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October 27, 2022

Via Email
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RE: Proposed abortion licensing ordinance

Dear City Commissioners:

This letter and its attachments are for your consideration for the upcoming City Council meeting on November 3, 2022, regarding an ordinance requiring licensing of abortion providers in the City of Clovis. You have received, or will receive, many comments from the Governor, The ACLU and a newly formed group, Eastern New Mexico Women Rising, claiming that the proposed ordinance violates women's rights and bodily autonomy, as well as using the phrase "abortion is healthcare". The scandal ridden history of the abortion industry shows a history that is inconsistent with

those claims. The unsafe and unregulated abortion industry presents an imminent danger to women's rights and the bodily autonomy of women in New Mexico. The City Commissioners of Clovis, not only has the legal authority to protect its citizens from the harms of this dangerous industry, but a moral duty to keep its citizens safe. I have explained this below.

1. The scandal ridden New Mexico abortion industry has repeatedly violated the rights and autonomy of women.

The New Mexico abortion industry has systematically violated the rights of women since 1995. From 1995 to 2015, the University of New Mexico was harvesting eyes, intestines, livers, lungs, hearts, brains and even skin of babies that were aborted for fetal tissue research. In addition, they used blood and placenta from women for experiments. This was done without the knowledge or consent of the women who aborted their babies at the clinic (See article attached).

One such instance of the insane fetal tissue research at the University of New Mexico was particularly heinous. A researcher at the University of New Mexico, custom ordered a brain of a 6 to7 month- old baby to be dissected in front of summer camp students who were attending a workshop at the University of New Mexico (See attached article).

As a result of the violations of women's autonomy, a Federal investigation by Congress ensued in 2016. The Federal Select Panel on Infant Lives investigated both the University of New Mexico and the late term abortionist, Curtis Boyd. The investigation resulted in two criminal referrals, one dated June 23, 2015, the second dated December 21, 2016. While the Attorney General refused to investigate the criminal complaint, Robin Ohls, the lead Fetal Tissue Researcher at the University of New Mexico, was fired. Further, Curtis Wayne Boyd was removed as a volunteer faculty member due to his participation in the scandal.

The abortion industry did not learn from the Select Panel investigation. Dr. Landau and Dr. Sella conspired with the University of California, San Francisco to begin a risky and unnecessary experiment of women undergoing abortions in Albuquerque. 501 were experimented on with the abortion pill regimen. Of those 501 women, 48 women were minors where parental consent was not obtained. Patients experienced complications such as hemorrhage, cervical laceration, retained placenta and extramural delivery. Patients in the study were transported to the hospital. Eight patients had a later term delivery of the stillborn outside the clinic. I have enclosed an article for your reference.

The bodily autonomy of these women was violated as they were not informed of the study. This experimentation could easily happen in Clovis, New Mexico, if the abortion industry remains unregulated in New Mexico. As such, Clovis Commission needs to protect women from an abortion industry that violates women's rights in New Mexico.

In a separate incident at Women's Reproductive Clinic of Sunland Park, a woman was the victim of two botched abortions, one chemical and one surgical. After the surgical abortion she went home and delivered a stillborn baby in her hand. She went down to the clinic demanding her medical records and to talk to the doctor. After being told she could not talk to the doctor and being refused copies of her medical records, she asked for her baby's body back, which she had previously given to the clinic for inspection. The clinic denied her request which led her to become enraged. The clinic then had her arrested for disturbing the peace.

In an effort to defend herself in court, she needed her medical records. She repeatedly asked for her medical records and was denied. Her request went unanswered. After filing a medical board complaint, she finally received her

medical records and was able to get the case dismissed. This woman should not have to have gone through this pain and inconvenience.

These violations of women's rights and autonomy by the New Mexico abortion industry entitles the City of Clovis to protect their citizens. Poor women facing unplanned pregnancy need protection from an industry that sells baby parts without consent, conducts experiments without patient's knowledge, and cannot comply with simple medical records requests. It is incumbent that Clovis pass this licensing ordinance to protect women from these abuses.

2. The New Mexico abortion industry is not providing healthcare to women

The method abortion providers are conducting business in New Mexico is not considered healthcare. The abortion industry in New Mexico has adopted insane medical procedures, injured multiple women, and is endangering the general public. These practices are not in any way being regulated by the State of New Mexico and will lead to more deaths and injuries.

According to a press release from New Mexico Alliance for Life, over 50 women have been transferred to the University of New Mexico Hospital, a Level 1 trauma, in the past 5 years as a result of injuries sustained at the New Mexico abortion clinics. I have enclosed the press release for your reference. This is par for the course for these clinics as their procedures are far afield from recognized standards of care. I have detailed a few of those procedures below.

In one of those procedures that falls below the standard of care is performing abortions inside of hotel rooms. It is a common event that on March 27, 2018, Shelly Sella performed an abortion inside a hotel room on a thirteen -year-old girl who was sitting on a toilet and was previously given oxycontin, Versed and Fentanyl.

The deposition of Shelly Sella states as follows:

Q: **And can you tell me how you had contact with her:**
A: **Yes. Either her mother, or another person who was with her, called our on-call person; we have someone on call 24 hours a day, a phone counselor, and said that she was in labor. I was then called, and I went to see her t the hotel.**
Q: **Okay. And when you arrived at the hotel, what did you observe?**
A: **She was in active labor. She was in the bathroom, sitting on the toilet.**
Q: **Okay. Ando, did you have to take any steps after you saw that?**
A: **Yeah, I attended her while she delivered.**
Q: **Okay. So, you delivered the baby there?**
A: **Yes**

This is also offered by the testimony of an unlicensed medical assistant, Italia Aranda, who testified as follows:

Q: **And do you counsel the patients about what to do if they deliver the stillborn fetus outside of the clinic?**
A: **Yes. I walk them through what that might look like or what that might feel like.**
Q: **What would you say to a patient in that situation?**
A: **Yeah, so, if at any point you feel like you really need to, like, you had a lot of cramping or you really need to push or like there's a lot of pressure on your bottom, I tell them to call the clinic right away. Because, you know, us—or the person whos' answering the phone can help identify if, you know, if the patient can come into the clinic or what is necessarily going on.**

Additionally, they have told women not to go to the emergency room first. But this has led to the death of one woman, Keisha Atkins, who died as a result of poor medical decisions such as this. Carmen Landau testified as follows:

Q: **If you look here on the right-hand column of Exhibit Number 18, toward the bottom, it says:**
We will see you here in our office if necessary. Do not go to the emergency room.

Why is—why is that instruction given?

A: Because oftentimes when unexpected or concerning things are happening overnight, one might be—have—the first impulse would be to go to the emergency room. And the emergency room personnel are, in the vast majority of cases, not the best qualified to take care of a patient who's undergoing an abortion procedure, we are.

Q: Why are emergency personnel not the best qualified persons?

A: Emergency room personnel are the best people to see when you're having an emergency, not when you're having an abortion. If you're having an abortion, then your abortion doctor is the most qualified to take care of you.

Q: If a patient is undergoing an emergency, would it be best for them to contact or go straight to the emergency room?

A: What is your definition of an emergency?

Q: Wonderful question. Are patients given a list of the types of emergencies that should result in their contacting the emergency room?

A: I believe that that list would be too long to give to a person. And so, on the contrary, we tell them all of the reasons to call us. If any of our staff received a phone call from a patient who's describing an emergency that was not within our purview, then the decision would be made to have them go straight to the emergency room or call 9-1-1. But that would be a very rare situation.

Q: And is it fair to say, then, that you discourage your patients from contacting hospitals or emergency room on their own?

A: Yes

Even University of New Mexico officials acknowledge their mistake by paying the sum of $365,000.00 for neglect referral to the clinic for not performing abortions in a hospital setting where they are constantly monitored.

When 13-year-old girls are left alone in a hotel room, on high powered sedatives to give birth to a stillborn on the toilet, you not only have a right, but a duty to act to prevent harm. Allowing the unregulated and unsafe abortion industry into your city is a recipe for disaster. Not only will these substandard practices hurt women, but they will also put a strain on your hospitals with few medical personnel but utilize emergency personnel in detriment to the citizens of Clovis. Clovis must protect the safety of other citizens by not overburdening its medical and emergency personnel. By enacting the proposed ordinance, it will accomplish such protection.

3. Clovis has the power to regulate safety concerns for women and the general public

It is clear, Clovis has the power to regulate abortion. The State of New Mexico vacated its authority to regulate abortion by repealing the 1969 abortion statute. Further, section 3-17-1 N.M.S.A. states as follows:
The governing body of a municipality may adopt ordinances or resolutions not inconsistent with the laws of New Mexico for the purpose of:
A. effecting or discharging the powers and duties conferred by law upon the municipality.
B. providing for the safety, preserving the health, promoting the prosperity and improving the morals, order, comfort and convenience of the municipality and its inhabitants; and
C. enforcing obedience to the ordinances by prosecution in the municipal court and metropolitan courts and upon conviction the imposition of:
1. except for those violations of ordinances described in Paragraphs (2) and (3) of this subsection, a find of not more than five hundred dollars ($500) or imprisonment for not more than ninety days or both;
2. for violation of an ordinance prohibiting driving a motor vehicle while under the influence of intoxicating liquor or drugs, a find of not more than one thousand dollars ($1000) or imprisonment of not more than three hundred sixty-four days or both; and
3. for violations of an industrial user wastewater pretreatment ordinance as required by the United States environmental protection agency, a find of not more than one thousand dollars ($1000) a day for each violation.

The above-referenced Statute allows the City Commission the power to protect the safety and health of its citizens. Enacting this ordinance will not only protect women, but the travelling public from blood borne pathogens that may be spread from abortions performed in hotel rooms. It is vital that the city adopt this ordinance as it will protect the community.

Conclusion

It is imperative this ordinance be enacted and require abortion licensing. Contrary to the slogans used by the Governor, the ACLU and Eastern New Mexico Women Rising, the abortion industry has destroyed the bodily autonomy and rights of women in New Mexico. Further, the abortion industry fails to follow reasonable standards of care which are the protocols adopted by the rest of the medical profession. Abortion, as it is currently being practiced in New Mexico, is not healthcare. Since the City of Clovis has the authority to act, it must protect women from an unsafe and unregulated abortion industry.

If you have any questions or need additional information, please do not hesitate to call my office. I also encourage you to visit www.abortionontrial.org for more information on how abortion hurts women.

Sincerely,

Michael J. Seibel

Enclosures as stated

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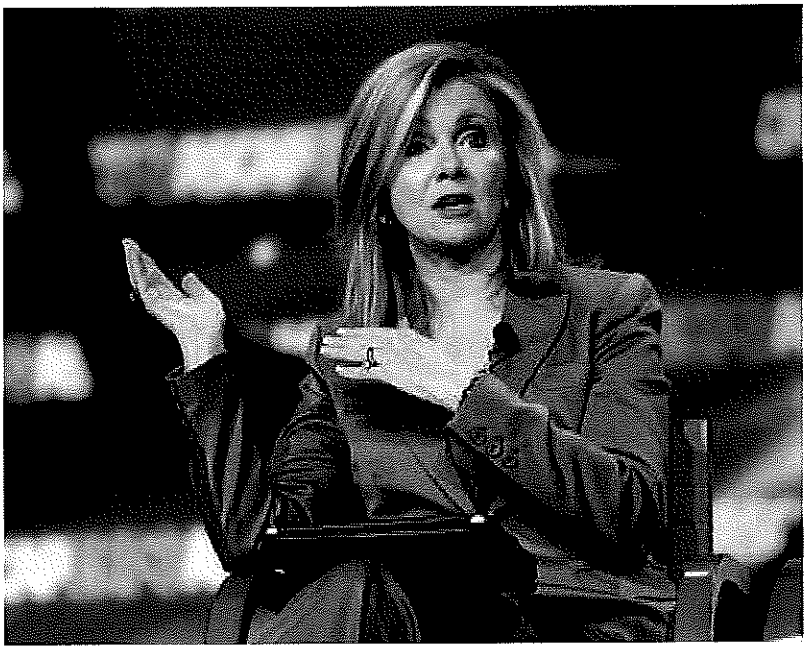
ALBUQUERQUE JOURNAL

U.S. House panel asks Balderas to investigate UNM on fetal tissue research

BY MICHAEL COLEMAN / JOURNAL WASHINGTON BUREAU

THURSDAY, JUNE 23RD, 2016 AT 3:04PM



The Republican chairman of a congressional panel examining the fetal tissue research industry has asked New Mexico Attorney General Hector Balderas to investigate whether the University of New Mexico and an Albuquerque abortion provider broke a state law when they transferred aborted fetuses.

Rep. Marsha Blackburn, a Tennessee Republican who chairs the U.S. House Select Panel on Infant Lives, said Thursday that UNM Health Sciences Center and Southwestern Women's Options appear to be in violation of a New Mexico law called The Jonathan Spradling Revised

Uniform Anatomical Gift Act, or Spradling Act. A spokesman for UNMHSC disputed Blackburn's claim.

Southwestern Women's Options provides UNM with tissue from aborted fetuses for medical research. The Albuquerque clinic and UNMHSC officials contend the fetal tissue transfer is legal and integral to the study of human diseases.

Lawyers working for Blackburn on the Select Panel interpret the 2007 Spradling Act, which establishes state law on the donation of body parts such as kidneys for medical purposes, as allowing for the donation or transfer of stillbirth fetuses and fetuses resulting from miscarriages. But they cite a clause that says "not including a fetus that is the subject of an induced abortion" as prohibiting the transfer of remains in such cases.

"Documentation obtained by the panel in the course of our investigation reflects the transfer of fetal tissue from Southwestern Women's Options and the University of New Mexico for research purposes is a systematic violation of New Mexico's Spradling Act," Blackburn said in a statement. "These violations occurred as UNM personnel procured fetal tissue from patients at Southwestern Women's Options for use by UNM entities for research."

But UNMHSC spokesman Billy Sparks said the very section of the law the Select Panel cites actually provides for the fetal tissue transfer. Sparks said UNM was "profoundly disappointed" by Blackburn's assertion.

"We categorically deny the Chair's assertions in every respect," Sparks said. "The University of New Mexico and its medical providers are committed to complying with all federal and state laws, rules and regulations. This includes the New Mexico Jonathan Spradling Uniform Anatomical Gift Act. This act only applies to 'decedents.' The act

specifically excludes fetuses from induced abortions from the definition of 'decedents'.

"In other words, contrary to Chairman Blackburn's assertions, this act does not apply to fetuses from pregnancies that may have been terminated at Southwestern Women's Options," Sparks added. "Additionally, UNM has never paid for this tissue—it has been provided free to the University of New Mexico for medical research."

The section of the New Mexico law that both Sparks and Blackburn are citing is found in the "definitions" part of the law.

It says: "Decedent means a deceased individual whose body or part is or may be the source of an anatomical gift. 'Decedent' includes a stillborn infant and, subject to restrictions imposed by law other than the Jonathan Spradling Revised Uniform Anatomical Gift Act, a fetus but not including a fetus that is the subject of an induced abortion."

Balderas spokesman James Hallinan said the attorney general has received the letter but declined to comment in detail.

"We can confirm the Office of the Attorney General has received a public referral and this matter is under review," Hallinan said. "All complaints received by the Office of the Attorney General are fully reviewed and appropriate action is taken."

The Select Panel is locked in a months-long legal battle with UNMHSC and the Albuquerque abortion clinic stemming from the fetal tissue donations. The panel has subpoenaed hundreds of pages of records and documents from both. But UNMHSC and Southwestern Women's Options have refused to provide names of doctors, researchers and

others requested by the committee, citing concerns for those individuals' safety.Rep. Jane Schakowsky, the top Democrat on the Select Panel, has characterized the panel's inquiry as a partisan witch hunt and asked that it be disbanded.

Under federal law, abortion providers can't sell fetal tissue, but they can transfer it for purposes of medical research. Abortion providers are permitted to recover the cost of processing and shipping the tissue, although those costs are not specified or capped in law.

The New Mexico state law referenced by Blackburn on Thursday is named for Jonathan Spradling, who died in 2001 at age 23 during a single-car crash in Los Lunas. The statute in his honor was designed to address organ shortages by authorizing additional ways to donate organs, eyes, and tissue for medical and research purposes.

The legal battle between UNMHSC and Blackburn's panel stems from last summer's controversy over secretly-filmed videos that appeared to show Planned Parenthood doctors haggling for fees in exchange for fetal tissue from abortions. A Texas grand jury later indicted exonerated Planned Parenthood and indicted two of the videographers on charges of tampering with a governmental record, a second-degree felony with a possible sentence of up to 20 years in prison.

Rep. Steve Pearce, a New Mexico Republican, is not on the panel. But he told the Journal Thursday he has tried to mediate the dispute between UNMHSC and the Select Panel, and encouraged the health center's officials to cooperate more readily with the congressional inquiry.

"From my perspective, we want the research for kids' health – everyone wants their kids to be healthy – but we also feel like the research ought to be falling within the guidelines," Pearce said. "What I don't want is a black eye for our state or the university."

ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225–2927
Minority (202) 225–3641

December 21, 2016

VIA EMAIL

The Honorable Hector H. Balderas, Jr.
Attorney General of New Mexico
408 Galisteo Street
Villagra Building
Santa Fe, NM 87501

Dear Attorney General Balderas:

On June 23, 2016, I sent you a criminal referral report pursuant to the investigation of the Select Investigative Panel (the "Panel") authorized by the U.S. House of Representatives under H. Res. 461. I now write to submit for your attention a supplementary referral concerning additional allegations regarding the University of New Mexico ("UNM") and Southwestern Women's Options ("SWWO"), the entities that were the subjects of our June referral report. This referral is based on information obtained in document productions by UNM and SWWO, [redacted], and a complaint and affidavit with supporting documents submitted by a former patient at SWWO.

Allegations Against SWWO and UNM

As noted in the June referral report and admitted by UNM, since 1995, SWWO has served as the only source of aborted infant tissue procured for the University of New Mexico Health and Sciences Center ("UNMHSC") for research purposes.[2] From the Panel's investigation, it is apparent that there were several deficiencies in the consent process used to procure fetal tissue. Although both SWWO and UNM provided the Panel a consent form that purported to give patients notice that tissue from their pregnancies would be donated to UNM,[3] there is evidence that this form was not used. While *Doctor #5* testified that SWWO's practice was to provide women an opportunity to donate the tissue that resulted from their abortions and to obtain their

[1] Names in this letter are redacted with the same pseudonyms used in the June 23 letter. *See* redaction key.
[2] UNM Document, UNM00560, attachment 1; UNM First Submission to House Select Panel, Jan. 29, 2016, p. 1, attachment 2; UNM Second Submission to House Select Panel, Feb. 16, 2016, p. 1, attachment 3; UNM Response to House Select Panel Subpoena, Mar. 3, 2016, p.1, attachment 4.
[3] Client Information for Informed Consent, Donation of Fetal Tissue for Medical Research, SWWO000524, attachment 5. UNM produced the same form with Bates number UNM01103.

consent to do so, she admitted she had never gotten a consent from a patient at SWWO to make a fetal tissue donation—and did not even recognize the consent form that SWWO and UNM produced to the Panel.[4] She also admitted she was unaware of whether consent was required prior to the donation of fetal tissue.[5]

Further evidence supports the inference that patients were not regularly given a fetal tissue donation consent form at SWWO. *Patient*, a patient who obtained an abortion from SWWO, has brought suit against the clinic and attested in an affidavit that she was never given a "consent to donate tissue that was separate from the consent for the [abortion] procedure."[6] Moreover, she alleges she was never informed by the doctors and staff at SWWO that her infant's remains were to be donated to UNM or another entity.[7] Neither, she alleged, was she informed of the nature and extent of any use of such remains, "which body parts were going to be used or donated," or what benefits could be expected from such use.[8] She added that she was not informed by SWWO doctors or staff that the doctor who treated her, *Doctor #6*, and the director of SWWO, *Doctor #3*, were volunteer faculty members at UNM, or that the clinic and the university had been collaborating on fetal tissue research since 1995.[9]

Even more problematically, the only semblance of consent SWWO allegedly sought from *Patient* for fetal tissue research was a phrase mentioning the use of "tissue and parts . . . in medical research" within a two-page consent form provided to her for the abortion procedure itself.[10] Thus, the only consent sought from her for fetal tissue donation came during what should have been a separate process of consent to the abortion procedure itself. A letter from *Patient* to SWWO dated December 2, 2015, requested "all information regarding the disposal, donation or sale of any medical waste," but she allegedly never received any records regarding the disposition of her infant's remains.[11] In September 2016, *Patient* read procurement notes dated October 17, 2012, that were attached to the Panel's referral of UNM and SWWO to your office that indicated brain tissue had been taken from one infant estimated at 11.5 weeks gestation and another at 12.7 weeks gestation.[12] Because *Patient's* ultrasound taken on October 5, 2012, stated she was 12 weeks and two days pregnant, and because she obtained her abortion five days later on October 10—when staff informed her she was between 12 and 13 weeks pregnant—she believed her "baby was one of the two babies given to the University of New Mexico for their research."[13] This belief is consistent with SWWO's practice of storing fetal tissue in an on-site

[4] [redacted]

[5]

[6] Affidavit of *Patient*, Nov. 18, 2016 ("*Patient* Aff."), ¶ 30, attachment 6. *See also* Complaint ¶ 47, *Patient* v. *Doctor #3*, No. [redacted] (N.M. Dis. Ct. Bernalillo County Nov. 30, 2016) ("*Patient* Compl."), attachment 7. In an email dated Nov. 28, 2016, *Patient* gave permission to the Panel to disclose her identity publicly, but the Panel decided nonetheless to redact her name in the instant letter.

[7] *Patient* Aff. ¶ 10; *Patient* Compl. ¶ 32.

[8] *Patient* Aff. ¶¶ 21-22, 26; *Patient* Compl. ¶¶ 35-38.

[9] *Patient* Aff. ¶¶ 15, 18-20; *Patient* Compl. ¶ 32.

[10] *Patient* Aff. ¶ 8 & Ex. A, at 1; *Patient* Compl. ¶¶ 11-12 & Ex. A.

[11] *Patient* Aff. ¶¶ 32-33 & Ex. B; *Patient* Compl. ¶¶ 54-57.

[12] Compare *Patient* Aff. ¶¶ 35-36 and Procurement notes, UNM00029, *See also Patient* Compl. ¶ 52.

[13] *Patient* Aff. ¶¶ 7, 12-13, 37-38; *Patient* Compl. ¶¶ 49-53.

freezer until it is periodically picked up for transfer to UNM.[14] *Patient* attested, "If I had known my baby was going to be used for research I would have probably changed my mind about going through with the abortion," and added that the actions of SWWO and its doctors caused her "emotional distress and mental anguish."[15] *Patient* additionally alleged that she was advised by staff that she could apply for Medicaid funding for her abortion procedure and that the paperwork supporting such funding was prepared by a doctor she never saw, *Doctor #7*, and not her treating physician, *Doctor #6*.[16]

Violations of Applicable Laws

If true, *Patient's* allegation that the only informed consent to tissue donation sought from her was the cursory reference to the use of "tissue and parts . . . in medical research" in SWWO's abortion consent form amounts to violations of federal and state law by UNM and SWWO.

HHS regulations, which govern much of the human subject research conducted at UNM, requires in 45 C.F.R. § 46.116 a number of basic elements of informed consent:

> (1) A statement that the study involves research, an explanation of the purposes of the research and the expected duration of the subject's participation, a description of the procedures to be followed, and identification of any procedures which are experimental;
>
> (2) A description of any reasonably foreseeable risks or discomforts to the subject;
>
> (3) A description of any benefits to the subject or to others which may reasonably be expected from the research;
>
> (4) A disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the subject;
>
> (5) A statement describing the extent, if any, to which confidentiality of records identifying the subject will be maintained;
>
> (6) For research involving more than minimal risk, an explanation as to whether any compensation and an explanation as to whether any medical treatments are available if injury occurs and, if so, what they consist of, or where further information may be obtained;
>
> (7) An explanation of whom to contact for answers to pertinent questions about the research and research subjects' rights, and

[14] SWWO letter responding to document request (Feb. 12, 2016), at 5; [redacted]. According to SWWO's Feb. 12 letter, pickup occurred weekly, but procurement notes record that pickup occurred an average of 39 times per year since 2010, 45 times in 2012.
[15] *Patient* Aff. ¶¶ 39, 42; *Patient* Compl. ¶¶ 60, 142.
[16] *Patient* Aff. ¶¶ 14-17; *Patient* Compl. ¶¶ 61-64, 110.

> whom to contact in the event of a research-related injury to the subject; and
>
> (8) A statement that participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled.[17]

According to *Patient*'s allegations, both SWWO and UNM failed to provide any of these elements of informed consent, in violation of 45 C.F.R. § 46.116, accompanied by a violation of 45 C.F.R. § 46.117 for failing to present such consent in writing.

To the extent the research of the fetal tissue acquired by UNM related to transplantation for therapeutic purposes, any violations by SWWO and UNM would include violation of 42 U.S.C. § 289g-1(b)(1), which requires written consent from the woman acknowledging the nature of the research, the lack of "restriction regarding the identity of individuals who may be the recipients of transplantation of the tissue," and that the woman was not informed of any such recipients' identities. Moreover, the use of a consent form that simultaneously seeks consent for abortion and for fetal tissue donation under the alleged circumstances would appear to violate 42 U.S.C. § 289g-1(b)(2)(A)(i), which requires the abortion consent to be "obtained prior to requesting or obtaining consent for a donation of the tissue . . . ."

UNM's own oversight policy provided as of 2015 that "appropriate informed consent by the mother" is required for "[t]he collection and storage of all fetal tissue for research."[18] The policy as revised April 11, 2016, further clarifies that UNMHSC

> will not acquire such fetal tissue from outside entities (a) without contractual and/or written assurance that the fetal tissue being acquired was collected in accordance with a process that separates the informed consent for the abortion procedure from the informed consent to donate such fetal tissue to the UNM HSC for Research, and (b) where there is contractual assurance that the terms of the acquisition complies fully with Section 112(a) of the NIH Act (42 U.S.C. § 289g-2(a)). In addition, the contractual assurance contemplated in Subsection 2 must indicate that there are no legal, ethical, or other restrictions against transferring the Research Tissues to the UNM HSC, nor against the UNM HSC's use of them.[19]

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[17] 45 C.F.R. § 46.116(a). These elements are the minimum required, subject to exceptions for public benefit or service programs under § 46.116(c) and potentially additional requirements under § 46.116(b).

[18] UNMHSC, Oversight of Human Tissue in Research, Policy # RC.05.002.PP (Sept. 16, 2015), UNM03420-UNM03428 at UNM03423.

[19] UNMHSC, Oversight of Human Tissue in Research, Policy # RC.05.002.PP (Apr. 11, 2016), at 3. This revised policy additionally reinforces the Panel's June 23, 2016, referral regarding violation of the Spradling Act by requiring that fetal tissue for research be acquired "in accordance with the provisions of the" Spradling Act "and/or with contractual assurance that it was obtained in accordance with" that statute. *Id.* at 3-4.

UNM did not produce this revised policy to the Panel.

Despite SWWO's inclusion of a fetal tissue donation consent form in its production, *Patient*'s allegation that it was never shown to her, combined with *Doctor #5*'s admission that she did not even recognize the form, raises a serious question as to whether SWWO and UNM systematically violated the law, not to mention UNM's own internal policy, by conducting fetal tissue donations without more than the perfunctory reference to tissue research in SWWO's abortion consent form.

The same alleged deficiencies in the consent process at SWWO would constitute a violation of New Mexico's state law. Regardless of whether government funding or transplantation research is involved, N.M. Stat. Ann. § 24-9A-5, which is part of the Maternal, Fetal and Infant Experimentation Act, prohibits any "clinical research activity involving fetuses, live-born infants or pregnant women" unless the woman

> has been fully informed of the following:
>
> > (1) a fair explanation of the procedures to be followed and their purposes, including identification of any procedures which are experimental;
> > (2) a description of any attendant discomforts and risks reasonably to be expected;
> > (3) a description of any benefits reasonably to be expected;
> > (4) a disclosure of any appropriate alternative procedures that might be advantageous for the subject;
> > (5) an offer to answer any inquiries concerning the procedure; and
> > (6) an instruction that the person who gave the consent is free to withdraw his consent and to discontinue participation in the project or activity at any time without prejudice to the subject.[20]

[20] N.M. Stat. Ann. § 24-9A-5(C). As discussed in the Panel's June 23 referral, the Spradling Act prohibits use of fetal tissue resulting from induced abortion, but this informed consent provision provides a basis for liability separate from the underlying use of such tissue. It additionally should be noted that the Maternal, Fetal and Infant Experimentation Act defines the term "clinical research" as follows:

> "clinical research" means any biomedical or behavioral research involving human subjects, including the unborn, conducted according to a formal procedure. The term is to be construed liberally to embrace research concerning all physiological processes in human beings and includes research involving human in vitro fertilization, but shall not include diagnostic testing, treatment, therapy or related procedures conducted by formal protocols deemed necessary for the care of the particular patient upon whom such activity is performed and shall not include human in vitro fertilization performed to treat infertility; provided that this procedure shall include provisions to ensure that each living fertilized ovum, zygote or embryo is implanted in a human female recipient, and no physician may stipulate that a woman must abort in the event the pregnancy should produce a child with a disability. Provided that emergency medical procedures necessary to

This statute is notably cited in the standard operating procedures of UNM's Office of the Institutional Review Board, but UNM failed to produce that document to the Panel.[21] Other sections of the Maternal, Fetal and Infant Experimentation Act make clear that neither a pregnant woman nor a fetus shall be involved as subjects in clinical research activity unless "the mother is legally competent and has given her informed consent,"[22] subject to penalties of imprisonment for less than one year and/or payment of a fine up to $1,000.[23]

I urge your office to conduct a thorough investigation into whether the University of New Mexico and Southwestern Women's Options violated federal and state law, and, if you conclude that such violations occurred, to take all appropriate action. If you have any questions about this request, please contact Frank Scaturro, at (202) 225-2927, Frank.Scaturro@mail.house.gov.

Sincerely yours,

Marsha Blackburn

Marsha Blackburn
Chairman
Select Investigative Panel

Attachment(s)

cc: The Honorable Jan Schakowsky, Ranking Member
Select Panel on Infant Lives

The Honorable Susana Martinez
Governor of New Mexico

The Honorable John A. Sanchez
Lieutenant Governor of New Mexico

The Honorable Steve Pearce
Second Congressional District, New Mexico

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preserve the life or health of the mother or the fetus shall not be considered to be clinical research . . . ."

N.M. Stat. Ann. § 24-9A-1(D).

[21] See UNM Office of the Institutional Review Board, Standard Operating Procedures, effective Mar. 1, 2016, at 1-2, http://irb.unm.edu/sites/default/files/511.0%20Compliance%20with%20Applicable%20Laws%20and%20Regulations.pdf, attachment 8.

[22] N.M. Stat. Ann. §§ 24-9A-2(B), 24-9A-3(B).

[23] N.M. Stat. Ann. § 24-9A-6.

ANALYSIS

New Mexico late-term abortion facility recorded 50 injuries in just seven years

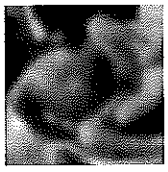
By Cassy Fiano-Chesser | September 25, 2021 , 03:48pm

A new report from the New Mexico Alliance for Life has revealed just how dangerous the Southwestern Women's Options (SWO) abortion business in Albuquerque, New Mexico, truly is and has exposed their collusion with the University of New Mexico Hospital (UNMH).

In reviewing emergency transfer logs, the New Mexico Alliance for Life found that there were 50 medical emergencies at SWO between 2014 and 2021. The most recent incident took place on July 7, 2021, during an abortion committed by Shelly Sella, in which a patient suffered bleeding severe enough to require a transfer to the hospital. Other injuries over the last seven years included sepsis, uncontrollable bleeding, perforations, chemical exposure, pulmonary embolism, and infection.

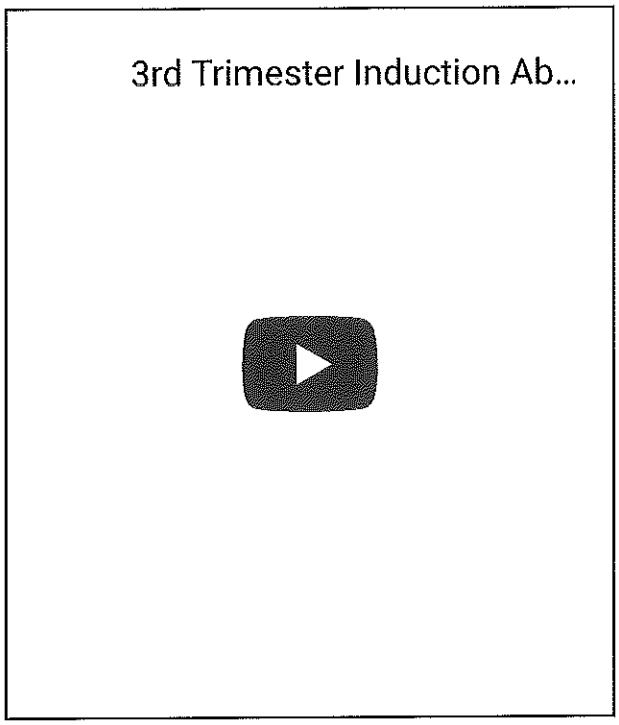
SWO gained greater notoriety in 2017 following the death of Keisha Atkins, who underwent a late-term abortion at the facility beginning on January 31 of that year. That day, Atkins, who was approximately six months pregnant, visited SWO to begin an induction abortion procedure. Documents found that abortion staff administered multiple doses of dangerous medications — fentanyl, Versed (midazolam), and oxycodone — to Atkins for several days, and did not monitor her condition after she left the facility. When Atkins began suffering from labored breathing, a known potential side effect of the drugs, SWO continued to administer them to her.

FEATURED



Aborted babies discovered in DC may indicate infanticide after attempted abortions

What you need to know about the COVID-19 vaccines



Mom's photos of 'perfect' 14-week miscarried son have saved other babies

TO TOP

In addition to those drugs, Atkins was also given at least two doses of Mifeprex (mifepristone, one of the two drugs used in the abortion pill regimen), which is not typically used during late-term abortions. She may have been an unknowing participant in an experiment, where hundreds of women were given the abortion pill during an induction abortion.

READ: ***UNCOVERED: Late-term abortionists experimented on hundreds of women***

Atkins was not the only woman to experience complications following the use of Mifeprex in such abortions. Other women experimented on in this way reportedly suffered "hemorrhage, cervical laceration, retained placenta, and extramural delivery." Seven patients

were reported as having to be admitted to the hospital; it's not clear if Atkins is included as one of those seven. Ultimately, after finding "no perceived benefit" to using the drug during the induction abortion procedure, the abortionists at SWO reverted back to committing induction abortions without Mifeprex in May of 2017.

TO TOP

As for Atkins, a final operative report from UNMH showed that she also suffered from sepsis during the abortion. Sepsis is a known potential side effect of the abortion pill regimen.

Atkins' sister, Nicole Atkins, likewise experienced a botched abortion at SWO years earlier in 2010. Nicole, like her sister, was repeatedly drugged for days. Misoprostol (the second drug of the abortion pill regimen) was one of the drugs administered. Abortionist Sella committed that induction abortion as well using digoxin, even though Nicole was only 17 weeks pregnant. Digoxin is not recommended for use earlier than 20 weeks, and Nicole did not consent to the use of digoxin or misoprostol.

TO TOP

Nicole also did not consent for her baby's body or organs to be donated, and was not told that SWO had partnered with the University of New Mexico (UNM) for its research program — which specifically wanted "digoxin treated brain." Documents seem to indicate that Atkins' baby was given to UNM, which could be why Sella used digoxin and an induction abortion instead of a dilation and extraction (D&E) procedure, which is the most common second-trimester procedure and would normally be used at 17 weeks gestation.

Ultimately, Nicole's procedure was badly botched, with Sella's cervical dilators causing lacerations that led to a

hysterectomy and ongoing physical pain. The injury log discovered by New Mexico Alliance for Life shows that the Atkins sisters are unfortunately far from alone in their suffering at the hands of SWO abortionists.

TO TOP

"Women seeking an abortion in New Mexico from Texas and elsewhere must be warned that abortion centers here are allowed to operate unregulated, are ill-equipped to handle medical emergencies and as a result, one clinic alone sent 50 women and counting to the Emergency Room," said Elisa Martinez, executive director and founder of New Mexico Alliance for Life, in an e-mailed statement. "At least one of these women, the late Keisha Atkins died from injuries suffered during an elective, unsafe abortion at 6 months in New Mexico. How many more women will suffer serious injury or death from unsafe and unregulated abortions in New Mexico?"

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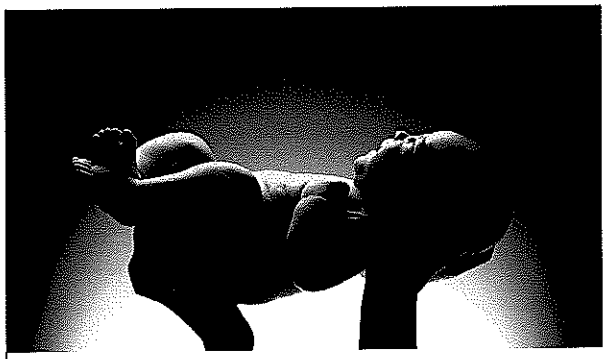
INVESTIGATIVE

Abortion clinic provided "whole brains" for youth summer camp

By Kristi Burton Brown | June 23, 2016 , 06:39pm



Today, the House Select Investigative Panel on Infant Lives released a gruesome journal of "Procurement Notes," which was given to the Panel by the University of New Mexico. The notes were made by a lab technician who was employed by the University of New Mexico Health Sciences Center.

ABOUT

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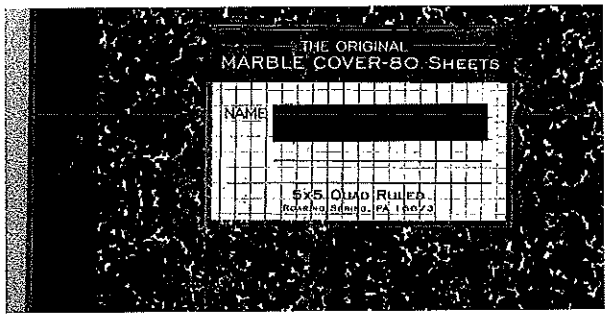
UNMHSC partnered with the Southwestern Women's Options abortion facility and would send a tech over to collect aborted babies and their body parts.

In explicit detail, the journal describes various body parts of aborted babies and, in some cases, what happened to them.

Perhaps the most disturbing revelation to come from the journal is a description of baby brains that were passed on to someone who wanted to use them at a youth summer camp.



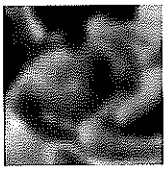
The cover of the "Procurement Notes"

The journal notes:

> **5-24-12 "Asked clinic for digoxin treated tissue 24-28 wks. for methylation study & because [redacted] wants whole, fixed brains to dissect w/ summer camp students."**

While details about the summer camp and the students remain scarce, the horror of having young people handle

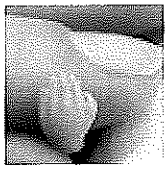
FEATURED



Aborted babies discovered in DC may indicate infanticide after attempted abortions

What you need to know about the COVID-19 vaccines

and cut into the brains of aborted, likely viable babies – possibly without their knowledge – is hardly conceivable.



Mom's photos of 'perfect' 14-week miscarried son have saved other babies

TO TOP

UNMHSC offers the Dream Makers Health Careers Program, in which it "provides middle and high school students with unique opportunities to gain exposure to the many possibilities in the health professions while enhancing their science and math skills." According to UNMHSC's website, this includes "dissection of various specimens."

The journal continues in a similarly horrifying fashion, describing triplets, twins, and babies past the point of viability.

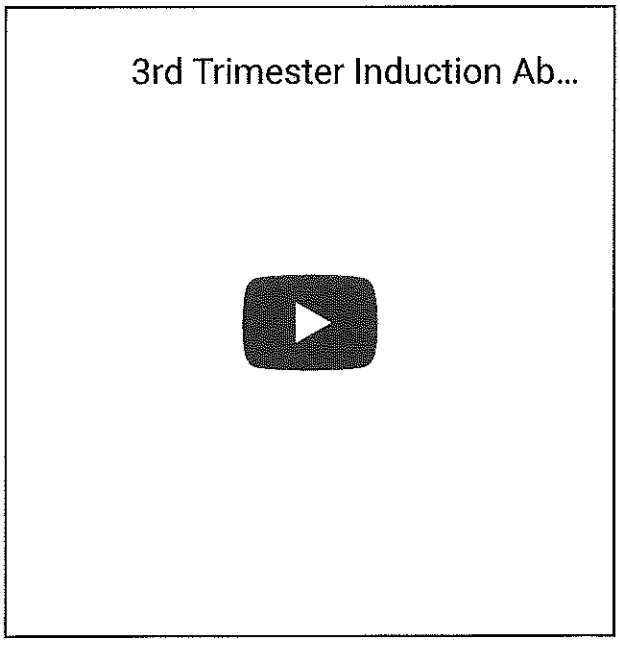
> **12.7 week triplets. Three eyes, used two, 2 heart, lung, brain.**
>
> **DIG. Clinic labeled 28 week.**
>
> **26+ DIG – intact head. Clinic thought 30 wk; Researcher #1 thought 32.**
>
> **20 wk twins – intact brains**
>
> **brain, 2 eyes, heart [from a 24 week old]**
>
> **24 wk dig. head not intact**

The journal notes a "30.5 wks" baby who was "intact – did not dissect." "Twins = 1 w/ clubbed feet" are mentioned, and the weight of their brains calculated.

TO TOP

"Dig" is shorthand for digoxin, a drug that is sometimes injected into the hearts or bodies of late-term babies as part of the abortion. Digoxin can be used as a feticide, as it causes the fetal heart to stop, killing the child. A 25-week-old baby is described as "treated with digoxin, skin loose, eyes discolored red" due to the effects of the drug that killed her.

The video below demonstrates, through medical animation, what happens in an abortion using digoxin:



Many believe digoxin enables a baby to stay intact, but this is hardly always true. As the journal describes, at 21.5

weeks, even though digoxin had been used, there were "tiny bits of brain tissue everywhere." Late-term abortionist LeRoy Carhart has referred to babies who are poisoned with digoxin as "meat in a crockpot."

TO TOP

While it is sometimes thought that babies in the first trimester are not harvested for their body parts and organs, the procurement notes prove this false. Brains, hearts, lungs, and eyes from 10-12 week old babies are noted all throughout the journal. The journal also reveals that a "tiny bit of brain" from a 10.4 week old "grew wonderfully!!" In the case of one first trimester baby, the notes state that only "1 leg" could be found.

> **"10 weeks 2 eyes – [redacted] will try! One entire Retina! & pieces of the other"**

One 15-week-old was so broken up that the technician notes they "could not find anything." Other disturbing details include:

> **BROKEN FOOT: CLINIC VERIFIED 16 weeks**
>
> **12.3 week, Skin from back/shoulder**

> **19.2 week, Skin from one arm (forearm)**

TO TOP

One notation speaks of "meconium shipped" to an undisclosed location. It appears the meconium (the "first feces of a newborn infant") was taken from 16.7- and 15.6-week-old babies. Meconium is usually only present if a baby has been in distress or has been born alive.

The tech also makes it clear when they were excited or disappointed with the body parts that were harvested. "Stomach broken – no panc" (short for pancreas) was written with a frowning face. Then, "ENTIRE PANCREAS – whoo hoo!!" appears.

Lila Rose, president and founder of Live Action, released a statement:

> **"The select panel's gruesome discovery that summer camp students were given whole brains of viable aborted children to dissect shows the barbaric nature of the abortion industry and the total disrespect for basic human rights that its allies share. At 24-28 weeks old, many of these babies could have survived outside the womb; instead, they were aborted by**

Southwestern Women's Options and their body parts given to students to carve up. This unimaginable inhumane activity — as well as Southwestern Women's Options and the University of New Mexico, which facilitated it — must be unanimously condemned.

As horrific as this is, we must admit that it's no stretch for an industry to traffick in the bodies of the children it kills — after all, the killing and dismembering of these viable children in utero is the greater crime against humanity. The piecemealing and experimentation on their corpses adds insult to the already grave human rights injury of abortion."

DEAR READER,

Did this article make you wish for an end to abortion? If so, there's something urgent that you need to know...

Roe v. Wade is history; however, abortion remains

AOT Jul 7, 2021 3 min read

BREAKING: Late Term Abortionists caught experimenting on hundreds of women.

A shocking discovery was made in the pursuit of evidence in the wrongful death case of Keisha Atkins. It appears that late term abortion providers Carmen Landau and Shelley Sella were actually experimenting on women receiving induction abortions in hopes of making the service quicker to accommodate an increasing patient load.

Dr. Landau and Dr. Sella have been named as authors along with staff of UCSF on a published research article (pictured below) discussing the differences in induction abortions when adding the risky and unnecessary use of Mifepristone. 501 women were included in this study between 2016 & 2017. Approximately half of the women were given Mifepristone and half were not. All 501 were 24 or more weeks pregnant. And 48 of those 501 women were minors.

The article says that all 501 induction abortions occurred at "one freestanding clinic". We know that clinic was Southwestern Women's Options in Albuquerque, New Mexico. It appears that in 2016 Landau and Sella decided to test the theory that Mifepristone would make the induction abortion occur quicker and after a year of "no perceived benefit" to them, they again changed the procedure back to inducing without the use of Mifepristone in May 2017.

We know S.W.O. was the site of this experimental study not only by the fact that both Sella and Landau are providers of late term inductions at S.W.O., but by the blatant inclusion of one Keisha Marie Atkins in the medical research article itself. Did these authors truly think they could list detailed medical information about Keisha's death without someone connecting those dots?

Although the authors claim there were updated policies and procedures manuals documenting these changes no such documentation was given to attorneys when S.W.O. was subpoenaed for documents regarding Keisha's death that occurred in February 2017...shortly before Dr. Landau stopped giving her patients Mifepristone experimentally. In fact, no mention of this study was included in Keisha's file at all, nor was any mention of it made by Landau when deposed about Keisha's death. It appears as though Dr. Landau didn't want attorneys to learn about this piece of literature.

But the reality is this "research" is far bigger than just including the Keisha Atkins case.
500 other women were included in that medical research without being told. Some of whom were injured. 501 viable unborn babies were admittedly killed by injection of digoxin in less than 24 months time. Approximately 250 women were given a drug as part of their altered procedure despite their doctors not knowing what the result would really be. And that doesn't even touch on the numerous claims in this study that are direct contradictions to under oath admissions by Dr. Landau as well as official documents collected as part of wrongful death and malpractice cases against S.W.O.

AOT Director Jamie Jeffries said "This study not only confirms our claims that S.W.O. performs elective late term abortions regularly, it confirms our theory that abortion procedures are being altered by S.W.O. providers and women are being injured as a result. Women aren't lab rats, we shouldn't be used by medical providers for their research without our knowledge. But S.W.O. staff seem to have, once again, missed the memo that consent matters."

AOT will be breaking this study down piece by piece over the coming weeks to show the public just how much is hiding in what's been written by Landau, Sella, and UCSF. Discussing the broken laws, dehumanizing experimental care, and blatant misrepresentation published in this research is just too much for one article. This "research" proves so much about so much. It's actually a little shocking the authors didn't realize all they were revealing when they chose to put this piece of work out into the world. But out it is...and now we know.

See the complete research article below:

Contraception 102 (2020) 99–103

Contents lists available at ScienceDirect

Contraception

journal homepage: www.elsevier.com/locate/con

Original Research Article

Mifepristone–misoprostol versus misoprostol-alone regimen for medication abortion at ≥24 weeks' gestation ☆,☆☆

Erin Wingo [a,*], Sarah Raifman [a], Carmen Landau [b], Shelley Sella [b], Daniel Grossman [a]

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ARTICLE INFO

Article history:
Received 12 December 2019
Received in revised form 30 April 2020
Accepted 1 May 2020

Keywords:
Mifepristone
Misoprostol
Abortion
Third trimester
Medication abortion

ABSTRACT

Objective: To compare time from misoprostol initiation to fetal expulsion for mifepristone–misoprostol versus misoprostol-alone regimens of medication abortion performed at ≥24 weeks' gestation.

Study design: We conducted a retrospective study of medication abortion performed at ≥24 weeks' gestation between May 2016 and January 2018 at one site, comparing outcomes of patients receiving mifepristone–misoprostol versus misoprostol alone during two periods. All patients received feticidal injection and laminaria; the mifepristone–misoprostol group also received mifepristone 200 mg orally around the time of initial laminaria. Beginning 24–72 h later (depending on cervical assessment), both groups received misoprostol buccally every two hours.

Results: Analyses included 257 patients in the mifepristone–misoprostol group and 152 patients in the misoprostol-alone group. Median time from misoprostol initiation to fetal expulsion was similar between groups (4.8 h vs. 4.9 h; $p = 0.43$). Patients in the mifepristone–misoprostol group received less misoprostol overall (median [IQR]: 800 mcg [800–1200 mcg] vs. 1200 mcg [800–1600 mcg]; $p < 0.01$) and fewer patients received a second round of laminaria ($n = 56$, 22% vs. $n = 58$, 33%; $p < 0.01$) than the misoprostol-alone group. Seven patients (2%) were transferred to a hospital for complications; this proportion did not vary by regimen.

Conclusions: Addition of mifepristone was not associated with a reduction in induction interval at ≥24 weeks. However, patients in the mifepristone–misoprostol group received a lower total dose of misoprostol and were less likely to require two days of laminaria. The clinical significance of these differences is unclear, but may have implications for patient experience. Both regimens had low rates of complications.

Implications: A randomized controlled trial comparing the mifepristone–misoprostol and misoprostol-alone regimens at ≥24 weeks is needed, as is evidence on patient perspectives on these regimens. Given the existing evidence, either regimen is reasonable.

1. Introduction

According to the U.S. Centers for Disease Control and Prevention, 1.3% of all abortions occur at ≥21 weeks, with even fewer at ≥24 weeks [1]. Most abortions at ≥24 weeks' gestation are performed via labor induction with medications, referred to as medication abortion [2]. Similar to medication abortion earlier in pregnancy, recommended regimens ≥24 weeks often include misoprostol used alone or in combination with mifepristone pretreatment [3], sometimes with other interventions such as feticidal injection, osmotic dilator placement, and early rupture of membranes [4–8].

Abortion is relatively uncommon in this gestational age range, and published evidence to inform best practice is limited. Studies

☆ Funding: This research was supported by a grant from the Society of Family Planning (SFPRF 11-06). The sponsor had no involvement in study design; in the collection, analysis and interpretation of data; in the writing of the report; or in the decision to submit the article for publication. The views and opinions expressed are those of the authors, and do not necessarily represent the views and opinions of the Society of Family Planning Research Fund.

☆☆ Declaration of interests: The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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https://doi.org/10.1016/j.contraception.2020.05.001
0010-7824/

evaluating the efficacy and safety of medication abortion beyond 24 weeks' gestation often include earlier second-trimester procedures as well, and few studies include abortions after 28 weeks' gestation [4,5,9–14]. Study design and clinical regimens vary greatly between reports, and many are limited in scope to abortions performed only for fetal anomaly or fetal demise [4,9,10,12,15–18]. It is unclear if results of studies of treatment in case of fetal demise can be extrapolated to induced abortion.

An important question is the utility of mifepristone pretreatment with medication abortion at ≥24 weeks. In second-trimester abortion trials, mifepristone pretreatment before misoprostol administration shortens the time to fetal expulsion and increases the effectiveness of the regimen without increasing risk of complications [13,19–22]. The mifepristone–misoprostol combination regimen may also improve patient satisfaction compared to misoprostol alone, as well as shorten duration of hospitalization in the second trimester [19,21]. However, we lack specific evidence about whether pretreatment with mifepristone has similar effects when used at ≥24 weeks' gestation. A clinical guideline from the Society of Family Planning on interruption of nonviable pregnancies of 24–28 weeks' gestation states that "a regimen combining mifepristone and misoprostol may shorten the time to expulsion, though the overall success rates are similar to those seen with misoprostol-only regimens" [16].

We performed a retrospective study of abortions performed at ≥24 weeks' gestation at one freestanding U.S. clinic that used a misoprostol-alone regimen during one period and a combined mifepristone–misoprostol regimen during another. We aimed to assess differences in time from misoprostol initiation to fetal expulsion by regimen group. We also explored whether procedure characteristics and clinical outcomes, including complications, differed by regimen group.

2. Material and methods

The study sample included all abortions performed at one U.S. clinic between May 2016 and January 2018. In 2016, the clinic updated their standard protocol for medication abortions performed at ≥24 weeks' gestation to accommodate an increase in patient volume. The new protocol triaged patients into induction days based on cervical assessment. It also included mifepristone pre-treatment, based on second-trimester medication abortion trials that suggested the addition of mifepristone could safely shorten total procedure time to fetal expulsion [23]. Approximately one year later (in May 2017), the clinic stopped administering mifepristone as part of the standard regimen because of a lack of perceived benefit. This created two sequential groups that received a similar treatment regimen with the difference of mifepristone pretreatment. The University of California, San Francisco institutional review board approved this study as exempt for use of de-identified records.

2.1. Summary of clinical procedures

Abortion procedures typically took place over the course of two to four days. On the morning of day one, a clinician examined the patient, provided counseling, requested patient consent for the procedure, and confirmed gestational age with ultrasound. The clinician then administered an intrafetal injection of digoxin 2–3 mg trans-vaginally [24,25]. Following feticidal injection, the clinician placed a paracervical block (1% lidocaine HCL 21 cc with epinephrine or vasopressin plus 3 cc bicarbonate buffer) and placed laminaria for cervical preparation. Clinicians inserted the maximum number of laminaria the cervix could accommodate, ranging from two to seven. No specific protocol was used for patients presenting at later gestations; however, these patients often presented with a softer and/or more dilated cervix that allowed for placement of more laminaria. Patients who were seen between May 2016 and May 2017 received mifepristone 200 mg orally, typically within an hour before or after laminaria placement.

During initial laminaria placement on day one, the clinician assessed the readiness of the patient to be induced the following day, based on cervical assessment and patient characteristics, including pregnancy history, number and type of previous deliveries, and maternal age. All patients were told to return on the morning of day two for a repeat cervical examination to confirm or update the treatment plan, approximately 18 h after initial laminaria placement. Patients deemed ready were induced 18–24 h after initial laminaria placement. Those deemed not ready for induction received a second placement of laminaria, approximately 19–25 h after initial placement. They were then scheduled to be induced on day three, approximately 24 h after second laminaria placement.

After receiving digoxin and initial laminaria on the morning of day one, patients returned approximately 2–6 h after receiving digoxin and laminaria for an ultrasound examination to confirm fetal demise. When fetal demise could not be confirmed, clinicians administered 20 cc 1% lidocaine intra-amniotically via the abdomen in the evening of day one if there was a concern about precipitous delivery, or, otherwise, in the morning on day two.

On the day of induction (day two or three depending on the patient), clinicians removed laminaria and performed amniotomy if membranes had not yet ruptured. Patients used misoprostol buccally every two hours until delivery using the regimen in Appendix A. After expulsion of the fetus and placenta, all patients underwent uterine aspiration and sharp curettage and then spent a minimum of two hours in recovery. If the placenta had not delivered spontaneously after fetal expulsion using cord traction and uterotonics, clinicians removed the placenta using forceps with transabdominal ultrasound guidance prior to the aspiration procedure.

2.2. Data source

We obtained data from a clinic-maintained Microsoft Access database of all patients who received abortion at ≥24 weeks' gestation from May 2016 to January 2018, recorded at time of abortion by clinicians with support from clinic staff. Collected records included patient characteristics (state of residence, date of birth, parity, previous cesarean delivery, and previous abortions), procedural characteristics (dosage of misoprostol, number of laminaria placed, delivery method, and date and time of digoxin injection, misoprostol initiation, and fetal expulsion), and complications (hemorrhage, cervical laceration requiring repair, retained placenta, and hospital transport due to complication). We reviewed a comment field in the database to capture details about complications and protocol deviations, reasons for delivery outside of the clinic, and to identify cases of death and blood transfusion. To obtain data missing from the database, clinic staff reviewed select charts and provided this information without identifiers to the researchers.

2.3. Study outcomes and covariate measurement

We defined our primary outcome as the interval from misoprostol initiation to fetal expulsion. We chose this as our primary outcome since patients usually remain in the facility once misoprostol treatment begins, and this interval has been the focus of research in the second trimester [19–21]. Secondary outcomes included the proportion who completed fetal expulsion within 6, 12, and 24 h after misoprostol initiation, procedural differences between the groups related to number of laminaria, proportion who received a second round of laminaria, median time from

digoxin injection to fetal expulsion, total misoprostol dosage, delivery method, and complications. We categorized delivery method as spontaneous (requiring no instrumental assistance), assisted (requiring use of forceps or other instruments placed in the vaginal canal with traction to assist in fetal expulsion), or dilation and evacuation (failed induction; requiring use of instruments placed within the cervix or uterus to remove fetal parts). The specific complications we assessed included hemorrhage (≥500 ml estimated blood loss), cervical laceration requiring intervention, retained placenta, transport to hospital facility due to complications, precipitous extramural delivery, and death.

2.4. Data analysis

We analyzed data using Stata v 14 (Statcorp LP, College Station, TX). We calculated chi-squared, Fisher's exact, or Kruskal–Wallis tests for two-group comparisons. We used Kaplan–Meier analyses and log-rank tests to compare time from misoprostol initiation to fetal expulsion between groups. We calculated a hazard ratio using Cox regression to adjust for potential confounders including gestational age (categorical), prior vaginal delivery (binary) and prior abortion (binary). These covariates were chosen a priori based on published literature [19].

3. Results

3.1. Sample description

Clinicians evaluated 501 patients at ≥24 weeks' gestation in the clinic between May 2016 and January 2018, of whom 257 received the mifepristone–misoprostol regimen between May 2016 and May 2017 and 172 received the misoprostol-alone regimen from May 2017 to January 2018. We excluded the other 72 patients who received oxytocin in place of misoprostol ($n = 54$), patients in the misoprostol-only group that started spontaneous labor before misoprostol treatment ($n = 4$), and patients in both groups for whom the physician altered the standard regimen ($n = 14$). Subject characteristics are presented in Table 1.

We included eight patients in analyses of participant characteristics, procedures, and complications, but removed them from the time-to-event analysis because fetal expulsion did not occur at the clinic.

Table 1
Demographic and clinical characteristics of patients undergoing medication abortion at 24 weeks' gestation or later.[a,b]

	Mifepristone-Misoprostol $n = 257$	Misoprostol-alone $n = 172$	p-value[c]
Age (years)			
≤17	22 (9)	26 (15)	0.16
18–25	100 (39)	63 (37)	
26–35	107 (41)	62 (36)	
>35	28 (11)	21 (12)	
Parity			
Nulliparous	160 (62)	106 (61)	0.89
Previous vaginal delivery	89 (35)	62 (36)	0.62
Previous cesarean delivery	12 (5)	5 (3)	0.36
Previous abortion	70 (27)	58 (34)	0.15
Gestational age (weeks)			
24–27	139 (54)	107 (62)	0.23

3.2. Clinical outcomes

Median time from misoprostol initiation to fetal expulsion did not differ in unadjusted analysis (Table 2 and Fig. 1) or adjusted analyses (aHR 1.06 [0.87, 1.30]; $p = 0.54$).

Median total misoprostol administered among patients in the mifepristone–misoprostol group was lower than among the misoprostol-alone group and the median number of laminaria placed was lower among mifepristone–misoprostol patients. Patients did experience a shorter median time from digoxin injection (start of the procedure) to fetal expulsion with mifepristone–misoprostol (26.7 h [IQR 23.8–36.5]) compared to misoprostol-alone (27.7 h [IQR 24.8–46.4]), $p < 0.01$). This difference in interval appears to be the result of the difference in proportion who received an additional round of laminaria. Fewer patients in the mifepristone–misoprostol group received a second day of laminaria priming compared to the misoprostol-alone group ($n = 56$, 22% vs. $n = 58$, 33%; $p < 0.01$). Total laminaria among those who only received one day of laminaria were similar between groups (median [IQR]: 5 [4–6] vs. 5 [4–7]; p = 0.07; data not shown). We further explored whether this varied by parity and gestational age. Among parous patients, 18% in the mifepristone–misoprostol group required a second day of laminaria compared to 33% in the misoprostol-alone group ($p = 0.02$). Among nulliparous patients 24% in the mifepristone–misoprostol group required a second day of laminaria compared to 34% in the misoprostol-alone group (p = 0.09). Among patients pregnant at 24–27 weeks, 24% in the mifepristone–misoprostol group required a second day of laminaria compared to 37% in the misoprostol-alone group ($p = 0.03$). This was not significant among patients pregnant at 28–35 weeks (19% vs. 28%, $p = 0.16$; data not shown). Distribution of delivery method did not vary between groups, with most delivering spontaneously.

Patients experienced complications, including hemorrhage, cervical laceration, retained placenta, and extramural delivery infrequently in both groups (Table 3). One death (0.4%) occurred in a patient who received mifepristone and misoprostol who developed

Table 2
Procedure characteristics and clinical outcomes among patients undergoing medication abortion at 24 weeks' gestation or later.[a]

	Mifepristone–misoprostol $n = 252$	Misoprostol-alone $n = 169$	p-value[b]
Total laminaria	5 (4–7)	6 (4–10)	**<0.01**
Received second day of laminaria[c]	56 (22)	58 (33)	**<0.01**
Misoprostol dosage (mcg)	800 (800–1200)	1200 (800–1600)	**<0.01**
Delivery method[c]			
Spontaneous	246 (97)	159 (94)	0.17
Assisted	4 (2)	7 (4)	
D&E	2 (1)	3 (2)	
Time from first misoprostol to fetal expulsion[c]	4.8 (2.9–6.9)	4.9 (3.4–7.5)	0.43
Fetal expulsion from first misoprostol[c]			
≤6 h	163 (65)	101 (60)	0.30
≤12 h	236 (94)	156 (92)	0.59
≤24 h	247 (98)	166 (98)	1.00
Time from digoxin injection to fetal expulsion[c]	26.7 (23.8–36.5)	27.7 (24.8–46.4)	**<0.01**

AOT Mar 31, 2021 2 min read

BREAKING: Charges against woman arrested after botched abortion dismissed

Updated: May 15, 2021

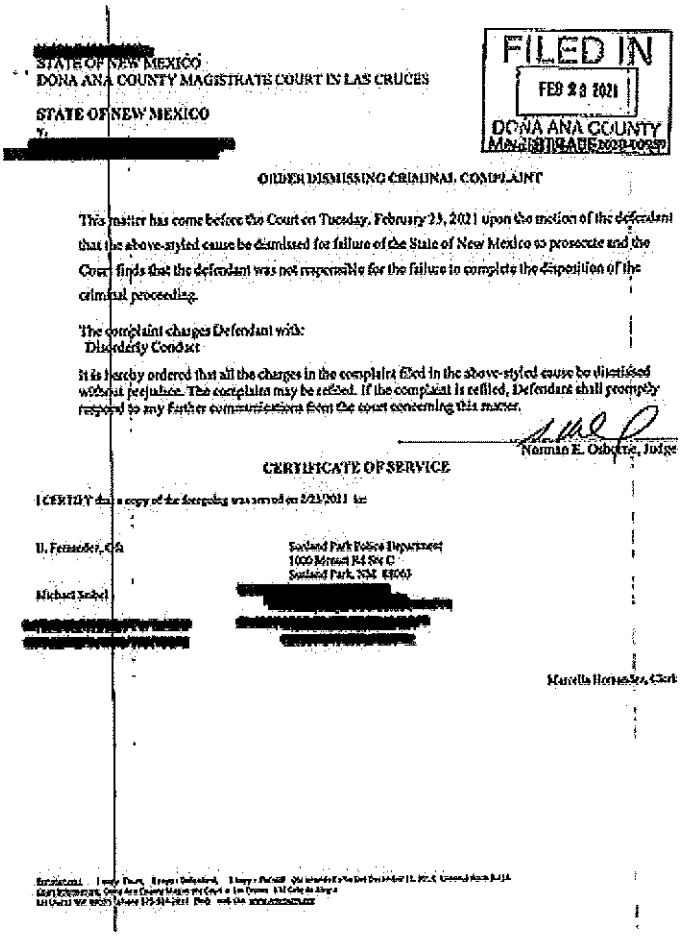
After nearly seven months of legal battles, criminal charges against Jane Doe have been dismissed!

On September 1st, 2020, Jane Doe was arrested by Sunland Park Police Department and was charged with criminal disturbance. She had returned to Women's Reproductive Clinic of Sunland Park on 9/1/20 with the body of her deceased baby, who was delivered at home following a botched surgical abortion. Jane went to the clinic in physical pain and emotional panic in order to get help, answers, and her medical records. The abortion provider, Dr. Franz Theard, refused to speak with Jane and instead fled the scene in his car after instructing police to be called on her.

After the abortion facility illegally took custody of her baby's body, police arrested both Jane and her husband. Jane's husband's charges were later dropped, but Jane's remained.

Thankfully there were prepared sidewalk advocates on the scene that day to provide Jane with the offer for help. Those advocates from Southwest Coalition For Life not only made sure Jane was given medical care following her botched abortion and home delivery, but they also called Abortion On Trial's attorney from the scene of the incident. Together immediate steps were taken to defend Jane against the abortion provider she previously trusted.

AOT's attorney has fought tirelessly not only against the bogus criminal charges but for Jane's right to receive her own medical records. It took more than 120 days for Women's Reproductive Clinic to release Jane's medical records to her. That delay resulted in even more court battles as AOT's attorney, Mike Siebel, sought to hold Women's Reproductive Clinic in contempt of a court order. Women's reproductive clinic responded to that attempt with proposed sanctions against Mr. Seibel.



STATE OF NEW MEXICO
DONA ANA COUNTY MAGISTRATE COURT IN LAS CRUCES

STATE OF NEW MEXICO
v.
[redacted]

FILED IN
FEB 23 2021
DONA ANA COUNTY
MAGISTRATE COURT

ORDER DISMISSING CRIMINAL COMPLAINT

This matter has come before the Court on Tuesday, February 23, 2021 upon the motion of the defendant that the above-styled cause be dismissed for failure of the State of New Mexico to prosecute and the Court finds that the defendant was not responsible for the failure to complete the disposition of the criminal proceeding.

The complaint charges Defendant with:
Disorderly Conduct

It is hereby ordered that all the charges in the complaint filed in the above-styled cause be dismissed without prejudice. The complaint may be refiled. If the complaint is refiled, Defendant shall promptly respond to any further communications from the court concerning this matter.

Norman E. Osborne, Judge

CERTIFICATE OF SERVICE

I CERTIFY that a copy of the foregoing was served on 2/23/2021 to:

U. Fernandez, CSA

Sunland Park Police Department
1000 Mirasol #4 Ste C
Sunland Park, NM 88063

Michael Seibel

[redacted]

Marella Hernandez, Clerk

In the end, not only were charges against Jane "dismissed without prejudice," but the proposed sanctions against Mr. Seibel and the request for Women's Reproductive Clinic to have their legal fees paid for were denied. The judge ruled in Jane's favor on both accounts. Franz Theard's facility not only lost in their criminal pursuit against Jane, but they also lost in their pursuit to save on the legal fees Jane's case cost them.

STATE OF NEW MEXICO
DONA ANA COUNTY MAGISTRATE COURT IN LAS CRUCES

FILED IN
FEB 2 3 2021
DOÑA ANA
MAGISTRATE COURT

State of New Mexico
v
[redacted]

ORDER ON MOTIONS

THIS MATTER having come before the court on Tuesday, February 23, 2021 on Motion for contempt against Woman's Reproductive Center and Motion for Attorney's fee. Michael Seibel is representing the defendant appeared by telephone. Steven Almanza appeared by telephone on behalf of the Woman's Reproductive Center. The court, having been sufficiently advised of the matters herein stated, finds just cause to deny these motions.

IT IS THEREFORE ORDERED that the Motion for Contempt against Woman's Reproductive Center be denied.

IT IS ORDERD the Motion for Attorney's fee is Denied. All parties will carry their own financial burden.

Judge Samantha Madrid

CERTIFICATE OF SERVICE

I CERTIFY that a copy of the foregoing was served on 2/26/2021 to:

Steven Almanza — 770 E Boutz, Las Cruces NM 88001

R. Fernandez, Ofc — Sunland Park Police Department, 1000 McNutt Rd Ste C, Sunland Park, NM 88063

Michael Seibel — [redacted]

[redacted]

Marcella Hernandez, Clerk

Distribution: 1 copy Court 1 copy Defendant 1 copy Prosecutor [illegible]

Page 1 of 1

Dona Ana County Magistrate Court [illegible]

Las Cruces NM [illegible]

Jane's case is the beginning of fighting back against the bullying women so often experience before and after abortion. Franz Theard and his staff now know that people will push back and stand up for the women they previously got away with mistreating. Women watching this case now know that people will stand beside them in a battle against corrupt doctors.

This may not be the last we see of Jane and her story, but it is the last we will see of Franz Theard harming women without being actively opposed.

"We hope Jane's story will continue to spread as a beacon of awareness and precaution to those considering abortion," says AOT Executive Director Jamie Jeffries. "We hope those who oppose abortion see this case and realize just how much women need compassionate care after abortion. And we hope those who support providers like Franz Theard see this case and realize who is having women arrested at abortion clinics and who is fighting for them when that happens."

To support the work Abortion On Trial is doing, click HERE.

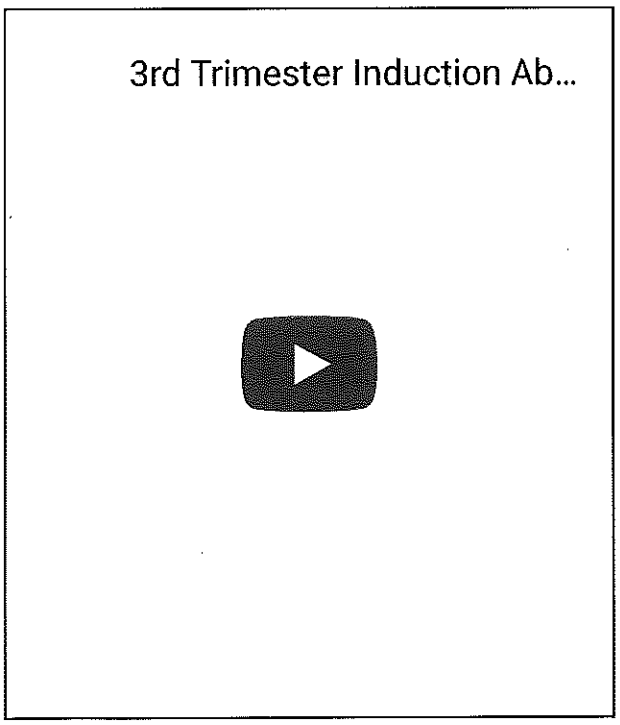
INVESTIGATIVE

University of New Mexico agrees to pay settlement to family of woman killed by abortion

By Nancy Flanders | April 24, 2022 , 11:07am

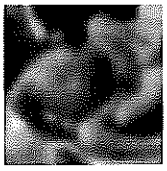
According to the pro-life group Abortion on Trial, the University of New Mexico (UNM) has agreed to pay a settlement of $365,000 to the Estate of Keisha Atkins, including her mother Tina Atkins, for negligently referring the 23-year-old Atkins to an abortionist that led to her death in 2017.

Atkins died of sepsis during a 24-week elective abortion at Southwestern Women's Options abortion facility in Albuquerque, New Mexico, after UNM referred her to the facility for a non-medical late abortion. Since Medicaid does not cover elective abortions, abortionist Dr. Shannon Carr testified under oath that she marked the abortion as necessary for Atkins' mental, physical, emotional, and familial health based on "sheer speculation." This allowed Medicaid to cover the abortion at six months, but put Atkins' health and life in danger from the serious risks associated with late abortions.



"UNM should have never referred Keisha to Curtis Boyd's outpatient abortion facility, Southwestern

FEATURED



Aborted babies discovered in DC may indicate infanticide after attempted abortions

What you need to know about the COVID-19 vaccines

Women's Options," said Jamie Jeffries, executive director of Abortion on Trial. "It is unacceptable medical care to perform an induction abortion outside of a hospital. Practitioners everywhere should be aware that referring women to private abortion clinics can result in legal action and subsequent liability."

Despite the abortion facility's claim that Atkins needed a late abortion to prevent "substantial and irreversible harm to her physical health, her mental health, her family health, her safety and her well being," Atkins and her baby were believed to have been healthy overall — and Carr only spoke with Atkins for 20 minutes prior to the abortion. She admitted that she was only speculating that Atkins would struggle with depression, anxiety, and financial instability as a young, single mother.

An abortion at 24 weeks takes up to four days to complete. Documents obtained by Abortion on Trial show that, following her first appointment on January 31, 2017, Atkins was repeatedly drugged by the staff of Southwestern Women's Options, with fentanyl and Versed (midazolam), both of which are known to cause "serious breathing problems." In addition, they gave Atkins oxycodone and two doses of Mifeprex (the abortion pill) as part of

Mom's photos of 'perfect' 14-week miscarried son have saved other babies

TO TOP

an experiment. Each time Atkins returned to the facility over the course of the following four days, she was drugged and sent back to her hotel with no medical supervision.

TO TOP

READ: *What the research really shows about abortion's potential physical risks*

When Atkins returned to the abortion facility on February 3, she went into respiratory distress and was taken to the hospital where she died. Originally, the medical examiner ruled Atkins' death as "natural" from pregnancy, a decision that stumped the doctors at the hospital who tried to save her and who agreed she had died from a septic abortion.

"While the settlement against the UNM Board of Regents provides important financial relief to the Atkins family, it also underscores the need for safety laws for late term abortions," said New Mexico Rep. Rebecca Dow (R). "The New Mexico Legislature has chosen many times to ignore the safety of the mother during a late term abortion. Informed consent of the risks of any procedure is a foundational patient right and should be honored in the abortion context as well. It is a shame that UNM continues to fail to provide adequate information about the serious

risks of these procedures. While I believe there are many alternatives to abortion, the simple truth is that a woman who opts to receive an abortion should receive the same information of the risks of the procedure that is afforded in every other medical environment."

TO TOP

Abortion is legal in New Mexico at all stages of pregnancy. Southwestern Women's Options is facing its own wrongful death case regarding Atkins.

"Like" Live Action News on Facebook for more pro-life news and commentary!

IN THE CIRCUIT COURT OF UNION COUNTY, ARKANSAS
FOURTH DIVISION

STATE OF ARKANSAS

Plaintiff,

vs. 70CR-2018-0215-4

ERIC JEROME LACY

Defendant.

VIDEOTAPED DEPOSITION OF SHELLEY SELLA, MD

April 22, 2019
12:58 p.m.
500 4th Street NW, Suite 105
Albuquerque, New Mexico 87102

PURSUANT TO THE ARKANSAS RULES OF CIVIL PROCEDURE, this deposition was:

TAKEN BY: CARLA R. GIBSON, ESQ.
ATTORNEY FOR THE PLAINTIFF

REPORTED BY: KATHLEEN H. O'DONNELL, RPR
New Mexico CCR No. 75
Arizona CR No. 50177

Q. All right.

So, Dr. Sella, did you have occasion to have contact with Jacoreyia later in the evening of March 27th, 2018?

A. Yes.

Q. And can you tell me how you had contact with her?

A. Yes.

Either her mother, or another person who was with her, called our on-call person; we have someone on call 24 hours a day, a phone counselor, and said that she was in labor. I was, then, called and I went to see her at the hotel.

Q. Okay. And when you arrived at the hotel, what did you observe?

A. She was in active labor. She was in the bathroom, sitting on the toilet.

Q. Okay. And so, did you have to take any steps after you saw that?

A. Yeah, I attended her while she delivered.

Q. Okay. So, you delivered the baby there –

A. Yes.

Q. – in the hotel? Okay.

And what did you do with the fetus once you delivered it?

A. So, what I did was I cut the cord, and I placed it in a bag.

Q. Okay. A bag that you had with you?

A. Correct.

Q. Okay. And what did you do with the fetus after that?

A. I brought Jacoreyia and her mother, and maybe another person, I really don't remember that, with the pregnancy, with the fetus, we went to the clinic, and there I was met by a counselor.

Q. Okay. I'm sorry. Repeat that again about the counselor.

A. Oh, I was met at the clinic by a counselor.

Q. Okay. And so, did Jacoreyia have to see the counselor at that point?

A. Well, the counselor was with her when we went to the procedure room for the next step, which was removing the placenta. The placenta had not been expelled in the hotel.

Q. Okay. And did you review the placenta?

A. Correct, yes.

Q. Okay. Were there any complications during delivery?

A. No.

Q. Okay. And so, once you extracted the

placenta, what do you do with that next, Dr. Sella?

A. So, the placenta went into a bag, as well.

Q. Okay. And what did you do with that bag?

A. So, that was with the fetus.

Q. Uh-huh.

A. I -- I labeled the bag. I placed her initials and the date and the gender of the fetus, and I placed it across the bag, including my initials and the date.

Q. Okay. And where was it placed?

A. It was, then, placed in the refrigerator.

Q. Okay. All right. And when you did this, do you mark the bag or seal it in any type of special way, or how do you know that it's Jacoreyia's

A. Well, because I had written her initials and the date and my initials, as well.

Q. Okay. Give me one second. I'm trying to find that, that I'm talking about.

Do you document those steps that you take after taking the fetus and the placenta and storing it, is that documented?

A. Yes, it's in the chart.

Q. Okay. I have my copy, and I'm sure you have your –

A. Yes.

Q. – medical records with you.

Are those medical records kept as part of New Mexico law and procedure for your clinic?

A. Correct, yes.

Q. Okay. And were they compiled and maintained during the course of the treatment of Jacoreyia while she was at your facility?

A. Yes.

Q. Okay. And are the medical records that you have with you, are they the original copies, original documents?

A. Yes.

Q. Okay. And your office, under subpoena from my office, subpoenaed her medical records to be hand-delivered to Detective Morrow.

Were you aware of that?

A. No, but thank you for telling me.

Q. Okay. We'll get to that later. All right.

A. Okay.

Q. So, I have a copy here, and I don't know what page it is in the actual medical chart.

I'll show it to you --

A. Uh-huh.

Q. – and you tell me if you are familiar with it and know what it is.

STATE OF NEW MEXICO
COUNTY OF BERNALILLO
SECOND JUDICIAL DISTRICT

NO. D-202-CV-2018-05696

TINA ADKINS, individually
and as Personal Representative
of the ESTATE of
KEISHA MARIE ATKINS,
and NICOLE ATKINS,

Plaintiff(s),

vs.

CURTIS BOYD, M.D. P.C. d/b/a
SOUTHWESTERN WOMEN'S OPTIONS,
CURTIS W. BOYD, Individually,
CARMEN LANDAU, Individually,
SHANNON CARR, Individually,
THE UNIVERSITY OF NEW MEXICO
BOARD OF REGENTS, THE UNIVERSITY
OF NEW MEXICO HEALTH SCIENCES
CENTER, LISA HOFLER, M.D.,
Individually, UNM MEDICAL GROUP,
INC., LILY BAYAT, M.D.,
Individually, and BRENDA PEREDA, M.D.,
Individually ,

Defendant(s).

ORAL AND VIDEOTAPED DEPOSITION OF
ITALIA ARANDA GONZALEZ
OCTOBER 22, 2019
10:10 A.M.
MICHAEL J. SEIBEL & ASSOCIATES
8500 MENAUL NE, SUITE A319
ALBUQUERQUE. NEW MEXICO

PURSUANT TO THE NEW MEXICO RULES OF CIVIL PROCEDURE, this deposition was:

TAKEN BY: MR. JUSTIN HALL, ESQ.
ATTORNEY FOR PLAINTIFFS

A. Yes.
Q. Okay. And do you counsel the patients about what to do if they deliver the stillborn fetus outside of the clinic?
A. Yes. I walk them through what that might look like or what that might feel like.
Q. What would you say to a patient in that situation?
A. Yeah. So, if at any point you feel like you really need to, like, you had a lot of cramping or you really need to push or like there's a lot of pressure on your bottom, I tell them to call the clinic right away. Because, you know, us -- or the person who's answering the phone can help identify if, you know, if the patient can come into the clinic or what is necessarily going on.

I say if it seems like things are moving quicker than we'd like them to, we might instruct you to sit on the toilet, put a towel over your lap, and the phone on call person will be with you at all times while our staff gets to you.
Q. And when you say "while our staff gets to you," are you referring to an employee of the clinic going to meet the patient at the location where they are?
A. Yes.

Q. And that would be if they were on the toilet actually delivering the stillborn fetus?
A. Yes.
Q. How often does that occur?
A. Not very often.
Q. Has it occurred -- has it ever occurred in the three years of your employment with the clinic?
A. Yes.
Q. Just for purposes of me getting an understanding, would you say it's occurred more than ten times in your three years of employment at the clinic?
A. I would -- maybe. I -- I don't really have an exact number.
Q. Have you yourself ever picked up any patients that were outside of the clinic and brought them to the clinic?
A. Yes.
Q. How many occasions has that occurred?
A. I mean, that's also hard to tell. We would -- every time we pick up a patient, that doesn't necessarily mean that the patient has delivered outside of the clinic. That means that maybe they don't have a ride overnight. That their ride didn't show up. So, we could pick them up even if they haven't delivered.
Q. And what about out-of-town patients? In other

words, patients that live outside of the Albuquerque community, have you ever picked up any of those folks?
A. Have I ever -- can you rephrase the question?
Q. Sure.

Have you ever traveled outside of Albuquerque for the purpose of picking up patients and bringing them to the clinic?
A. No.
Q. How about picking up patients at a hotel in the area?
A. Yes.
Q. What hotels, typically, do your patients stay at?
A. I mean, we ask them to stay in a hotel close by to the clinic, within 10 minutes.
Q. Do you give them a list of hotels where they can stay?
A. No. We tell them what hotels are around us, but that's suggestion.
Q. And you have picked up patients from hotels and brought them to the clinic?
A. Yes.
Q. How many occasions has that occurred?
A. With picking up patients and bringing them to the clinic, I would say more than ten times.

Q. And is that typically in an after hour setting?
A. Yes.
Q. And do you meet the doctor at the clinic?
A. Yes.
Q. And is -- are the doctors on rotation for their on call after hours clinic appointments?
A. What do you mean by "rotation"?
Q. That's a poor question, let me say that.

My understanding is that there -- let's say 2017, 2017 there were two doctors that were on call; is that correct?
A. I mean, not -- do you mean like at the same time or like in the same day? Can you rephrase that question?
Q. Sure.

How many doctors had on call after hour duties in 2017 at the clinic?
A. Two. On call -- two doctors have had on call duties.
Q. And on any given night would it be accurate to say that only one of those doctors would be responsible for the after hours on call patients?
A. Yes.
Q. In 2017, who were those two doctors?
A. The two doctors that had on call duties would

STATE OF NEW MEXICO
COUNTY OF BERNALILLO
SECOND JUDICIAL DISTRICT

NO. D-202-CV-2018-05696

TINA ADKINS, individually
and as Personal Representative
of the ESTATE of
KEISHA MARIE ATKINS,
and NICOLE ATKINS,

Plaintiff(s),

vs.

CURTIS BOYD, M.D. P.C. d/b/a
SOUTHWESTERN WOMEN'S OPTIONS,
CURTIS W. BOYD, Individually,
CARMEN LANDAU, Individually,
SHANNON CARR, Individually,
THE UNIVERSITY OF NEW MEXICO
BOARD OF REGENTS, THE UNIVERSITY
OF NEW MEXICO HEALTH SCIENCES
CENTER, LISA HOFLER, M.D.,
Individually, UNM MEDICAL GROUP,
INC., LILY BAYAT, M.D.,
Individually, and BRENDA PEREDA, M.D.,
Individually ,

Defendant(s).

ORAL AND VIDEOTAPED DEPOSITION OF
DR. CARMEN LANDAU
OCTOBER 25, 2019
9:07 A.M.
MICHAEL J. SEIBEL & ASSOCIATES
8500 MENAUL NE, SUITE A319
ALBUQUERQUE. NEW MEXICO

PURSUANT TO THE NEW MEXICO RULES OF CIVIL PROCEDURE, this deposition was:

TAKEN BY: MR. JUSTIN HALL, ESQ.
ATTORNEY FOR PLAINTIFFS

discharged?

A. When laminaria or dilators are inserted, typically we will also place a small sterile gauze sponge, which is primarily to prevent the laminaria – the end of the laminaria from poking the inside of the vagina which can be uncomfortable.

Q. And is it typical or a regular occurrence that the gauze sometimes falls out?

A. It happens sometimes.

Q. And what instructions do you give to the patients if that – if that occurs?

A. We just like to know about it so that we do not search for it unnecessarily.

Q. So, if the gauze falls out of a patient in an after hours setting, when the clinic's closed, what is the patient instructed to do?

A. Nothing.

Q. Will the patient be encouraged to contact the clinic if that occurs?

A. No. We tell the patients that it is nothing to worry about. However, patients do sometimes contact the clinic, and we are able to provide reassurance in that case.

Q. And, typically, how would you instruct or how would you have one of your medical assistants instruct

the patient if they call in complaining of the gauze falling out?

A. We would reassure them that it is nothing to worry about.

Q. And if one of the dilators falls out, what happens then?

A. Similarly, it is typically not an indicator of anything concerning. Sometimes when patients have dilators coming out, they are also experiencing strong cramps or contractions, which is a reason to call, so that would be separate.

Q. And are patients ever instructed to reapply or reinsert the dilators?

A. Absolutely not.

Q. What are they instructed to do?

A. Throw them in the garbage.

Q. Why is that?

A. I'm sorry, I don't understand the question.

Q. Why are they instructed to discard the dilators if they fall out?

A. Well, I guess I'm not – I don't understand what the alternative would be. We're not placing them back into the vagina. So, they could bring them to us if they were – if they wanted to, but it's also something that would be okay to throw out, similar to a

tampon.

Q. Is there a risk of infection with dilators, if it were to be reapplied or reinserted?

A. Potentially.

Q. Is there a risk of infection if the gauze is reinserted?

A. Potentially.

Q. If you look here on the right-hand column of Exhibit Number 18, toward the bottom, it says: (Reading)

We will see you here in our office if necessary. Do not go to the emergency room.

Why is – why is that instruction given?

A. Because oftentimes when unexpected or concerning things are happening overnight, one might be – have – the first impulse would be to go to the emergency room. And the emergency room personnel are, in the vast majority of cases, not the best qualified to take care of a patient who's undergoing an abortion procedure, we are.

Q. Why are emergency personnel not the best qualified persons?

A. Emergency room personnel are the best people to see when you're having an emergency, not when you're

having an abortion. If you're having an abortion, then your abortion doctor is the most qualified person to take care of you.

Q. If a patient is undergoing an emergency, would it be best for them to contact or go straight to the emergency room?

A. What is your definition of an emergency?

Q. Wonderful question.

Are patients given a list of the types of emergencies that should result in their contacting the emergency room?

A. I believe that that list would be too long to give to a person. And so on the contrary, we tell them all of the reasons to call us. If any of our staff received a phone call from a patient who's describing an emergency that was not within our purview, then the decision would be made to have them go straight to the emergency room or call 9-1-1. But that would be a very rare situation.

Q. And is it fair to say, then, that you discourage your patients from contacting hospitals or emergency rooms on their own?

A. Yes.

Q. On February 2nd, 2017, do you recall whether or not you were one of the doctors that were serving in an