding as to whether Dr. Timor enjoys a reputation of excellence in this subspecialty in the area?
A. Absolutely he's an expert in this.
Q. Go ahead.
A. And he confirmed a poor prognosis.
Q. And was it on the basis of this information that you made -- did you review this information, you and Dr. -- actually Dr. Robinson was the doctor on intake at that time when she -- when the first call was made, correct?
A. Yes.
Q. But you reviewed it with Dr. Robinson, right?
A. Absolutely.
Q. Did you review this information?
A. Yes.
Q. And did you concur?
A. Yes.
Q. Now, I want to ask -- I want to run through the three days and ask you specific questions about the three days, just so we have a clear record with respect to that. On day one after the intake, after your medical examination,

brief medical examination you did of her and the ultrasound, what was the first procedure?
A. The first procedure was to get samples that had been requested, amniocentesis.
Q. That would be the samples requested by Dr. Rosenberg?
A. By her referring physician, Dr. Rosenberg, amniocentesis and fetal blood draw. This was followed by Degoxin to effect demise, Laminaria and then vaginal Misoprostol.
Q. How many -- how many insertions of Laminaria occurred on the first day?
A. On the first day one, one insertion.
Q. How many applications of Misoprostol occurred on the first day?
A. One.
Q. What was the dosage of Misoprostol on the first day?
A. A hundred micrograms.
Q. And what was the means of delivery of the Misoprostol medicine on the first day?
A. That was inserted vaginally.
Q. And who did that?
A. I did.
Q. Was Pitocin provided on the first day?

A. No.
Q. Was ML provided with Misoprostol to take home with her and take herself buccally on the first day?
A. No.
Q. Did you see ML any further on that first day?
A. No.
Q. Let's turn to the second day. How many times did ML present at the clinic on that second day?
A. Twice.
Q. How many times -- how many times did you plan on ML presenting at the clinic on the second day?
A. On the -- on the morning of the first day, I planned just to see her that day rather -- not just that day but just in the morning, but based on my findings, I decided to see her again in the afternoon.
Q. Did you see ML a third time on that second day?
A. Very late at night when she came in in spontaneous labor.
Q. So the initial plan was that ML was going to present only once in the morning on the second day?
A. Yes.
Q. What was it about your examination of ML that caused you to change the plan and have her come in a second time in the afternoon on the second day?
A. Well, there were -- there were two things. One

was that she was fairly anxious, and I wanted to check in with her just to see how she was doing, and the other was I wanted to have as much dilatation as possible when I started to induce on the fourth day, and I thought it would be helpful to see her again.
Q. So let's take that first morning visit on the second day.
A. Uh-huh.
Q. Describe to me the procedures that you applied to ML in the morning?
A. First I checked with an ultrasound, and that confirmed the demise, I removed the Laminaria, and I checked her cervix. I put in more laminaria, and I put in another Misoprostol.
Q. And what was the dosage of Misoprostol?
A. A hundred micrograms.
Q. Did you administered any Pitocin to ML on the morning of the second day?
A. No.
Q. And did you perform any further procedures on her in the morning of the second day?
A. No.
Q. When did she return to the clinic the second time on the second day?
A. She came in at about 5:00.