BEFORE THE NEW MEXICO MEDICAL BOARD

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

RESPONDENT DR. SHELLEY SELLA'S CLOSING BRIEF

INTRODUCTION

At issue in this case is Respondent Dr. Shelley Sella's care for a single patient, M.L., who underwent a third trimester abortion procedure in May of 2011. M.L. learned in her thirty-third week of pregnancy that her fetus had head and brain anomalies that created very severe risk of significant brain and developmental deficits on birth. Tr. Day 2 at 57-58; 61. After consulting with her physicians in New York (the place of her residence), she was referred to Southwestern Women's Options Clinic (SWOC) for a pregnancy termination. Tr. Day 2 at 63. M.L. was determined to present an appropriate fetal-indicated abortion, which determination is not contested by the Board. Tr. Day 2 at 57. M.L. had had a prior Cesarean section which increased her risk for uterine rupture as a result of an abortion. Tr. Day 1 at 32 and Sella Exhibit 8 at 000001-000003. M.L. and her family were counseled of this risk by both her physicians in New York and by SWOC; and this is also not contested by the Board. Tr. Day 1 at 30-31. Unfortunately, the increased risk of uterine rupture was realized and on the third day of the abortion procedure, M.L. went into labor and in the course of delivering the terminated fetus, she suffered a uterine rupture. Tr. Day 1 at 71. Dr. Sella correctly diagnosed this event; M.L. was

appropriately transferred from SWOC to UNM Hospital, where the uterine rupture was surgically repaired. Tr. Day 1 at 73-74; 81-82. M.L. returned to New York City. Dr. Sella, of course, regretted the uterine rupture[1] and testified to her regrets. Tr. Day 2 at 82.

This case came before the New Mexico Medical Board (the Board) not based on a patient complaint, a complaint from another medical provider, or a complaint from anyone with actual knowledge of the case. Instead, anti-abortion activists forwarded this case (along with more than a dozen others) to the Board after making a public records request for 911 calls from Southwestern Women's Options Clinic, the abortion clinic where Dr. Sella works in Albuquerque.

We respectfully submit that this case never should have come this far. The abortion foes that brought this case to the Board did so to promote their own political agenda of ending all legal abortion. This is a well-known tactic employed around the country by Operation Rescue and other anti-abortion groups. Tr. Day 2 at 34. The "complainants" in this matter knew nothing about the actual facts of this case or Dr. Sella's practice of medicine. Unfortunately, Dr. Gerald Bullock, the physician hired to review the medical records in this case, further misled the Board, leading to its decision to issue the Notice of Contemplated Action in this case. Dr. Bullock profoundly misread and mischaracterized the medical records, applied the incorrect standard of care when evaluating the case, and, we believe, injected his own bias against these procedures when he opined that Dr. Sella was "grossly negligent" in her care of M.L. But the record from two-day hearing on November 29 and 30, 2012 reveals that Dr. Sella was not grossly negligent and was, in fact, not at all negligent in her care of M.L. The overwhelming evidence

[1] Dr. Sella visited M.L. and her family every day that M.L. was in UNMH and she checked in with M.L.'s Maternal Fetal Medicine doctor in New York. Tr. Day 1 at 79-80.

demonstrates that Dr. Sella is a highly experienced and deeply conscientious physician who in this case carefully followed the standard of care applicable in third trimester abortion procedures. The Board has failed to meet its burden of showing by a preponderance of the evidence that Dr. Sella violated the Medical Practice Act.

FACTUAL BACKGROUND

Third trimester abortions are medical procedures, not surgical procedures. Tr. Day 2 at 14. The procedure is typically a three day process that starts with injecting the fetus with Digoxin to effect demise, continues with a two day softening and ripening of the fetal tissue and the cervix, and, finally, induction of labor. Tr. Day 2 at 14. To achieve cervical ripening, Dr. Sella's protocol, consistent with the protocols she had learned while practicing with Dr. George Tiller, one of the world's leading practitioners of third trimester abortions and consistent with the practice around the country, includes use of Laminaria (seaweed sticks that help dilate the cervix) and Misoprostol, a prostaglandin that is extremely effective in softening the cervix. Tr. Day 1 at 49-50; Day 2 at 14. Dr. Sella then typically uses Pitocin, at the appropriate time, another uterine agent, to induce labor, or if labor has naturally started, to augment labor. Tr. Day 2 at 14. In the case of a patient with a prior C-section, Dr. Sella increases the amount of time for cervical ripening from the normal two days to three days and induces labor on the fourth day. Tr. Day 2 at 15.

Dr. Sella has dedicated her practice solely to the provision of abortion services since 2000 and has performed thousands of first, second and third trimester procedures. Tr. Day 1 at 26-27. She has performed between 500 and 1000 third trimester abortions and in approximately 75 cases, the patients had had prior C-sections. Tr. Day 1 at 27. Dr. Sella learned the protocol

she employed in this case in Wichita, Kansas, from Dr. George Tiller, who was a leading expert in the provision of abortion services, including, specifically, third trimester abortions. Tr. Day 2 at 8-10, 26. Dr. Sella practiced medicine with Dr. Tiller until he was assassinated in 2009. Tr. Day 2 at 27.

Because M.L. had had a prior C-section, she was at elevated risk for a uterine rupture, whether she had an abortion or an obstetrical delivery.[2] Tr. Day 1 at 74. Dr. Robinson and Dr. Sella both counseled the patient about this elevated risk, as well as her MFM physician in New York, and the patient consented with full knowledge that it was a possible complication. Tr. Day 1 at 32; Sella Exhibit 8 at 00002-00003.

The facts of what occurred during the patient's treatment at SWOC are essential to understanding why Dr. Sella was not grossly negligent. The patient was treated over the course of a three-day period, from May 10-May 12, 2011.

Day 1 of Treatment

The patient presented for treatment on May 10, 2011. Tr. Day 1 at 33. On Day 1, the patient met with a counselor and Dr. Sella and signed consent forms. Tr. Day 1 at 33. Dr. Sella

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[2] One of the themes implicit in the Board's case against Dr. Sella is that there was elevated risk in the manner in which M.L. was treated by Dr. Sella and SWOC but that there were alternatives that did not contain elevated risk of harm to M.L. The evidence, as well as common sense, is to the contrary. As with many situations in life, there were no risk-free pathways available here. If Dr. Sella did not provide abortion services to M.L. in the SWOC it is likely that M.L. would not have been able to obtain an abortion (since few third trimester abortion services are provided in hospital settings) and would have suffered the risks to her associated with a live birth of this seriously deformed fetus. Tr. Day 1 at 115-118. Following the standard of care suggested by Dr. Bullock would likely have increased the employment of C-sections to the population generally (and to M.L.) and as Dr. Darney testified, the increased incidence of C-sections is associated with increased risk of maternal mortality and morbidity. Tr. Day 1 at 144. Quite simply, there were no risk-free pathways here. Dr. Sella employed the pathway she had been taught, she had employed in all previous third trimester abortion procedures and to her understanding was universally employed by providers of third trimester abortion procedures throughout this country. Tr. Day 2 at 26.

examined the patient and performed an ultrasound. Tr. Day 1 at 38. Dr. Sella then effected fetal demise using Digoxin. Tr. Day 2 at 63. After effecting fetal demise, Dr. Sella inserted Laminaria and administered 100 micrograms (mcg) in tablet form of Misoprostol vaginally. Tr. Day 1 at 49-50. The patient was then discharged from the clinic and returned to her hotel. Tr. Day 2 at 64. At no time during day 1 was M.L. administered Pitocin. Tr. Day 2 at 63-64.

Day 2 of Treatment

On Day 2, May 11, 2011, Dr. Sella saw M.L. a total of three times. First, the patient returned to the clinic in the morning. Tr. Day 2 at 64. The patient's cervix had not dilated very much. Tr. Day 2 at 64. Dr. Sella again administered 100 mcg of Misoprostol vaginally in the morning after examining the patient and removed and replaced the Laminaria. Tr. Day 2 at 65. The patient was then discharged with tablets of Misoprostol with instructions to take one tablet buccally (in the cheek) at 3:00 p.m. and to return to the clinic in the afternoon to be examined again. Tr. Day 2 at 65-66. Because the purpose of the Misoprostol was to soften the cervix and not to induce labor, the patient was instructed not to take the Misoprostol should she start having contractions. Tr. Day 1 at 50; Day 2 at 68-69.

On the same day (Day 2), the patient returned at approximately 5:00 p.m. Tr. Day 2 at 69. Dr. Sella examined her again and determined that again, the patient's cervix had not changed since the morning. Tr. Day 2 at 69. Dr. Sella advised the patient to take Misoprostol every six hours (with the next dose to be at 9:00 p.m.), but to discontinue the Misoprostol if she started having contractions. Tr. Day 2 at 69.

The patient returned to the clinic around 11:00 p.m. on Day 2 in labor. Tr. Day 2 at 70. She had not taken the 9:00 p.m. dose of Misoprostol as instructed because she had started having

contractions. Tr. Day 1 at 60-61. She was admitted to the clinic. Dr. Sella, who was on site, administered 100 mcg of Misoprostol buccally at 11:18 p.m. to the patient to augment the labor. Tr. Day 1 at 62-63; Day 2 at 70-71. At no time during Day 2 was M.L. administered Pitocin. Tr. Day 2 at 69.

Day 3 of Treatment

Day 3 (May 12, 2011) started shortly after the patient was admitted to the clinic. At 12:24 a.m. on Day 3, Dr. Sella administered a second dose of 100 mcg of Misoprostol to the patient, and also started the patient on an IV drip of a low dose of Pitocin (10 units/1000 ccs), also to augment the patient's labor. Tr. Day 1 at 64-65. The patient threw up the dose of Misoprostol administered at 12:24 a.m. at approximately 12:50 a.m.[3] Tr. Day 2 at 70-71. Dr. Sella, consistent with what she had learned at Wichita under Dr. Tiller, then changed her treatment plan to respond to the specific circumstances of the patient. Tr. Day 1 at 66. She discontinued any use of Misoprostol and placed the patient on therapeutic rest, meaning that she placed the patient on Fentanyl (a pain medication), Versed (a sedative), and the low dose of Pitocin for the patient to sleep for several hours. Tr. Day 1 at 66. In Dr. Sella's experience, therapeutic rest allows for the patient to rest and increases the likelihood of labor progressing. Tr. Day 1 at 66.

At approximately 7:12 a.m. on Day 3, Dr. Sella examined the patient. Tr. Day 1 at 69. M.L. had progressed some, but not as much as Dr. Sella expected. Tr. Day 2 at 73. Dr. Sella

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[3] The evidence is uncontradicted that it was only for this approximately half-hour period that M.L. was given both Misoprostol and Pitocin simultaneously. Tr. Day 2 at 71-72. Since Misoprostol has a half-life of approximately 20-40 minutes, by early morning – hours before the uterine rupture—the Misoprostol was out of M.L.'s system. Tr. Day 2 at 71-72. Contrary to Dr. Bullock's initial reading of the record, Sella Exhibit 12 at 120, Dr. Sella did **not** administer Misoprostol and Pitocin simultaneously for all three days and the simultaneous administration of these prostaglandins could not have been the factor that caused the uterine rupture.

then increased the dose of Pitocin to 60 units/1000 ccs to facilitate labor. Tr. Day 1 at 69; Day 2 at 72-73. She then examined the patient again at approximately 1:15 p.m. to check the patient's progress and to decompress the fetus's cranium in order to facilitate delivery. Tr. Day 1 at 71-72. Dr. Sella discovered during this examination of the patient that the fetus's station had changed significantly—it had gone from being vertical in the birth canal to being transverse—causing Dr. Sella to strongly suspect a uterine rupture. Tr. Day 1 at 71, 74. Dr. Sella discontinued the Pitocin and immediately arranged for the patient to be emergency transported to University of New Mexico Health Sciences Center, where SWOC has its backup team in the unusual event of a complication. Tr. Day 1 at 71, 73-74.

The hospital is minutes away from the clinic and the patient was quickly transported. Tr. Day 1 at 77. At the hospital, it was confirmed that M.L. had experienced a uterine rupture. Tr. Day 1 at 81-82. UNM doctors operated; the uterus was repaired and M.L. did not have a blood transfusion. Tr. Day 1 at 81-82. She was discharged after three days and returned to New York. Dr. Sella was in close contact with the patient and her family during her stay at UNMHSC. Tr. Day 1 at 79-80.

Throughout the patient's care at the SWOC clinic, Dr. Sella and the SWOC staff monitored the patient's vital signs. Sella Exhibit 8 at 000022, 000024, 000026 and 000032-33. Dr. Sella also demonstrated careful and individualized care of the patient, redirecting her plan according to the patient's needs and response to treatment. Tr. Day 2 at 69-73.

The Board's Prosecutor rested his case for gross negligence on the word of Dr. Bullock, who is an experienced OB/GYN, but not an experienced abortion provider. Tr. Day 1 at 201. In fact, Dr. Bullock performs at most two to three abortions per year and has never performed a

third trimester medical abortion. Tr. Day 1 at 201. Dr. Bullock, in his report to the Board, stated that he finds this type of third trimester procedure morally appalling.[4] Sella Exhibit 12 at 120. Moreover, Dr. Bullock's opinion, in large part, is based on a series of significant errors in reading the medical records. For example, Dr. Bullock appears to have believed until the hearing that Dr. Sella had administered Misoprostol and Pitocin simultaneously throughout the patient's treatment. Tr. Day 1 at 233-237; Sella Exhibit 12 at 119. This is incorrect, as discussed above. Dr. Bullock also opined that the appropriate standard of care in this case was an obstetrical standard of care applicable to so-called VBACs (vaginal births after Cesarean) or TOLACs (trial of labor after Cesarean), which are not abortion procedures. Tr. Day 1 at 248. Dr. Bullock went so far as to claim that there is no independent standard of care for a third trimester abortion under these circumstances. Tr. Day 1 at 248.

Dr. Bullock opined that it was grossly negligent for Dr. Sella to (1) have administered Pitocin and Misoprostol simultaneously (even for the extremely short overlap that was actually, factually correct); (2) for the abortion to have been performed in a outpatient clinic; and (3) for the patient to have been given Misoprostol to take with her to the hotel to take buccally. Tr. Day 1 at 244-245. Dr. Bullock based this opinion on his application of what he perceives is an obstetrical standard of care and a misreading of the American College of Obstetricians and Gynecologists (ACOG) Bulletin No. 115, as explained in further detail below. Tr. Day 1 at 204. Dr. Bullock's opinions also ignored the reality that the vast majority (approximately 90%) of third trimester abortions are performed in an outpatient setting, including third trimester abortions on patients with prior C-sections. Tr. Day 2 at 9, 38. Indeed, the record evidence is

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[4] While Dr. Bullock states that his moral antagonism to the procedure did not influence his judgment, Sella Exhibit 12 at 120, we respectfully suggest that the contrary is true.

that no hospital in New Mexico will perform a third trimester abortion[5] and as a consequence, if Dr. Bullock's standard of care is accepted, many women in New Mexico will go without needed abortions that are clearly legal in this State. Tr. Day 1 at 117.

Dr. Bullock's testimony at trial was inconsistent with statements he had made earlier in both his report to the Board and in his deposition on October 18, 2012. He gave no explanation for the discrepancies, but attempted to minimize them by stating that they did not matter. Tr. Day 1 at 239.

Dr. Bullock's testimony and opinions were undercut entirely by the testimony of Dr. Phillip Darney, an expert called by Dr. Sella. Dr. Darney is a world-renowned expert in women's health and the provision of abortion services. Tr. Day 1 at 98-99. Dr. Darney is a Distinguished Professor of Obstetrics, Gynecology and Reproductive Sciences and Health Policy at the University of California, San Francisco Medical School.[6] Tr. Day 1 at 98. Among Dr. Darney's significant academic and clinical achievements (over 200 articles in peer review journals published, long-standing reviewer for the New England Journal of Medicine and Lancet, significant research grants) is the establishment of a Fellowship in Family Planning Medicine that has been extended to twenty-six medical schools throughout the country, including UNM. Tr. Day 1 at 102-104; 107. SWOC is a part of the UNM fellowship, in that fellows do part of their clinical training at SWOC. Tr. Day 1 at 110-111. As part of his role in the development and maintenance of the fellowship, Dr. Darney travels throughout the country visiting the clinics

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[5] In addition, the record is clear that it is common practice in New Mexico for certified nurse midwives and licensed midwives to perform TOLACs and VBACs on women with prior C-sections outside of a hospital setting – the type of procedure that Dr. Bullock opines is below the standard of care.

[6] UCSF Medical School is ranked one of the top five in the country and in maternal medicine is ranked number two in the country. Tr. Day 1 at 99.

and hospitals where fellows do their training, including SWOC. Tr. Day 1 at 111. It is his experience that SWOC provides exemplary care to its patients. Tr. Day 1 at 111.

Dr. Darney, who has performed thousands of abortions and hundreds of third trimester abortions, opined that there is a separate standard of care for a third trimester abortion that is significantly different than the obstetrical standard of care Dr. Bullock applied to this case. Tr. Day 1 at 131-135. The criteria for an appropriate setting for a third trimester abortion includes (1) an appropriate physical facility with the necessary equipment and medication but not necessarily one that is in a hospital setting; (2) staff with specialized training in abortion care; and (3) ready access to emergency services if necessary. Tr. Day 1 at 193-194. Dr. Darney, who has both visited SWOC and spoken with Dr. Sella about this case, opined that the care in this case exceeded the standard of care applicable to third trimester abortions. Tr. Day 1 at 188, 192. Dr. Darney explained that it was perfectly appropriate for the procedure to have been performed at this clinic and that it would be extremely unlikely that this patient would have found a hospital to perform the procedure, given hospital bureaucracies and the heterogeneous nursing staff found at most hospitals that often do not have specialized training or where some or all staff members are opposed to abortions for political or religious reasons. Tr. Day 1 at 115-117. Dr. Darney also noted that Dr. Sella's use of medication was necessary and consistent with the basic protocol followed by all third trimester providers throughout the country. Tr. Day 1 at 135-139.

Dr. Darney also explained that not only is ACOG Bulletin 115 inapplicable to this case because it described care in an obstetrical case, not an abortion case, but Dr. Bullock had fundamentally misread ACOG 115 to prohibit VBACs or TOLACs in a non-hospital clinic setting. Tr. Day 1 at 141-146. In fact, as Dr. Darney explained, ACOG 115 was issued in 2010

in response to a backlash against an earlier, more restrictive bulletin from 2006 that did categorically prohibit VBACs or TOLACs in an outpatient clinic. Tr. Day 1 at 141-146. ACOG 115 stands for the proposition that as long as the patient has given informed consent and emergency care is readily available, a patient may choose to have a TOLAC or VBAC in a non-hospital based clinic. Sella Exhibit 10; Tr. Day 1 at 141-146. This testimony is further corroborated by Sella Exhibit 16, a chart of non-hospital based clinics in New Mexico that assist TOLAC and VBAC patients in live deliveries.

Finally, Dr. Bullock offered no support from any literature to support his suggestion that it was grossly negligent for Dr. Sella to give Misoprostol to the patient to take back to her hotel and this opinion—which he offered for the first time at the hearing—was contradicted by the record evidence. Tr. Day 2 at 81-82.

In all, the great weight of evidence adduced at trial showed that Dr. Sella was not grossly negligence in her care of M.L. In fact, the evidence showed that Dr. Sella was well within the standard of care applicable to third trimester abortions. The Board's Prosecutor failed to meet the necessary burden to show Dr. Sella violated the Medical Practice Act. If the Prosecutor and Dr. Bullock's theory of this case were accepted, the reality would be that no third trimester patient with a history of a C-section could have a pregnancy termination.

ARGUMENT

I. The Prosecution has failed to sustain its burden of showing that Dr. Sella was "grossly negligent", as required by the Notice of Contemplated Action against Dr. Sella and the Medical Licensing Act .

A. The test of "gross negligence" is whether Dr. Sella engaged in willful and wanton conduct; a conscious and deliberate disregard for the interests, safety and well-being of her patient.

The Medical Licensing Act's provisions for refusing, revoking or suspending licenses are found at NMSA 1978 §61-6-15(D), which provides such action for "unprofessional or dishonorable conduct," which is defined, *inter alia*, as "(12) gross negligence in the practice of a licensee". Simple negligence will not suffice for the suspension or revocation of a license to practice medicine.

> Policy considerations also suggest that the legislature did not intend to authorize sanctions against a licensee for ordinary negligence committed during a single episode of treatment. Review of other statutes addressing the licensing and sanctioning of health care providers indicates that the legislature requires more to warrant discipline. We note that none of the other statutes concerning healthcare provider licensing authorize the discipline of a practitioner/licensee for an act of ordinary negligence. [citing and discussing licensing statutes for other health care professionals.]

New Mexico Board of Veterinary Medicine v. *Riegger*, 2006-NMCA-069, ¶15, 139 N.M. 679, 137 P.3d 619, *rev'd.* on unrelated point only at 2007-NMSC-044, 142 N.M. 248, 164 P.3d 947 (holding that the Board lacked authority to impose sanctions for single act of ordinary negligence). *Paiz* v. *State Farm Fire & Cas. Co.*, 118 N.M. 203, 211, 880 P.2d 300 (1994) (holding that an award of punitive damages for gross negligence in a contract case must be based on willful and wanton conduct, not mere negligence).

There is no dispute between the parties to this proceeding that the "willful and wanton" standard defines "gross negligence" for the purpose of this case. The Prosecution and its expert agree. While the Prosecution's expert, Dr. Bullock, opined that Dr. Sella had been grossly negligent, when asked what gross negligence constituted, he testified that gross negligence was "willful and wanton disregard for the welfare of the patient ...."

Q. Okay. Going back to whether – I believe you testified that this

> is a case involving gross negligence. What is your understanding of gross negligence?
> A. My definition?
> Q. Yes.
> A. Oh, what I've been told is that it's a willful and wanton disregard of the welfare of the patient.

Tr. Day 1 at 217.[7]

Both Dr. Sella and the Board agree that to find her "grossly negligent" the Board must find that Dr. Sella engaged in willful and wanton conduct in treating M.L. The concept of willful and wanton conduct is well understood in New Mexico law. These terms are defined in the Uniform Jury Instruction in terms of intentional or deliberate conduct without regard to the consequences or the known risks to others.

> Willful conduct is the intentional doing of an act with knowledge that harm may result.
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> Wanton conduct is the doing of an act with utter indifference to or conscious disregard for a person's [rights] [safety].

UJI 13-1827. The decisional gloss on willful and wanton conduct speaks in terms of intent to do harm or indifference to a known risk of harm. In *Paiz*, in considering what constitutes willful and wanton conduct necessary to award punitive damages, the Court endorsed the language of Professor Dobbs: "a conscious and deliberate disregard of the interests of others ...." *Paiz*, 118

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[7] There can be little doubt that Dr. Bullock was "told" this by the prosecution. Dr. Bullock was under direct examination by the prosecutor, Mr. Rubin at the time of this colloquy, and in a subsequent question, shortly thereafter. Mr. Rubin himself used the same "willful and wanton" definition of gross negligence.

> Q. So let me ask it again. Given your understanding of gross negligence as the willful wanton disregard of risks and it appears that there is only one option to a physician, is there – are you more likely to weigh the risks and benefits than you would if there's one option?

Tr. Day 1 at 217-2918.

N. M, at 211, quoting 1 Dan B. Dobbs, Dobbs' Law of Remedies § 3.11(2), at 472 (2nd Ed. 1993). The *Paiz* court went further, requiring not only a heightened level of misconduct, but also a different state of mind. The conduct must be "actuated by ill will" and "evince a conscious disregard of the rights of others ...." *Paiz*, 118 N.M. at 211, quoting Charles T. McCormick, Handbook of the Law of Damages § 79 at 280-81 (1935).

Certainly, willful and wanton conduct can mean no less when the matter involves the licensure of a medical professional. It is not enough (and should not be enough) to show negligence in any degree. We expect and require medical doctors to exercise judgment and skill. Conduct egregious enough to warrant revocation of a medical practitioner's license should go beyond a mere failure to exercise judgment from the perspective of hindsight. Rather it should require evidence of knowledge of risks involved and evidence of a conscious disregard of those risks and of the safety or health of the patient. *And*, it should require evidence of intent to do harm.

There is no such evidence here. There is no evidence that Dr. Sella set out consciously and deliberately to do harm to her patient. Indeed, the evidence is just the opposite – that everything Dr. Sella did was consistent with accepted practice and that she responded to circumstances with only the safety of her patient in mind. There is no evidence that Dr. Sella deliberately and consciously disregarded M.L.'s health, safety or welfare, *or* that she was in any way motivated by ill will toward her patient.

B. The record is bereft of evidence that Dr. Sella's conduct reached the heightened state of wrongful conduct or that she acted with any wrongful state of mind with respect to her treatment of her patient M.L., both of which are necessary to justify any Board sanction.

The charges against Dr. Sella arise exclusively from the treatment and care she provided to M.L., a woman who presented for a third-trimester abortion procedure.[8] The Hearing Officer and Board have testimony from three medical witnesses concerning the care Dr. Sella provided to M.L.: (1) Dr. Sella; (2) the Board's expert, Dr. Bullock; and (3) Dr. Sella's expert, Dr. Philip Darney. The *only* opinion offered that Dr. Sella's conduct was improper was offered by the Board's expert, Dr. Bullock; and that opinion was based on his fundamentally erroneous misreading of the medical records and misunderstanding of what he considered to be the pertinent ACOG bulletin. The record evidence overwhelmingly refutes Dr. Bullock's erroneous opinion and establishes that Dr. Sella's treatment of M.L. was fully consistent with the standard of care applied universally in third-trimester abortion procedures.

Dr. Sella testified fully, in detail and candidly about her extensive background and experience in providing abortion procedures, and particularly third-trimester abortion procedures; about her care for and treatment of the patient at issue in these proceedings, M.L.; and how that treatment was consistent with (i) how Dr. Sella had been trained, (ii) how she had provided third-trimester abortion procedures in the past, and (iii) the protocols of all other medical practitioners of third-trimester abortions in the United States. Tr. Day 2 at 19-26. Dr. Darney, if not the world's leading expert on women's health issues and abortion procedures, certainly one of a handful of internationally recognized experts in this field, not only contested

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[8] It is undisputed that M.L.'s abortion procedure, while successful in terminating the pregnancy, had an unfortunate and adverse outcome in the uterine rupture that occurred while M.L. was in active labor to deliver the dead fetus. This adverse outcome (which is a known risk for a woman like M.L. with a prior C-section who seeks either the delivery of a live baby or an abortion and of which M.L. was fully advised), of course, does not in itself constitute or suggest a departure from the standard of care, much less the type of willful or wanton disregard for the safety of the patient, as is required by the "gross negligence" standard applicable here.

Dr. Bullock's opinion but established through his testimony (i) that Dr. Sella's use of the drugs at issue (Misoprostol and Pitocin), in their selection, dosage, and timing, was appropriate; (ii) that Dr. Sella's treatment was consistent with the standard of care employed in third-trimester abortions throughout the country, including in the post-residency fellowship programs (which Dr. Darney had founded) where abortion procedures are taught; and (iii) that Dr. Bullock's reliance on the outdated ACOG bulletin and committee opinion[9] as a basis for his opinions was inappropriate, detailing the reasons why the ACOG bulletin – whether the outdated one (No. 54) or the current one (No. 115) are applicable only to live birth procedures and are inappropriate for and should not be applied to abortion procedures. Tr. Day 1 at 113-117; 135-146.

The Board's expert, Dr. Bullock was the only medical witness testifying with limited abortion experience and the only person who has offered the opinion that Dr. Sella was grossly negligent in providing abortion services to M.L. Tr. Day 1 at 205-206. Dr. Bullock's understanding of the care that Dr. Sella provided was a constantly moving target – changing radically from his numerous misreadings of the medical records[10] evidenced in his initial report; to his stated understandings at his deposition (also erroneous); to what he finally testified to at trial.[11] Dr. Bullock's report (Sella Exhibit 12) – which provides the basis for his opinions when he first reached them and on which the Board made the determination to issue the Notice of

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[9] Significantly, ACOG itself recognizes the bulletin and committee opinion on which Dr. Bullock relies for his opinion as "superseded" and not current. Sella Exhibits 10, 13 and 14. Dr. Bullock admitted as much in his testimony. Tr. Day 1 at 224-226.

[10] Dr. Bullock's numerous and significant misreadings of the medical record call into question not only the care and diligence he exercised in his investigation and analysis but also the soundness of his opinions.

[11] Dr. Bullock refused to concede at trial his previous and obvious misreading of the medical record (Tr. Day 1 at 228, 231-232, 234-236, 239) -- calling into question his impartiality and his veracity.

Contemplated Action that is the basis for these proceedings – is replete with errors, both insignificant[12] and fundamental. For example, in his report, Dr. Bullock, among other things:

- erroneously stated that Dr. Sella had administered Pitocin to M.L. continuously from the first day of treatment through the third day of treatment (Sella Exhibit 12 at 120);[13] in fact, Dr. Sella did not administer Pitocin to M.L. until shortly after midnight on Day 3, and administered Pitocin in conjunction with Misoprostol for only a short period (less than an hour) shortly after midnight on the third day of treatment;
- erroneously stated that the M.L.'s medical records did not record her vital signs when in fact they did, which Dr. Bullock ultimately had to concede;
- repeatedly mistakenly characterized the method of delivery of the Misoprostol.

Tr. Day 226-228; 243; 252-255. Dr. Bullock based his opinion of gross negligence on the following factors:

1. Dr. Sella's administration of Misoprostol in conjunction with the use of Pitocin,
2. Dr. Sella's performing the procedure in a clinic as opposed to in a hospital, as an "extreme" breach of the standard of care,

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[12] For example, Dr. Bullock repeatedly got dates wrong in his recitation of the chronology of M.L.'s treatment. Tr. Day 1 at 226, 237-239.

[13] Curiously, Dr. Bullock came to his erroneous conclusion that Pitocin was administered continuously from the first day of M.L.'s treatment by mistakenly taking as applicable a pre-printed standard protocol in the records for expressly surgical (second-term) abortions even though M.L.'s third-term abortions was not surgical. Even more curious and significant, Dr. Bullock adhered to his belief that Pitocin was continuously administered to M.L., notwithstanding that he knew or should have known that Pitocin is administered intravenously and the medical records clearly showed that M.L. was treated as an outpatient for the first two days, coming to the clinic for procedures and returning then to her hotel; and was not treated as an inpatient until the very end of the second day of treatment (around eleven o'clock p.m.), thereby making continuous administration of Pitocin (intravenously) implausible. Tr. Day 1 at 228, 231-232, 234-236, 239.

3. Dr. Sella giving the patient Misoprostol to take with her back to her hotel.

Tr. Day 1 at 211-213.

Dr. Bullock opined that gross negligence was "knowing the rules and just ignoring them." Tr. Day 1 at 212. But it is clear that Dr. Bullock was referring to a set of rules that are inapplicable to abortion practice. As we discuss more fully below, the standard of care by which Dr. Bullock purported to assess Dr. Sella's medical treatment of her patient M.L. was the standard applicable to obstetrical delivery of a live fetus, not the standard applicable to abortion practice. Dr. Sella's expert, Dr. Darney made clear that the ACOG Bulletins that Dr. Bullock was relying on for his opinion that Dr. Sella had been grossly negligent were intended to describe obstetrical procedures for a live birth, not for an abortion. Tr. Day 1 at 131-132.

With respect to Dr. Bullock's first criticism (the combination of Misoprostol and Pitocin), Dr. Darney explained that according to the abortion standard of care, the use of those medications (Misoprostol and Pitocin), separately and in conjunction, is appropriate. Dr. Darney, Respondent's expert testified as to the appropriate use of those drugs in abortion procedure, Tr. Day 1 at 132 - 136, where, as he explained, the key difference between the obstetrical procedures and the abortion procedures was the intent to deliver a live baby in the one and not in the other and why that difference made the risk attendant to the use of these uterine stimulants greater in a live birth than in an abortion procedure.

> Very different, because we're talking in this – in this particular case and in all third trimester abortions about a dead fetus. You're not concerned about the effects of the stimulants over a long period of time on fetal heart rate and compromising fetal welfare.

Tr. Day 1 at 133-134. In addition, Dr. Darney testified that the tissue of a fetus softens after fetal demise. Tr. Day 1 at 169. Moreover, as all three doctors testified, the head can be compressed

to facilitate delivery. Tr. Day 1 at 72, 134, 206. Both the compressed cranium and the softened fetal tissue reduce the pressure on the uterus and hence reduce the risk of uterine rupture. Tr. Day 1 at 72, 169. Finally, in opining that the combination of drugs was grossly negligent, Dr. Bullock also relied on an outdated ACOG Committee Opinion No. 342, Sella Exhibit 14, which has been superseded. Tr. Day 1 at 224-226.

Moreover, there is no evidence to suggest that in using these medications, Dr. Sella did so in conscious and deliberate disregard for the interests and safety of her patient, M.L., given that Dr. Sella has followed this protocol in the more than 500 third trimester abortions she has performed in the last decade. Tr. Day 2 at 26. The evidence at hearing was that Dr. Sella's treatment of her patient M.L. was in accordance with procedures that she had used throughout her career as a physician providing thousands of abortions, including between 500 and 1,000 third trimester abortions, Tr. Day 1 at 26 – 27,[14] and was consistent with accepted practice of abortion clinics across the nation. Tr. Day 2 at 26. Dr. Darney testified that use of those drugs for those purposes and in those doses in third trimester abortions is the accepted practice at his abortion clinic at the San Francisco General Hospital and around the rest of the country by practitioners of third trimester abortions. Tr. Day 1 at 136, 162.

When Dr. Sella followed procedures and used drugs routinely used by all physicians who perform third trimester abortions, including those used routinely in third trimester abortions on women who previously had had C-sections, it simply cannot be said that Dr. Sella was acting in conscious and deliberate disregard of the safety and well being of her patient. *Stone* v. *Sobol*, 171 A.D.2d 235, 242-43, 578 N.Y.S.2d 939 (N.Y.A.D. 1991) (annulling the determination of the

[14] By contrast, Dr. Bullock testified that he had done approximately 10,000 live births over his career (Tr. Day 1 at 199), and that he has performed perhaps 2-3 abortions a year, but never had done a medical third trimester abortion. Tr. Day 1 at 201.

Commission on Education censuring and reprimanding a first year medical intern, upon a determination that the intern's conduct did not deviate from accepted medical practice, which precluded a determination that the intern had been grossly negligent).

Second, Dr. Bullock's opinion that Dr. Sella was grossly negligent rested on his belief that this procedure should have been done in a hospital setting, not at the clinic. But Dr. Bullock's opinion with regard to this point again conflates obstetrical care with abortion procedures. The record evidence shows that 90% of third trimester abortions—including those patients with a prior-C-section history—occur at non-hospital based clinics around the country. Tr. Day 1 at 193. Moreover, the evidence adduced at trial demonstrated that it would have been virtually impossible for the patient to have this procedure at a hospital. Tr. Day 1 at 115-117; Day 2 at 76-77. Dr. Darney testified that this is because of hospital bureaucracy and hospital staff that is ill-equipped, ill-trained, and/or opposed to abortion. Tr. Day 1 at 115-117.

Dr. Bullock's opinion as to this point had its genesis in Dr. Bullock's misreading and misapplication of ACOG Bulletin No. 115 and his misapplication of the outdated and superseded ACOG Bulletin No. 54 and ACOG Committee Opinion No. 342. First, Dr. Darney clarified that, contrary to Dr. Bullock's assertions, ACOG Bulletin 115 is inapplicable to this case because it addresses obstetrical practices, not abortion procedures. Second, the ACOG Practice Bulletins relied on by Dr. Bullock do not even define the standard of care for obstetrical practice. Dr. Darney, who had himself participated in several of the ACOG committees that promulgated Practice Bulletins and Committee Reports, testified that the ACOG guides specifically do not intend to establish a standard of care. Tr. Day 1 at 174 - 175. Second, Dr. Darney explained that, contrary to Dr. Bullock's understanding, ACOG Bulletin No. 115 does not categorically prohibit

a patient having a VBAC or TOLAC in a non-hospital based clinic. Tr. Day 1 at 183-184. Indeed, as Dr. Darney explained, ACOG Bulletin 115 was in response to outcry over an surge in C-section numbers after ACOG Bulletin 54 was published, which included much more categorical language prohibiting VBACs or TOLACs in a non-hospital setting. Tr. Day 1 at 141-146, 183-184.[15]

Finally, Dr. Bullock offered no evidence to support his assertion that it was grossly negligent for Dr. Sella to give M.L. Misoprostol to take back to her hotel and self-administer. The evidence shows conclusively that Dr. Sella was not grossly negligent in this regard; this was Dr. Sella's standard practice and the patient was carefully instructed as to how to administer the medication and to stop taking the medication if labor started. Tr. Day 2 at 68, 81-82.

At its most basic, Dr. Bullock's opinion applied the wrong standard of care to this case. Dr. Bullock applied a third trimester obstetrical delivery of a live baby standard, not a third trimester abortion standard. Tr. Day 1 at 131-132. The standard of care, where it is applicable, establishes a level of medical practice and procedure deemed appropriate for a given situation. Failure to adhere to the applicable standard of care may well be simple negligence, but as we have demonstrated negligence by itself does not establish willful and wanton conduct. Missing from a failure to adhere to the applicable standard of care, if there was such a failure here (which the overwhelming evidence demonstrates there was not) is the element of conscious and deliberate disregard for the safety and welfare of the patient. Without that conscious and deliberate disregard there can be no "gross negligence" sufficient to terminate the license of a physician.

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[15] Both the Committee Opinion (Sella Exhibit14) and the Practice Bulletin 115 (Sella Exhibit 10) specifically state on their first page that they "should not be construed as dictating an exclusive course of treatment or procedure ...."

> A mental state sufficient to support an award of punitive damages will exist when the defendant acts with "reckless disregard" for the rights of the plaintiff—i.e., when the defendant knows of potential harm to the interests of the plaintiff but nonetheless "utterly fail[s] to exercise care" to avoid the harm. By contrast, a defendant acting with gross negligence—which UJI Civil 13–1827 defines as a failure to exercise even slight care—cannot, solely because the defendant acted with such negligence, be regarded as having a culpable or "evil" state of mind.

Paiz, 118 N.M. at 211. No witness, not Dr. Bullock, nor Dr. Darney, nor Dr. Sella provided any evidence that would support a finding that to the extent that anyone believes that Dr. Sella fell beneath the applicable standard of care, she did so with conscious and deliberate disregard for the health and safety of her patient, M.L.

II. New Mexico law precludes restricting or revoking the license of a medical practitioner based on a single incident of gross negligence.

As already demonstrated, Dr. Sella's treatment of her patient M.L. neither fell below the applicable standard of care, nor did it constitute gross negligence on her part. But in any event, this prosecution and this hearing addresses but a single incident of Dr. Sella's years of medical practice in New Mexico. So even if it was beneath the standard of care or even if it could somehow be considered gross negligence within the meaning of the Medical Licensing Act (NMSA 1978 §61-6-1 *et seq.*), New Mexico law has long been clear: a medical practitioner's license to practice medicine cannot be restricted, denied or revoked based on a single incident of gross negligence.

> Policy considerations also suggest that the legislature did not intend to authorize sanctions against a licensee for ordinary negligence committed during a single episode of treatment.

New Mexico Board of Veterinary Medicine v. *Riegger*, 2006-NMCA-069, ¶15, 139 N.M. 679, 137 P.3d 619 (finding that the Board lacked authority to impose sanctions for a single act of

ordinary negligence), *rev'd.* on unrelated point only at 2007-NMSC-044, 142 N.M. 248, 164 P.3d 947. Similarly, in *Lopez* v. *New Mexico Board of Medical Examiners*, 107 N.M. 145, 754 P.2d 522 (1988), the Supreme Court affirmed the district court's restoration of Dr. Lopez's license, notwithstanding evidence of gross negligence on Dr. Lopez's part, on the ground, *inter alia*, that this was Dr. Lopez's first disciplinary proceeding since his licensure twenty years previously.

While Respondent believes that she has demonstrated clearly that she neither fell beneath the Standard of Care here nor that her treatment of her patient M.L. was grossly negligent as that term is defined in New Mexico law, she can say unequivocally that the hearing addressed but a single incident. There was no evidence whatsoever of Dr. Sella's treatment of any other of her New Mexico patients. So whether Dr. Sella's treatment of M.L. fell beneath the applicable Standards of Care (which it did not) or whether it was grossly negligent as that term is defined in New Mexico (which it was not) the single incident that was the sole subject of these two days of hearing cannot, by itself, support the restriction or revocation of Dr. Sella's license under New Mexico law.

CONCLUSION

For the reasons stated herein and based on the evidence adduced at hearing, the Hearing Officer must recommend that the complaint against Dr. Sella be dismissed and that her license to practice medicine in the State of New Mexico be maintained without restriction.

Respectfully submitted,

/s/ Joseph Goldberg
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I certify that a copy of the foregoing was sent to David Thomson via first class and electronic mail, and to Daniel Rubin via first-class mail, this 4th day of January, 2013:

/s/ Joseph Goldberg
Joseph Goldberg