New Mexico Medical Board
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January 22, 2013

I, Lynn S. Hart, Executive Director of the New Mexico Medical Board, as a custodian of this record, certify that it is a true and exact copy of all public records in case number 2012-026, accurately recorded, maintained and reproduced by this agency. The case involved:

Shelly Sella, M.D.
License #92-62
Public File

IN TESTIMONY WHEREOF, I have hereunto subscribed my name and caused the seal of the New Mexico Medical Board to be affixed, the day and year first above written.

SEAL

Lynn S. Hart
Executive Director
Records Custodian

BEFORE THE NEW MEXICO MEDICAL BOARD

IN THE MATTER OF	)	
	)	
Shelly Sella, MD	)	
License No. 92-62	)	**No. 2012-026**
	)	
Respondent.	)	

CLOSING ARGUMENT AND PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW BY THE PROSECUTION

The Prosecution, in accordance with the order of the Hearing Officer at the conclusion of the presentation of evidence in the hearing on November 30, 2012, hereby submits a brief on the issue of the standard of care, and proposed findings of fact and conclusions of law as follows[1]:

I. BRIEFING ON THE ISSUE OF THE STANDARD OF CARE

The trier of fact must determine the standard care to be applied to a specific medical procedure by looking at "proper standard of medical practice recognized in the community." *See, Blauwkamp v. University of New Mexico Hosp.*, 114 N.M. 228, 231, 836 P.2d 1249, 1251 (Ct. App.1992). As to what constitutes a "community," courts have adopted either a "strict locality rule" or a rule based upon national standards. *See, e.g., Orcutt v. Miller*, 595 P.2d 1191 (Nev. 1979); see also *Shipley v. Williams*, 350 S.W.3d 527 (Tenn. 2011); *see also, Hookman, Medical Malpractice Expert Witnessessing*, §17.3 (2008).

In *Orcutt*, the Court explained the rationality behind the "strict locality rule":

> Historically, the strict locality rule is based on the rationale that there exists gross inequality between physicians practicing in large urban areas and those practicing in more remote rural communities. The policy behind the rule was to prevent the small town practitioner from being held to the standard of practice of the more sophisticated urban areas.

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1 The Prosecution otherwise rests upon his closing argument made at the closing of the hearing on November 30, 2012.

Orcutt, 595 P.2d at 413.[2] With respect to specialized areas of practice, the *Orcutt* decision criticized the "strict locality rule," stating that "the reasons underlying the strict locality rule a century ago simply do not justify its continued existence today" (citing An Evaluation of Changes in the Medical Standard of Care, 23 Vand.L.Rev. 729 (1970). The Court reasoned that, with regard to certified specialists:

> In this age of ubiquitous national communication networks and increasing standardization of medical training, the underpinnings of the locality rule are extremely doubtful. Board certified specialists should be held to national standards of the specialty. Some nineteen medical specialties have been recognized and national requirements for certification are imposed. Additionally, a national accrediting system contributes to the standardization of medical schools throughout the nation. Moreover, the duration of the residency training, curriculum requirements and examinations are established by the national boards. New techniques, data and medical literature are immediately available to doctors through medical journals, other periodicals, and correspondence courses. It is clear to us that the locality rule is no longer the favored rule, in great part due to the improvement of medical standards and the enhancement of communications systems among the medical profession.

Id (citations omitted). Moreover, the "medical community" of specialists must be defined to include a sufficiently broad sample of experts so that the possibility of disagreement exists. *See*, *Bernardoni v. Industrial Com'n*, 362 Ill.App.3d 582, 595, 840 N.E.2d 311, Ill.App. 3 Dist.,2005 (citing *Canavan's Case,* 432 Mass. 304, 314 n. 6, 733 N.E.2d 1042, 1050 n. 6 (2000)).

With regard to general practitioners, the Court commented that the "similar communities" standard generally holds sway:

> Unless he represents that he has greater or less skill or knowledge, one who undertakes to render services in the practice of a profession or trade is required to exercise the skill and knowledge normally possessed by members of that profession or trade in good standing in similar communities

Id. (citing *Restatement (Second) of Torts s* 299A *(1965).*

From the above, where there is no national standard of care, the trier of fact cannot apply a national rule. In such instances, the only rule that remains, i.e., the locality rule, should apply.

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2 *Orcutt* has been cited as authority on this issue almost 250 times since its publication.

Regardless of which rule applies to establish the standard of care, establishing a medical standard of care requires competent expert testimony. *Blauwkamp, supra*, 114 N.M. at 234. Provided the expert is otherwise qualified, he or she need not practice medicine in the same state where the procedure at issue occurred, nor need to be in the same field as the physician whose practices are at issue. *Id.* (Where affidavit of medical expert was sufficient to establish prima facie showing of expert's qualifications to testify concerning the applicable standard of care in medical malpractice case, although expert was not a specialist in the identical field of practice as each of defendant physicians, and expert did not practice medicine in state).

Determining the standard of care is a prerequisite for a finding of gross negligence, or of any negligence. A finding of negligence requires a determination that (1) the defendant owed the plaintiff a duty recognized by law; (2) the defendant breached the duty by departing from the proper standard of medical practice recognized in the community; and (3) the acts or omissions complained of proximately caused the plaintiff's injuries." *Id.*, 114 N.M. at 231. Generally, an expert is required to establish both a deviation from the standard of care and causation, and a defendant can make a prima facie case for summary judgment by demonstrating that the plaintiff cannot establish the elements of malpractice without such an expert. *Id.* at 232.

The Administrative Prosecutor's proposed findings of fact and conclusions of law submitted below incorporate the above authorities. In short, with respect to the standard of care, the preponderance of evidence in this case establishes that (1) no specific national standard exists with respect to late-term abortions, (2) under the facts of this case, the standard of care should be determined under obstetrical standards, not abortion standards, (3) the specific obstetrical standard of care is analogous to the obstetrical standard for "TOLAC's" (Trial of Labor after Cesearean), and (4) ACOG Bulletin establishes a different standard of care between standard large urban areas and more remote rural communities with respect to TOLAC's. Based upon this

standard of care, a preponderance of the evidence supports a finding that Respondent was grossly negligent in her care of patient M.L.

II. FINDINGS OF FACT

A. Prehearing Procedures

1. The Board issued a Notice of Contemplated Action ("NCA") on or about August 15, 2012, against the respondent Shelly Sella, M.D. ("Respondent").

2. The NCA alleged violation of Section 61-6-15(D)(12) of the Medical Practice Act.

3. Respondent received the NCA via certified mail on or about August 20, 2012, through service on her counsel.

4. By order dated September 19, 2012, the Board appointed Mr. David Thomson as the hearing officer for this matter.

5. By agreement of the parties, the hearing date was amended from November 1-2, 2012, to November 29-30, 2012.

6. Respondent received notice of the November 29-30, 2012 hearing date by certified mail in a timely manner.

7. The hearing was held in Albuquerque, New Mexico. Respondent appeared with co-counsels Molly Schmidt-Nowara and Joseph Goldberg. Respondent testified in person. Respondent's additional witnesses, Dr. Philip Darney and Ms. Deborah Tope, testified in person. Dr. Gerald Bullock appeared in person as witness for the prosecution.

8. By order dated November 28, 2012, the Hearing Officer ordered the hearing to be closed to the public and further ordered the Board to "provide all safeguards necessary to protect the liberty, property, and personal safety of Respondent..."

9. The Board's staff hired additional security to secure the premises in which the

hearing was held.

B. Findings of Fact that Establish the Procedure at Issue:

1. Respondent practices as an abortionist at the Southwest Women's Options, an abortion clinic located in Albuquerque, New Mexico. *Respondent's Exhibit 1.*

2. On May 10, 2011, Respondent first examined patient M.L. at "Southwestern Women's Health Options" ("the Clinic") in Albuquerque, New Mexico. *Testimony of Dr. Sella, Tr. 1, Page 33, lines 7-8.*

3. The Clinic provides outpatient services only. *Testimony of Dr. Sella, Tr.2, page 54, lines 20-21.* In the event that serious complications occur to a patient, the Clinic's protocol is to call 911 for an ambulance to transport the patient to UNM hospital. *Testimony of Dr. Sella, Tr.2, pages 55-56.*

4. An ultrasound taken on May 2, 2011, the biparietal diameter of M.L's fetus was 96.3 millimeters, which was equivalent to the average BPD for a gestational age of 39 weeks, 2 days; the head circumference ("HC") was equivalent to a gestational age of 40 weeks, four days. *Testimony of Dr. Sella, Tr. 1,* Pages 35-36; *Prosecution Exhibit 1*; this was due to the fetus' macrocephaly and megalencephaly. *Testimony of Dr. Sella, Tr.2, page 57-58; Testimony of Dr. Darney, Tr. 1,* Page 165, lines 8-13.

4. Prior to M.L. travelling from New York to Albuquerque Respondent was aware of M.L.'s prior history of having previous birth via a cesarean section ("c-section"). *Testimony of Dr. Sella, Tr. 1,* page 32, lines 4-11.

5. A trial of labor, i.e., an attempted vaginal delivery of a baby, after a prior cesarean section is known as a "TOLAC." *Testimony of Dr. Darney, Tr. 1,* Page 153, lines 9-12.

6. M.L.'s abortion was an elective procedure on a viable fetus. *Testimony of Dr. Sella, Tr.2, page 113, lines 17-18.*

7. Misoprostol is a prostaglandin gel used to soften and shorten the cervix. *Testimony of Dr. Sella, Tr. 1,* page 50, lines 5-12

8. On May 10th, at about 1:55 in the afternoon, Respondent administered 100 micrograms of misoprostol. *Testimony of Dr. Sella, Tr. 1, Pages 50-52; Prosecution Exhibit 1.*

9. Also on 5-11, Respondent administered digoxin vaginally to M.L., for the purpose of causing fetal demise. *Testimony of Dr. Sella, Tr. 1, Page 48; Prosecution Exhibit 1.*

10. On May 11, at about 9:15 in the morning, Respondent administered a second dose of 100 micrograms of misoprostol to M.L. *Testimony of Dr. Sella, Tr. 1, Page 53, lines 17-23; Prosecution Exhibit 1.*

11. An ultrasound on May 11 confirmed fetal demise. *Testimony of Dr. Sella, Tr. 1, Page 54, lines 20-25; Prosecution Exhibit 1.*

12. On May 11, 2011, Respondent instructed M.L. to take a third dose of misaprostol buccally, to be self-administered while at a hotel. *Testimony of Dr. Sella, Tr. 1, Page 55, lines 8-25.*

13. M.L. took the third dose of misoprostol as instructed. *Testimony of Dr. Sella, Tr. 1, Page 57, lines 20-22.*

14. M.L. returned to the Clinic at about 4:50 p.m. due to contractions. *Testimony of Dr. Sella, Tr. 1, Pages 56-57, lines 22-2.*

15. On both May 10 and 11, 2011, Respondent inserted Laminaria to facilitate dilation of the cervix. *Testimony of Dr. Sella, Tr. 1, Page 58, lines 3-4; Prosecution Exhibit 1.*

16. M.L. began having contractions late on the evening on May 11, 2012, and returned to the clinic. *Testimony of Dr. Sella, Tr. 1, Page 62, lines 7-12.*

17. Respondent administered a fourth dose of misoprostol to M.L. shortly after midnight, on the morning of May 12, 2011. *Testimony of Dr. Sella, Tr. 1, Page 62, lines 24-25.*

18. Unlike the previous doses of misoprostol, administered to prepare the cervix, Respondent administered the fourth dose of misoprostol for the purpose of "moving toward delivery." *Testimony of Dr. Sella, Tr. 1, Page 63-64, lines 22-6.*

19. While M.L. was receiving misoprostol late in the evening on May 11, 2012, Respondent began administering low dose pitocin to M.L. until approximately 7:00 a.m. on May 12, 2011, 10 units in 1,000 cc of an IV solution. *Testimony of Dr. Sella, Tr. 1, Page 67, lines 1-5; page 70, lines 10-15; Prosecution Exhibit 1.*

20. At about 7:00 on May 12, 2012, Respondent increased the dosage of pitocin to 60 units in 1,00 cc of an IV solution, in order to facilitate labor. *Testimony of Dr. Sella, Tr. 1, Page 69, lines 2-4; page 70, lines 7-9.*

22. Misoprostol and pitocin were administered at the same time, so that they remained in M.L.'s system simultaneously for approximately three and one-half hours. *Testimony of Dr. Bullock, Tr. 1, page 241, lines 2-5.*

23. Respondent administered the same amount of Pitocin and misoprostol to M.L. as to her typical third-trimester patients. *Testimony of Dr. Sella, Tr.2, page 6-24.*

23. At 1:17 in the afternoon on May 12, 2012, Respondent turned off the pitocin when she suspected a uterine rupture had occurred, and immediately transferred M.L. to the University of New Mexico Hospital, where the staff confirmed a uterine rupture.. *Testimony of Dr. Sella, Tr. 1, Page 71, lines 7-13.*

24. From the time Respondent identified the rupture to the time she was first seen at UNM, approximately 24 minutes elapsed. *Testimony of Dr. Sella, Tr. 1, Page 79, lines 1-6.*

25. The uterine rupture was caused by the uterine contractions. *Testimony of Dr. Darney, Tr. 1, page 194, lines 23-24.*

C. Qualifications of the Witnesses

1. Dr. Bullock is a licensed physician in Texas, and had been practicing medicine since 1969. *Prosecution Exhibit 3.*

2. Dr. Bullock is a fellow with the American College of Obstretrics and Gynocology ("ACOG"), and has been certified as a specialist with ACOG since 1975. *Prosecution Exhibit 3.*

3. Dr. Darney's and Dr. Sella's credentials establish each of them as pre-eminent abortion specialists in the United States; both are fellows with ACOG and certified as specialists in the field of obstretrics and gynocology . *Respondent's Exhibits 1 and 13.*

4. Of all the third trimester abortions with C-section history that Respondent has performed, patient M.L. was of the oldest gestational age at 35 weeks. *Testimony of Dr. Sella, Tr. 1, Page 28, lines 4-5.*

5. Dr. Bullock has significantly more experience with obstetrical standards then either Dr. Barney or Dr. Sella; Dr. Bullock has delivered approximately 10,000 babies since his licensure, compared with the specialized abortion practice of Dr. Darney; both Dr. Darney and Dr. Bullock have performed "hundreds" of TOLAC's, while Dr. Sella performed none since 2000. *Testimony of Dr. Darney, Tr. 1,* Page 153, lines 22-23; *Testimony of Dr. Sella, Tr. 1, Pages 25-26, lines 18-3; testimony of Dr. Bullock, page 199-200, lines 18-12.*

6. Dr. Bullock never uses misoprostol in TOLAC cases, nor sends a patient home after giving them a dose of misoprostol, "because the contraction pattern of misoprostol is unpredictable and quite often very powerful." *Testimony of Dr. Bullock, Tr.1, page 210, lines 20-22,* page 211, lines 17-24.

7. The medical records provided by Respondent included a surgical protocol signed by Respondent that was not followed, although she made no notation on the form to indicate that it was not followed. *Testimony of Dr. Sella, Tr. 1, Pages 42-43.*

8. Dr. Bullock relied on the aforementioned surgical protocol in part when making his initial report; his testimony at the hearing differed from his initial report only with respect to the total amounts of misoprostol and pitocin administered; both his initial report and his testimony at the hearing noted the improper use of misoprostol and the dangerous combination of misoprostol and pitocin as part of the grounds for his opinion.

9. Dr. Darney has never performed a third trimester abortion on a fetus with a gestational age older than 33 weeks, and has never performed a third trimester abortion in a clinic, always in a hospital. *Testimony of Dr. Darney, Tr. 1,* Page 150.

10. Dr. Bullock has never performed a TOLAC outside of a hospital setting. *Testimony of Dr. Bullock, Tr. 1, page 210, lines 19-23.*

D. Findings of fact regarding the applicable standard of care:

1. There is no national standard of care specific to third trimester abortions as published by ACOG. *Testimony of Dr. Bullock, Tr. 1, page 248, lines 16-25; Tr.2, page 125-126, lines 25-14.*

2. There are no published studies by ACOG of abortions at 35 weeks gestational age, regardless of the presentation of a prior C-section history. *Testimony of Dr. Bullock, Tr. 1, page 202, lines 10-19; testimony of Dr. Sella, Tr.2, page 111, lines 20-22.*

3. A prior history of C-section increases the risks of uterine rupture in a subsequent vaginal delivery. *Testimony of Dr. Sella, Tr. 2, page 16, lines 14-25; Prosecution Exhibit 2.*

4. The larger the fetus, the more likely the risk of uterine rupture. *Testimony of Dr. Darney, Tr. 1, Page 163, lines 9-11.*

5. The size of the head of the fetus is the biggest constraint in terms of how hard uterine contractions need to be. *Testimony of Dr. Darney, Tr. 1, Page 165, lines 4-7.*

6. The size of the head in M.L.'s case increased the risks of uterine rupture to that of delivering a full term baby at 40 weeks. *Testimony of Dr. Bullock, Tr. 1, page 206, lines 13-20.*

7. Dr. Darney and Dr. Sella both testified regarding the standard of care applicable to the facts of this case by generalizing to the risks generally applicable to all third trimester abortions. *Testimony of Dr. Darney, Tr. 1, Page 112- 113, lines 19-4, page 131-132, lines 23-2, page 137, lines 13-16; page 166, lines 14-16; Testimony of Dr. Sella, Tr.2, page 81, lines 3-12.*

8. There are important distinctions in the risk factors between the facts of this case, and the typical third trimester abortion with regard to the standard of care. These distinctions included the advanced gestational age of 36 weeks, the size of the fetus' head, and the presence of a C-section history. *Testimony of Dr. Bullock, Tr. 1, page 204-205, lines 21-5.*

9. The risks associated with third trimester abortions are best viewed as a continuum, with the risks at 25 weeks surgical in nature, while at some point towards the end of the third trimester, the risks are obstetric in nature. *Testimony of Dr. Bullock, Tr.2, page 125, lines 14-20.*

10. Dr. Darney based his opinion regarding the standard of care applicable to the facts of this case at least in part on the general availability of third trimester abortions in clinics, and Respondent's counsel, Mr. Goldberg, strenuously argued this point; however, both Dr. Sella and Dr. Darney later admitted that the standard of care to be applied to this case is independent of the availability of other abortion options to the patient. *Testimony of Dr. Darney, Pages 114-118; page 190-191, lines 20-3; argument of Mr. Goldberg, Tr.2, page 30-31, lines 20-21; testimony of Dr. sella, Tr.2, page 95, lines 11-15.*

11. Dr. Darney testified that the risks of uterine rupture are reduced when the fetus is dead because of necrosis of the tissue and because the size of the fetus' head can be mechanically reduced, although he could not quantify the former with any specificity, particularly over a short

period of time, and acknowledged that in this case, no such mechanical reduction occurred. *Testimony of Dr. Darney, Tr. 1, page 162, lines 2-4, page 166, lines 9-11, pages 168-170.*

12. Uterine rupture can often result in catastrophic hemorrhaging. *Testimony of Dr. Bullock, Tr.2, page 134, lines 5-8.*

13. Respondent's procedure on M.L. was fairly characterized as an induction of labor, not an augmentation of labor, because M.L. did not present on May 10, 2011 in labor, and the labor was stimulated by misoprostol. *Testimony of Dr. Bullock, Tr. 1, page 208, lines 1-9, Tr.2, page 129, lines 14-23.*

14. From a risk assessment standpoint, the abortion performed on M.L. was analogous to induction of labor with a live full-term baby, due in part to the fact that with respect to the fetus' characteristics, the size of the head is the primary risk factor for uterine rupture. *Testimony of Dr. Bullock, Tr. 1, page 207, lines 20-21, Tr.2, page 131, lines 7-12.*

15. Because M.L. presented with a prior C-section, the standard of care for TOLAC's is most analogous to the facts of this case. *Testimony of Dr. Bullock, Tr.2, page 124-125, lines 24-7.*

16. ACOG standards, as published in Bulletin no. 115 in August 2010, clearly proscribes the use of misoprostol in TOLAC's because of the elevated risk of uterine rupture. *Testimony of Dr. Bullock, Tr.2, page 132; Prosecution Exhibit 2.*

17. ACOG takes "special care" when issuing blanket prohibitions, as it did with regard to misoprostol in Bulletin no. 115. *Testimony of Dr. Darney, Tr. 1, page 175 .*

18. Prior to ACOG's prohibition on the use of misoprostol in Bulletin no. 115, ACOG advised against the conjunctive use of misoprostol and Pitocin in TOLAC's in its Committee Opinion no. 342, dated August, 2006. *Testimony of Dr. Bullock, Tr.1, page 208, lines 21-25; testimony of Dr. Sella, Tr.2, page 98, lines 20-24.*

19. Misoprostol and Pitocin are generally not used or necessary in the typical delivery of a baby at 35 weeks gestational age. *Testimony of Dr. Bullock, Tr. 1, page 202-203, lines 20-9.*

20. The amount of misoprostol appropriate for inducing labor is 50 micrograms every 4-5 hours, or roughly half the amount Respondent administered to M.L. *Testimony of Dr. Bullock, Tr. 2, page 130, lines 6-10.*

21. The only reason Dr. Darney ever administered misoprostol in a TOLAC was to effect a rapid vaginal delivery, which he acknowledged is not a consideration in this case. *Testimony of Dr. Darney, Tr. 1, page 180, lines 13-17.*

22. Assuming that the obstetrical standard of care for a TOLAC applies to the facts of this case, Dr. Sella admits that she did not follow such standard of care with respect to her use of misoprostol. *Testimony of Dr. Sella, Tr. 2, page 104-105, lines 25-22.*

23. Prior to 2010, ACOG proscribed the administering of TOLACs in a clinical setting. *Testimony of Dr. Sella, Tr.2, page 78, lines 16-18.*

24. Prior to 2010, the rate of C-sections among births in the United States was rising because of the lack of the availability of the procedure to certain populations of women unable to access hospital facilities. *Testimony of Dr. Sella, Tr.2, page 79, lines 1-15.*

25. In 2010, as reflected in ACOG Bulletin 115, ACOG amended its prohibition against TOLAC's to allow clinical deliveries, but did not amend its recommendations. *Testimony of Dr. Bullock, Tr.2, page 132, lines 6-15; Prosecution Exhibit 3, Practice Bulletin No. 115 at p.8.* This change reflected a concern that women "in rural areas where the option to travel to large centers is difficult," should have access to TOLAC. *Id.*

26. With respect to urban settings, such as Albuquerque, where hospitals are available, ACOG standards reflect that TOLACs should be performed in hospital settings. *Id.*

27. The American College of Nurse Midwifery is the national certifying organization

for nurse midwives, which has standards and rules that prohibit TOLAC's in a freestanding birthing clinic. *Testimony of Dr. Bullock, Tr.2, page 127, lines 2-8.*

E. Findings of fact regarding Respondent's Gross Negligence:

1. Respondent breached the standard of care for TOLAC's in her treatment of M.L. because she (1) administered misoprostol, (2), sent M.L. to a hotel after administering misoprostol, (3) administered misoprostol and Pitocin simultaneously, and (4) aborted M.L.'s fetus in a clinic instead of a hospital. *Testimony of Dr. Bullock, Tr. 1, page 245, lines 1-15; Respondent's Exhibit 14.*

2. Respondent's breach of the standard of care proximately caused M.L.'s uterine rupture.

3. Respondent was well aware of the risks of uterine rupture associated with her treatment of M.L., but willfully ignored such risks.

III. CONCLUSIONS OF LAW

1. The Board has jurisdiction over Respondent's actions as set forth above.

2. Respondent has been afforded all due process of her right to be heard pursuant to Sections 61-1-3 and 61-1-8 of the Uniform Licensing Act.

3. The standard of care should be based upon established national standards to the extent reasonable. *Blauwkamp, supra.*

4. With respect to late-term abortion services, the "medical community" of specialists must be defined to include more than physicians who perform late-term abortion services so that the possibility of disagreement exists between a sufficiently broad sample of experts. *See, Bernardoni, supra.*

5. The standard of care in this case should be established based upon similar urban communities, not rural communities where access to hospitals is more limited. *Orcutt, supra.*

6. Respondent should be disciplined pursuant to Section 61-6-15(D)(12) of the Medical Practice Act for gross negligence in her care of patient M.L.

7. This Board Action is reportable to the National Practitioner Data Bank.

WHEREFORE, the Administrative Prosecutor respectfully submits his proposed findings of fact and conclusions of law.

Respectfully submitted,

Daniel Rubin
Administrative Prosecutor
New Mexico Medical Board
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Building 400
Santa Fe, New Mexico 87505

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing was mailed, postage prepaid, on December 4, 2013 to:

Molly Schmidt-Nowara
201 Third Street, Suite 480
Albuquerque, New Mexico 87102

Daniel Rubin