.

BEFORE THE KANSAS STATE BOARD OF HEALING ARTS

.

IN THE MATTER OF Docket No. 10-HA00129

ANN K. NEUHAUS, M.D. OAH No. 10HA0014

.

Kansas License No. 04-21596

.

.

.

VOLUME IV

TRANSCRIPT OF PROCEEDINGS

.

taken on the 15th day of September, 2011, beginning at 8:30 a.m., at the Kansas State Board of Healing Arts, 800 Southwest Jackson, Lower Level, in the City of Topeka, County of Shawnee, State of Kansas, before, Edward J. Gaschler, Presiding Officer.

.

.

.

.

.

APPEARANCES

.

.

ON BEHALF OF THE PETITIONER:

.

Mr. Reese H. Hays
Ms. Jessica Bryson
Kansas State Board of Healing Arts
800 Southwest Jackson
Suite A
Topeka, Kansas 66612
785-296-7413
rhays@ksbha.ks.gov

.

.

ON BEHALF OF THE RESPONDENT:

.

Mr. Robert V. Eye
Ms. Kelly Kauffman
Mr. Kori Trussell
Kauffman & Eye
123 Southeast 6th Street
Suite 200
Topeka, Kansas 66603
bob@kauffmaneye.com

ALSO PRESENT:

.

Ms. Hester Jay

.

.

.

.

.

.

.

.

.

.

.

.

.

.

.

.

.

.

.

.

.

.

INDEX

WITNESS

PRESIDING OFFICER: All right. We're back on the record. If I understand correctly, Mr. Hays, the Board has rested its case?

MR. HAYS: Yes, sir.

PRESIDING OFFICER: Mr. Eye, are you ready to proceed?

MR. EYE: Yes, sir, we are.

PRESIDING OFFICER: First witness.

MR. EYE: Joan Armentrout and this will be by telephone testimony, Your Honor. You can go ahead and dial it up.

(THEREUPON, a discussion was had off the record.)

MR. EYE: Good morning again, Erin, this is Bob.

MS. THOMPSON: Hi, Bob.

MR. EYE: And we're ready to proceed with Joan Armentrout.

MS. THOMPSON: Okay. Let me put it on speaker.

MR. EYE: Great. Thank you.

THE REPORTER: Who is present with them?

MR. EYE: We'll have them announced.

MS. THOMPSON: Can you hear us?

MR. EYE: Yes. And -- and, Erin, will

you announce your presence and also whoever else is in the room with you.

MS. THOMPSON: Sure. This is Erin Thompson. I have Joan Armentrout and Debra -- Debbie Esquina and that's all that we have here right now.

MR. EYE: All right. We have called Joan Armentrout as our witness. Joan, are you there?

THE WITNESS: Yes.

MR. EYE: Okay. And you'll be -- the oath will be administered at this time.

THE WITNESS: All right. And just for the record the spelling on my first name is J-O-A-N.

THE REPORTER: Thank you.

JOAN ARMENTROUT,

called as a witness on behalf of the Respondent, was sworn and testified as follows:

MR. EYE: Ms. Armentrout, are you able to hear my -- hear my voice all right?

THE WITNESS: Yes.

MR. EYE: Thank you. We can hear you well, too, I believe.

THE WITNESS: All right.

DIRECT-EXAMINATION

BY MR. EYE:

Q. Would you please state your name for the record.

A. Yes. Joan Armentrout.

Q. Are you a resident of Wichita, Kansas?

A. Yes.

Q. And at -- did you at one time work for the Women's Health Care Services in Wichita?

A. Yes.

Q. And what were your dates of employment at that facility?

A. From February 1st of 1996 through August of 2000 and --

THE REPORTER: 2000

BY MR. EYE:

Q. 2000 and what?

A. 2009. August of 2009.

Q. Thank you. Were you -- so you were employed in 2003 at the Women's Health Care Services clinic?

A. Correct.

Q. And in what capacity were you employed in 2003?

A. I was the bookkeeper and the office manager.

Q. What -- and what were the general nature of your duties as the office manager?

A. I helped answer phones, schedule patients, completed payroll, general office duties.

Q. Did you have any occasion in 2003 to have contact with Doctor Kristin Neuhaus?

A. Yes.

Q. And what was the -- how did you happen to have contact with Doctor Neuhaus?

A. Well, we would -- as patients called we would take information from the patient if -- depending on their gestation if we would take what we referred to as an MI Statement. We would then fax that information to her if -- if the patient was scheduled.

Q. And what do you mean by if the patient was scheduled?

A. Okay. Well often times patients would call and we would take statements and get information from the patient but they -- they wouldn't be scheduled. Once we took the statement it would have to be approved first by Doctor Tiller to even schedule the patient.

Q. And what is an MI Statement, Ms.

Armentrout?

A. Okay. Well, it was a form that we used to question patients based on their gestation when they were referred to us, and we would take the information and just ask the questions as the form was written out.

Q. Is -- I'm sorry, please continue.

A. Okay. And based on their answers to those questions would give us an indication if they might qualify for a late-term termination.

Q. Did you have an occasion to use the MI Statement in receiving information from a potential patient who called the clinic?

A. Yes.

Q. Were you trained or did you receive any training on how to administer the MI Statement?

A. Yes. The form -- there were usually just three or four people in the office that took the statements and before we were able to take the statements our supervisor at the time would go over the form with us. We all knew the importance of the form and she would go through the form with us and you know, so we did receive training that way.

Q. And what was -- what was the importance

of the MI Statement?

A. To determine if they under Kansas law would qualify for a late-term termination.

Q. And -- and in 2003 did you take any of the MI Statements.

A. Correct, yes.

Q. And who else in 2003 as you recall would have been taking MI statements at the clinic?

A. Sara Love, our supervisor Carrie, that's who was the supervisor at that time, Debra Esquina, myself. I can't really recall at this time who else would have been there that probably would have been the ones that would have been taking them.

Q. Would there have been another person named Margarite.

A. Oh, Margarite, yes.

Q. And what was Margarite's last name or what is her last name?

A. Reed.

Q. R-E-E-D?

A. D.

Q. All right. Ms. Armentrout, you mentioned that the MI statements after being -- well, let me ask this question. In terms of how you were

supposed to administer the MI, was it your understanding that you were to fill in the answers from the -- from the potential patient who would call in that you were to --

MR. HAYS: Objection --

BY MR. EYE:

Q. -- to fill in those answers as close to verbatim as possible?

MR. HAYS: Objection, leading.

A. Correct, yes.

PRESIDING OFFICER: Overruled.

BY MR. EYE:

Q. And, in that regard was -- was that the -- as far as you know was that the training that other people who were responsible for taking the MI Statements that they were also instructed to do?

A. Yes.

Q. Once the MI states were completed what would be done with them?

A. We would take the MI statements along with the personal information on the patient, name, address, et cetera to Doctor Tiller for his approval for scheduling.

Q. And -- and then what would happen?

A. He would look at the statement and let us know if we could schedule the patient.

Q. Would Doctor Tiller always direct that the patient be scheduled for an appointment?

A. No. There were some that he would say that they didn't just based on their answers to the questions did not qualify, and then we would inform the patient, we would contact the patient again and let them know that they did not qualify and they would not be scheduled.

Q. For the patients that Doctor Tiller cleared for scheduling, what happened to their MI Statements after that step in the process?

A. Okay. We would contact the patient and let them know that they qualified for an appointment. We would make it clear to them that they at that time did not qualify for the abortion but based on their answers in the statement they qualified to have an appointment scheduled and then we would go ahead and complete the scheduling process usually for the next week.

Q. Did Doctor Neuhaus, did -- did she play a role in any of this process at that point?

A. Not up to that point. After the patient was scheduled we would then fax the personal

information and the MI Statement to Doctor Neuhaus.

Q. And --

A. To let her know who was scheduled.

Q. And what would be the next step in the process then, Ms. Armentrout?

A. Okay. When the -- on the day that we started those patients the patient would come in, they would fill out an extensive medical history. They would in there own words would write out why they were wanting to terminate the pregnancy so they wrote an additional MI Statement, and they would have a sonogram to verify gestation and meet briefly with Doctor Tiller or the medical personnel that did the sonogram and then they would wait for Doctor Neuhaus' interview.

Q. And did Doctor Neuhaus come to the clinic in Wichita?

A. Yes.

Q. And, was there room provided for her to conduct the interviews?

A. Yes, yes. There was a private room that she had available.

Q. And what was your understanding of the nature of the interviews that would be conducted?

MR. HAYS: Objection, speculation.
PRESIDING OFFICER: Overruled.
A. She would go through --
BY MR. EYE:
Q. Hold on, Ms. Armentrout, there is an objection that's pending.
PRESIDING OFFICER: Overruled.
BY MR. EYE:
Q. You may continue. You can go ahead and tell us --
A. Okay.
Q. -- what the nature of Doctor Neuhaus' interviews were.
A. All right. She would take a patient with the patient's permission she could include after she interviewed the patient, could include patient family members or who had accompanied the patient and oftentimes would -- would meet with all of the support people that were with the patient, and the patient would have been told that -- what Kansas law was requiring a second Kansas doctor to, you know, approve them. So I was never present during the interviews so I can't tell you the nature of -- of the exam and the interview, but the patient knew, you know, what -- what to expect that it was

required by law that -- that two Kansas doctors approve them.

MR. HAYS: Objection. I move to strike the last part of that answer because how can she know what the patients knew and did not know.

MR. EYE: We -- I can ask a couple clarifying questions if you would like to know.

PRESIDING OFFICER: Yes.

BY MR. EYE:

Q. Ms. Armentrout, what's the -- how do you know that patients were informed about the requirements of obtaining a second opinion before a late-term abortion could be performed?

A. Because when the patient called to schedule the appointment they were told in fairly good detail what the Kansas law was.

Q. All right. And, Ms. Armentrout, when Doctor Neuhaus would come to the clinic would the records that had been accumulated for a patient be available and provided to her?

A. Yes. She would have access to the patient's chart and all of the records that it contained once the patient finished with the medical history, and she would have that available to her before she ever met the patients.

Q. Ms. Armentrout, what would the usual compilation of patient information consist of that would be provided to Doctor Neuhaus?

A. Okay. Well, the original what we called the top sheet which contained all the personal information and a few medical questions allergies et cetera, height, weight, the MI Statement that she would have already seen a copy of. Then the complete medical history front and back pages, about four pages that they would have filled out and that concerned, you know, any kind of previous illnesses, surgeries, it was a fairly complete medical questions that they had to fill out. They also would have filled out the consent form , the 24 hour consent, they would have filled out their MI Statement. And then the sonogram records would have been included in that because they would have had a sonogram prior to meeting with her.

Q. Ms. Armentrout, and these records would be provided to Doctor Neuhaus prior to the interview commencing, is that correct?

A. Correct. A chart would have already been made up for that patient with all of that information in it, and that would have been provided to her prior to her meeting.

Q. Based on your observation -- well did you have an opportunity to observe Doctor Neuhaus as she -- other than behind closed doors as she worked in the clinic?

A. Yes.

Q. Did you ever see Doctor Neuhaus review the chart materials that had been provided to her?

A. Correct. She would have a place often downstairs away from the patients where she could sit and review the charts.

Q. And how would you describe Doctor Neuhaus' demeanor in terms of the work that she did around -- or that she did at the clinic?

A. Doctor Neuhaus was always very professional and very caring.

Q. Ms. Armentrout, during the time that Doctor Neuhaus did the second opinion function at the clinic, did you ever have any patients complain to you about her contact with them?

A. No.

Q. During that time that Doctor Neuhaus was doing the second opinions at the clinic, did Doctor Tiller ever complain that you know of about Doctor Neuhaus' work with the patients?

A. No.

Q. Ms. Armentrout, do you have any knowledge concerning the origins of the MI form that is who -- who worked it up and so forth?

A. Doctor Tiller is the one that compiled the forms and chose the questions.

Q. And -- and how do you know that?

A. Well, he would -- he would go over it with us when if there was any changes to it. It evolved over the years but he would go over it with us.

Q. And in the course of going over that MI form, was that in the nature of additional instruction or training on how to work with that form?

A. Yes.

Q. Ms. Armentrout, are you aware of any patients for whom Doctor Neuhaus performed a second opinion function that were ultimately determined not to be qualified to receive a late-term abortion due to that consultation by Doctor Neuhaus?

A. Yes. There were times that she did not approve.

Q. And, Ms. Armentrout, did -- did you ever witness any patients that were upset as a result

of that decision by Doctor Neuhaus not to approve them for a late-term abortion?

A. Yes.

Q. And can you give us a description of the demeanor of any of these patients that had been denied of the -- the second -- the late-term abortion?

MR. HAYS: Objection, relevance.

A. There were --

PRESIDING OFFICER: Stop, stop, stop.

MR. EYE: Hold on. Joan, hold on one second. There is -- there is a -- there's an objection that's been lodged that needs to be ruled on.

PRESIDING OFFICER: I don't see the relevance in that question.

MR. EYE: The relevance is essentially to set the scene and show that Doctor Neuhaus took her role seriously even though patients had expectations about obtaining these late-term abortions and I want to demonstrate that, in fact, even though there was if you want to characterize it as pressure from the patients to approve this that -- that she had in mind to follow the dictates of the requirements of the law even in

spite of that patient expectation.

PRESIDING OFFICER: Objection sustained.

THE WITNESS: All right.

BY MR. EYE:

Q. You should not answer that question.

A. All right.

Q. Ms. Armentrout, were the consultations that Ms. Neuhaus -- that Doctor Neuhaus did for the clinic generally done in person with patients?

A. Yes.

Q. Were there exceptions to that? That is, were there exceptions where she -- where she spoke with patients over the phone?

MR. HAYS: Objection, relevance.

PRESIDING OFFICER: Overruled. You can answer.

THE WITNESS: Okay, I can answer?

BY MR. EYE:

Q. You may answer, yes.

A. Yes. There were on rare occasions a time when she would conduct a phone interview.

Q. And what would the circumstances be that would require the phone interview?

A. Most generally if there was weather conditions that prevented her from driving to the

clinic.

Q. And at the time that's in 2003 when Doctor Neuhaus was conducting these second opinion consultations where did she live?

A. She lived outside of Lawrence.

Q. I believe that you -- your testimony said that these would be rare occasions, correct?

A. Correct.

Q. Ms. Armentrout, in the situations where Doctor Neuhaus would decline to approve a patient for a late-term abortion, what would the clinic -- what was the clinic's policy as far as what to do with the MI Statements that had been generated up to that point?

MR. HAYS: Objection, relevance.

MR. EYE: I'm -- I'm just trying to show what their process involved, Your Honor.

PRESIDING OFFICER: Overruled.

MR. EYE: You may answer.

A. All right. If -- if a patient was not approved to continue on and have the procedure, the paperwork -- if they had actually been to the clinic they would have had a sonogram. So all of that paperwork was transferred into a sonogram chart and then filed but all of the paperwork

remained. We didn't do anything with any of the paperwork. The MI Statement, everything would have been intact but would have been transferred into a sonogram chart to show that they were not an abortion patient.

BY MR. EYE:

Q. And would this include any records that had been generated during the consultation process by Doctor Tiller and Doctor Neuhaus?

A. Yes. Any -- any -- any paperwork that would have been generated on that patient up to the point that they left the clinic would be left in the -- in the chart?

Q. Ms. Armentrout, did you have an occasion to actually witness patients entering the room where the second opinion consultations would occur and -- and that the door would be closed with Doctor Neuhaus in that room?

A. Yes.

Q. Did you have an occasion to observe the duration of time that would pass for -- that -- that would pass while these consultations were being conducted?

A. Yes.

Q. Can you give us sort of a range of -- of

how long based on your observations these consultations would last?

A. I would say, you know, it would range from one hour to over two hours would -- would not be unusual at all.

Q. Did you ever observe consultations that were longer than two hours or have an occasion to observe where a consultation would last longer than that?

A. There would be occasions where it would last longer than three, that wouldn't be the norm but there would be an occasion that that would occur.

Q. Did you have an occasion to be able to witness at least not during the consultation itself but witness Doctor Neuhaus' interaction with patients?

A. Yes.

Q. How would you describe her demeanor in terms of how she interacted with patients?

A. She was always very caring with the patients. Very professional but very caring. The patients would arrive at the clinic and oftentimes especially the younger patients she seemed to be able to put them at ease.

Q. Ms. Armentrout, in terms of the overall policies of the clinic while you were an employee there, was there a concern about compliance with legal requirements related to late-term abortions?

A. That guided everything that we did.

Q. And was there an -- do you based upon your experience there, how would you describe the attitude of -- well what was your attitude toward meeting the requirements of the law related to late-term abortions?

A. That was of utmost importance.

Q. And was that impressed upon you by Doctor Tiller?

A. Very definitely.

Q. Did you ever observe any conduct by Doctor Neuhaus that would reflect a contrary view that she was not taking those requirements seriously?

A. No.

MR. EYE: That concludes my direct examination, Your Honor.

MS. THOMPSON: Your Honor, this is Erin Thompson. I would note that Sara Love has joined us and is in here.

PRESIDING OFFICER: Mr. Hays, do you have

questions for this witness?

MR. HAYS: Yes, sir.

CROSS-EXAMINATION

BY MR. HAYS:

Q. Good morning, Ms. Armentrout, how are you doing?

A. Good morning, fine.

Q. I believe we met earlier a couple months ago?

A. Yes.

Q. Okay. And I asked you some questions that day, right?

A. Correct.

Q. And you had your attorney present with you that day?

A. Yes.

Q. Prior to going to work at Doctor Tiller's office were you a bookkeeper at K&N motorcycle dealership?

A. Yes.

Q. For about 16 years, right?

A. Correct.

Q. Okay. And you do not have any formal medical training, correct?

A. No. I mean that is correct.

Q. And you spoke about the MI Statement. You use the same type of form for each pa - for each patient?

A. It -- it would have been consistent. As -- as I stated it evolved over the years but through 2003 it would have been the -- the statement that was in use then would have remained the same for each patient.

Q. And the forms were not adjusted due to the age of the patient?

A. No.

Q. And you mentioned your supervisor, what was her name?

A. Carrie Ellston.

THE REPORTER: Say that name again.

BY MR. HAYS:

Q. How do you spell the last name?

A. Okay. She -- she did get married. Her last name -- her maiden name was Ellston, E-L-L-S-T-O-N. Her married name was Kleage.

Q. Can you spell that?

A. K-L-E-A-G-E.

Q. And what was her first name again?

A. Carrie with a C.

Q. And none of the other individuals that

did the MI Statements had any formal medical training, correct?

MR. EYE: I'm going to object based on foundation.

PRESIDING OFFICER: Rephrase the question.

BY MR. HAYS:

Q. Do you know the medical training of the other individuals who performed MI Statements?

A. No.

Q. Now Doctor Tiller's file had a label on it, correct?

A. You mean the patient's file?

Q. Correct, the patient's file.

A. Yes. Yes, they were labeled.

Q. And the front label had a sticker on it that had MHC, Doctor Neuhaus and Doctor Tiller written on it?

A. Yes.

Q. And the MHC writing means mental health consultation?

A. Correct.

Q. And it was to be filled out after someone other than the person who did the telephone interview would talk to the patient, correct?

A. There was the tracking device for us to know, you know, at what stage the patient was at to make sure that all of the steps had been followed so that it was initialed off or checked once Doctor Neuhaus had met with the patient.

Q. But the MHC was checked off at the time that the MI Statement was completed, correct?

A. No. That would have been checked off once Doctor -- if you're talking about the sticker on the front of the chart?

Q. Correct.

A. Okay. That would have been checked off after she met with them.

Q. Then when was the Doctor Neuhaus entry on that sticker checked off?

A. It was checked at -- once she met with them and we would receive the check back -- or the chart back we would check it off knowing that that patient had met with Doctor Neuhaus.

Q. So the MHC entry was checked off after one of the personnel in your office spoke with the patient?

MR. EYE: Objection, misstates the testimony.

PRESIDING OFFICER: Sustained.

BY MR. HAYS:

Q. Do you remember testifying at a criminal trial?

A. Yes.

Q. Were you sworn before you gave that testimony?

A. Yes.

Q. And that criminal trial was held in Wichita, Kansas?

A. Yes.

Q. And do you remember the testimony that you provided in that case?

A. Yes.

Q. And you provided that testimony on March 25th, 2009? Ms. Armentrout?

A. Uh-huh.

Q. You provided that testimony on March 25th, of 2009?

A. Yes.

Q. Okay. Sorry we didn't hear an answer for that one. And that testimony was held before Judge Owens?

A. Yes, it was.

Q. Do you remember testifying about the sticker in the front of the folder?

A. Okay. The -- yes. The sticker in the front of the folder, yes. And then there's another sticker down below on the right-hand side that also has some things on it that we initialed off on once each half or thing occurred. So, we -- that was just our way of knowing that everything had been done.

Q. Okay. Well, I'm just asking you about the sticker that has MHC Doctor Neuhaus and Doctor Tiller on it.

A. Okay.

Q. Do you remember being asked a question about the MHC on the top, does that stand for mental health consultation or consultant? And your answer was correct. That would be the one I spoke of where someone other than the person that didn't have -- that hadn't done the telephone interview would go ahead and talk to the patient, and once that had been done they would initial that off because that was done before Licensee 2 met with them and Licensee 2 you spoke with Doctor Neuhaus, correct?

A. I'm sorry, can you repeat.

Q. I will. Your answer to the question was correct. That would be the one I spoke of where

someone other than the person that hadn't done the telephone interview would go ahead and talk to the patient. And once that had been done they would initial that off because that was done before Doctor Neuhaus met with them. Do you remember?

A. The large sticker with the --

Q. Was that your testimony?

A. Okay. I do remember the testimony, yes.

Q. And was that testimony correct?

A. Yes.

Q. And then you went on to say then the second one after -- would be after Doctor Neuhaus had told us that she had met with them and would check that off.

A. Yes.

Q. And is that testimony correct?

A. Yes.

Q. Okay. And you testified today that the evaluations that Doctor Neuhaus performed took an hour or two hours?

A. I would say on average an hour and a half.

Q. Do you remember testifying to the length of time that Doctor Neuhaus would spend with the patients during your same testimony that we just

spoke about?

A. Yes.

Q. And you were asked the question, and how long would Doctor Neuhaus typically be with a perspective patient. Do you remember asking that question -- being asked that question?

A. Yes.

Q. And your answer was probably from -- it varied but from 30 minutes to an hour. Was that testimony correct?

A. Yes. It was -- and it would vary.

Q. But was that testimony correct, yes or no? Ms. Armentrout, did you have an answer? We didn't hear it.

A. Yes.

Q. And let's talk about the medical history page that was filled out. Do you remember that medical history page?

A. Well, there is the medical history that the patient filled out once they arrived at the clinic. There are several pages of medical history. A medical history page that often times we speak of would be on the original intake page where it has all of the patient's information, but in addition previous pregnancies, allergies, some

general health questions that way and they would fill out a more extensive medical history once they arrived at the clinic.

Q. Well, let's talk about that more extensive medical history. It was a three-page document, correct?

A. Front and back pages, yes.

Q. And it would ask the patients to fill out their names and pertinent information?

A. Yes.

Q. And ask them to check what educational level they had?

A. That would -- that would be part of it, yes.

Q. And marital status?

A. Yes.

Q. Ethnic group?

A. Yes.

Q. And then they would ask whether they had a doctor who knows about the abortion?

A. Yes.

Q. And then they would ask them questions about the pregnancy history, correct?

A. Correct.

Q. And then it would ask them when their

last normal period was?

A. Okay. They would repeat that. That would have been on the intake as well because we would determine gestation by that or by sonogram information that they had.

Q. Okay. Well, we're just talking about the medical history page for right now.

A. All right.

Q. It asked about the period and whether they had heavy, light or medium bleeding?

A. Yes.

Q. And whether they had cramps?

A. Correct.

Q. And whether they've had any complications from previous pregnancies before in their deliveries?

A. Yes.

Q. Then, they'd ask them about their birth control?

A. Yes.

Q. And describe any problems that they've had with any birth control methods?

A. Yes.

Q. And then ask them whether they're allergic to any drugs or medications?

A. Yes, the allergies were listed.
Q. And then they'd ask them whether they had sickle cell disease?
A. That would be one of the questions, yes.
Q. Varicose veins is another question.
A. Yes. There would be -- yes.
Q. Diabetes was another question?
A. Yes.
Q. Blood clots in veins was another question?
A. Yes.
Q. Breast or uterine -- uterine cancer was another question?
A. Yes.
Q. High blood pressure was another question?
A. Yes.
Q. Breast tumors was another question?
A. Breast tumors?
Q. Correct.
A. I -- I don't recall.
Q. What about uterine fibroid tumors, was that another question they were asked?
A. Yes.
Q. And if they said yes to any of those they were asked to explain it further?

A. Yes.
Q. And then they were asked about whether they had any history of anemia?
A. Yes.
Q. Cancer?
A. Repeat.
Q. Cancer?
A. Yes.
Q. Chest pain or angina?
A. Yes.
Q. Dyspnea or fainting spells?
A. Yes.
Q. Heart disease?
A. Yes.
Q. Inflammation of the veins?
A. I don't recall if it was worded that way. It was extensive.
Q. Shortness of breath, slash, asthma?
A. Yes.
Q. Thyroid disease or goiter?
A. Yes.
Q. Kidney disease, slash, infection?
A. Yes.
Q. Blood clotting?
A. Yes.

Q. Vagina infections?
A. Yes.
Q. Hypoglycemia?
A. I don't recall.
Q. Epilepsy, slash, convulsions?
A. Yes.
Q. Liver disease?
A. I don't recall.
Q. Mononucleosis?
A. Yes.
Q. Painful or bloody urination, slash, bladder infection?
A. Yes.
Q. Psychiatric treatment?
A. I don't recall.
Q. Nervous disorder?
A. Yes.
Q. Depression.
A. Yes.
Q. Rheumatic fever?
A. Yes.
Q. Migraine headaches?
A. Yes.
Q. Pelvic inflammatory disease?
A. Yes.

Q. Jaundice, slash, hepatitis?
A. Yes.
Q. Veneral disease?
A. Yes.
Q. And if they had any positives on those they would further explain or have the opportunity to further explain?
A. Yes.
Q. And then it would go on about birth control and what medications they were taking, correct?
A. Correct.
MR. EYE: Counsel, just to make our record clear can you give us a page or an exhibit number page that you're reading from just so we'll have a reference in the record?
MR. HAYS: Patient 3, Bates page 29, 30 and 31.
MR. EYE: Thank you.
BY MR. HAYS:
Q. And then it would ask them about some information about when they -- what they first thought when they were pregnant, correct?
A. Yes.
Q. And then it asks who was with them?

A. I'm sorry, repeat.

Q. Asked who was with them?

A. Yes. They -- they would list who accompanied them to the clinic.

Q. Anything else -- and there was nothing else listed on those documents?

A. Well, I -- without the benefit of having a -- a chart in front of me I can't -- I know there were a few other questions but I -- I -- I don't recall the exact questions.

Q. And then also you -- during Doctor Neuhaus' consultation with the patients there was not anyone from Doctor Tiller's office in the room with her ever, was there?

A. There was if it required a translator if -- if you're speaking of clinic personnel.

Q. Correct. Do you remember testifying as to whether there were individuals within Doctor Neuhaus' evaluations during the criminal trial?

A. I don't recall my testimony on that.

Q. Do you remember being asked, okay, during Doctor Neuhaus' consultation with the patient, was there anyone from Doctor Tiller's office in the room with her? And your answer was no. Is that --

A. Well, I was just going to say I probably would have said, no, not thinking about.

Q. But that was your testimony, correct?

MR. EYE: Can I --

A. (Inaudible) -- my testimony no --

THE REPORTER: I'm sorry. That wasn't clear. What was your answer?

A. Okay. My answer would be if I were just to ask was anyone from Women's Health Care in the clinic with Doctor Neuhaus my answer would be no because it was a private consultation. I would have not been thinking about an interpreter being needed because that was not a weekly occurrence.

BY MR. HAYS:

Q. But, your testimony during that trial was no, correct?

A. Was no.

MR. HAYS: No further questions.

REDIRECT-EXAMINATION

BY MR. EYE:

Q. Ms. Armentrout, it was the general practice of the clinic that there would be no other Women's Health Care Service employees in the room with Doctor Neuhaus while she conducted her consultation, correct?

A. Correct.

Q. And the only exception to that is if there needed to be a translator or an interpreter?

A. That's correct.

Q. And -- excuse me.

(THEREUPON, a discussion was had off the record.)

BY MR. EYE:

Q. Ms. Armentrout, are you aware -- do you have any knowledge about whether Kristin Neuhaus speaks French?

A. Yes, I believe she does speak some French.

Q. Would she however need an interpreter for Spanish speakers?

MR. HAYS: Objection, outside the scope of cross.

MR. EYE: I think it was consistent with an answer that was provided during cross.

PRESIDING OFFICER: Yes.

BY MR. EYE:

Q. Would she need an interpreter for people who were Spanish speakers or patients who were Spanish speakers?

A. Yes.

Q. And did the -- did the Women's Health Care Services arrange for a Spanish speaking interpreter or translator to be present during those interviews?

A. Yes.

Q. Counsel went through the form that contained the patients -- or the patient's medical history. Do you remember going through that -- that form with him?

A. Yes.

Q. Okay. Now this was a form that would have been made available to Doctor Neuhaus for purposes of her consultation, correct?

A. Yes.

Q. And that would have been a routine part of the process that was followed at the Women's Health Care Services?

A. That's correct.

Q. You were asked a question about the duration of time that would be typical and for Doctor Neuhaus to take to conduct her interview, did you -- do you recall that -- those questions?

A. Yes.

Q. And in terms of the duration of time that Doctor Neuhaus took did -- did anybody on the

medical staff ever complain that that was taking too long?

A. We really didn't ever -- no one there worked on -- on a time limit. We were there -- we didn't have regular office hours and oftentimes it -- it would run quite late, but everyone there was aware of why sometimes it would run longer than other times.

Q. All right. So the time -- would it be fair to say that the time required to do the interviews was the time that was allowed for them to be conducted?

A. Correct. There was -- there was not time limits set for any stage of -- of the patient's care.

Q. Ms. Armentrout, you were asked some questions about the labels that would be on the front of charts, do you remember those questions?

A. Yes.

Q. I want to just make sure the record is clear on that. If the box where -- that would be next to Doctor Neuhaus' name, if that box is checked what does that mean to you?

A. It would mean that she had met with the patient.

MR. EYE: That's all the redirect I have, Your Honor.

MR. HAYS: I just have one question, sir.

RECROSS-EXAMINATION

BY MR. HAYS:

Q. Ms. Armentrout.

A. Yes.

Q. How many versions of the medical history were there?

MR. EYE: Objection. In 2003?

BY MR. HAYS:

Q. In 2003?

A. The medical history was -- the only variance would have been a patient that had fetal anomalies.

THE REPORTER: Repeat that word.

A. I'm sorry.

MR. EYE: Fetal anomalies.

THE REPORTER: Thank you.

MR. EYE: We got it.

THE WITNESS: Okay.

BY MR. HAYS:

Q. Was there just one English version?

A. We had Spanish paperwork and French paperwork but the questions were the same as far

as the medical history.

MR. HAYS: I have no further questions.

MR. EYE: I don't have anything further.

(THEREUPON, a discussion was had off the record.)

PRESIDING OFFICER: Next witness.

MR. EYE: Yes. Ms. Armentrout, you may be excused, I believe.

THE WITNESS: All right. Thank you.

MR. EYE: Thank you. The next witness we would call is Sara Love.

THE WITNESS: Hello.

MR. EYE: Hold on for one second and we'll administer the oath, Ms. Love

THE WITNESS: All right.

SARA LOVE,

called as a witness on behalf of the Respondent, was sworn and testified as follows:

DIRECT-EXAMINATION

BY MR. EYE:

Q. Would you please state your name for the record.

A. Sara Love.

Q. And Sara -- Ms. Love, where do you live, what city?

A. Wichita, Kansas.

Q. And, Ms. Love, at some time in your working life were you employed by the Women's Health Care Services clinic in Wichita?

A. Yes, sir.

Q. And approximately what were the dates when you were -- when you worked there?

A. March of 2000 to June of 2009.

Q. And so you would have been employed there in 2003?

A. Correct.

Q. And in 2003 what did you do for the clinic?

A. Multiple things. Answer the phones, do the filing, do the intakes on the late-term patients. I did a lot of work with the FI patients and M.D.'s.

Q. One second, Ms. Love. You used the acronym FI, what does that mean?

A. Fetal indications. The patients that were there because their babies had major problems, major anomalies.

Q. All right. Please continue. And you were listing the various functions that you performed for the clinic in 2003. Was there

anything else?

A. That was basically all I did other than just helping check in the patients during the day and taking paperwork to them and answering questions and answering the phone, those kinds of things.

Q. All right. Ms. Love, did you ever complete the MI form on -- during a patient contact?

A. Yes.

Q. And what was -- what instruction had you received prior to beginning that part of your work for the clinic?

A. I was also trained by Doctor Tiller.

Q. And what did your -- did - was your training -- was the object of the training to record the information from patients in an accurate way?

A. Correct.

Q. Did you try to do it word for word or verbatim?

A. Yes.

Q. Ms. Love, when you were -- in 2003 when you were working with the MI, can -- were those -- when you filled those out was that generally based

upon a telephone interview with the perspective patients?

A. Correct.

Q. Now once the MI form was filled out -- let me check that were there times when the MI form would serve as a basis to decline taking on an individual as a patient?

A. Yes.

Q. And if -- if that were the case was that the end of the patient contact between the patient that is and Women's Health Care Services?

A. Yes.

Q. If the MI was satisfactory to go to the next stage in the process what would happen?

A. That paperwork would be taken in to Doctor Tiller for review.

Q. And what would happen then?

A. If he felt that the statement met the criteria that he set forth from the DSM-IV then he would give it back to us with an okay.

Q. And then what would happen, Ms. Love?

A. Then he would call the patient back and tell them that they had been approved to come, but that there were other hurdles to complete before they would actually have the procedure.

Q. And what would those hurdles be?

A. They would have to get there, they would have to meet with a second Kansas physician and Doctor Tiller personally.

Q. And the second Kansas physician that they would have to meet with during 2003, was that Doctor Neuhaus?

A. Correct. Excuse me.

Q. Ms. Love, did you have an occasion to observe Ms. -- Doctor Neuhaus interact with patients?

A. Yes.

Q. And, was this inside or outside the consultation room?

A. Outside.

Q. What was your obser -- how would you describe Doctor Neuhaus' conduct or demeanor related to these patients that you observed?

A. She was always very professional, but she was very kind and compassionate and caring and was able to put the patient at ease, but she was also direct with them.

Q. Ms. Love, do you have any knowledge as to whether -- as to what records would be made available to Doctor Neuhaus prior to the time that

she would commence her second consultation with these -- or let me -- let me start over. Do you know what records that Doctor Neuhaus would have available to her for purposes of the consultation she would conduct?

A. The forms she would actually get at the clinic they would scan the original intake with patient information on it and a copy of the statement that we had taken over the phone, the interview, and once she got to the clinic and the patient was checked in and they had finished their paperwork which included the pap history and those kind of things and a chart was put together. Then she would be given the chart and that included the intake and the MI Statements, as well as other paperwork.

Q. Would the paperwork that she would be provided, would it include a medical information such as a sonogram results?

A. Yes.

Q. Lab work, would that be included?

A. Yes.

Q. Would it be the case that any medical procedures that had been conducted at Women's Health Care Services clinic records of that would

have been made available to Doctor Neuhaus prior to her consultations?

A. That's correct.

MR. HAYS: Can I inquire real quick? Was she present in the testimony of Joan Armentrout or were they sequestered as pursuant to your --

MR. EYE: I -- I don't know.

MS. THOMPSON: She came in later. I was not aware of the sequestering. She had not been sequestered.

MR. EYE: Go ahead and --

MR. HAYS: I would object to having her testimony stricken because he didn't have his witness comply with the sequester order.

MR. EYE: Your Honor, to the extent and that is -- that is -- I apologize for that -- nobody was.

PRESIDING OFFICER: And I believe the other person is sitting in the same room?

MR. EYE: I -- I don't know.

MR. HAYS: I believe that's what --

PRESIDING OFFICER: I don't have a phone.

MR. HAYS: I believe that's what she just said. I can get you a --

MR. EYE: I -- I don't know if that's --

if that's the case.

MR. HAYS: I believe that's what Ms. Thompson just said.

PRESIDING OFFICER: Do I understand that Ms. Esquina has also been sitting in the room the entire time?

MS. THOMPSON: Yes, Your Honor.

MR. HAYS: And I move to object to her testimony also pursuant to your sequester --

MR. EYE: Well the --

MR. HAYS: -- order.

MR. EYE: -- the problem is that this was announced on the record at the beginning and there wasn't any objection to it. I mean to the extent that counsel was aware that they were sitting there. I -- I honestly --

PRESIDING OFFICER: I was unaware they were all in the same room.

MR. HAYS: I was not either.

MR. EYE: It didn't occur to me either.

MS. THOMPSON: That was the question. My understanding was who was in the room with you and that's why I identified the witnesses as in the room and that's why identified that Sara Love came in the room.

MR. EYE: That's -- that's true. I mean I wasn't aware of what the arrangement was as far as the room was concerned but I --

MR. HAYS: Sir, opposing counsel had a duty to notify and take care of his witnesses. If my witnesses were not sequestered he would have had the same objection.

MR. EYE: Well, if - unless I waived it by not objecting. It seems that -- that based upon what Ms. Thompson said that it does appear that there was some awareness that they were all in the room or that there was.

PRESIDING OFFICER: No. I -- I knew they were all present in the -- in the office. I did not know they were all present in the same room listening to each other's testimony.

MR. EYE: Well, I'm not sure exactly what was said, but it was my recollection that -- that they were in the same space. But, again, what they had access to that I did not -- I was not aware of.

PRESIDING OFFICER: Ms. Love's testimony will be stricken and the testimony of the other witness will not be allowed.

MR. EYE: May we -- may I move, Your

Honor, for the other witness to be removed from the room and then I -- and then the motion to -- or your order to strike her testimony up to this point be imposed but she be allowed to testify going forward from this point without the presence of the other witness in the room as -- as a means to finish her testimony without Ms. Esquina being present.

PRESIDING OFFICER: Ms. Love heard the testimony of the first witness, Ms. Armentrout.

MR. EYE: I will cover questions that are not the same as Ms. Armentrout's. I have -- in that regard I can cover just a few more questions and they would be essentially separate from what she would have heard from Ms. Armentrout.

MR. HAYS: Sir, they're all testifying about the same point in time about the same practices.

MR. EYE: Well, not --

MR. HAYS: It's got to be related so the whole testimony needs to be stricken and her -- prevented from testifying.

MR. EYE: May I proffer, Your Honor, may I make a proffer?

PRESIDING OFFICER: Yes.

MR. EYE: The proffer would be that -- that Ms. Love now works for Doctor Leroy Carhart who is also an abortion provider who also uses the same MI form that Doctor Tiller used or used to use -- used to use and that it has been done -- used successfully in the course of Doctor Carhart's pregnancy termination practice. And the other part of the proffer would be that there were frequent communications among the staff at Women's Health Care Services about the process that was used to screen patients for purposes of late-term abortions and that that frequent communication was consistent with what was encouraged by Doctor Tiller and the other medical staff at the -- at the facility in order to provide patient care consistent with what the law required. I believe that would be the -- the extent of the proffer I would offer at this time.

PRESIDING OFFICER: You covered the importance of the MI with Ms. Armentrout so why are you covering the MI again with this witness?

MR. EYE: Well, it's -- the MI here is -- the only thing that I want to do is to show that another physician has essentially adopted the same MI because there is some lingering question

about whether it's sufficiently comprehensive or adequate to serve the purpose as intended, and I just wanted to make a record that another physician who has a similar kind of practice that Doctor Tiller had is using the same MI form thereby establishing that it has the validity or has been determined valid by another practitioner because of its use.

PRESIDING OFFICER: Okay. Help me out here. Who -- who -- who?

MR. HAYS: What's the relevance?

PRESIDING OFFICER: Did Doctor Gold in her testimony ever say the MI used was improper, not suitable, not good?

MR. EYE: There was -- there was some question as to whether it was -- I mean there -- there seemed to be some question about whether it was adequate for purposes of doing the screening.

PRESIDING OFFICER: Ms. Love's testimony thus far is stricken. You may go with a short leash on these questions.

MR. EYE: Very well.

PRESIDING OFFICER: Be ready to object if you so need.

MR. HAYS: Yes, sir.

BY MR. EYE:

Q. Ms. Love, do you work for Doctor Leroy Carhart?

A. Yes, sir.

Q. And what kind of work do you do for Doctor Carhart?

A. I interview late-term patients as part of the approval process according to Maryland law.

Q. And what is your --

MR. HAYS: Objection, relevance.

MR. EYE: I'm trying to establish a foundation so that she can discuss the MI form that is used in Doctor Carhart's practice.

MR. HAYS: What does Maryland have to do with Kansas?

MR. EYE: I am suggesting -- well, for one thing your own witness said that there was a national standard of care here, and if there is then there ought to be some opportunity for us to establish what goes on elsewhere if that's going to be the finding.

PRESIDING OFFICER: Objection overruled.

MR. HAYS: Sir, I guess it -- we're talking about a point in time in 2003 not 2011 where she's currently working.

MR. EYE: I'm attempting to establish that this MI form has been battle tested and is -- and is adequate for purposes of the screening process.

PRESIDING OFFICER: Objection is overruled, please continue.

MR. EYE: Thank you.

BY MR. EYE:

Q. What kind of -- so does Doctor Carhart do late-term abortions?

A. Yes, sir.

Q. And do you use an MI screening form in Doctor Carhart's practice?

A. Yes, sir.

Q. And can you compare that MI screening form with the one used by Doctor Tiller's office?

A. It's the same.

MR. EYE: Your Honor, may I inquire in terms of the proffer I made concerning the communications amongst the staff, may I ask -- may I inquire on that?

PRESIDING OFFICER: You may ask and he may object.

MR. EYE: Right.

BY MR. EYE:

Q. When you were working -- Ms. Love, when you were working for Women's Health Care Services in Wichita, was there communication amongst the staff about how the MI form should be used?

MR. HAYS: Objection. I believe this was covered in Ms. Armentrout's testimony.

PRESIDING OFFICER: Sustained.

BY MR. EYE:

Q. Ms. Love, how were -- can you describe the training that you got to administer the MI form when you worked for Women's Health Care Services?

MR. HAYS: Objection. I believe Ms. Armentrout described the training.

MR. EYE: Well, she described her training.

PRESIDING OFFICER: This witness testified she was trained by Doctor Tiller.

MR. EYE: Right. And I just wanted to find out what that training consisted of.

MR. HAYS: And I would renew my objection because Ms. Armentrout said that she was trained by Doctor Tiller.

PRESIDING OFFICER: No, she didn't.

MR. EYE: That --

PRESIDING OFFICER: She testified that she was trained by her supervisor --

MR. EYE: Right.

PRESIDING OFFICER: -- which is Carrie somebody.

THE REPORTER: Which is?

PRESIDING OFFICER: Carrie somebody.

MR. EYE: Carrie.

DOCTOR NEUHAUS: (Inaudible).

MR. EYE: Right.

THE REPORTER: I didn't hear that. Carrie who?

MR. EYE: Carrie.

DOCTOR NEUHAUS: Klaege, K-L-A-E-G-E.

THE REPORTER: Thank you.

BY MR. EYE:

Q. Ms. Love, can you tell us what the nature of the training was that you received to administer the MI form when you were working for Women's Health Care Services?

A. There was a meeting room which is where Doctor Tiller would go over the questions and explain to us what kind of things he was needing according to the DSM-IV to determine whether or not the patient qualified on certain points to

know whether or not they rated -- the DSM-IV depending on the issue with the patient is psychotic or mental issue the patient has to meet certain criteria before they can qualify to have that issue, and so he was wanting us to ask certain questions that would let him know whether or not those qualifications were met.

Q. Based upon --

MR. EYE: Your Honor, may I inquire -- may I inquire as to whether Ms. Love observed the demeanor of patients who had been turned down for late-term abortions?

PRESIDING OFFICER: No. That was -- that objection was sustained in Ms. Armentrout's direct testimony.

MR. EYE: That would be based on Ms. Armentrout's observations. I was wanting to see what Ms. Love observed.

MR. HAYS: Do I need -- I just want to put a formal objection for that same purpose.

MR. EYE: That would complete my examination.

PRESIDING OFFICER: Your cross-examination is limited to the beginning of Doctor Carhart, the rest is stricken.

MR. HAYS: Yes, sir. I just have a couple questions.

CROSS-EXAMINATION

BY MR. HAYS:

Q. Ms. Love, do you know whether or not Doctor Carhart worked with Doctor Tiller?

A. Yes, he did.

Q. And where was that?

A. That was here in Wichita, Kansas.

Q. And what was the time frame for that?

A. I know he was on staff before I started in 2000 and he was working up until the time that Doctor Tiller was murdered.

Q. Okay. And you also don't have any formal medical training, do you?

MR. EYE: Objection, exceeds the scope of direct.

MR. HAYS: He inquired about the training of the --

MR. EYE: I'll withdraw it.

MR. HAYS: -- MI Statement.

MR. EYE: I'll withdraw my objection I mean if that's --

PRESIDING OFFICER: You may answer the question. Ms. Love?

A. Yes, sir. Could you repeat the question?
BY MR. HAYS:
Q. You do not have any formal medical training, correct?
A. No. I am a doctor trained.
Q. You do not have any formal medical training, correct?
MR. EYE: Objection, asked and answered.
PRESIDING OFFICER: Sustained. She asked and answered the question. Go ahead and move along.
MR. HAYS: I have no further questions
REDIRECT-EXAMINATION
BY MR. EYE:
Q. Ms. Love, in terms of the training that you have received have -- have you -- as your training on the MI form has it enabled you in terms of the work that you do administering that MI form, did it enable you to interact in an effective way with the patients who were providing you information?
A. Yes, sir.
Q. And was the training that you received at Women's Health Care Services on the MI form as I understand it that was personally administered by

Doctor Tiller?

A. That's correct.

Q. And was that done prior to the time that you engaged in administering the MI?

A. Yes, sir.

MR. EYE: I don't have any more redirect.

MR. HAYS: I don't have any questions, sir.

MR. EYE: I -- I believe those witnesses may be excused at least as far as I'm concerned.

PRESIDING OFFICER: Hang up.

MR. EYE: Thank you.

MR. HAYS: We'll take care of it.

MS. THOMPSON: Sorry. Are you guys done with us?

MR. EYE: Yes, Erin, thank you.

MS. THOMPSON: Thank you.

PRESIDING OFFICER: Who will your next witness be, Mr. Eye?

MR. EYE: It will be Doctor Neuhaus.

PRESIDING OFFICER: Okay. We'll take a short break.

(THEREUPON, a recess was taken.)

PRESIDING OFFICER: All right, we're back on the record. I think something needs to be made

clear just from my standpoint. There was not, I repeat there was not any intentional violation of the sequestration order. I think it was an oversight on all -- of most of our part. There was a violation but it was not intentional on anyone's part.

MR. EYE: Thank you, Your Honor.

MR. HAYS: Yes, sir, the board agrees also.

PRESIDING OFFICER: Next witness.

MR. EYE: We call Doctor Kristin Neuhaus.

KRISTIN NEUHAUS, M.D.,

called as a witness on behalf of the Respondent, was sworn and testified as follows:

DIRECT-EXAMINATION

BY MR. EYE:

Q. Are you Doctor Ann Kristin Neuhaus?

A. Yes, I am.

Q. Doctor Neuhaus, where did you attend college to get your undergraduate degree?

A. Kansas State University in Manhattan, Kansas.

Q. And did you obtain a degree?

A. Yes, I did.

Q. And in what?

A. Pre-medicine psychology and a minor in French.

Q. And what year did you graduate from K-State?

A. 1980.

Q. After you graduated from Kansas State what did you do?

A. I went to medical school at the University of Kansas in Kansas City.

Q. And did you obtain a degree from?

A. Yes, I did.

Q. And was it a medical degree?

A. Yes.

Q. In what year?

A. 1985.

Q. In the course of your medical school training were you exposed to any course work related to maternal health?

A. Yes.

Q. And could you describe what that course work consisted of?

A. Well, I don't remember it was either a two or three-month rotation on OB-GYN which was as Doctor Gold suggested mostly inpatient, but we also had clinic one afternoon a week. And in

addition I did for my two months of required rural preceptorship I --

THE REPORTER: I'm sorry, required?

A. Rural

THE REPORTER: Rural. Thank you.

A. I did both of my months with a practice in Wamego which was exclusively OB-GYN in a very busy progressive obstetrical practice where we delivered an average of a baby a day.

BY MR. EYE:

Q. During the course of your -- you mentioned that as an undergrad I believe you had a degree in psychology?

A. Yes.

Q. And can you briefly describe the -- how many hours -- do you recall how many credit hours were required to get that?

A. Not specifically. Actually at this point in -- in an undergraduate degree it actually isn't directly related to patient care, but it produces the -- the foundation basically for further study. We -- we study basic normal and abnormal psychology, developmental psychology including child developmental stages. I also took some graduate level courses in conducting research and

literature reviews and experimental models, and so basically I took pretty much everything that I could that I can recall. It's been awhile.

Q. All right. When you were in medical school did you have any course work related to mental health?

A. Yes. We had a -- a mandatory rotation in psychiatry during our third year, and I chose to do my two months in child and adolescent psychology.

Q. And where did that occur? I mean where did that -- you just said a rotation?

A. That was at the University of Kansas with Doctor Elizabeth Weller who's a well recognized specialist in pediatric depression and most traumatic disorder.

Q. Okay.

THE REPORTER: Would you repeat that doctor's last name?

A. Doctor Elizabeth Weller. And she also very much wanted me to go into child psychology or -- or psychiatry.

BY MR. EYE:

Q. Once you graduated from medical school with your degree what did you do?

A. I -- I had originally wanted to go into emergency medicine so I did a year rotation at Truman Medical Center in internal medicine, and after that year I changed my mind about wanting to do emergency medicine and had considered -- I actually was accepted to the KU pediatric program. But, in the meantime, I had met a family practitioner in Kansas City, Kansas, downtown and I decided to spend some time working in a family practice setting prior to re -- resuming a residency.

Q. And who was the physician that you associated with in downtown Kansas City?

A. Doctor Malcom Knarr.

Q. And his last name is spelled how?

A. K-N-A-R-R.

Q. What did you do -- and did you go to work for Doctor Knarr ?

A. Yes, I did?

Q. And, what did you do in that capacity?

A. Just general family medicine. Basically, we saw age groups from pediatrics to geriatrics and did prenatal care. I didn't actually do hospital deliveries, Doctor Knarr did the deliveries but I did the prenatal care, took care

of the kids and, you know, just anything, just general office practice.

Q. Did that practice require you to do evaluations of patient's mental status on occasion?

A. Yes.

Q. And did you do those?

A. Yes, I did. Actually, in fact, I diagnosed a patient with schizophrenia that nobody else had noticed and I remember that distinctly, but of course it's general office based practice you're going to have patients with psychiatric disorders.

Q. And at this time when you were working in Doctor Knarr's office were you a licensed physician?

A. Yes, I was.

Q. And how long had you been licensed at that point when you went to work for him?

A. I think when you're a resident you have a temporary license and that would have been in Missouri so this would have been my first year with a Kansas license.

Q. And what year would that have been, Doctor?

A. 1986.

Q. In the course of working at Doctor Knarr's clinic did you have to -- did you work with pregnant women?

A. Yes.

Q. And were there occasions when in working with pregnant women you had to assess their mental status?

A. Yes.

Q. And did you do so?

A. Yes.

Q. And in the course of those evaluations, I know each patient is different, but can you give us any kind of general overview about how you went about assessing patient's mental status during the time you were working at Doctor Knarr's clinic?

A. Well, most of these were regular patients, people we knew over a long period of time. But in general -- in general how would you do with a new patient or?

Q. Yes.

A. Okay. Well, with a new patient normally I mean a lot of it is observational. You just observe their speech, you know, for appropriateness, just general demeanor, affect.

Those things that you observe just in any kind of normal communication, but, you know, if anything is abnormal then you just -- you know you pursue that more, you know, more -- in more depth. I guess I'm kind of nervous. But, basically, if you're actually doing a formal exam you would go through a list of things like, you know, there is a thing called mini mental status exam which is used as a screening tool where you ask people basically what the date is, who the president is, ask them to remember three particular objects and then you have them repeat it immediately and then five minutes later you ask them again. So I mean there are a whole series of like simple cognitive tests. Counting backwards by three from 100, and then you can go on to more abstract questions like what does a particular saying mean like, for example, a rolling stone gathers no moss. That's one that's commonly used. And then there some other kind of narrow cognitive tests like drawing a face of a clock or whatever, but basically they're a series of different basic examinations that you do to try to get a --

Q. Now, Doctor, in terms of the testing that you just described, would you do that on every new

patient that -- that required some sort of a mental health status evaluation?

A. No. A lot of those are related to dementia (inaudible) --

THE REPORTER: What's after dementia?

A. Dementia. Related to dementia.

BY MR. EYE:

Q. And if it was your determination that a patient wasn't suffering from any major cognitive impairments would you not use that more in-depth testing that you just described?

A. That's correct.

Q. How long did you practice with Doctor Knarr in his clinic approximately?

A. About three years.

Q. And during the course of that time was your practice satisfactory as far as Doctor Knarr was concerned based on your knowledge?

A. Yes.

Q. Based upon your knowledge did Doctor Knarr consider your practice with him within the standard of care?

A. Yes.

Q. After you left -- well, why did you leave Doctor Knarr's clinic?

A. I had a Kansas medical scholarship and his clinic had been within the map area at the time when I engaged in that contract with the KMS, but in spite of the fact that the contract stated that I should have been permitted to use that path as part of my scholarship they argued, you know -- in my opinion, it was arbitrary that they would not count that. So I had to relocate to an area that was now in a current designated under served area so.

Q. You used the acronym KMS, what's that stand for?

A. Kansas Medical Scholarship.

Q. And when you relocated then from Kansas City where you're practicing in Kansas City where did you go?

A. Westmoreland, Kansas.

Q. Okay. And what did you do in Westmoreland?

A. General medical practice including hospital and emergency.

Q. Did you have your own office?

A. Well I was --

Q. How --

A. -- I was contracted with another

physician that owned the practice.

Q. Describe your practice in Westmoreland, please.

A. It was a general medical rural practice. Basically we took care of the community, everyone that chose to use that facility and we had just -- we had no appointments. People would just walk in and be seen when they wanted to be. We did not deliver babies, but we had a surgeon that came in and did surgical procedures, you know, a couple times a month. A cardiologist group that would come in and an orthopedic group, and we also had a small hospital and emergency room that we took turns staffing and Doctor Mingus actually was the county coroner which I didn't do that part of it, but I did everything else that he did.

Q. In terms of your practice in Westmoreland -- well, let me back up. What year did that begin?

A. 1989.

Q. And in terms of your practice in Westmoreland, did you ever have to assess the mental status and mental functioning of patients?

A. Yes.

Q. And were these new patients on occasion?

A. They could be. I mean, we were in an area where we were the emergency room so we had accidents and things happen, head injuries, people getting shot, various things that would require a more in-depth cognitive evaluations --

Q. Now --

A. -- as well as a highly geriatric population because healthy young people don't come to the doctor. You only come if you're really sick or have a major injury and in that type of practice people are fairly stoical and so we did have a need to be competent at that type of screening.

Q. Where did you learn how to do these mental health examinations?

A. Well, in medical school initially, of course, on the psychiatric rotation. But, you know, I don't like to memorize things so I, you know, would refer to texts as necessary to refresh my memory or -- so, I mean I would keep on it.

Q. So learning how to conduct a medical health -- I'm sorry, a mental health exam was part of your medical school training?

A. Right. That's one of the main focuses of that rotation.

Q. And did you complete that rotation successfully?

A. Yes, I did. I had a superior in it which is like an A or?

Q. All right. Now let's go back to the Westmoreland practice. Did you treat pregnant women, pregnant patients during that time?

A. They did prenatal care up to, you know, halfway.

Q. In terms of the prenatal care that you provided at the Westmoreland clinic did that ever require you to assess the mental status and mental functioning of a pregnant person?

A. I'm sure it did. I don't remember specifically but certainly would have, yes.

Q. In terms of your normal patient contact when you were in the Westmoreland clinic, when you would have a -- a pregnant patient -- when -- when you would meet with a pregnant patient did you routinely assess their mental functioning as in the course of your patient contact?

A. Yes. That's done with every patient regardless of their pregnancy status.

Q. And in order to do that did you -- did you do that kind of function of -- based upon the

training and experience that you acquired up to that point?

A. Yes.

Q. Would the mental status examination that you used during the course of your Westmoreland practice, was that observational?

A. Yes.

Q. And -- and -- and an observational examination is what?

A. You just take into account the person's demeanor, behavior, speech, the relevance of what they're saying, you know, in relation to your own perception of reality. Just -- just so many factors that are really almost subconscious, it's kind of hard to list, but --

Q. Well, Doctor Neuhaus, what -- what does the term "clinical judgment" mean to you?

A. Clinical judgment means to me taking all the knowledge and experience that you have and applying it to a particular patient situation.

Q. Does that include observational functions during the course of an examination?

A. Yes, of course.

Q. In terms of the -- your Westmoreland practice, how long did you remain in that setting?

A. Oh, probably close to three years.
Q. And what did you do after that?
A. I worked at K-State at the student health -- Lafene.
Q. In -- in -- in what capacity?
A. Just -- it's general outpatient and urgent care.
Q. Did you see patients?
A. Yes.
Q. And in the course of seeing patients at -- at Lafene Student Health Center, K-State, did you do mental status -- mental health examinations?
A. Yes.
Q. Mental status examinations?
A. Yes.
Q. Would they be -- in terms of how you conducted those, would those have been similar to what you had done in Malcolm Knarr's clinic?
A. Yes.
Q. And similar to what you did in the Westmoreland clinic?
A. Correct.
Q. And was there any -- was there ever any question about your doing those examinations in

the Westmoreland clinic -- was there ever any question about whether they were within the standard of care?

A. Not that I know of.

Q. And the -- at Lafene Student Health Center at K-State -- and I apologize if I asked you -- you -- you conducted mental status and mental health examinations there as well, correct?

A. On occasion. I mean, formally, I guess, but mostly just an informal type.

Q. And was there ever any indication from any source, that you're aware of, that that work that you did was related to the mental health examinations, below the standard of care?

A. No.

Q. How long did you remain at K-State in the student health center?

A. I think around two years.

Q. And what did you do then?

A. I went back to -- to work with Doctor Knarr in Kansas City -- or actually, for him.

Q. And what -- what was the nature of your practice when you went back to Doctor Knarr's clinic?

A. I assumed his medical practice.

Q. And what all did that include?

A. At that time, it still was general family medicine, but the -- portion of the practice that was devoted exclusively to abortion or pregnancy termination had increased. Prior, it had been just a small percentage and now it was over half.

Q. As -- as far as pregnancy termination practice, was this -- was Doctor Knarr's clinic your first exposure to -- at least the -- the actual work of pregnancy termination?

A. Yes. At KU, there was a provider, but we actually did not participate in that as students.

Q. Did you learn how to conduct pregnancy termination procedures while at Doctor Knarr's clinic the second time around?

A. The first time, actually.

Q. I'm sorry. The first time around, is that when you first --

A. Yes.

Q. Okay. And then when you came back the second time, did you pick up on that aspect of Doctor Knarr's practice?

A. Yes.

MR. HAYS: Objection, leading.

A. Well, I already said that I was doing --

MR. HAYS: Well --

MR. EYE: Hold on, Kris.

PRESIDING OFFICER: Sustained.

BY MR. EYE:

Q. When you went back to Doctor Knarr's practice the second time around, describe what you did related to pregnancy termination?

A. I would evaluate patients, review their records, counsel them and consent them and do their procedures.

Q. And now, Doctor Knarr's clinic was located where?

A. Originally, it had been 7th and Central, and at this point, it was -- I -- or maybe it originally had been 10th and Central in Kansas City, Kansas. And, at this point, he had moved to 7th and Central.

Q. Still in Kansas City, Kansas?

A. Right. Just three blocks down the road.

Q. But still in Kansas?

A. Yes.

Q. Were you -- and in terms of the pregnancy termination work that you did at the Knarr clinic, did it require you to assess the mental health of patients that would undergo a pregnancy

termination?

A. Yes.

Q. And did you?

A. Yes.

Q. How did you go about doing those?

A. Well, mostly informally. Although, a certain -- because of the fact that these were patients that we usually hadn't seen before, we had a series of -- of -- well, of course, the medical history to elicit any past history and also because of the area being socially and economically depressed, to a certain extent, that the risk factors for that are a little higher. So we would specifically ask questions about the history of depression, anything related to prior pregnancies and psychiatric medication. It's not uncommon to see people that are already on anti anxiety or antidepressant medications. So, in general, versus a regular medical practice, there was more attention paid to that. And if anything was positive on any of that screening, of course, that would be examined in greater depth.

Q. Did you do the screening or did somebody else do the screening?

A. No, I did the screening. I mean, some of

the forms would have been administered administratively, but I was the one -- I was the one responsible, so I did the screening.

Q. And then did you remain the -- the -- the physician who would take the lead on that case subsequent to doing the mental health screening?

A. I'm sorry?

Q. That is, would you -- would you complete the pregnancy termination --

A. Yes.

Q. -- part of the -- now, where did -- how did you learn how to take care of patients who wanted to terminate a pregnancy?

A. Well, there actually wasn't a textbook. But this is kind of sad, I don't remember the name of the book now. But there's a -- a physician in California who did actually write an excellent text on that. So when I went back into the practice, I read that entire book. And this is really bad, it's been awhile, I don't remember his name. But, I read through that entire book. And this is a person who's in academia and is recognized as probably the preeminent expert on every aspect of abortion care, basically including the mental health, anesthesia, the different

processes, everything to do with it. And if someone would mention his name, I would recognize it, but I can't think of it right now.

Q. Doctor Neuhaus, the author of that text --

MR. HAYS: Objection, leading.

PRESIDING OFFICER: (Inaudible.)

MR. EYE: May I complete my question? May I -- may I proceed?

PRESIDING OFFICER: Yes.

MR. EYE: Proceed. Thank you.

BY MR. EYE:

Q. What -- if you know, what medical specialty was the author of that textbook? If you recall?

A. I think he was an OB-GYN.

Q. Did you receive any so-called -- I'll call it on-the-job training in order to learn how to take care of patients who wanted to terminate a pregnancy?

A. Yes. I --

Q. And from whom did you receive that training?

A. Doctor Knarr.

Q. And what -- can you explain that

training?

A. Well, in med -- I mean, medical training, because so much of it is procedurally oriented, or at least functionally oriented, all medical training has involved basically one-on-one or small group training from a person who already knows how to do whatever that procedure is. And, you know, where you first observe it for a number of times and then you actually perform that procedure under their direct scrutiny until at some point, they feel that you're competent to perform it alone without supervision. And then at that point, presumably, you're competent to teach the next person. So, it's sort of like an old guild type of arrangement, where you have an apprenticeship, you know. And then at some point, you become capable of working on your own.

Q. Did that training include the -- the so-called on the job training that you just described, did that include how to deal with questions concerning a woman who -- patient who may be pregnant and to determine what their mental status would be at the time that they presented with the -- with the idea that they wanted to terminate their pregnancy?

A. Yes, it did. And as I mentioned before, because of the area that we lived in, there's a higher level of stress and can command their issues that people are dealing with. So it was a much more relevant concern than, say, in a suburban affluent area.

Q. When you went to work for Doctor Knarr and began to be involved in the pregnancy termination aspect of his practice, did you actually sit in on consultations that he conducted with patients?

A. Yes.

Q. And did you observe how he conducted those mental status examinations?

MR. HAYS: Objection, leading.

MR. EYE: I just asked if she saw that.

PRESIDING OFFICER: Overruled.

BY MR. EYE:

Q. Did you observe those examinations that Doctor Knarr would perform?

A. Yes, I did.

Q. And did you in -- in your observations, did you -- did you, essentially having observed him, begin to do your own mental status examinations or mental health examinations in a

similar fashion?

MR. HAYS: Objection, leading.

PRESIDING OFFICER: Overruled. You can answer.

A. I mean, it's been while. I -- I assume I assimilated a lot of his techniques, but I would have brought my own experience and training, as well.

BY MR. EYE:

Q. Based upon your experience at Doctor Knarr's office -- strike that. Can you approximate the number of pregnant patients you worked with at Doctor Knarr's office who sought pregnancy termination? And again, I know this has been awhile and -- and an approximation is all I'm really looking for.

A. Well, in the early years, in the '86 to '89, probably five or six a week. In the '90s, 50 a week, maybe. And I also was working at other clinics independently in Wichita, and then later, in Topeka. So overall, 10,000 maybe.

Q. During the course of how many years?

A. From '86 to 2002.

Q. That would be prior to the time that you began your consultation at Women's Health Care

Services in 2000 --

A. No, I started in 1999, so let's shave off, whatever, you know, that three years.

Q. So from -- when was the first year that you would have been actively involved in taking care of patients who wanted to terminate a pregnancy?

A. 1986.

Q. Okay. And you began your work at Women's Health Care Services in Wichita in '99?

A. '99.

Q. Doctor Neuhaus, focusing on the 1986 to 1999 time frame, was all of that time spent at Doctor Knarr's clinic?

A. No.

Q. Okay. Where else did you -- you just ticked off some other places where you practiced. Can you chronologically begin with the next place where you worked with patients who were pregnant and wanted to terminate that pregnancy?

A. Well, Doctor Knarr had a clinic in Topeka, which I staffed, but, I mean, that was essentially his practice, also. And then roughly the next year, I started working at Wichita Family Planning in Wichita, Kansas, which is on Central

-- or was. And I -- I worked there once or twice a week, mostly once. Usually, I'd spend the night, so I'd spend two days. I can't remember when I quit, maybe '98. So, I had been there from '95 -- I -- I think I was there six years, I can't remember exactly. I was there awhile. And then, uh -- and, in the meantime, I also worked at Fort Leavenworth at the acute care for a year-and-a-half, almost two years.

Q. When you were at Fort Leavenworth, did that involve working with pregnant patients?

A. I mean, it could, but it wasn't a big part of the practice because this was the urgent care. So it was more like -- it was supposed to not be emergency, but we did have emergencies. So it really wasn't a routine office care. And, I did later work at the Gentry Clinic --

THE REPORTER: I'm sorry. You worked at the Gentry?

A. It's call the Gentry Clinic, the outpatient clinic. But, I had just had a baby and I -- I resigned that position shortly after that.

BY MR. EYE:

Q. And the Gentry Clinic was located at Fort Leavenworth?

A. Yes, it was. And they had an OB-GYN that took care of pregnant patients. I had an occasion to do an ultrasound here and there, but mostly, not a lot. Because I was the only one that could do an ultrasound, so -- I mean, in the clinic. So, I did a a little bit of internal care, but not very much.

Q. And, Doctor Neuhaus, did you also have an occasion to be an attending physician at the delivery of -- of babies?

A. Well, I wouldn't say attending, no. Because I had never had a hospital base pre -- like maternal care. Doctor Knarr did all the deliveries and practices that I was in. In Westmoreland, we referred to OB-GYNs because they -- they were close and --

THE REPORTER: Because they were?

A. They were close. Geographically, it wasn't really any more difficult for people to drive to Wamego or Manhattan for deliveries. And we felt that -- that we really didn't want to have that responsibility.

BY MR. EYE:

Q. In terms of the mental health examinations that you administered -- again, let's

talk from '86 to '99 before you went to work at Women's Health Care Services, did your ability to -- to do those examinations change over time?

A. Oh, yes.

Q. Okay. And -- and -- and can you describe how that changed over time?

A. Well, I mean, I can describe how in general. Anything changes over time. When you first learn something, you don't know it very well and you may not even know that you don't know it that well. So you, at some point, become aware of the fact that you don't know everything that you need to know. You know, where some -- something that seems kind of easy and rote, suddenly -- or not suddenly -- but you understand the subtleties and complexities a little bit better. And you go through a phase or at least, I mean, I -- I have -- I understand learning based on applying that, but also trying to look at my own practice. And at some point, you actually do know what you're doing and it becomes somewhat less conscious, so you just do it routinely, like driving a car. When you're in a car, you aren't thinking about the turn signals or looking in the rearview mirror or not hitting the gas and the accelerator at the

same -- you're -- you know, with different -- you know, whatever, it just becomes subconscious. So, I would say, you know, at this point, that's where I'm at. And, you know, along the way, you incorporate new theory or different observed or -- or suggested ways of doing things. So I would say over that period of time, it does happen.

Q. Judging your only abilities in that regard, how would you consider your proficiency at administering these mental health examinations, how did that progress over that time span of '86 to '99?

A. Well, I think really the basic thing that could be said is that I got a lot more proficient at it and I can get to what I consider the core issues a lot more adeptly and accurately than I could at first.

Q. During the time of this '86 to '99 time frame, did you have an occasion to work with pregnant patients of various ages?

A. Yes.

Q. Did that include teenagers?

A. Yes.

Q. Do you recall during that '86 to '99, what the youngest patient would have been that you

ever worked --

A. 13. I remember her very well -- (inaudible).

THE REPORTER: I'm sorry. I didn't hear you.

A. A 13-year-old that was one of my -- I -- you know, we kind of took care of people by family, so this family was one of mine. It was a 13-year-old.

BY MR. EYE:

Q. Who presented pregnant?

A. Yes. And she was a regular patient, was an ongoing patient.

Q. Did you during this '86 to '99 time frame work with pregnant patients who were new patients to you?

A. Yes, yes.

Q. And did that include administering a mental health examination?

A. It -- it -- yes. I mean, the informal, just normal assessment that you do along with a physical and -- and -- and then, you know, as I've said before, a more in-depth, if necessary.

Q. Now -- and -- and what would require a more in-depth examination?

A. Well, any observed abnormal behavior responses. By abnormal, I mean outside of what's generally recognized as a healthy mental state.

Q. During this '86 to '99 time frame that you were working in that capacity as you've described, was there ever any suggestion from any source that the mental health examinations that you conducted with patients were below the standard of care?

A. No.

Q. Same question for mental -- mental functioning or mental status examinations?

A. No.

Q. Would you -- for -- would you differentiate between a mental health examination and a mental functioning examination?

A. Well, when you say functioning, it kind of brings to mind a cognitive aspect. But technically, they should be synonymous.

Q. And would that also -- in the course of -- of administering those examinations, would there be an occasion for you to go into more depth if you detected that there was an abnormality?

A. Yes.

Q. And what would you do when you went into

more depth?

A. You just proceed through whatever testing is relevant for that particular abnormality.

Q. Would you have had the capacity to order, for example, lab tests if you thought that that was appropriate?

A. Yes.

Q. And -- and did you ever do that?

A. Yes.

Q. Or other diagnostic procedures?

A. Yes.

Q. Did you order those if you believed they were not necessary to determine the mental health or -- or mental functioning status of a patient?

A. Well, hopefully not. I mean, that -- I mean, I know there's a lot of defensive medicine and I try to avoid --

THE REPORTER: I didn't get the very end of that.

A. Try to avoid --

THE REPORTER: Thank you.

A. -- defensive medicine. Basically, ordering things that aren't necessary simply to CYA.

BY MR. EYE:

Q. Now, you worked with another physician that did pregnancy termination in Lawrence, correct?

A. Yes.

Q. And who was that?

A. Oh, Doctor Dale Clinton. I'm sorry. I totally wiped him off the list.

Q. And what kind of work did you do for Doctor Clinton?

A. Doctor Clinton was wanting to retire his abortion practice. I mean, he had had a general reproductive care practice for many, many years in Lawrence, since the 50s, I believe. And he also did FAA examinations for pilots licenses. And he had a very long devoted list of patients who came to him for birth control. So he needed someone to take over that part of his practice and still allow him to be able to do his pilot license exams. And so he had attempted to sell the practice and that had fallen through, so at this point, he contacted me and asked me if I would be interested in assuming his practice.

Q. And --

A. And --

Q. I'm sorry. Go ahead.

A. -- so I did. And we worked together for awhile on -- assuming what he had done with his regular patients.

Q. What year was it that you began to work with Doctor Clinton?

A. It was in -- well, I was like eight months pregnant and I delivered in -- in March of 1997. We moved there the day that that bicycle shop caught on fire, so I remember the exact date that we moved to the building and it was some time early in 1997.

Q. Explain what the -- strike that. Did you work with patients who were pregnant at Doctor Clinton's practice?

A. Yes.

Q. Did you work with patients who were pregnant and sought termination of those pregnancies?

A. Yes.

Q. Had Doctor Clinton done pregnancy terminations?

A. Yes.

Q. And as a part of his practice, if you know, did he conduct mental health and mental status examinations of -- of patients who were

seeking pregnancy termination?

A. I didn't observe him personally, but I had all of his records going way back, and I reviewed those records regularly, yes.

Q. And what -- was there -- were there indications in those records --

A. Yes.

Q. -- that those sorts of mental health examinations had been conducted?

A. Yes, there were.

Q. Were you -- in the course of -- and -- and we'll call it Doctor Clinton's practice, although you were assuming his practice. In the course of doing that, did you do pregnancy termination work?

A. Yes, I did.

Q. And did you work with patients prior to the time that the pregnancy termination procedure was actually done?

A. Yes.

Q. Did that include mental health examinations?

A. Yes.

Q. Were the mental health examinations that you did in -- in the Doctor Clinton practice

comparable to those that you did when you were working at Doctor Knarr's clinic?

A. Yes.

Q. Was there ever a suggestion from anybody during the time that you were in Doctor Clinton's practice that the mental health exams that you conducted were below the standard of care?

A. No.

Q. Were the examinations that you did in Doctor Clinton's practice, again, were they in the nature of observational exams?

A. Observational, history, just the same things as before.

Q. In 1999, did you assume a -- a -- a practice role related to a Doctor Tiller's clinic, the women -- the Women's Health Care Services clinic in Wichita?

A. Yes.

Q. How did that come about?

A. As I remember, I got a call from Doctor Tiller and he explained -- and, you know, because I actually was running, at this point, Doctor Clinton's practice, but it was in a different location, we'd moved, and we were quite a bit busier actually than we'd been at doctor clinic --

Clinton's clinic. So I'm trying to think. I wasn't working at Leavenworth anymore, but I was still working -- I can't remember if I was still working at Wichita or not. But I remember him calling, but I had to keep track of a little bit -- you know, we -- we just try to keep track of any abortion legislation. And so I -- you know, I was familiar with what was going on with him.

Q. Him, meaning Doctor Tiller?

A. Right. But I wasn't very clear on -- I hadn't been reading any of the legal opinions, just the articles in the newspaper. So I mean, when he called me, I guess I was vaguely aware of what was going on -- or maybe more than vague. So I think he explained that he had come to some kind of compromise with the Board of Healing Arts based on a conversation that he'd had with Mr. Buening, who I think was the --

MR. HAYS: Objection, relevance.

A. Well, he's asking me about --

MR. EYE: Hold on, hold on. I'm just trying to set the stage in terms of what the nature of her involvement was with the Wichita clinic or the Women's Health Care Services clinic.

PRESIDING OFFICER: Objection overruled.

A. I was just trying to describe the conversation as I recalled, which, obviously, was a long time ago. But, as I recall, he said, well, you -- you know, you probably know there's this stuff going on about the late terms. And, I mean, he wouldn't have said it like that. But so he was orienting me to his problem legally. And that in -- and I distinctly remember him saying that Mr. Buening had suggested that I be the second Kansas physician, which kind of surprised me because I didn't see myself as being a prominent person in the field. I figured Doctor Cohee or Doctor Kris or someone with more stature than me would be asked. I mean, I just had this dinky little clinic in Lawrence, blah, blah, blah. But anyway, so I was kind of shocked that he would say that and that's why I remembered it.

BY MR. EYE:

Q. Well, what was it that Doctor Tiller asked you to do related to his practice in Wichita?

A. He asked me to consider being the second person to evaluate patients for a necessity for post-viability pregnancy termination.

Q. Do you know whether -- during the course

of your experience at Women's Health Care -- Health Care Services, did you become aware of any efforts that Doctor Tiller had engaged to attempt to have, for example, child psychiatrists provide these second opinions?

A. Well, what he -- what I remember him saying was that he had -- and this is a man you have to remember is highly connected. He was like the preeminent provider in the country and the world, actually, at least in the world of -- we know, excluding China and whatever. But he -- and plus his father had founded the family medicine program at Wesley or related to KU Medical Center in Wichita. So this is a highly connected, highly capable individual. And he told me that he had asked around and nobody was interested in doing this. And I -- whether he, you know -- why he would say that, I don't know, but that's what I remember him saying. And we had these conversations over a number of years, actually. This was very difficult, to get people to deal with the consequences, the -- my predecessor quit when he was picketed.

Q. Picketed by whom?

A. By these people out here (indicating.)

Q. The people who are opposed to abortions?

A. Right. The Scott Roeders and Troy Newmans and Cheryl Sullengers and Kathy Ostrowskis of the world.

Q. Doctor Neuhaus, what did Doctor Tiller expect of you -- and let me back up. Did you accept the position that he offered to be the second opinion person at the Women's Health Care Services clinic?

A. Not in the original conversation, but ultimately, yes.

Q. And -- and when you did, was that with the understanding that you would be legally separate from his operation?

A. It was that whole process, yes.

Q. Just -- yeah -- all right. And were you financially independent, as well?

A. Yes.

Q. All right. Was it your expectation that you would provide a -- an independent medical opinion related to this consultation for late terms?

A. Yes.

Q. Did Doctor Tiller ever express to you that he had an expectation that you would approve

patients that you consulted for late-term abortions?

A. No.

Q. Were you ever -- did you ever -- from whatever source, were you ever pressured to approve patients to obtain -- who wanted to obtain a late-term abortion? Did you -- were you ever pressured to approve those?

A. The opposite.

Q. What do you mean?

A. That he told me never to take his opinion or feel any pressure. He wanted a completely independent opinion and how extremely important that was.

Q. When you took the -- took on the responsibilities to do the second opinions at the Women's Health Care Services clinic, where were you living at the time?

A. In northeast Kansas.

Q. Did it require you then to drive down to Wichita to do these consultations?

A. Yes.

Q. And did you?

A. Yes, I did.

Q. Did you ever -- okay. And -- and let's

talk about for a moment 2003. Do you recall in 2003 approximately how many times you would have traveled to Wichita to do these consultations?

A. Oh, roughly once a week, so in the range of 40 to 50.

Q. And on the average, how many consultations would you do each time that you went to Wichita?

A. It varied a lot. The range was zero to 10. The average varied by the year too, so I can't pinpoint what it was like in 2003. Over time, it decreased. So just a wild guess would be five.

Q. Doctor Neuhaus, were you told by Doctor Tiller how long to take to do these evaluations?

A. No.

Q. Were you told by anybody how long to take?

A. No.

Q. Did you exercise your independent clinical judgment about how long a -- an evaluation would require?

A. Yes.

Q. When you would -- please tell us what your -- in general terms, what your routine would

be upon arriving at the clinic in Wichita for the purpose of rendering or -- or consulting with patients for these second opinions?

A. Well, considering that it may have varied to some extent over the years, I was there, you know, roughly seven years. As I recall, the first thing I would do is walk in the door into the office area where the office staff, which were the people that testified this morning, and get a list of the current -- well, I think -- I think they had the list or else -- I mean, anyway, I would come in and say, hi, I'm here. And then I would go back to the clinical area, where the -- the nurse in charge there was Kathy. And she would give me their current working list and designate -- because she had already done the ultrasounds or someone had done the ultrasounds. So I knew who was going to be the post viability patients to see at that point. And I'm trying to remember. There were two separate lists, one for the MI and one for the FI patients. And, I would look through that and then I would get the records that they had already copied for me, which for the MI patients would be the top sheet and the -- the one or two MI Statements that were there. And for

the fetal indication patients, there was a huge stack of medical records that accompanied -- that were all copied for me. The MI Statement -- the MI patients a lot of times didn't have an extensive medical record, but there might be a referral letter there from an outside physician or another clinic, but usually there wasn't a medical -- an outside medical record for that. So, then, I had my stack of paperwork including the letter that I had them write up so that I wouldn't be dragging my computer around.

Q. What letter are you referring to?

A. Well, I mean, at some -- I used to print out my own referral letters that -- which is stupid of me. And I know we went over this whole thing about why it says why I'm referring back or whatever. But, basically, the letter for me stating that the patient was going to have substantial and irreversible harm if they continued the pregnancy. And at some point, I had them type that -- or printout the letter for me because of the issues that we had with the printer. So that was already done. And, you know, of course, it wasn't signed or anything, but it was in the stack of things that they gave me.

And, then, so I knew who I was going to probably be seeing, assuming that they didn't washout at some point in the process. But, I mean, I think what people need to understand about how it was working there is that each person had a role. And even though I'm an outside consultant, I still have to interface with the other steps of this process, which was actually fairly complex and involved them seeing someone in the lab, someone in -- doing ultrasounds, you know, a separate mental health eval -- whatever, evaluation is required by Kansas law for minors, that was a separate piece that was involved. They had to see a video. They had to meet with a physician that was going to be the attending physician. And, all of these things were either done individually or in a group. And, then, I had to kind of interface with all of this, so the chart was moving all around the clinic during this period of time. And, you know, at some point, I had my stack of papers and my list, I knew who I was going to be seeing. And, then, at some point after they had done, whatever, any number of steps, then I actually had access to the chart. And I would sit down and review the chart, go through all the

material I had and then I would go out and try to find the patient somewhere in the -- you know, one of the waiting rooms.

Q. So by the time you actually had an opportunity for contact with the patient, the patient had already had -- had been worked up by other clinic staff?

A. That's correct.

Q. Well, didn't that create an expectation by the clinic staff that this person was going to get the late-term abortion?

A. Oh, no. They're informed at every point along the way, and I had multiple opportunities to observe the staff on the telephone during times when I was just hanging out in the office area, and in every stage along the way that this was an ongoing approval process. And, that there were still people who would have arrive in the consultation with me with misunderstandings about that, but it was never due to anything the staff said that I observed.

Q. So if I understand your testimony there were times where you met with patients who assumed that they were going to get an abortion?

A. Yes, they still did. I mean and I can go

in-depth about all of that at some point.

Q. And we will. But, I want to ask a question about how -- strike that. What Doctor Tiller did in terms of providing training related to the termination of pregnancies at his office that had a bearing on the mental health examinations that you were expected to conduct for purposes of this second opinion?

A. Well, I only have just observational knowledge about that. I never actually sat in on any of the training for that, so.

Q. But was there -- in terms of the orientation I suppose maybe is the better word. Was there an orientation that you underwent in order to get familiar with the process and procedures at -- at the clinic in Wichita?

A. You're asking me if I remember --

Q. Yes.

A. -- an orientation?

Q. In order to learn what happens at that clinic?

A. Right. Oh, yes. I mean, I do remember -- actually before -- I mean probably a year or two even before any of this I had an orientation process there. Just he was kind of conducting an

ongoing open house, I think he invited the legislature, different colleagues from the community to an open house tour of Women's Health Care after they had done an addition and some other things had gone on. And so I -- that was my first time being there. All of that was reviewed in that and took a tour of the facility. My staff from the other clinic, the Wichita Family Planning.

THE REPORTER: I'm sorry. Your staff from the --

A. My staff from the Wichita Family Planning. I say "my." It wasn't my clinic but the staff that worked there.

BY MR. EYE:

Q. They attended this function?

A. Yes. We all took a tour and they showed us everything, the whole process from beginning to end.

Q. Did that familiarize you then with their process in order for you to be able to -- to essentially go to work doing these second opinions or give you sufficient introduction so that you could do that?

A. Well, I think what it did was gave me,

you know, a view of his facility and as a totality I guess -- at this point this was prior to this -- this new legislation so it really wouldn't have specifically included that. But I think all along he had category of, you know, therapeutic interventions that were post viability. So, he had been doing the counseling himself at that point and all that and he covered that in this orientation. But, I mean, specifically the MI Statement, I don't remember seeing that, and -- and of course I was familiar with it and aware of what was on it and its origins but I don't specifically remember exact training about that particular part of it. Just -- I think he assumed that because I'm a clinician I would be familiar with it.

Q. And were you -- as a clinician were you familiar with at least the -- the nature of the information that was being sought --

A. Oh, yes.

Q. -- through the MI?

A. Right.

Q. And, what was your understanding as to the objectives of the evaluations that you undertook at Women's Health Care Services?

A. The objective was to attempt to determine whether or not continuation of the pregnancy would constitute a substantial and irreversible impairment of a patient's functioning.

Q. How did you go about conducting those? And I want to talk in general terms here and we'll get into the specifics of the charts in a moment, but how did you in general conduct those evaluations?

A. Well, it evolved over time. So do you want me to talk about the evolution process?

Q. Yes.

A. Okay. Initially I took as basic information all of my prior medical experience understanding a person's mental health at that moment, and then I had to then form that decision based on my understanding of the interpretation of Doe v. Bolton which suggested that a person's socioeconomic status, their age, their educational level, and other private viewpoints about how their life should be allowed to proceed as influencing the totality of their health.

Q. How did you learn about those requirements that you just articulated?

A. When I first had discussed it with --

discussed it with Doctor Tiller, at some point and I don't remember exactly where it came up whether it was in the original phone conversation, I'm assuming it must have been, he said that he had constitutional legal scholars who could help me understand the legal issues involved. And he also I believe was aware that my father is a criminal attorney in Wichita and that he could help me understand what -- what the legal language was, so. And -- and you - there's a lot of this I'm not really remembering, it just was pointed out to me during some of these various legal proceedings. And then I remembered, oh, yeah, I guess that really did happen. But, you know, I think at the time I was really busy and I had a young son and so I mean honestly my memory isn't totally clear, but I do remember at some point getting a big stack of material and it was Doe v. Bolton. I know that's easy to remember because it sounds like Roe v. Wade and I read through the whole thing and the decisions, and you know, how much of that I understood is probably questionable. But, I did get that part about the health and I remember that it was about a woman who had tried to get an abortion in some southern state like

Georgia and that she -- and in that state she was required to have three different medical opinions and that the court had determined -- the supreme court of the United States had determined that this was an undue burden on her in that there was a absolutely no rationale for three doctors versus one and so that that -- I understood that to be the preeminent legal status of that decision. That was the highest court of the land and that was therefore the law.

Q. Did you have any other any contact with lawyers to provide you guidance with how to conduct these -- or these mental health examinations that you did in the course of these second opinion consults?

A. I don't remember the lawyers ever telling me anything about how to conduct a mental status exam or any of that. They just were elucidating the case law or whatever you call it, the law, and -- and at some point I did meet Rach -- Rachael Pirner and I was reviewing my testimony at some point and apparently that was well after this and she just happened to be in her office but I -- I don't know if I ever talked to her on the phone. But, I do remember being told that if I had any

questions about it I could call the number and talk about it and whether I did or not I don't remember. I felt like I understood that -- that segment that applied what I was doing.

Q. Where would the consultations be conducted?

A. Most generally in this little private area that was set aside for meditation or prayer, and I can't remember what they called it, but it was a small room between the main lobby and then a waiting area in the clinical area. So there was -- there was the main lobby off the front entrance, then a clinical area with exam rooms, then there was a little room and then there was another waiting room and then the operative areas.

Q. And did you begin these consultations in 1999?

A. Yes.

Q. Doctor Neuhaus, let's take a look at the exhibits that constitute both your medical records related to the patients involved in this case and Doctor Tiller's. And --

MR. EYE: May I approach the witness?

PRESIDING OFFICER: (Nods head.)

BY MR. EYE:

Q. As we work with these, Doctor, please refer to them by exhibit number, and then also refer to them by the page number down in the -- in the lower right-hand corner of each exhibit. And, for example, for patient -- or for -- I'm sorry, for Patient No. 1, it's Exhibit 34 for Doctor Tiller's records and it would be Exhibit 23 for your records. Are you clear on that?

A. Okay.

Q. All right. Let's take a look at the records for Patient No. 1 and let's -- let's first go to your records and that would be exhibit what for Patient No. 1?

A. 23.

Q. All right. And what is the -- please look at Bates stamp page No. 1 for Exhibit 23. Do you see that?

A. Yes.

Q. And what is that?

A. That is what I used to call a cover sheet that Joan referred to in her testimony as a top sheet.

Q. Okay. And that's Joan Armentrout who testified earlier today?

A. Correct.

Q. And what is the significance of this -- of this Bates stamped No. 1 that's part of Exhibit 23? What's the significance to you as you would conduct your consultations?

A. This is the first intake. Basically, represents the first contact of anyone from Doctor Tiller's office with a perspective patient or the patient's contact person. A parent or family member and so it contains the data of their appointment, and, I mean, and, I think, that these possibly might have been reprinted sometimes so the dates aren't always consistent with the appointment date, but, you know, if you look at the top it tells whether they were a maternal indication or fetal indication, and then it tells who was expected to be coming on the right, the patient's mom, for example. And then the other is an internal office things having to do with when certain -- I don't -- I don't even remember what IC stands for, but apparently was possibly, you know, actually that might have been when (inaudible) --

THE REPORTER: I'm sorry. Actually then when they first?

A. That might have been the first contact

but honestly I don't remember what IC stands for.

BY MR. EYE:

Q. I want you to look at Bates number --

A. Or consent I think.

Q. That Bates No. 1, part of Exhibit 23 and tell me what the clinical -- the clinically significant information is --

A. Oh --

Q. -- on this?

A. Sure, okay. I thought I had to go through it. So I mean it has their obstetric history. If you go down below the main line how many times have you been pregnant, how many deliveries, and whether they're a vaginal, C-section, if they had an miscarriage, or abortion, if they were on any medication, and, you know, some -- some administrative things. Then just a real basic medical history as it would pertain to the procedure itself. It's not extensive but things that could be a risk for them and might need extra information from the staff, so. And, then just some basic health information, their height and weight, and the approximate gestation was based on their menstrual period or any other material that was available from prior

medical contact. Then immediately below that is the referral source. In this case it's a clinical social worker from the hospital?

Q. And is that clinically significant?

A. Yes.

Q. Why?

A. Because that demonstrates that someone had evaluated this patient, presumably including a mental health examination, and had made the referral to Doctor Tiller directly rather than the patient contacting him.

Q. Now --

A. I mean it doesn't guarantee that she was the one that made the call, but she had basically referred this patient to Doctor Tiller since he was an authority and the person (inaudible) --

THE REPORTER: That -- I'm sorry.

A. That because of Doctor Tiller's status he received lots of referrals from all of over the world, and this would have been an example of that.

MR. EYE: Doctor, your voice is going to have to -- you're going to have to raise your voice so our court reporter can make sure that she is getting all of your testimony.

BY MR. EYE:

Q. Again, looking at page No. 1 of Exhibit 23 is there other -- is there any other clinically significant information on this page related to Patient 1?

A. Well, I guess in the sense that we were required to report any illegal or, you know, potentially illegal sexual contact. It says there is no police report and part of it I can't read. But, it says something F-O-R-M report so I don't know whether that's relevant or not because I can't see it.

Q. Is that because the photocopying --

A. Yes.

Q. -- doesn't capture all of the image?

A. Right. And there is nothing else that I can see that's clinically relevant.

Q. Let's go to page 2, Exhibit 23, please.

A. This is just a standard HIPAA disclosure form.

Q. Does this have anything -- at least as to Patient No. 1 does this have clinically significant information in it?

A. Not really.

Q. All right. And Exhibit 23, page 3, what

is that?

A. That is a form authorizing me to release information to Doctor Tiller's office to Women's Health Care Services.

Q. And does your name appear on that document that is page 3 of Exhibit 23?

A. Yes, it does.

Q. Page 4, Exhibit 23, do you see that?

A. Yes.

Q. What is it?

A. That's a printout from the DTREE.

Q. And explain this document, please. What is it?

A. Well it's --

Q. Strike that. What is its purpose.

A. Its purpose is to document positive and negative findings from my mental health exam.

Q. And how did you do that? How did you do the mental health exam?

A. Well, originally -- in the very, very beginning I did it in a more kind of rogue fashion, and then at some point I was looking for a way to document it more -- I mean, very systematically. So I reviewed all the various programs that I could find that were available and

settled on this since it was based on the DSM-IV and I was familiar with it, and the authors of this were the same so it seemed to me that it was the best tool that I had available --

Q. Now --

A. -- to help me with that and so that's how that came about. And I -- do you want me to elaborate.

Q. Let me back up and ask another question. You said you were familiar with it. Did you - what is it -- what's the "it" that you refer to?

A. Oh, the DSM, this the DSM-IV-TR.

Q. And how did you familiarize yourself with the DSM?

A. Well, I can't remember when it first came out, but at some point, probably in the '90s I actually had contemplated doing a psychiatric residency again. So, in preparation for that I bought what version -- I think was version three then and read through the whole thing just because it's interesting to me, I guess. And, then, so, when I started doing the consultations again I bought the more updated version, as well as a pocket version, and I left the big one at home and --

Q. The pocket version of the DSM?

A. The DSM-IV that TR and I kept that Doctor Tiller's where I think it's still there probably but.

Q. And did you use it as a reference, Doctor?

A. Yes, I did.

Q. In the course of selecting the DTREE as a tool to assist in doing your exams, did you review other programs as well?

A. There weren't a lot of programs. I reviewed a lot of various screening devices, but most of those were things that I really -- they were mostly used by clinical psychologists or counseling psychologists from what I understood about it, and they were more specific documents that didn't have, you know, more general or medical perspective so I selected this because it was medically based and it was within the realm of family medicine.

Q. When you selected the DTREE, did you understand that it was a -- a valid instrument to be used for the purposes you had in mind?

A. Well in -- inasmuch as it basically just walks you through an algorithm and algorithms are

recognized as being clinically useful, yes.

Q. What can you tell us about the DTREE process that you used for Patient 1?

A. At this point I wasn't using it as a direct face-to-face thing. I found -- I tried that in the beginning and found it really awkward --

Q. So --

A. -- because it --

Q. What do you mean?

A. Right. I mean, the way it's designed to -- I mean you can use it however you see fit. I mean, to even buy the program you have to provide your license. They will only sell it to a licensed mental health professional or a physician, and so I had to actually go through an approval process to even buy it and it was quite expensive. Actually, it took a number of weeks before they would even send me the program.

Q. Now let me -- let me back. When you went through this approval process, did you have any indication that this was an instrument to be used only by mental health professionals such as psychiatrists?

A. No, I actually did not. I miss --

possibly misunderstood the intent of it at the time when I bought it.

Q. Were you approved to buy this, however?

A. Yes, I was. And they were aware that I was a general practitioner.

Q. Please continue. I -- I was asking how you -- you used to use the DTREE in a more face-to-face, but you abandoned that. And, explain what you mean by that?

A. Right. Well, I put it on my laptop and because I had this little room that I used. I would use it in the room with the patient, but I didn't have the key to lock the door, so I had to in between patients unplug the computer because it didn't have a good battery, and, you know, shut it down, go out and get the patient and reboot it just to keep it secure. I didn't have a place to lock it up. And, in addition, it was a bit awkward because there was this little low table and I'm sitting here trying to talk with the patient and go through this algorithm --

Q. And you were typing --

A. -- and I found it very kind of distancing and because I -- you know, I guess I can get into this at some point, but I have to be able to

rapidly develop a rapport and get to core issues with people without a lot of -- and I mean this is in the face of all of the chaos that's going on outside, all of the -- fanatic activity --

Q. What do you mean by chaos outside?

A. - well the protesters, and the truck with gory stuff all over it parked right across the street, and people yelling, and security guards, and wands and beeping machinery, and then they're all in a room with a bunch of people they don't know and they're embarrassed about it being an abortion -- they're at an abortion clinic and, you know, it's just the whole chaos of their life for the past few weeks trying to get from another country or another state and trying to get lodging and I mean just the chaos that people come in to that setting with is -- is fairly intense. So, I have to be able to cut through all of that and with somebody that doesn't know me from Adam, and they understand that they have this huge expectation that they have to convince me that this is medically necessary and I'm aware of this, and I know they're going to tell me anything they need to say to get me to do it and I can't do that?

Q. What do you mean, "do it"?

A. To give them this letter that they have to have to go on. So, I understand all of these expectations and the stress that they're under. I still need to get at the reality, the genuine state of mind of the person. Not what they're putting on for me or being influenced by the difference between being at home and being desperate and not having any solution and now they've got this one little ray of hope to save their -- whatever they perceive is the rest of their life for whatever reason. So, I mean, I have to be able to cut through all of that, and just sitting down in some room with a computer I found that really inhibiting. So, at some point I just disposed of it and completed it later because it interfered with my interview style.

Q. What do you mean you completed it later?

A. Well, when I got home or even the next day or whatever sometimes in some cases it might have been even later but.

Q. So, do I understand that you would get the information that -- that the DTREE algorithm would anticipate that you gather, and then later you would enter it into your computer?

A. Right, correct.

Q. And on page 4 of Exhibit 23 there is a rating date and time and that indicates it was July 21st of 2003 at 1427 and then a report date and time of July 21st, 2003, at 1431. Can you explain why those two numbers -- those two times are so close to each other?

A. Because I would have just been filling it out. I wouldn't be interviewing the patient.

Q. So --

A. I would answer the algorithm questions from my notes or memory.

Q. So there's -- this is not -- it's not -- does the four minutes represented between 1427 and 1431, that doesn't correlate to the duration of your interview with patients, does it?

A. No. It doesn't even overlap with it.

Q. What -- what were the kinds of questions that were part of the DTREE process that were posed to patients that would enable you to evaluate their mental status and mental health?

A. The SIGECAPSS covers all of the major depressives, vegetative symptoms.

Q. And what is SIGECAPSS, what is that process?

A. That's the device that was -- well, that's the MI Statement includes that, and that was a mnemonic I think that was devised for teaching psychiatric residents the basic, mostly vegetative symptoms that are part of a major depressive disorder, and then there are other mnemonics for like bipolar or other things but this is the -- the ones for major depressive disorder. It does not necessarily include anxiety disorders, but it -- there -- some of the symptoms that there would be symptoms of an anxiety disorder potentially also.

Q. Was it your routine with patients that you consulted with to review the MI form prior to consulting with the patient?

A. Yes.

Q. And did you use the MI form to help you do the evaluation?

A. I -- I -- I allowed it to inform me.

Q. Did it essentially control your conclusions --

A. No.

Q. -- that is the MI form?

A. No.

Q. But it -- but it was part of the

evaluation process --

A. It was --

Q. -- that you used?

A. -- it was one piece of data, yes.

Q. Please explain what -- the kinds of questions that the DTREE would ask or would -- would be required to have asked that you would then later enter into the computer for the DTREE process?

A. Well, I mean, given it's been so many years since I actually used it. There's an initial screening that basically covers all of the basic diagnostic categories like depressive disorders, anxiety disorders, eating disorders, psychotic disorders, substance abuse disorders, somatization disorders. So, there's some basic screening questions that if those are positive then the computer -- I guess the module flags it and then we'll walk through those in a chron -- in a -- whatever in an order that's determined by the program. So if -- if there's nothing positive then nothing would go -- that would be the end of it, it would be negative. But if there is something positive in there, then you go into each of the individual branches. So, it would ask

questions like have you had -- has it -- and these aren't questions that you would ask face-to-face with the patient anyway. It'll say things like has there been for at least two weeks symptoms of a low mood or -- and then if that's negative then it'll say have there been for at least two weeks. And then there is some more language like that -- that's not previously there but, you know, I don't remember exactly anymore. But, basically it asks if there has been at least two weeks of a low mood or in the absence of that has there been at least two weeks of -- of a lack of pleasure or something. The anhedonia questions. So -- and if either of those are positive then it goes on and asks more specific questions, things that are addressed in the SIGECAPSS like has there been a change in appetite or sleep, interest, you know, sleep, interest, guilt. All of the questions that are in the SIGECAPSS are in -- are marched through by that program. And then there are also branches for if it's recurrent or if it's been in the past and then no longer, it could be in remission or partial remission. And then there's a whole series for the anxiety disorders, there is a whole series for psychotic disorders. So, if someone has had

in any hallucinations or delusions then you kind of walk through that. If there's a history of substance abuse from the front which is something that Doctor Tiller was always concerned about because that affects, you know, your anesthesia and a whole myriad of other clinical considerations then you could walk through that and then it would specify, you know, cocaine, marijuana, whatever. So, basically, just marched through what's in the DSM. In the Axis I disorders it does not include Axis II disorders. Which I had chosen not to pick a program that did Axis II because those are primarily personality disorders. And, I mean, it's -- I think it's important to understand that the DSM is a compilation of old and new psychiatry. It's the biomedical psychiatry that is mostly practiced in the U.S., but it also had to take into account that many of the older trained practitioners had a psychoanalytic background and used a whole different language. Things like, oh, I can't even remember. Oh, you know, things based in Greek mythology or whatnot, but kind of more colorful but not as possibly as scientific things like -- oh, God, I can't think. I mean certainly there's

borderline personality disorder which isn't psychoanalytic really I don't think. But, things like -- oh, what is it when you love yourself or whatever. There's a whole series of personality disorders that are -- can only be determined by long-term contact with someone. Usually it's not something you would pick up on a very first visit. So it seemed somewhat irrelevant and I'm saying that with the kind of conditioning that a borderline personality disorder can be a problem clinically and in an ongoing fashion because these people are less compliant often and they have much more trouble with relationships and things that. But, for the most part they were things that really weren't relevant to what we were trying to address so I chose to just exclude those and mark them if there was a history. Like, you know, if we had a case of a patient with something on the MR spectrum.

Q. What do you mean MR spectrum?

A. Oh, the mental retardation. It's an unfortunate choice of words but I believe that it is still in the DSM in that form. So, I mean, it includes some other things, too -- too that just really most -- for the most part were not an area

of clinical relevance for me.

Q. While you were asking these questions that -- that are derived from the DTREE, were you able to observe the patient and how they were conducting themselves at that point?

A. Yes.

Q. And did that inform your judgment about whether this person would qualify for a late-term abortion, your actual -- your actual observance?

A. Yes. But, I think I need to qualify that, too. I mean, understanding also on my part that their situation now in front of me in this particularly discrete unusual setting is not necessarily reflective of what they have been at home in their own comfortable environment. So while, yes, it certainly does. I ascribe less weight to it because so much of the demeanor of so many patients over so many years was all the same. They're all apprehensive, they're all highly eager to please, they're all distraught, they're all, you know, quietly frantic about their situation, so, so much of it just appeared very, very similar. It kind of obliterated a lot of the individuality that I know underlied their actual state and that's why to me, yes, it's certainly

relevant whether someone is tapping their foot or just sitting there in a lump catatonically staring at the wall, yes, that's a clue, but to me it's not necessarily their normal state outside of this highly unusual environment of Doctor Tiller's clinic. So, yes, it informed but it's certainly wouldn't have been like high on my priority list whether or not they're agitated versus catatonic?

Q. Was it one other piece of information that you would --

A. Yes.

Q. -- consider?

A. Yes, it is. Right, was.

Q. Explain -- again looking at page 4 of Exhibit 23, explain what it -- what it means when it says indicate whether the GAF rating represents the lowest or highest level achieved in and it has tree IV? What does that mean?

A. Are we on page 5?

Q. No, we're still on page 4. Do you see on page 4 it's --

A. Oh, the lowest or high -- oh, okay.

Q. Right.

A. I'm sorry.

Q. What does that mean?

A. You're supposed to -- well, it's one of the options in there. I mean, there's several options that can be set in these. You can set them to either printout everything or print out just positives, and I didn't set it to printout everything because it just kept saying that this is not present, that is not present, whatever. And you can also set it so that when you do the GAF, the global assessment of function that what you're intending it to be is the best functioning that they achieved during that time span or the worst. So, I mean, let's say that someone -- we're talking about a week and, you know, on day one say Monday they're feeling pretty good and they go to work, you know, let's just say for example. But, then, Tuesday they're not feeling so good and they went home at noon. And then by Wednesday they're feeling so bad they're just staying in bed and this is overall assuming that this is psychiatric, not because they're sick or pregnant or whatever. So what you decide when you're doing that GAF rating over that particular period of time is am I going to rate Monday or Wednesday? And so you're just saying I'm rating it based on Wednesday or Monday and the worst day

or the best day. That's -- that's what that -- I understand that to be.

Q. And it says tree 4 and then underneath that it says tree 5, what's the difference there between?

A. That would have meant the -- the D2's, the two algorithms that were explored.

Q. After that it indicates that the following -- again looking at page 4 of Exhibit 23, the following diagnosis in tree 5 has been made and it says anxiety disorder NOS. How was that diagnosis made that is specified?

A. Well, it explored tree IV -- I mean whatever, the program had entries from me that were related to tree IV which is the depression algorithm as I recall, and apparently there wasn't enough to meet any kind of criteria. So, then, it explored tree 5 because it goes in numerical order, and then according to the symptoms that were entered that particular diagnosis had criteria that suggests that diagnosis. You know, assuming that I entered them correctly, that I obtained them correctly, and I knew that, too. I wasn't expecting this thing to make decisions for me. I was fully aware of what the tool was and

how it was using it.

Q. So it wasn't necessarily -- you didn't consider this conclusive, it was another piece of information that you used.

A. Right. There is no computer module that can -- as far as I know unless the government has some secret one somewhere that can make medical decisions.

Q. You were still making an independent medical decision?

A. Right, correct.

Q. Let me - before we move on. When you purchased the DTREE for use at the Wichita health -- I'm sorry, Women's Health Care Services clinic, did it come with any indication that had been discredited or was unreliable?

A. No. That would have been the last thing on my mind since the authors are the same as the DSM. I wouldn't have even bothered to try it -- other than it's like just this seems kind of ridiculous to -- to try to evaluate it in that sense and certainly not then. I mean, if it's possibly been discredited since then I'm unaware of it.

Q. Let's go to page 5 of Exhibit 23, what is

that?

A. That is the printout from the GAF module.

Q. And what is the GAF module?

A. That is, once again, an automated algorithm for entering, you know, options, and then it -- I mean this could be done easily on a piece of paper, too, but it's just a way of automating answers to questions relating to a person's functioning level -- functional level.

Q. What kind of -- of questions would you -- strike that. Would the questions that you would ask track along with the -- the -- the declaratory sentences that are on page 5 of Exhibit 23, for example, the patient has not been suicidal or in danger of intentionally hurting herself. I mean was that the question that you would ask or would it be a question that was -- would it be word for word with what you see on the GAF?

A. Sometimes.

Q. And what else -- how else would you pose it?

A. Well, do you want me to talk about my interviewing --

Q. Yes.

A. -- style? Okay. I guess if this is the

time. Do we have like -- okay.

Q. Proceed, please.

A. Okay. Well, basically when -- when I first started doing these I used a more semi -- you know semi structured interview style in which you have a specific set of questions and the answers to those are -- are you still free form. So, you don't give somebody an A, B, C, D. You ask a specific question but they can answer it in their own words. As time went on my interview style became more unstructured because I found the material to be more valid and genuine and less contrived. Because really my concern was compliance with what we -- or what I understood to be the requirements and I wanted genuine information. I didn't want somebody telling me what they thought I wanted to hear, and -- and they'd had some, you know, some -- a lot of instruction about how they had to meet criteria but those criteria were never elucidated so we had patients who were really eager to meet whatever these criteria were, but they didn't know what they were. So, they were in a highly anxious state of mind a lot of the time, and in order to get a valid genuine feeling about a person's life

they have to be somewhat at ease and they also have to not necessarily feel compelled to say something. So, my interview style became really unstructured to the point where I gave them no information whatsoever about what I wanted to hear, and I would just let them tell their story in their own words. And, a lot of this was based on current theory about patient standard of care anyway so I felt this was compatible with the trends in family medicine that we listen to the patient's perspective about their particular illness. And, with the understanding that illness is also socially contrive to the extent that it's not the same in other cultures and I think it needs to be understood that we had patients from all around the world. I had women living in countries under sharia law where their family members would have stoned them or and other -- you know, other means of dispatching not only them but their other female members for shaming the family. I had a father who had brought his daughter for an abortion and in his equivalent currency in his own country the fee that he paid for that pregnancy termination was $250,000 and he had no money to pay my fee so I waived my fee which when in his

money would still have been an astronomical amount of money.

Q. Let's focus on the interviews that you did.

A. Right. So, basically, I'm trying to explain that my interview style had to incorporate a lot of different cultures and a lot of different religious perspectives, so in the end I made it as unstructured as I could and I would just say things like why are you here? How do you see your life? I mean, things that were so general that they had no idea what I was really wanting or expecting from them, and from that wealth of material that would eventually come after 15, 30, 45 minutes, two hours, two days, I would derive all the material that I needed to make my assessment. And, if they hadn't answered specific questions then I would ask those but only at the end or if there was some interjection where it was appropriate and wouldn't interfere with the flow of their narrative.

Q. Now, as far as Patient 1 is concerned, there is no indication here as to the duration of your contact with the patient or the duration of your interview, correct?

A. Correct.

Q. Was it your understanding that you needed to record that to satisfy any legal requirements related to the process for obtaining a late-term abortion?

A. No. I was never aware of any such requirement.

Q. Was there a -- a policy or procedure at WHCS that would have specified recording the duration of time that these interviews lasted?

A. Not that I was ever made aware of.

Q. Did -- did Doctor Tiller ever tell you that that's something you should do?

A. No.

Q. As far as Patient No. 1 is concerned, can you summarize based upon the documentation that is in Exhibit 23, can you summarize the information that you -- you would have utilized in order to reach a conclusion or an opinion? What all would -- looking at Exhibit 23 what all information would you have been -- what all information would you have utilized to arrive at a conclusion regarding Patient 1 and whether she would be appropriate to obtain a late-term abortion?

A. Well, I mean understanding that I had

this other material over here?

Q. Well, let's go into that then because Exhibit 23 is not the only information that you would have reviewed, correct?

A. Correct.

Q. Let's turn to exhibit -- Exhibit 34 and go to Bates number -- Bates stamp -- page 1. First of all, can you identify Exhibit 34?

A. Yes. This is the KDHE form --

Q. No, hold on. Not -- not page 1, but the entire exhibit can you --

A. Oh.

Q. -- can you tell us what page -- or what Exhibit 34 is?

A. It's -- it's Women's Health Care Services patient record for -- I don't know Patient No. 1.

Q. All right. Look at the very -- the cover sheet that was generated by the Board of Healing Arts. Does this indicate that it was for Patient 1?

A. Yes.

Q. And is this WHCS's chart for Patient 1?

A. Yes.

Q. All right. On page 1 of Exhibit 34 can you identify what that document is?

A. That's a form that's required to document that the proper counseling is done for abortion patients in Kansas.

Q. It has -- does it have -- does it have clinical -- clinical significance in terms of the evaluations that you were doing?

A. Well, I'd say it has medical/legal significance. I mean, it documents that people are given certain information that's required by Kansas law, and some basic information about their rights, patient rights. So, it documents that the provider has complied with this particular regulation so I would say, not particularly. I mean, maybe there's something I'm not thinking about but.

Q. Well, Doctor Neuhaus, at the -- toward the top of page 1 of Exhibit 34 it says this is from Kansas Department of Health and Environment Bureau for Children Youth and Families.

A. Uh-huh.

Q. Under that what does it say?

A. Certification of informed consent abortion.

Q. What does that -- what does that convey to you?

A. Well, I mean, what it conveys is that they've been given in writing certain material that's required by the state of Kansas. It includes the name of the physician, a description of the type of abortion that will be done, a handbook that is printed up at great taxpayer expense at which we offer to patients, and it talks about the risks of -- and so there's some useful information for patients as far as risk and alternative. We also have to provide the - the presumed gestational age based on their dating, and then there's a quote from the statutes about abortion. So, I mean, it's -- I mean, I don't know what people actually take away from this, but they are given all of this material.

Q. Is this something that you would have had access to as you did your consultation?

A. Yes.

Q. All right.

A. Yes.

Q. Let's go to page 2 of Exhibit 34. What is this?

A. This is Doctor Tiller's mental health evaluation of this particular patient.

Q. And, would you have had access to this

document in the course of doing your consultation?

A. Possibly. But, I usually did mine first.

Q. All right. Were there times when Doctor Tiller would perform his mental health examination first?

A. Yes.

Q. But as a normal routine would it be that you would conduct yours first?

A. Generally.

Q. Let's go to page 3 of Exhibit 34, please. What is that?

A. That is my consultation letter saying that I had seen the patient and in my opinion continuing the pregnancy would cause a substantial and irreversible -- irreversible impairment of a major physical or mental function.

Q. And is that your signature on page 3 of Exhibit 34?

A. Yes, it is.

Q. There wasn't a copy of this document in Exhibit 23, correct?

A. Correct.

Q. Did you keep copies of this referral letter that you would send back to Doctor Tiller?

A. Not at that time I did not.

Q. Was there a reason why you didn't?

A. It -- I just didn't think it was necessary.

Q. Let's take a look at page 4 of Exhibit 34. What is this?

A. This is the DTREE positive report for Patient No. 1.

Q. And is this the document that you would have generated?

A. Yes.

Q. And let's go to page 5. Is that the second page of the DTREE?

A. Yes, it is.

Q. Let's go to page 6. Is this the GAF that you generated for Patient No. 1?

A. Yes.

Q. Is it the same as the GAF that was in Exhibit 23?

A. Well, it's -- it -- it's -- I don't know why it's smaller. I guess just because it's faxed, but it appears to be. I mean, the printing is smaller. See -- well -- so I can't say that it -- but at the time and everything is the same so it must have been.

Q. Let's go to page 7 of Exhibit 34, And

what is this document, Doctor?

A. This is the MI indicator sheet.

Q. Now, is this for Patient No. 1, is this an MI indicator sheet that you would have had access to when you conducted your consultation?

THE REPORTER: I'm sorry. Now is this?

BY MR. EYE:

Q. Sure. For Patient No. 1 is this the MI indicator that you would have had access to when you did your consultation?

A. Yes.

Q. There is a name up in the right-hand corner of this document, do you know who that is?

A. Sara Fairs or Sara Love.

Q. Okay. And would she have been the person who would have completed this or it would have been her writing?

A. Yes.

Q. And is it your testimony that you routinely would review the MI indicators as a part of your evaluation of patients for purposes of determining whether they were suitable for a late-term abortion?

A. Yes, I did.

Q. Let's look at the content of page 7 of

Exhibit 34. Is there anything that's clinically significant to you that -- that you would have -- strike that. Is there anything on here that you would have found clinically significant at the time that you did your evaluation for Patient No. 1?

A. Yes.

Q. And can you point those things out?

A. Well, she's talking about some sleep disturbance, some symptoms of worry. She -- it's on her mind a lot. She wakes up. It's the first thing she thinks about. It doesn't say what time she wakes up because that would be clinically significant. You know, it can be a sign of depression that -- but anyway it's -- it's obvious just from that question it's on her mind. And then under interests it says I don't go out as often any more because I'm thinking about this. I've been trying to hide this. I didn't want anyone to tell my parents. So she's fearful of the secret that she's hiding and concerned about, you know, what the consequences presumably. And that's very typical for this age group which is why they get so far along.

Q. How old is this patient?

A. 14. And this is under guilt, it says, yeah, because I didn't know this was going to happen. You know which is another typical kind of response people are just in disbelief about it. I wanted to finish school. And then she under energy she says she feels nervous. I mean, whether that's the right place for that it doesn't really matter, it's the response. Concentration. Mostly on this. It's what I think about, so. I can't focus on my school work so that shows that she's in school but -- presumably in school but distracted so there's some impairment in that sphere. And then under appetite. I don't really eat that much any more which is kind of unusual in pregnancy usually your appetite is increased unless you're nauseous. So, and she doesn't say I'm -- I'm nauseated. She says I thought I would be more hungry being pregnant, but I don't eat dinner a lot. Just don't have any appetite, I used to eat fine. So, there's no statement in there about nausea so I wouldn't attribute that to pregnancy yet. I'm attributing it to her mental state, but that could be clarified and obviously and it would come out during our discussion, too.

Q. And this is a good time for me to ask

this question. Did you use the MI indicators sheet or page, whatever you want to call it, as a way to prompt further inquiry about a particular patient?

A. Yes.

Q. Okay. Please continue.

A. And, then, under psychomotor, but I think there -- that was one of the things that was not very well understood sometimes so the information in there wasn't always as useful, but and then denied suicidal thinking. That's relevant. And then under sex, the reason they ask sex is because libido is influenced by your mental state if you're depressed usually your libido is decreased. So the reason that question is in there is because of that, but once again a lot of times it was misinterpreted so the answer there is not terribly clinically relevant, but then there is some other screening like for substance use, alcohol, history of STDs, high risk sex behavior, multiple partners, screening for incest, screening for other like disorders of adolescents because running away is fairly significant for psychosocial disruption in the house and other things. Eating disorder which is very common in

girls. And then as -- as far as just kind of adding some extra information as far as like suicidal risk level he's added some questions about access to various means to -- to perform a suicide presumably, and, you know, sometimes that information is relevant. And, then, there's a question at the bottom, how long have you known you were pregnant? About five months. How long -- how come you waited so long? I was afraid to tell my mom. I thought she would get mad and punish me so, I mean, that's a real typical finding in this age group.

Q. Okay. I'm sorry.

A. So that's clinically relevant and, yes, I would explore that more.

Q. All right. Now, Doctor Neuhaus, this page 7 of Exhibit 34 doesn't show up in Exhibit 23 which are your records. Why didn't you keep a copy of this for your records?

A. Well, I just -- I must not have had it at the time or I don't know. I mean normally they are in there.

Q. But did you routinely review MI indicators as a part of your --

A. Yes.

Q. -- evaluation?

A. Yes.

Q. Can you think of any time when you didn't do that?

A. Only if they weren't there for some reason.

Q. If they weren't there did you explore the information that would have been derived from the MI indicators on your own?

A. Yes. My evaluation is completely independent. Simply informed by, but not dependant on their's.

Q. Is it the case that each evaluation that you did for all 11 of the patients that are involved in this case would have included deriving information that is consistent with that in the MI indicators?

A. Yes.

Q. Whether it came from the MI indicators or not?

A. Right, correct.

Q. Let's take a look at page 8 of Exhibit 34, please. What's this?

A. This is a statement that Doctor Tiller's office had people complete upon arrival, and it

was also a source of potentially being any, you know, further proceeding could -- could be withdrawn based on that and that did happen. I did observe that.

Q. Do you mean that based upon the patient's response that's written, for example, on page 8 that that might be a basis to refuse a late-term abortion?

A. Right. In which case I would not see that patient even, but I did know that that happened a number of times while I was there.

Q. And in -- in the case of Patient No. 1 would this have been a document that although it doesn't show up in your chart that you would have had a -- that would have been available to you?

A. Yes.

Q. Would it have been the kind of document that you would have routinely reviewed as a part of your consultation?

A. Yes.

Q. Let's go to page 9 of Exhibit 34, please. And, what is this?

A. This is documenting that Doctor Tiller has reviewed the patient's chart, interviewed the patient, has a referral letter, and it also

documents that gestational date and some physical findings.

Q. Now, down in the -- it's past the halfway point of this -- of this exhibit -- or page 9 rather of Exhibit 34 there is a paragraph, a typed paragraph, do you see that?

A. Uh-huh.

Q. And, part of that paragraph indicates that Doctor Tiller says that he had reviewed the referral letter from a Kansas physician. Do you know --

A. Yes.

Q. -- what that means?

A. That means that he looked at the -- either the letter that I sent or potentially some other provider. At this time presumably it was the letter that was included here from me.

Q. All right. Now, this would not have been a document that would have even been prepared at the time that you would have done your exam?

A. No.

Q. Is that correct?

A. Yes.

Q. Go to page 10, please. What is this document?

A. It's an ultrasound report.

Q. Were ultrasound reports available to you when you did your consultation?

A. The actual ultrasound images were and this -- this probably -- presumably -- this should have been too, yes. I'm not sure if it was always this exact same form, but I always had the actual ultrasound images with the date generated by the ultrasound machine.

Q. All right. And let's look at pages 11 and 12 of Exhibit 34. What are those?

A. Those are images from an ultrasound.

Q. And were those used -- did you use these in any way to conduct your consultations or did they form any part of your consultation?

A. Yes.

Q. Why?

A. It documents the date and potentially any fetal anomalies that were detected.

Q. And why would that be significant to you?

A. Because that impacts on the patient's status and their health and also whether or not they're considered pre or post viability.

Q. Are you qualified to interpret a sonogram image?

A. I'm qualified to interpret dating. I've done that routinely in thousands of cases. I'm not qualified to do a diagnostic ultrasound beyond, you know, very obvious anomalies.

Q. So, if you saw an anomaly that would be part of the assessment that you did of a patient?

A. Yes. But most of those patients already have extensive records and had Level II ultrasounds that this wouldn't have been in that category.

Q. All right. Let's go to 13, page 13 of Exhibit 34. What is this?

A. This is a letter that must have been included in the packet of information that Doctor Tiller's office would send out. Partly to be in compliance with the KDHE law, and also just general informative material about, you know, the providers, their dating based on their period, how far along they were expected to be and in elucidation of risk. This appears to be in compliance with the KDHE -- or that statute that requires disclosure, the 24-hour consent form.

Q. And, excuse me, I -- were you done with your answer?

A. Sorry.

Q. That's all right.

A. I'm just trying to be thorough.

Q. Would this have been a document that had clinical significance to you in terms of your assessment of these patients?

A. Yes.

Q. Why?

A. Because it has the date, a gestational date.

Q. All right. Any other clinical significance?

A. Well, I guess that they've been given information that's potentially significant and --

Q. Let's go to the next page, which I believe is 14, the Bates photocopy is partially cut off my copy, but I believe it's page 14. Is this another MI indicator?

A. Yes.

Q. And, please compare it to page 7.

A. Should I go ahead?

Q. Well, I -- I want you to -- to in terms of this particular MI there is a notation at the very top left-hand corner that says unidentified patient?

A. Uh.

Q. Are you -- do you have any explanation for why it says unidentified patient?

A. No, I do not.

Q. And these -- these are documents that -- is it your understanding that these are documents that have been sponsered by the petitioner in this case and offered into evidence?

A. Yes.

Q. Well, this MI indicator sheet assuming that it's -- that it's still for Patient 1, and since it's an unidentified patient I guess we don't know for sure, but assuming on that basis it is, is it unusual to have two MI indicators in the same -- for the same patient?

A. No.

Q. Why?

A. Because usually one is generated on the phone at the time of patient contact or shortly thereafter, and then the second one is completed in the office.

Q. Why have two MI indicators for the same patient?

A. Well, I'm not sure why they ultimately evolved that. I think the first one it's pretty reasonable to assume that it was because they

needed to have some criteria for issuing an appointment and some criteria for Doctor Tiller to review before even allowing them to come, and then the second one presumably is to just verify that nothing -- that the criteria or either present or absent or there hasn't been some change in status to document it on the time of actually seeing the patient, so.

Q. Now, I want to ask another question about this in the -- where it says unidentified patient it says underneath that says 15 years old?

A. Uh-huh.

MR. HAYS: Sir --

A. Yeah, I see that and I would have -- oh --

MR.HAYS: I'm going to interrupt. Once again I see another one of opposing counsel's witnesses and --

MR. EYE: He's an expert. He's an expert.

MR. HAYS: They've been sequestered.

MR. EYE: We -- we sequestered fact witnesses, counsel, not experts.

MR. HAYS: I believe that all witnesses were sequestered, correct?

MR. EYE: No. We can go back and look at the record but I said fact witnesses. We specified fact witnesses in that motion.

PRESIDING OFFICER: I believe that was the case.

MR. EYE: Generally, experts aren't sequestered.

PRESIDING OFFICER: Do you dispute that he asked for fact witnesses?

MR. HAYS: I was under the understanding it was all witnesses.

MR. EYE: We can go back and check the transcript, but I am virtually positive that your order was for fact witnesses, Your Honor.

PRESIDING OFFICER: I recall fact witnesses.

MR. HAYS: And I'll defer to your order.

PRESIDING OFFICER: Since we have the interruption it's --

MR. EYE: Oh.

PRESIDING OFFICER: No. Are you -- do you want to stop at this point or continue?

MR. EYE: Yeah, it's fine.

PRESIDING OFFICER: It's up to you.

MR. EYE: No. This is as good a time as

any, Your Honor, this is fine. I didn't realize it was right at the noon hour so that's fine.

PRESIDING OFFICER: Back at 1.

(THEREUPON, a recess was taken.)

PRESIDING OFFICER: All right. We're back on the record. Mr. Eye, continue.

MR. EYE: Thank you, Your Honor.

BY MR. EYE:

Q. Doctor, Neuhaus, when we -- before we broke for lunch, we were looking at Exhibit 34, page 33 of that exhibit -- I'm sorry -- not page 30 -- I'm -- I'm sorry -- it was page 14 of -- of Exhibit 34. I beg your pardon. On the premise that this MI Indicator relates to the same patient that is Patient No. 1, would this have been a document that you would have reviewed in the course of your evaluation for Patient No. 1?

A. Yes, I would have.

Q. And to the extent that it included clinically in -- significant information, would you have used that to inquire further of the patient to determine whether she was a suitable candidate for a late-term abortion?

A. Yes, I would have.

Q. Excuse me. Please turn to page 16 of

Exhibit 34. Is this essentially the same document that we looked at earlier in this chart that --

A. On No. 7?

Q. I believe so.

A. Are you asking me to see if I think it's the same patient?

Q. It -- it -- it -- hold on one second. Page 9. This is -- this is the same form, correct, as we see on page 16?

A. Page 9 is the -- the ultrasound.

Q. Right. And page 16 is what?

A. Is -- oh, an ultrasound. Yeah, okay. That's different. It does not appear to be the same patient.

Q. All right. Assuming that it -- it does relate to Patient 1, is this a document you would have reviewed for purposes of doing your evaluation of that patient?

A. Yes.

Q. Excuse me. And it would have -- the -- the reasons for that would have been the same as you testified about related to page 9 of -- of Exhibit 34, correct?

A. Yes.

Q. You didn't put this exhibit together, did

you?

A. No, I did not.

Q. And you didn't have access to Doctor Tiller's files when they were -- after they were subpoenaed by the Board of Healing Arts, correct?

A. That's correct.

Q. You -- please turn to page 17 of Exhibit 34. What's -- what is this document, Doctor?

A. An ultrasound report.

Q. Is this a document that would have been typically available to you in the course of you doing an assessment for Patient No. 1?

A. Yes.

Q. Would -- does it have clinical significance in terms of the evaluation that you were doing?

A. Yes.

Q. Why?

A. The -- the gestational date is available and possibly some other information, but generally not. But theoretically possible that position and other things could have some bearing. But in general, the main thing I would have been interested in was the gestational date.

Q. All right. Now, pages 18 and 19 -- I'm

sorry -- yeah, page 18 is a -- is what?

A. Some ultrasound images.

Q. And there were ultrasound images earlier in this exhibit, correct?

A. Correct, yes.

Q. You -- you used ultrasound images in the process of your evaluation, correct?

A. In general, but -- yes, yes, I did. I didn't obtain them, but I used them, yes.

Q. All right. And they proved some -- of some clinical significance to you in doing your evaluations?

A. Yes.

Q. Page 19 looks a great deal like a former page that we looked at, correct?

A. Yes, it does,

Q. Now, page 20 and 21, what is that? And again, we're looking at Exhibit 34 for the record.

A. This is a typed MI Statement.

Q. Is -- is this an MI -- were -- what's the difference in terms of what -- in terms of your knowledge concerning the process used at Women's Health Care Services between a typewritten MI Statement and a handwritten MI Statement?

A. Well, theoretically, it would just have

been the way that it was recorded. But I guess I could go further and say that it might indicate that Margarite was the one that took it because she would bring a laptop in and type that while talking with the patient.

Q. Would this have been a document that was available to you to do your evaluation of Patient 1?

A. Yes.

Q. Would you have utilized this to prompt other questions that you believe clinically significant in doing your evaluation of Patient 1?

A. Yes.

Q. Let's go to page 22, please. What's -- what's page 22 of Exhibit 34?

A. It's a -- a -- a Xeroxed and presumably faxed copy of a medical record from Metropolitan Medical Associates in Englewood, New Jersey.

Q. And -- excuse me.

A. I'm looking at it, it's kind of blurry, so I'm trying to figure out exactly what it is. But it has some medical history on the front and obstetrical history. And it appears to be something related to a surgical procedure, a record that would have been used for like an

outpatient surgery or something of that nature.

Q. Doctor, were medical records that were provided to WHCS from other healthcare providers or facilities available to you for your use in doing evaluations of patients?

A. Yes.

Q. And would you typically review those?

A. Yes, I would.

Q. And would you use those to prompt additional questions that would aid in your clinical judgment that would come to bear in your assessment of these patients?

A. Yes.

Q. Let's go to page 23 of Exhibit 34, please. What do you -- what is this page or what's it -- what's it depict?

A. It appears to be a Xeroxed copy of the front of a chart.

Q. Does it look familiar?

A. Yes.

Q. All right. And can you explain the entries in the rectangle that's in the top one-third of that -- of the page?

A. Well, it's a sticker that has my name and Doctor Tiller's name with check boxes -- or a

check -- checkmark in front of our names. And at the top it says, MHC, which presumably stands for mental health consultation. And it has an initial there that looks like Sara's, SP. And the significance of -- I mean, in -- presumably is that -- that both of those are completed because it's been checked off.

Q. What's the significance of your name being checked?

A. That the consultation with me had been completed at that point.

Q. Did you check it or would it be a staff person that would check it?

A. I don't recall checking it, no. I mean, I -- presumably I could, but, I mean, I don't recall that it was a routine. I recall more frequently just signing the thing at the bottom.

Q. Signing the --

A. The little sticker that's at the bottom left.

Q. Well, take a look at page 25 of Exhibit 34. The -- the sticker that you just mentioned, is that better shown at the bottom left-hand part of that page than --

A. Yes, yes, it is.

Q. Okay. And you would initial that document?

A. Yes, occasion -- I mean, not always. But, I mean, it wasn't really required. But if I remembered to do it, I would or -- or, I mean, I -- honestly, I -- I don't know what my routine was with that, but I certainly could.

Q. And what was the significance of that?

A. To indicate that it had been done.

Q. All right. Page 27, please. And this is another document that is labeled Maternal Indication. What is it? What is this document?

A. This is that top sheet or intake sheet or cover sheet of Doctor Tiller's that they would provide at my request.

Q. This is the same document that was in your chart for this patient, correct?

A. Yes.

Q. All right. Page 29, please.

A. The difference is you can see the ultrasound material has been added there at the bottom.

Q. On page 27?

A. Yes.

Q. All right. Now, you had ultrasound

information available to you when you did your evaluation?

A. Yes. That just indicates the patient had actually been there at that point.

Q. All right. Now page 29, what's that, of Exhibit 34?

A. It appears to be a student ID.

Q. Why does something like a -- why does something like a student ID get put in the chart?

A. Because photographic identification of all patients and guardians was required.

Q. Did it have clinical significance to you in terms of doing your eval --

A. Potentially, yes.

Q. All right.

A. Because it identified the patient for one thing and their age, generally. Not all of them do, but most driver's license have a date of birth --

Q. All right.

A. -- or IDs.

Q. All right. Now, Doctor, beginning on page 31 of Exhibit 34, it appears that this is a -- a -- a document that is part of the medical record related to the procedure itself, is that

correct?

A. Yes.

Q. Now, this is not something that would have even been generated by the time you did your evaluation, correct?

A. That's correct.

Q. And, in fact, this doesn't get generated unless you and Doctor Tiller agree that this person's a suitable candidate for late term?

A. That's right.

Q. Page 33, please, of Exhibit 34. And this is -- this is what?

A. This is a medical history form in Doctor Tiller's chart.

Q. Okay. And how many pages does this medical history form constitute?

A. Three -- oh, let me count. One, two, three -- I'm not sure if they're counting all this consent as part of the same thing, but it looks to me like the medical history itself is three pages.

Q. All right. Is this a -- a medical history that would have been compiled and made available to you at the time that you did your assessment of the patient?

A. Yes.

Q. Does it include clinically significant information related to your assessment?

A. It does.

Q. And would this have been used by you to prompt additional questions to determine the suitability or the -- the -- of Patient No. 1 as a person who would get a late-term abortion?

A. It would.

Q. Page 36 is what?

A. It's an informed consent for -- well, one -- number -- first of all, birth control, prescription of birth control as well as cautionary information about that. And page 37 -- oh.

Q. Yeah. Is -- is page 36 something that would have been generated prior to the time that you would have done your assessment, typically?

A. I'm trying to think. I think it all was in the same packet, but it would have been something that, you know, I wouldn't look at specifically for clinical information because it doesn't have a lot.

Q. All right. Page 37, this is a -- an additional informed consent, isn't it?

A. Yes.

Q. Would this have been something that you would have consulted during the course of your assessment?

A. Well, if it was there, I would have looked at and not seen a lot that was relevant to what I was doing. So I would have just glanced over it.

Q. All right.

A. I don't recall if it was there or not.

Q. Page 39 is what?

A. An informed consent from Doctor Tiller.

Q. And does it constitute two pages -- excuse me -- three pages?

A. Three. It looks like three, yes.

Q. All right. Is this -- is this informed consent something that would have been in the chart that you would have reviewed for purposes of your assessment of the patient -- patient?

A. I believe it was, yes.

Q. Did you consider this informed consent to have clinical significance in terms of what you were trying to do with the patient?

A. Not particularly.

Q. All right. Page 43 is what?

A. It is a lab and laminaria insertion

charting device.

Q. Now, by the time -- what's the laminaria?

A. Well, the lamin -- once the laminaria is inserted, that means the procedure's been started.

Q. So this would not have been a document that would have been available to you prior to the time that you did your assessment, correct?

A. Not in a completed form, no. The lab might have been present, but none of the other parts would be filled out.

Q. Did you review lab in -- lab information in the course of you doing -- of your assessments?

A. Well, as I flip through this chart, I would notice it, but it wasn't something particularly relevant to my function because it had to do with their blood type and -- and hemoglobin. So, I mean, it could be relevant, but it wasn't something that was of particular interest, so I wouldn't seek it out I'd just flip by and it mentally note it, I guess.

Q. All right. Page 44 is a surgery schedule, correct?

A. Yes -- well, it appears to be actually, a documentation record for the surgery, yes.

Q. And this would not have been available to

you when you did your assessment, correct?

A. It might have already been in there in a blank form --

Q. All right.

A. -- but not completed.

Q. Right. Likewise, would page 45 -- this is a document that relates to the procedure itself and would not have been completed until the procedure itself had been --

A. That's right.

Q. -- done? 46.

A. Same thing.

Q. 47. What is that?

A. That's a checkout, presumably immediately prior to their being discharged from the facility.

Q. Who was responsible for administering page 47 of Exhibit 34, that is --

A. I don't know.

Q. -- do you know whose duty it was to make sure that this form got filled out?

A. One of Doctor Tiller's staff. I don't know specifically.

Q. And -- and because it was done after the procedure, it would not have had any bearing on your assessment, correct?

A. No.

Q. Page 49, what is that?

A. It's a -- a record of medications used presumably during various stages of the procedure.

Q. Nothing that you would have had a chance to review or would have been available for you to review, correct?

A. No, that's correct.

Q. Pages 51 and 52?

A. 51 is a -- a blank continuation of that. 52 is what appears to be some type of, you know, intra procedure record. I'm not sure at what stage.

Q. This is a -- a -- a -- the record -- I'm sorry. This document would have been something that would have been prepared after your assessment?

A. Right. It might have been in the chart in a blank form, but it appears to be like something they used to monitor the labor, you know, the process.

Q. Look at page 53, please. What is this?

A. This, huh, is a supplemental informed consent for minors under the age of 18. It's a document that they sign to state that they had

read the informed consent and that they're requesting pregnancy termination and a -- a brief reason why. And it says, please meet with the counselor nurse after you see the video.

Q. Is this a document that would have been made available to you at the time of your assessment of patients?

A. Yes.

Q. Patient 1? I'm sorry. Yes?

A. Yes, it would have been in the chart.

Q. Would you -- would you have found clinically in -- clinically significant information in this document?

A. Yes.

Q. Would you have used it to perhaps prompt additional questions?

A. Yes.

Q. Let's go to page 55, please. What is this?

A. This is a form that they used when it might be necessary to report sexual contact that could be of a criminal nature. And --

Q. Is this a document that would be prepared and provided to you at the time that you did your assessment?

A. Yes. It would have been in the chart.

Q. And is it something you would have reviewed?

A. Yes, it is.

Q. In this particular instance, page 55, is there clinically significant information here that would have been useful to you in your -- conducting your assessment?

A. Yes.

Q. Would it have been something you would have used to prompt further questions?

A. Yes.

Q. 57, please. Again, we're still on Exhibit 34. What's -- what's page 57?

A. This is an acknowledgment for minors that they've been given the proper counseling regarding abortion options and everything under the Kansas statute for minors seeking pregnancy termination.

Q. Is this a document that would have been prepared and made available to you prior to your assessment?

A. Yes.

Q. Is this something that you would have utilized in your assessment?

A. Yes. And I wish to make it clear, too,

that this wasn't present except for minors, obviously, and it could be done at different stages during the day while we're all shuffling charts around. So it might have been completed already or it might not have. But in general, I believe it had been done. I mean, I saw many of them.

Q. Page 59, please, of Exhibit 34. What is this?

A. This is the same form we looked at earlier about an -- an acknowledgment by the patient and a witness that they had read the informed consent, understood their reason for being there to be for pregnancy termination, and an acknowledgment that it was necessary for mental or physical well-being and -- and a brief reason. So it's basically the same form, it looks like. I mean, it looks like they've got a copy -- a similar copy of the same.

Q. And the same questions as far as the -- the last time that we looked at this form earlier in the chart in terms of it being available to you, it would have been, correct?

A. Yes.

Q. And you would have used it for part of

your assessment?

A. Yes.

Q. Now, page 61 looks a great deal like a former page that we've reviewed, correct?

A. Yes.

Q. All right. Likewise is 63, correct?

A. Yes.

Q. Let's go to 65. What is this?

A. This is a -- a form from Doctor Tiller's chart just to record information for reporting abuse. And it has a date and patient name, date of birth, address, home telephone, who the -- who's with the patient, relationship, the reason for reporting, which in this case was because of the patient's age. And it indicates that it was consensual and there was no injury, I mean, other than the pregnancy. It just -- I mean, I think they're talking about as in forcible. And it would have named the -- the man involved in the pregnancy, if possible, male. It identifies his demographics, apparently at least his age. And it tells who it was reported to -- or by, telephone number, who was spoken to, the date and time, and then the -- the verbal report back from the reporting agent that -- it wasn't acceptable if

there wasn't substantial grounds by state law. So it indicates that the -- this case was reported.

Q. Because it was a potential case of child abuse?

A. Right, correct.

Q. Now, Doctor Neuhaus, were these reports of child abuse made available to you in -- in the course of your assessments of these patients?

A. Yes.

Q. Did you find clinical significance in these forms?

A. Yes.

Q. Or the information in the forms?

A. Yes. Potentially, yes.

Q. To -- would it be used to prompt additional questions?

A. Yes.

Q. 67, is this another version of same child abuse reporting form?

A. Yes, it is.

Q. Page 69, is this a report of some lab work?

A. It looks like an order form for lab. Like for something that would be sent to a lab with a patient to have blood drawn or whatever, a

lab test performed in an outside agent.

Q. Were lab tests and -- and I should say results of lab tests, were they made available to you for purposes of your assessment?

A. Well, something like this particular one probably wasn't because it wouldn't have been returned by the time I was there. But even if there were labs that were done in-house, it would be, or if there was something in a -- in a patient's record that was sent or brought with the patient, yes, it would have been.

Q. Take a look at 71, please. Is this a -- a report of a lab test?

A. Yes, it is.

Q. And is this something that if it was -- had been done by the time you did your assessment, that you would have been -- had access to for purposes of review?

A. Yes, it would be.

Q. Did you typically review lab work that was available to you in a patient chart as part of your assessment?

A. Yes, I did.

Q. Page 73, is that another report of a lab test?

A. Yes, it is.

Q. Same question, if it -- if it was in the chart, would you review it?

A. Yes, I would.

Q. Likewise on page 75?

A. Yes.

Q. Please go to page 85. And this is Exhibit 34. What is this, if you know?

A. This is something that looks like it would have been sent home with the patient at -- following -- well, during their discharge, while they're being discharged. Basically, it is a note for them to bring to their follow-up provider with a brief description of what they were there for and requesting that whoever takes care of her for the follow-up visit be provided with an examination and the -- the -- Doctor Tiller is requesting that the results of that be forwarded back to him or sent back to him. And then in addition, there's a -- a place for the patient to sign saying that they will get a pregnancy test at one and three weeks after their procedure.

Q. Now, obviously, this would not have been a document available for you when you did your assessment, correct?

A. Correct.

Q. But it brings up the question of what your routine was in terms of counseling patients at the end of an assessment as far as any follow-up care that you believed was necessary. Did you do that as far as additional mental health counseling, for example, that you would have advised the patient to get at the end of your assessment?

A. Yes, I -- I think. What was the question again?

Q. My question is, at the end of a mental health assessment, if it was your determination that additional follow-up mental healthcare was needed, would you advise a patient to pursue that?

A. Yes, I would.

Q. Why?

A. Because particularly in cases of -- of rape or other traumatic events or in cases where the patient was already suffering from something that could be life-threatening like suicidal ideation, that it was highly important that they get that follow-up.

Q. If a parent accompanied a minor, would you speak to the parent about that follow-up care?

A. Yes, I did.

Q. Now, if we go back to your chart for this patient, which is Exhibit 23, there's no documentation that reflects that advice that you would have given a patient about follow-up care.

A. That's correct.

Q. And I don't believe it's in any of -- any of your other charts either, correct?

A. No, it isn't, that's correct.

Q. Did you document that when you would -- when you would tell a patient or a patient's parent that follow-up care was advisable?

A. If I did, it would have been on the material that I sent home with them, the information that -- just basically contact information and their -- their receipt, so not in the medical record, no.

Q. Did you provide the patients routinely with your contact information?

A. Yes, I did.

Q. And why?

A. So they would be able to reach me if they needed to.

Q. Doctor, is there a reason why you didn't document this recommendation concerning follow-up

care?

A. No, not a good one. I should have, I guess.

Q. Let's go to Exhibit 35, please -- well, check that -- Exhibit 24. Let's cover your -- your's first. This is for Patient No. 2, correct?

A. Yes.

Q. All right. Now, some of these questions are going to relate to the same documents that we just looked at for Patient No. 1, so we will go through them in a -- in a fairly summary fashion. Are you with me on that?

A. Yes.

Q. All right. What is page 1 of Exhibit 24?

A. The top sheet or intake sheet from Doctor Tiller's office. It was also in my record.

Q. And this would have been available to you?

A. Yes.

Q. And in -- in terms of this particular page, page 1, is there anything of clinical significance to you as you review it now that -- that would have had -- I should say would have had clinical significance to you at the time that you did the assessment?

A. Yes.

Q. Can you briefly summarize what that is?

A. Patients age, who would be accompanying her, her pregnancy, history, all the -- the medical history basically there, the brief one. The referral from a physician, a Doctor Blanca Solis (spelled phonetically) -- or, I mean, presumably a physician. It could be a -- you know, a psychologist, I guess. But, I mean, I would have presumed it was a physician. The fact that this was a rape and incest victim. And --

Q. What's the clinical significance of -- of the report here that this is a rape and incest victim?

A. The clinical significance, well, it -- it has an -- a bearing on the potential mental state of the patient and the subsequent potential harm that she could suffer.

Q. Did you -- is this a document that you would have used in your assessment?

A. Yes.

Q. Page 2 of Exhibit 24, please. This is the same document we like -- or the form that we looked at for Patient No. 1, an authorization to disclose protected health information, correct?

A. That's correct.

Q. And your name appears on here a couple of times, it looks like, printed, correct? Once at the very top and once about a third of the way down.

A. Oh, right. Yes.

Q. Page 4 and 5 is the GAF report, correct?

A. Right.

Q. Would your use of the GAF report in terms of how you administered it been different for Patient 2 compared to Patient 1 in terms -- in terms of how you actually used the instrument?

A. Well, I'm just using it as a way to document what their functional status appeared to be over the time range, the time frame of the report. So in that sense, I'm using it in the same way, but -- so I'd have to say not substantially. I mean, the material that's used to inform it would be, obviously, different material, but the way it's being used is the same.

Q. The process is the same, but the information is different?

A. Right.

Q. All right.

A. Correct. Right.

Q. Now, one thing I want to -- want to clear up here. When you administered the -- the GAF, did you just say -- I'll use Patient 2 instead of the name -- Patient 2, have you had major impairment in several -- such as judgment, thinking or mood?

A. No.

Q. Is that what you did?

A. No, no.

Q. What did you do?

A. No. As I said before, basically, I just ask people to tell me what's going on or -- in really vague terms and then let that material come out of that.

Q. And from that narrative that you would receive from the patient in a face-to-face contact, you would then derive the responses that were used in the GAF report, correct?

A. That's correct.

Q. And is that essentially the same process that you would use in the DTREE?

A. Yes.

Q. And the DTREE here is pages 6 and 7, correct?

A. Yes.

Q. Of Exhibit 24?

A. Yes.

Q. And as far as the -- if you take a -- a -- a look at page 4, it's that -- is -- is same explanation -- in terms of the time for the rating and report times, is that the same explanation as you had for Patient 1?

A. Yes.

Q. And same question for the DTREE rating time and report time?

A. Yes.

Q. Please look at Exhibit 35, which would be Doctor Tiller's chart for Patient 2, please. Now, take a look at page 1 of that exhibit. Is this -- is this a Spanish speaker -- is this a Spanish language form?

A. Yes, it is.

Q. Are you a Spanish speaker?

A. Minimal. I mean, I can read this fine, but I -- my spoken Spanish is not very good.

Q. When you conducted a -- a -- an assessment -- a face-to-face interview rather with a patient who was a Spanish speaker, did you rely on the services of a translator or interpreter?

A. Yes, I did, if they didn't have someone

with them that could translate.

Q. Page 2, is this your standard letter informing Doctor Tiller of your findings derived from your assessment?

A. It is.

Q. Page 3 and 4 is the GAF report, correct?

A. Yes.

Q. And this would have been a GAF report that you generated that would have been passed along to Doctor Tiller, correct?

A. Yes. Later on, yes.

Q. But this originated with you?

A. Yes.

Q. And likewise with pages 5 and 6, is this the report that you would have generated which then would've been copied and passed along to Doctor Tiller?

A. Yes.

Q. Page 7 of Exhibit 35, is this a document that would have been made available to you?

A. Yes.

Q. And would you have used it in the course of your evaluation?

A. Yes.

Q. Now, this is -- the form is exactly like

the form that was used for Patient 1, correct?

A. Yes.

Q. The information presumably is different because it's a different patient, correct?

A. Right. And at the time when I see it, typically, the bottom part wouldn't have been completed. It might have or might not have, but the -- the ultrasound was not usually done by Doctor Tiller initially.

Q. All right. Now, it is the case that sometimes you did your assessment and then -- your mental health assessment and then Doctor Tiller would do his, correct?

A. Correct.

Q. Sometimes it was the other way around?

A. Right.

Q. There wasn't a necessity for it to be done in particular sequence --

A. No.

Q. -- as you understand it, was there?

A. No.

Q. As long as there were two physicians that concurred, correct?

A. Exactly.

Q. Doctor Neuhaus, on -- for Patients 3

through 11, to the extent that they each have a similar document as page 7 of Exhibit 35, if I were to ask you the same questions about those patients in terms of your knowledge concerning this form and its use in your assessment, would your answers be the same?

A. Yes.

Q. Page 8 of 35 -- exhibit 35, now, what is this?

A. An ultrasound report.

Q. Would this have typically been in the chart when you reviewed it for purposes of doing your assessment?

A. As I recall, yes.

Q. All right. And would you have reviewed it as a part of your assessment?

A. Primarily for the BPD, which isn't on here, just for gestational dating.

Q. Now, the BPD relates to gestational time, right?

A. Age, right.

Q. All right. Now, to the extent that -- that a similar form and information is found in charts 3 through 11 and I asked you the questions that I just did about this document, would your

answers be the same?

A. Yes.

Q. Page 9 of Exhibit 35, those are images of the sonogram, correct?

A. Yes.

Q. And you answered questions about images of a sonogram for Patient 1 earlier, correct?

A. Yes.

Q. Were these available to you?

A. Yes.

Q. And would you utilize them for some purpose during your -- to do your assessment?

A. Yes.

Q. And if the sonogram images appear in other charts, for example, Patients 3 through 11, and I ask you the same questions for those, would your answers be the same?

A. Yes, they would.

Q. Pages 12 and 13, and what -- what is this document?

A. This is a -- it's an informed consent in Spanish explaining who the physicians would be. It's similar to the English version. Gives the gestational approximate time of number of weeks or -- yeah, weeks and days. Talks a little bit about

the complications, the method. And No. 5 just tell -- tells people what to expect --

Q. All right.

A. -- complication wise.

Q. Now, to the extent informed consent documents, whether in English or another language, appear in other charts, for example, Patients 3 through 11, and I ask you the question whether it was available to you for your -- at the time of your -- at the time of your assessment, what would your answer be for those?

A. Whether they were available? I'm assuming they were all in there, but it would have been something I would have just kind of glanced over because it wasn't particularly informative.

Q. Didn't have clinical value?

A. Right. I'd just flip through a page at a time and that would've just been something I'd go by.

Q. Take a look at 14, page 14 of Exhibit 35. Now, this page has an overlay of what looks like an envelope. Do you see that?

A. Yes, I do.

Q. Can you tell what this document is otherwise?

A. No, other than the return address being from the Department of OB-GYN at UC Davis. So presumably it was some type of medical information or referral.

Q. Now, let's take a look at pages 15 and 16. What is this?

A. This is a form letter that I believe was in the packet of information that was sent out that I'm fairly sure had something to do with KDHE because we all did something similar that identifies the physician who is involved in the medical practice and provides certain statutorily required information for prospective abortion patients.

Q. Did this document have clinical significance to you in the course of you doing assessments for these patients?

A. Not particularly.

Q. If there are similar documents in charts for Patients 3 through 11 and I ask you that same question, would your answer be the same?

A. Yes, it would.

Q. Let's page -- go to pages 17 through 20 -- 17 through 20. What is this?

A. This is an obstetrical record.

Q. And from what hospital?

A. From the UC Davis in Sacramento.

Q. And would this have been a document that would have been available to you during the course of your evaluation of Patient 2?

A. Yes.

Q. Now, let's talk a little bit about Patient 2 here. How old was Patient 2?

A. 10.

Q. And in the course of you doing your assessment of Patient 2, did you take into account the fact that she was 10 years old?

A. Yes, certainly.

Q. And how did you -- did you adjust your assessment process to account for her age?

A. Did you ask how I did?

Q. Right, right. Or did you --

A. Yes, yes, I did.

Q. And how would you do that, how would you make adjustments for age, particularly for -- for example, a 10-year-old?

A. Well, my strategy with pediatric patients is to talk to them on their own level, which, you know -- which, obviously, there's a variation between one 10-year-old and another. So I would

approach them just like any other pediatric patient, trying to make them comfortable, you know, maybe being more -- or as unintimidating as possible, using simpler language. But once again, with the same approach of just building a rapport and allowing them to tell me their story. And in the process of that, making all the necessary clinical judgements as to what their mental and emotional age is, what their understanding of their situation is. And in a case like this, you know, would have -- and I recall specifically avoiding dealing with the traumatic incident itself because it wasn't something that the risk benefit ratio seemed worth engaging in, so having her relive that part of the experience wasn't in -- the harm of that would have been, in my opinion, more extreme than any clinical benefit that would be derived.

Q. Was your assessment of Patient 2 done with the same considerations as far as the core issues that you wanted to identify that you would do with other patients?

A. Yes. And a lot of the material was derived from the interview with the mom.

Q. But your technique of deriving this in --

information was -- was different and adjusted for the age?

A. Yes.

Q. And what role did the parent play, if you remember, in -- specifically for Patient 2?

A. Well, I -- I interviewed her separately, the mother.

Q. And was that with an interpreter or translator?

A. Yes.

Q. Doctor Neuhaus, was this 10-year-old the youngest patient that you'd ever consulted who was pregnant?

A. I believe there was a nine-and-a-half year old.

Q. Let's take a look at page 21 of Exhibit 35. What is this?

A. This is a report from UC Davis Radiology Department with a -- well, I don't know why it says radiology department, but I guess the -- it has a -- a -- a short history and it is an ultrasound report.

Q. Is -- is -- is this part of the medical record that would have been transferred --

A. Yes, it is.

Q. -- from UC Davis Hospital?

THE REPORTER: I'm sorry.

A. That's correct.

MR. EYE: Kris, wait until I'm finished so -- because she can only take one of us down at a time. So all right.

BY MR. EYE:

Q. And is -- is -- was it your practice to review medical records that had been provided by outside facilities, that is, facilities other than Women's Health Care Services?

A. It was.

Q. And please briefly look at pages 24 through 28. And are those also medical records from UC Davis?

A. Yes, they are.

Q. All right. Page 29. This is another one of the cover sheets, right?

A. Yes, the front of the chart.

Q. And if I were to ask you the same questions I did about the cover sheet that we covered for -- for Patient 1, would your answer be the same?

A. Yes.

Q. Or answers, would they be the same?

A. Yes.

Q. Take a look at page 70 of this exhibit, please. Can you identify what this document is?

A. This appears to be a letter which may have been faxed from the office of the District Attorney of Sacramento County.

THE REPORTER: Repeat that county.

A. Sacramento.

THE REPORTER: Thank you.

A. Sorry.

THE REPORTER: That's okay.

A. It has a date, it says American Airlines. I am writing this letter on behalf --

BY MR. EYE:

Q. That's -- that's all right. You don't need to necessarily read it verbatim. But would this have been in the -- the package of documents that you would have received related to Patient 2?

A. Yes.

Q. Would it have any significance to you? I mean, it's a -- it's a letter from the DA.

A. Yes.

Q. It's not exactly medical, is it?

A. No.

Q. But so why would it have significance to

you?

A. Well, it's referencing a patient needing a medical procedure.

Q. And does the fact that it comes from the -- the office of the District Attorney of Sacramento County, does that have independent significance to you?

A. Not particularly medical significance, but medical/legal. And -- and I guess -- I mean, it's -- it certainly identifies that the case has been reported.

Q. Does it have significance in terms of doing your assessment for this patient?

A. Yes.

Q. Why?

A. Because it's a result -- pregnancy is a result of a crime, a rape.

Q. Does the fact that a pregnancy has been -- is the result of a crime, a rape, does that have clinical significance to you in terms of doing your assessment?

A. Yes, it does.

Q. Why?

A. Because it -- it's relevant to the mental status of the patient and their his -- their --

the -- the outcome. Rape victims have high rates of PTSD, depression and substance abuse. Higher.

MR. EYE: Your Honor, can we take a short break? There seems to be a -- a document missing from this exhibit and I want to check it against our set of documents. Can we have just a few minutes? I don't want to needlessly hold anybody up, but if we could just take a break.

PRESIDING OFFICER: Sure. Five.

MR. EYE: Five minutes ought to do it. Thank you.

(THEREUPON, a recess was taken.)

BY MR. EYE:

Q. Doctor, would you -- again, we're in Exhibit 35. Would you please turn to page 51 of that document?

A. Oh, can I point out there's one more clinically relevant --

Q. Oh.

A. -- thing on that page too that I forgot to mention?

Q. Sure, please.

A. Was that this was a -- the letter was actually written by a master's in social work.

Q. All right. And what's the significance

-- and why that is significant?

A. Well, that's a mental health -- a trained mental health counselor. So this is the person making the referral to Doctor Tiller's office.

Q. All right. Page 51 of Exhibit 35, please.

A. 51?

Q. Yes. This is a child abuse reporting form, correct?

A. Yes, it is.

Q. Now, was it your understanding that child abuse that was determined to have occurred or there was a suspicion of child abuse that had occurred was something that was required to be reported?

A. Yes, it is.

Q. And is this the form that the clinic used to do that?

A. Yes, it is.

Q. Now, if this child abuse was reported by the clinic, there was no requirement for you to report it again, was there?

A. No. I just need to ascertain that it has been reported.

Q. All right. Doctor, in pages -- would you

please briefly review pages 52 through 78. And I don't believe there are any documents in that that would have been available to you at the time that you did your assessment, but I want to make sure that that's the case.

A. (Witness reading.) 63, no, but, I mean, that's mine.

Q. Right. And I'll ask you about that in just a moment.

A. Right. But up to 78.

Q. Now, I have all -- I've already asked you about page 70 and that's the letter from the direct attorney's office and we've -- we've -- you've answered our questions about that, correct?

A. Yes.

Q. All right. Page 63 of that exhibit, that's your standard letter that you provided to Doctor Tiller concerning your assessment of -- of patients and in this case, specifically Patient 2, correct?

A. Yes.

Q. Okay. And that's your signature?

A. It is.

Q. All right. Now that we've gotten through these first two charts, I want to ask you a couple

of questions about your general routine. How would you describe your extent of documentation that you did related to the mental health assessments for these patients?

A. It was what I considered to be necessary.

Q. Necessary for what purpose?

A. Documenting the -- that I had interviewed the patient and in my opinion, that it was a medically necessary procedure.

Q. Was there -- could you have documented more extensively?

A. Yes, I could have.

Q. Did you make a -- a determination as to why not to document more extensively?

A. I was acutely aware that we were in a -- as I've said, a fishbowl as far as every possible regulatory agency, including a hostile attorney general administration, and that he was actively involved in trying to make abortion illegal and was seeking records. And my concern was to make an adequate record that didn't have identifiable material that would not be redacted from a record on a normal basis, i.e., things like age, educational location, other -- well, other clues to a patient's identity. And, you know, I don't

recall if this had happened at the time, I don't think it had yet. But there was actually a case where Investigator Hacker requested records from me from, I think, a Harper's Bazaar magazine, some article where women had described their experiences with fetal indication termination of pregnancy with Doctor Tiller. And these people had used pseudonyms. Obviously, they were not wanting to be personally identified, they were not wanting their families to be exposed to having their medical situation well known or known by the public. But yet, their records were -- had enough ident -- this article had enough identifying material that Mr. Hacker had me actually locate these -- these identical patients and provide their records to the board. And also, because of my years of working with Doctor Knarr, I knew that there was a board attorney, Debra Billingsly, who had at one point, gotten a witness under oath to tell falsehoods. And this whole case was dropped under an agreement with Doctor Knarr that -- that he wouldn't pursue a -- a bar complaint against her. So I was aware that this woman was still working on the board and had been working with Mrs. Ostrowski against Doctor Knarr and that she

could potentially expose records or pass them on and they would end up eventually on Bill O'Reilly like what actually happened. So, I mean, all along, I tried to protect my patients' privacy as much as I could.

Q. In the process of documenting what you did in these assessments, was it with the intention to meet the standard of care?

A. Yes.

Q. Let's go to Exhibit 25, please. And that's in your records. Page 1 of Exhibit 25 is the so-called top sheet?

A. Yes.

Q. And if I were to ask you the same questions about the top sheet that I did in Patients 1 and 2, would your answers be the same?

A. Yes.

Q. And let's take a look at pages 2 and 3, please -- actually, two -- 2, 3, 4. This is a typed MI Statement?

A. Yes, it is.

Q. And you used MI Statements in your assessments?

A. Yes.

Q. And they were made available to you?

A. Yes, they were.

Q. Pages 7 and 8, please, would you turn to those. 7 and 8 are the DTREE record?

A. Yes.

Q. And I asked you as far as pray -- Patient 2 was concerned, how you administered the DTREE as far as how you derived data to enter into the -- into the DTREE program. If I ask you those same questions about Patient 3, would your answers be the same?

A. Yes.

Q. How about for the GAF report, which is 9 and -- pages 9 and 10, did you just ask the patient, have you been suicidal or in danger of intentionally hurting yourself?

A. Sometimes, but not -- not just verbatim from here.

Q. Did you -- was it your practice to seek a -- a narrative from the patient?

A. Yes.

Q. And was it from that narrative that you drew data which were then entered into the GAF?

A. Yes.

Q. And is that how you derived data that were inserted into the DTREE?

A. Yes.

Q. And if I asked you those same questions for each GAF for Patients 1 through 11, would your answer be the same?

A. Yes, it would.

Q. And how about for the -- did I ask about the DTREE just now?

A. I think so.

Q. Yes. And if I asked you the same questions about the GAF for Patients 1 through 11, would your answer be the same?

A. Yes, it would.

Q. Now, Doctor Neuhaus, if I were to ask you the questions about the difference in time between the rating time and the report time that I asked you for Patients 1 and 2, would your answers be the same for Patients 3 through 11?

A. They would.

Q. Now, we're recognizing that there's patient -- Patient 10 that didn't have a GAF and a DTREE, and we'll get to that in a moment, correct?

A. Correct.

Q. Or at least they didn't have it in the patient record that's in front of us, correct?

A. Correct.

Q. All right. What was the value in your technique of doing these assessments in allowing the patient to express their answers in a narrative form?

A. Well, for one thing, you get a lot more individualized material. And also, as they proceed without interruption from the interviewer, they can delve more into, you know, possibly deeper material about their situation. You know, I think that style of interviewing has long been recognized as eliciting much richer and more telling information than simply asking a list of questions and then writing down the answer and possibly interrupting even and then going on, so --

Q. Now, would you, from the narrative, ask additional questions that were prompted by the narrative?

A. Yes, occasionally, yes. Without attempting to -- I mean, hope -- I mean, actually, the -- the ultimate interview would be just to ask one question and just it go. But, you know, at certain points, it's necessary to -- to kind of prompted things or redirect. And depending on the -- the -- the verbosity of the patient.

Q. And did you ask questions to further clarify information that was being expressed during the narrative?

A. Yes.

Q. And was that your practice generally in terms of how you did these assessments?

A. It was.

Q. Exhibit 36. And you'll find that in the compilation of Doctor Tiller's records, Doctor. Doctor, take a look at Exhibit 36, page 3, please. What is this?

A. This is Doctor Tiller's mental health evaluation.

Q. Now, is there any way for you to determine based on a review of the chart that you compiled for Patient 3 and the chart for -- that was compiled by Women's Health Care Services, who did their assessment first, you or Doctor Tiller? Is there any way you can tell?

A. No.

Q. And -- and while -- let's assume for the moment that Doctor Tiller had done his -- his face-to-face interview first and generated a report, would that be something that you would review if, in fact, he had done his assessment

first?

A. If it was in the chart, I would have reviewed it.

Q. All right. Did it determine the conclusion that you would reach concerning a patient and whether the patient was a suitable candidate for a late-term abortion?

A. No.

Q. Was it part of the part of the entire compendium of information that you would rely on to draw conclusions about the suitability of a particular patient for a late-term abortion?

A. The information in it, yes.

Q. Page 4 of Exhibit 36 is your letter back to Doctor Tiller, correct?

A. Yes.

Q. And we've asked some questions about that with the other -- for the other patients, and I were to ask those questions again, would your answers be the same?

A. Yes, they would.

Q. Now, is it your understanding that the two clinicians that were doing these assessments for mental health purposes, you were the only one of the two -- the other -- the other one being, of

course, Doctor Tiller -- that you were the only one that used the DTREE?

A. That's correct.

Q. And Doctor Tiller would have been doing something with the GAF, correct, because he used --

A. Yes.

Q. -- the various axes, correct?

A. Right.

Q. Is it the case, Doctor Neuhaus, that if you did your assessment first, that it would have been Doctor Tiller's routine to look at all the records that were compiled before he did his assessment, similar to your routine?

A. Yes.

Q. So he would have had the benefit of a completed DTREE or report of that DTREE from -- from you to him?

A. No. Because I didn't print them out until I got home at this point. But in the beginning, yes.

Q. Did you tell him about your report?

A. I often -- I mean, it wasn't a routine that we would discuss every patient face-to-face, but he knew by getting the letter and that I had

checked -- or, you know, somebody had check -- he knew once it was done that if I had thought it was not indicated, I would have discussed it with him. And we often did discuss patients on a regular basis.

Q. Did -- in the -- in the process of discussing patients, did Doctor Tiller ever register any complaint about your use of the DTREE?

A. Oh, oh, no. No. And he was well aware of -- of, you know, the methodology I was using.

Q. And how about the -- the -- the GAF report that you would generate, did he ever --

A. No.

Q. -- register any complaints about that?

A. No. He was actually really happy about it.

Q. Let's go to Exhibit 26. And that's -- those -- those are your records again. And this would be for Patient 5.

PRESIDING OFFICER: 4.

MR. EYE: I'm sorry. Right. I beg your pardon. Right. Patient 4. Thank you, Your Honor.

BY MR. EYE:

Q. Do you have Exhibit 26, Doctor?
A. Yes, I do. Sorry.
Q. Page -- Exhibit 26 consists of the top sheet again, correct?
A. Yes.
Q. And we've already covered your -- how you use the top sheet in your assessment, correct?
A. Yes.
Q. The MI Indicators, the handwritten version, we've already covered how you use that, correct?
A. Right.
Q. There's a typed MI Statement and we've discussed how you used those as well, correct?
A. Yes.
Q. There is a DTREE report. And is the explanation for the difference in -- in the reporting of the -- I'm sorry -- the rating time and the report time the same as you've provided in -- in the case of other charts?
A. Yes, it is.
Q. Same question for the -- the GAF report, which is pages -- which is page 10.
A. Yes.
Q. Please take a look at Exhibit 37. This

is in Doctor Tiller's compilation of records. Doctor, in terms of Patient No. 4 in -- excuse me, in looking at -- in looking at page 3 of Exhibit 37, do you see the Axis V report there?

A. Yes.

Q. How does that compare with the GAF that you -- that you generated in terms of the rating? There's a difference, correct? And yours is page 10 of -- of -- of Exhibit 26?

A. Yes, mine is lower.

Q. Is this an indication that -- that the GAF report is relying on subjective information that might yield a difference in the -- in the rating?

A. Yes. It could be due to subjective. It could -- it -- right. Because of the information that's elicited from the patient is different from one interviewer to another.

Q. And is that indicative of -- of -- at least it's representative of independent evaluations of patients, correct?

A. Well, presume -- yes. I mean, that's certainly one inference and a logical one, in my opinion.

Q. Please take a look at page -- or Exhibit

27. And this would be for Patient No. 5. And we're looking at your records, correct?

A. Yes.

Q. I'm looking at page 1 of Exhibit 27. Where did this patient -- based on this record, where did this patient come from?

A. Quebec, Canada.

Q. Right. And who was this patient referred by?

A. The -- the Canadian health -- or the Quebec health service known as CLSC.

Q. Did you see patients from Quebec on -- on some regular basis or frequent basis?

A. I did.

Q. Did you have -- well, Quebec is a French-speaking --

A. Province.

Q. -- province of Canada, correct?

A. It is.

Q. Did you have difficulty in communicating in French with patients from Quebec?

A. I did not.

Q. Why?

A. Because I speak French.

Q. What is your level of proficiency in

French?

A. Well, I attend a public school in Switzerland for a year-and-a-half and in the Lycee Francis --

MR. EYE: Hold on.

THE REPORTER: Hold on. I don't know French.

A. I'm sorry.

BY MR. EYE:

Q. Right. You're going to have to translate for our court reporter what you said in French.

A. Okay. I went to French Lycee in London for two years. And then upon return to the United States, of course, we don't have very good language programs in our rural schools, so I wasn't able to continue my studies in French until college, at which time I took virtually every French class that was available, French I through IV, plus all the conversational levels that went along with that. I actually quizzed out of several classes. And I took French literature and history, as well. And I continue to speak French on a regular basis. My co-workers, many of them are from Francophone countries, the Congo, Paris. And many of our Spanish-speaking employees also

speak French, too. So we get together regularly and -- and speak French.

Q. Were you comfortable in terms of being able to conduct an interview with a French-speaking patient?

A. I was.

Q. Do you believe that your capacity to conduct a -- an interview with a French-speaking patient was as effective as an interview conducted with an English-speaking patient -- patient?

A. I would say 95 percent. Because most of the language that we use is not highly technical.

Q. Let's take a look at Doctor Tiller's pay -- patient record for Patient No. 5. And that would be Exhibit 38. And if you would please look at page 7. And -- and what is this -- this is an MI Indicator document, correct?

A. It is.

Q. Up in the upper right-hand corner, does it indicate who conducted this MI interview?

A. It does.

Q. Okay. And would that have been Sara Phares?

A. Yes. Phares, uh-huh.

Q. And does it indicate that -- that this

was done with a French interpreter?

A. It does.

Q. Were you -- did you have any concerns about receiving a document that had been derived from an interview that required the use of a French interpreter?

A. I mean, qualitatively, sometimes there is a reduction, but as far as the material that's asked being specific, the structured -- or semi-structured interview, I think that is -- that loss is somewhat negated. Also, the French translator was a French professor from Wichita State and was quite capable and experienced at doing translations there. So not substantially, no.

Q. Did you know the person that was utilized as a French interpreter?

A. Yes. And, in fact, I used her too in spite of the fact that I didn't really need to. I felt that her level of expertise in French as a native French speaker exceeded my own, so that there was no reason not to avail myself of her service.

Q. Doctor, please take a look at Exhibit 28. And that would be in your compilation of records.

And for which patient is this record compiled, by number?

A. Patient 6.

Q. Right. Doctor Neuhaus, in looking at page 1 of Exhibit 28, is there -- what is page 1?

A. This is a letter to Carrie, the -- who was at that time, the administrator at WHCS, the Wichita -- or Women's Health Care Services. And it's a letter from Planned Parenthood of New York City in which they are stating that they are paying for the procedure of this patient presumably. It doesn't say why, but I actually remember this was a rather extraordinary situation. The staff there was unable to provide her a procedure, presumably because she was past the point where they could do the procedure. But they felt such a compelling reason for her that they actually agreed to pay the fee of it.

Q. Was this a letter that would have been in the chart and available to you for your -- for purposes of your review?

A. Yes. And, in fact, as I recall, they had a separate one too for me, although I don't see it. I think it might be in my billing records or whatever, but I remember that they sent me

something, as well.

Q. Now, Doctor, when you saw this letter from Planned Parenthood of New York, did this essentially predispose you to find that Patient No. 6 was a suitable candidate for a late-term abortion? In other words --

A. Predispose me, no.

Q. -- did this -- did this bias you in your review?

A. No.

Q. And not withstanding the presence of this correspondence from Planned Parenthood in New York, did you conduct the same kind of interview that you would have conducted in the absence of the letter from Planned Parenthood?

A. Yes.

Q. And is the evidence of that in the DTREE and GAF reports?

A. It is.

Q. This raises another line of questions and this is, I think, as good a time to pursue it as any. When you interviewed patients -- strike that. In -- in the process of doing your face-to-face interview with patients, were there times that -- that patients presumed that they

were going to be designated as a suitable person to get a late-term abortion?

A. Yes, they were.

Q. Were there patients that -- who had that attitude or predisposition that you found were not suitable candidates for late-term abortion?

A. Yes.

Q. Did you decline to -- to find that they were suitable?

A. I did.

Q. Were there reactions from these patients?

A. Yes.

Q. What kind of reactions?

A. Usually, angry.

Q. Did the fact that some patients got angry as a result of you finding that they were not suitable candidates for a late-term abortion affect how you did subsequent interviews to determine the suitability of patients for late-term abortions?

A. No.

Q. And for the record, if I were to ask you the same questions about the DTREE that I asked you earlier about DTREEs in terms of how they were used in your -- in your work assessing these

patients, would your answer be the same for Patient 6?

A. It would.

Q. And the same for -- for the GAF?

A. Yes.

Q. Let's take a look at Exhibit 30 -- I'm -- I'm sorry -- Exhibit No. 40. That's the compilation for Doctor Tiller for Patient No. 6?

A. 7. 7?

Q. I stand corrected, yes. Well, let's look at 39. I -- and this -- I've gotten the wrong tab. But let's take a look at 39. And that's -- that's Doctor Tiller's compilation for Patient 6, correct?

A. Yes.

Q. All right. Page 3 of Exhibit 39 is your letter that you would have provided to Doctor Tiller?

A. It is.

Q. Doctor Neuhaus, in Exhibit 39, pages -- well, it's page 49. Would you take a look at that, please? Is -- is this a business card from a social worker at Planned Parenthood in New York?

A. It is.

Q. Now, this is in Doctor Tiller's chart,

that business card is not in your chart. But do you recall Doctor Tiller coming to you and expressing an opinion --

MR. HAYS: Objection, leading.

BY MR. EYE:

Q. -- that you should approve this patient for late-term abortion because of the --

PRESIDING OFFICER: Overruled.

MR. EYE: I'm sorry. I didn't -- I'm sorry, Counsel, I didn't hear you.

MR. HAYS: That's okay.

MR. EYE: All right.

BY MR. EYE:

Q. -- that because the Planned Parenthood of New York had gotten involved with this patient, that there was some reason that they should -- that you should approve this person for a late-term abortion because of that planned -- Planned Parenthood involvement?

A. I don't specifically remember that, but I know Doctor Tiller never ever, ever inferred anything of that nature with any patient. In fact, he constantly exhorted me never to be influenced by anything but my own opinion.

Q. And did you attempt to hew to that

standard?

A. I did.

Q. Please take a look at exhibit -- the exhibit for Patient 7 in your compilation of records. And is that Exhibit 29?

A. It is.

Q. There's a top sheet. If I were to ask you the same questions I've asked you about the significance of the top sheet in your assessments, would your answers be the same as they were for other patients?

A. They would.

Q. Now, a couple of points on this top sheet that I want to -- that I want to bring out. There's a -- it's about two-thirds of the way down the -- the page. It -- it -- there's something -- and -- and the photocopy didn't get all the way on the left side. But it says, something from website. Do you know what that's referring to?

A. Well, it says that informed consent was obtained from the website.

Q. What does that mean to you?

A. Well, I know his website had a calendar showing which doctors were working which weeks so that that would inform the patient, depending upon

when their appointment was, who the physician would be, the attending for that week. And in addition, there -- the -- all of the materials required by the statute as far as pre notifying patients about indications, complications, status of development at the time of gestation, all of that material was available on the website. And basically, all the patient would have to do is put in their last menstrual period and it would give them the number of weeks of gestation probable, you know, based on their LMP. And so they could review all the materials. The -- that packet didn't have to be sent out anymore, it was available on the web.

Q. And LMP is an acronym you just used --

A. Last -- last menstrual period. Sorry. So whatever your LMP date is actually two weeks farther along than what your actual pregnancy is because your period was two weeks earlier.

Q. All right. Now, the fact that this patient, No. 7, evidently got information from the website, did that influence how you assessed this patient?

A. No. In fact, this patient was actually referred from a clinic. At the top under referral

source. So --

Q. So this just indicates that they -- that they pulled the informed consent off the web?

A. Correct, right.

Q. Doctor, if you would take a look at Exhibit No. 40, which is compilation of documents for Patient 7 in Doctor Tiller's file. Do you see that?

A. I do.

Q. Page 4 of that exhibit, is -- is that your standard letter?

A. It is.

Q. The letter to -- to Doctor Tiller that is informing him that you found that doc -- Patient 7 was suitable for a late-term abortion based upon the assessment you had done, correct?

A. Yes.

Q. Please take a look at Patient 8, which is Exhibit 30 in the compilation of your records. Doctor, on page 5 -- well, let's first -- page 4 and 5 of this exhibit is what?

A. The MI Statement and the NMI Statement. The -- it looks like the one that was done on the day of the patient being there.

Q. All right. Now, on page 5 of that,

there's a -- a -- an entry for appetite. Do you see that?

A. I do.

Q. It says that the patient has been eating everything. Did you find -- would you have found that to be clinically significant given fact that this is a pregnant person?

A. I would not have.

Q. Is --

A. Not generally. I mean, the -- the way that's expressed there --

Q. Right.

A. -- probably not.

Q. Did you take into account the physiological changes that a person would go through during pregnancy when you did evaluations of these patients?

A. I did.

Q. Do you -- at the time in 2003 that you did these assessments, did you have enough experience as a physician to account for the physiological changes during pregnancy to make sure that they were properly indicated and assessed during the course of your evaluation of these patients? In other words, did you take

those into account in terms of arriving at a -- a conclusion?

A. Certainly.

Q. To -- all right. At this point in 2003, how long had you been involved as a licensed physician with maternal health patients?

A. Sorry. My math. I think 17 years.

Q. Is --

A. Well, more than that actually, if you count training time, but --

Q. In several different clinical settings, correct?

A. Yes, yes.

Q. And by 2003, how long had you been doing assessments for -- for Women's Health Care Services, approximately?

A. At least three years. Well, yeah, it was about three, maybe four.

Q. All right. In the course of those three to four years that you had been doing assessments for Women's Health Care Services, had Doctor Tiller or any other physician that practiced at WHCS ever express that your assessments that you were doing were below the standard of care?

A. He did not.

Q. How about any other physician that was there?

A. None of them did. They all seemed very happy with my performance.

Q. Take a look at Exhibit 31, please. These are patient records that you compiled for Patient No. 9, correct?

A. Yes.

Q. And -- and, Doctor Neuhaus, on page 6 of this exhibit, this is the MI Indicator, correct?

A. Yes.

Q. Now, this MI Indicator has writing in the margin that's -- that's running vertical on the page. Do you see that?

A. Yes.

Q. Now, did you get MI Indicators that would have a varying amount of in -- varying amounts of information on them?

A. Yes.

Q. Did it make any difference in terms of -- strike that. Is it -- was it the general rule that the more information you had from an MI Indicator, the -- the more expeditiously you could conduct your interview or did it make any difference?

A. Well, it depended on the overall quality, I guess. So, I mean, I don't know that that was a huge factor.

Q. Did --

A. I'd have to say probably --

Q. Doctor Neuhaus --

A. -- to some extent.

Q. -- did you, in any case, 1 through 11 or any -- for any Patient 1 through 11 or anywhere else that were for evaluations you did for WHCS, ever rely strictly on the MI -- MI Indicator to arrive at a conclusion as far as --

A. No.

Q. -- what the diagnosis would be?

A. I did not.

Q. And would it be the case that -- strike that. Please take a look at Exhibit 32. And this is for Patient 10, correct?

A. Yes. And it's interesting because it's from Comp Health from Doctor Kris, who could have just as easily provided a letter --

Q. Okay.

A. -- but he didn't.

Q. What -- what was doctor -- what -- what was your comment concerning Doctor Kris?

A. Well, Doctor Kris is a Kansas licensed physician. He certainly could have written this patient a letter, but I think Doctor Tiller was of the opinion that I would do a more thorough evaluation of the patient's impact than Doctor Kris would. Otherwise, he would have just asked Doctor Kris for a letter.

Q. Now, Doctor Neuhaus, there is a -- take a look at pages 8 and 9 of Exhibit 32, please. Is this the -- I'm sorry -- is this the DTREE for this patient?

A. It is.

Q. And page 10, is that the GAF for this patient?

A. Yes.

Q. Doctor, if you'd take a look at the -- here we go -- it's on page 4 and 5 -- I beg your pardon, I lost my place there -- of Exhibit 32. Doctor, there's this -- the MI Indicators at the -- kind of in the top half of that page, do you see those?

A. Yes, uh-huh.

Q. And then the bottom half of the page is the SIGECAPSS. Do you see that?

A. Yes.

Q. And that continues over to page 5, correct?

A. Yes.

Q. But what's the origin of the SIGECAPSS?

A. Well, from my understanding, it was developed by a professor of psychiatry at Mass Gen and --

Q. What's Mass Gen?

A. Massachusetts General Hospital, to teach residents the basic -- a basic mnemonic for remembering these elements that constitute the vegetative symptoms of depression and, you know, the sleep, interest, guilt. And it's common in medical training because we have so much material to memorize, to create mnemonics or use mnemonics that are kind of shared over the generations. So it's -- it's a normal technique for quickly reminding yourself what to ask or what to think about when considering certain disorders, differentials.

Q. So the SIGECAPSS originated in a healthcare institution, correct?

A. It did.

Q. And does that essentially help verify to you that it has been tested as an instrument that

has value in terms of doing these assessments?

A. I wouldn't even think it would need to be tested because it's simply the symptoms that are components used to assess whether a -- to rule in or out or, you know, to use their -- their symptoms that are known to be vegetative symptoms of depression. I mean, certainly, there are other causes of sleep disorders or -- or whatnot, but, I mean, those are well recognized. So, you know, whether you call it a SIGECAPSS or an instrument or whatever, I don't know that it would necessarily need to be validated. Because if it weren't valid, then the DSM criteria are not valid either, because that's where they're taken from. So I don't even think that it needs to be validated. But the fact that it was published in a family practice journal, American Family Physician in, I believe, 1998 or '97, and, you know, that's used routinely by family medicine, general medicine providers, other primary care providers, that's a standard journal that is provided, you know, free of charge to a lot people, so, I mean, I think it was widely circulated and people are familiar with it. So in that sense, I'd say it's valid because it's --

it's used routinely in -- in practice, but it actually derives from the DSM-IV.

Q. All right.

A. So I don't know that it needs to be validated, per se. I guess it's a fairly long answer, but --

Q. You found that it had value in terms of the work that you did doing these assessments, correct?

A. Yes.

Q. But you didn't rely upon it exclusively?

A. Correct.

Q. Please refer back to Exhibit 30. And that's in your compilation of records. Doctor Neuhaus, there is not a GAF report in Exhibit 30, correct?

A. That's correct.

Q. Nor is there a DTREE report in Exhibit 30, correct?

A. Correct.

Q. Can you explain the absence of those reports from the record that you've compiled?

A. Not specifically. I should have -- I probably did actually complete it at the time when I did the other patients for that week, but for

some reason, it didn't get printed out or -- and, you know, it's just a -- an oversight on my part.

Q. Now, not that anybody necessarily has -- expects you to have a specific recollection of the -- of the patient that was No. 8, but would it be the case -- do you have any recollection of a time when you did an assessment where you didn't rely on your standard method?

A. Well, I would have done the same method. I just -- I just didn't type in the answers -- or I probably did, but just didn't print it. Because I would do them all and then print them out afterwards. And I just may have neglected -- I obviously neglected to print it. Because I wouldn't have printed and not put in it the chart, so I evidently didn't print it. And it would have been on the computer for some period of time, but when I quit using that computer, that record would no longer have been accessible.

Q. Please take a look at Exhibit 41. And that's in Doctor Tiller's compilation of records. And take a look at page 2, please. Now, is this a copy of the standard letter that you provided to Doctor Tiller indicating that this person -- this patient would have been a suitable candidate for a

late-term abortion?

A. It is.

Q. And the date of this is what?

A. November 4, 2003.

Q. Take a look at Exhibit 31 -- I'm sorry Exhibit 30, page 1.

THE REPORTER: I'm sorry. Which exhibit?

BY MR. EYE:

Q. Exhibit 30, page 1. Is there a date at the top of that?

A. There is.

Q. And what's that date?

A. 11-4-03.

Q. The same date as your letter, correct?

A. Yes.

Q. That we just covered. And would you take a look at the page 4 of Exhibit 30.

A. It has the same date.

Q. It -- it carries the date of 11-4, is that correct?

A. It does.

Q. Is there any reason that you can think of that you would not have used the GAF and DTREE for the patient that has been designated No. 8 in -- in Exhibit No. 30?

A. No.

Q. Is the fact that you sent the letter that is Exhibit No. 2 in -- I'm sorry -- page No. 2 in Exhibit 41, would that be, to you, an indication that you had completed your assessment using the standard methodology that you used with other patients?

A. I didn't send it. I just would have, you know, put it in the -- Doctor Tiller's chart.

Q. All right. That --

A. Right, right. I didn't mail it or fax it, but, yes, it would have -- it would be an indicator, yes. The answer to the question is yes.

Q. All right. Because you were at WHCS when you prepared this -- this letter, correct?

A. That's right.

Q. And so you would just hand it off, basically?

A. Correct.

Q. All right.

MR. EYE: Your Honor, can we take a brief recess?

PRESIDING OFFICER: We can. The gentleman that came in before lunch, that is -- is

that your expert witness?

MR. EYE: Yes, it is.

PRESIDING OFFICER: All right. I don't want to tell you how to do things, but I've got serious doubts we'll get to him today.

MR. EYE: Well, we -- we understand, Your Honor. Right, yeah. We -- we're sort of figuring this out as we go on the schedule. Thank you.

(THEREUPON, a recess was taken.)

BY MR. EYE:

Q. Doctor, would you please refer to Exhibit 32 in your records? And that corresponds to Patient No. 10. Do you see that record?

A. I do.

Q. Doctor, on page one of Exhibit 32, that's the top -- so-called top sheet we've been referring to, correct?

A. Yes.

Q. And it includes some medical history information?

A. It does.

Q. Is there anything in looking at the top sheet, that is, page number one of Exhibit 32, that is clinically significant to you?

A. The medical history indicates that she

has a prescription medication -- well, her -- this -- this is the first pregnancy, she's on a prescription medication, it's not listed up there, but I think it's somewhere else on down here, the Paxil. And she's asthmatic. And in the -- the comment box, it lists the medication, the dosage and frequency and presumably what it was prescribed for. Also, it lists the time of the last anxiety attack was six months ago and that she uses an inhaler as needed.

Q. Doctor, what is the clinical significance of the report in the medical history of the use of Paxil?

A. Well, in conjunction with the -- the notation of anxiety attacks, it indicates that she has a past history of some anxiety disorder.

Q. In the -- in the DTREE, which is pages 8 through 10 of Exhibit 32, are you -- do you see that?

A. I do.

Q. Okay. On page 9 at the bottom, it indicates that that anxiety disorder was in partial remission.

A. Yes.

Q. Does that affect -- how do you -- in

effect, there are two DTREE reports here, is that correct?

A. Two diagnoses, yes.

Q. For the same patient?

A. Yes.

Q. Can you explain why there were two DTREE diagnoses for this one patient?

A. Well, it's possible to have more than one disorder, as I understand it. She had a previously diagnosed anxiety disorder which was not specified other than that she'd had these anxiety attacks or -- or as Doctor Gold mentioned, probably panic attacks, and that she'd been on medication at the time when I interviewed her. She either was not suffering from it, that particular variant of her symptomatology. Although, there's obviously some overlap in symptoms with acute stress disorder, also an anxiety manifestation. So, you know, apparently, she'd had this history and had -- the symptoms were not causing her any significant problem. And since she was still taking the medication, one could assume it was because of the medication or whatever other therapy, but, I mean, it was still noted because it was significant and the current

problem was the symptomatology that I attributed to acute stress disorder.

Q. Doctor Neuhaus, was it your practice in conducting these patient evaluations that for patients who indicated that they were on a medication for a -- in this instance, for an anxiety attack, how did you factor that in to your -- to your evaluation?

A. You mean, what in -- well, that's --

Q. Well, what weight did you give it?

A. Well, I mean, certainly, someone who's already prone to anxiety presumably is more sensitive to stressors and other things than someone that isn't. So I would have attributed some weight as far as prognostic potential for how she would deal with stress in general. I mean --

Q. Please refer to Exhibit 43 of Doctor Tiller's records that correspond to Patient 10.

A. It does.

Q. Page 12 of that exhibit, please. That'd be page -- or Exhibit 43. Do you see that?

A. I do.

Q. Is -- is this a document that would have been made available to you during the course of your evaluation?

A. Yes.

Q. In looking at this document right now, is there anything that you would consider to be clinically significant as far as what you would have considered in the course of your assessment of this patient?

A. Yes.

Q. What would that be?

A. Well, the first statement is in bold letters and says, I'm scared. And then it goes on to explain why. And then some, you know -- under the -- it -- it states her goals. And it also states that she has anxiety problems and that she's feeling incapable of coping with her situation.

Q. Now, Doctor, the -- the form of -- of page 12 or the -- the format of the information on page 12 looks different than many of the other entries that we've seen from patients in these charts as far as their own handwritten explanation of why they wanted to have the pregnancy terminated. Does that have any significance in terms of how you evaluated this patient?

A. Well, I mean, if it was in the chart, I would have looked at it and I would have taken it

along with others. But, I mean, honestly, I haven't seen something on like a lined notebook before, I don't recall this as being a standard form. It looks like the MI Statement that is normally on a -- a separate form that they write out by hand, but it just happens to be on a lined notebook paper for some reason. But if it was in the chart, I would have seen it.

Q. Please turn to page 19 of Exhibit 43. Is that your standard letter that you would have provided to Doctor Tiller?

A. It is.

Q. Please take a look at Exhibit 33 in your compilation of records. Take a look at page 1 of that exhibit.

A. Sorry.

Q. This is the top sheet that provides some medical history, correct?

A. It is.

Q. And in this particular pay -- or on this particular page, there's a -- a -- a notation that it indicates, unsure of LMP, maybe five months. Does that indicate that the patient -- patient wasn't sure when their last menstrual period had occurred?

A. It does.

Q. Is -- is that admission by the patient of any clinical significance to you? I mean, does it have -- does that have clinical significance?

A. It could.

Q. Why?

A. Well, if you haven't been pregnant before, which most of these young girls haven't, they may not be aware of the symptoms or if they do experience symptoms, they attribute it to some type of abdominal disorder, indigestion or, you know, thinking they're gaining weight or whatever. So it's possible they're just simply unaware, just don't have body awareness of it. But it also could be, and often is, symptomatic of -- what is that word -- God, I'm blanking out -- dis -- you know, a dissociative type of symptomatology where you actually just are completely unaware because the -- the thought of it is very stressful. And, I mean, I don't know if that's -- I mean, I -- I term it that and it may not be actually a standard interpretation of that, but it's somewhat similar to what, you know, adults might express in the form of denial. You have a little bit of heartburn type symptoms or chest heaviness and

think it's because you ate something bad and, in fact, you're actually having coronary symptoms. So, I mean, a -- a lot of times because the whole event of an unwanted pregnancy is such a stressful thing, that the symptomatology is often suppressed and ignored and denied. So that when they're really that far along and it should have been obvious, even to them, they -- they are -- are sort of consciously unaware of it.

Q. And would that have been your -- would it have been your practice that upon seeing a notation of a patient who was unsure of when their last LMP occurred, that you would inquire further into that to determine whether it had any clinical significance? Would that have been a common kind of thing for you to explore?

A. Certainly, that's a clue that someone is -- because, you know, most women, once they've missed two periods, they're acutely aware of it. And at 16, she should have, you know, been -- been fairly regular at that point. So to miss for five months would be unusual not to notice that.

Q. On page one of -- of Exhibit 33, is -- is there some indicator there as to how many pregnancies this person has --

A. This is the first --

Q. -- experienced?

A. -- according to the history provided.

Q. And -- and what parameter on Exhibit 1 -- or page one indicates the number of pregnancies?

A. A.

Q. All right. If you would turn to Exhibit 44, please. And that's Doctor Tiller's patient records for Patient No. 11. Page 16 of that exhibit, please. Is this your -- I'm sorry -- is this your standard letter that indicated that you found that this patient was -- would suffer substantial and irreversible impairment of a major physical or mental function if she were forced to continue the pregnancy?

A. It is.

Q. During the course of the time that you were at WHCS doing second opinions, was there ever a -- a concern that people who were opposed to women exercising their right to an abortion, was there ever a concern that those groups might attempt to send in false flag patients, that is, patients who were supposedly legitimately seeking services from WHCS, but who were, in fact, there to attempt to discredit WHCS?

MR. HAYS: Objection, relevance.

MR. EYE: This is all about the diligence -- or one of the reasons why there was diligence in -- in completing legal requirements related to these abortions. This goes to the state of mind -- state of mind of the -- of -- of Doctor Neuhaus.

PRESIDING OFFICER: Overruled. Answer the question.

A. It wasn't just a conjecture, it actually happened. And not just there, at other places.

BY MR. EYE:

Q. Were you aware that -- that such an attempt had -- had occurred?

A. After the fact, yeah.

Q. And did it affect your view of how to complete these assessments?

A. Yes.

Q. In what way?

A. Well, I mean, in the sense that you're being constantly scrutinized, you're not going to knowingly, consciously or otherwise, attempt to gain anything. And by gaining, I mean trying to get around or otherwise -- well, I don't know, that's -- that's a good word, I guess, is to

figure out how to, you know, somehow, you know, skirt or get around a regulation or whatever.

Q. Or -- or other legal requirement?

A. Right, correct.

Q. During the time that you were at WHCS, was it common to engage in conversations with other staff members about the evaluation process for these patients?

A. Oh, yes. I mean, just in the ordinary course of work.

Q. Would you -- would you characterize the -- during the time that you were at WHCS, the atmosphere as collegial?

A. Definitely.

Q. While you were at -- doing the second opinions at WHCS, was there ever any indication that you were able to perceive that there was pressure for the staff to rubber stamp approvals for late-term abortions?

A. No. I think everybody was aware that anything like that would just jeopardize the entire process. The -- nobody wanted to be the weak link in -- in whatever the system -- you know, the system as it was.

Q. Did you ever, based upon your work at

WHCS and your collaborative efforts in assessing these patients, get the impression that Doctor Tiller was a rubber stamp for late-term abortions?

A. No. I think if -- if there was anyone that didn't have an incentive to do that, it would have been him. He, obviously.

Q. And I think that you've answered this in other ways, but I'll ask it again. Was there any pressure on you from any source to be a rubber stamp for late-term abortion approvals?

A. There was not.

Q. Were you ever under any pressure to take less time than necessary in order to complete an assessment of these patients for late-term abortions?

A. Not that I was aware of. I mean, I'm sure -- I mean, I'm sure it didn't please the overall environment if, you know -- if it took two hours or three hours or whatever, but everybody understood that that was a necessity. And it's just like anything, you know, I mean, it was understood that that kind of thing could happen and people just chuckle about it and that's the way it went. There was never any pressure in that way.

Q. Doctor Neuhaus, in the course of working at the clinic with Doctor Knarr and learning from him to a certain extent in terms of how to -- to do a clinical practice, did he impress upon you that there was a necessity to put the duration of time that you spent with a patient in the -- in the chart as a routine entry?

A. That was --

MR. HAYS: Objection, asked and answered.

PRESIDING OFFICER: I believe it has been.

MR. EYE: Was it? Okay.

BY MR. EYE:

Q. How about with Doctor Clinton?

A. No. I never put a time on anything except a surgical procedure and that was only later.

Q. And why would you do it for a surgical procedure?

A. I don't know -- well, it'd be just because that is done standardly with surgical procedures. I don't know that it's done every time, I certainly didn't do it when I sewed up a laceration in the clinic in Westmoreland. But later on when I had a --

THE REPORTER: I'm sorry. I didn't do it when I?

A. When I was like sewing up a laceration or something. Unless it was in the emergency room and then, you know, the documentation's a little different. But if someone just came in and sat down in the waiting room and then we brought them back and I sewed it up, I wouldn't put a time on that. But -- or -- or casting a fracture or whatever. I don't remember ever putting times on any of those.

BY MR. EYE:

Q. During the time that you did this -- the second opinions at WHCS, were you ever directed to include the duration of time for your assessments in any record that was prepared?

A. I was not.

Q. Did you understand that follow-up care recommendations, in -- in addition to the ones that you testified about earlier that you provided, that there would be follow-up care recommendations made by Doctor Tiller or his staff?

A. I did.

Q. That was your understanding?

A. Yes. And, I mean, I know that that happened.

Q. Were the records that you generated at WHCS available for review by the other staff physicians at that clinic?

A. Later. I mean, they -- they weren't immediately because I didn't print them out right away.

Q. But --

A. But some of them were, yes.

Q. All right. And as I understand it, there was no indication from any of those physicians that they thought your records were below standard of care?

A. No.

Q. That's correct?

A. That is correct.

Q. Was there ever any indication from Doctor Tiller that he thought your evaluations of these patients for second opinion purposes was below standard of care?

MR. HAYS: Objection, asked and answered.

PRESIDING OFFICER: Sustained.

MR. EYE: I beg your pardon. I had forgotten, Your Honor.

PRESIDING OFFICER: It's been asked and answered, and the answer is no.

BY MR. EYE:

Q. And I probably also asked about the other staff physicians at WHCS?

A. You did.

Q. All right. If I asked that, then I withdraw it.

Doctor Neuhaus, whether we covered it specifically or not, is it your recollection that all 11 patients involved in this inquiry were the subject of your standard referral letter that you would provide to Doctor Tiller indicating that they were suitable candidates for a late-term abortion?

A. Yes.

Q. Now, your -- your letter that you would provide to Doctor Tiller didn't specify the -- the -- a late-term abortion would be provided, correct?

A. That's right.

Q. It would make a finding?

A. Exactly.

Q. And what was that finding?

A. That continuation of the pregnancy would

result in a substantial and irreversible impairment of a major bodily function or a mental function.

Q. Doctor Neuhaus, for the 11 charts that have been involved in this case, now that you've gone back over them in the course of this proceeding, are you confident that the assessment that you conducted for each one was consistent with the standard of care as you understand it?

A. I am.

Q. And the same question for the documentation?

A. I am.

MR. EYE: Thank you, Doctor Neuhaus. I tender the witness for cross-examination.

MR. HAYS: Yes, sir.

CROSS-EXAMINATION

BY MR. HAYS:

Q. Doctor Neuhaus, do you currently have a medical license?

A. I do.

Q. I'm sorry.

A. Yes, I do.

Q. I'm sorry. You'll to speak up.

A. I'm sorry. I do. Sorry.

Q. Okay. And you put in an application to switch your license from exempt to active?

A. That's correct.

MR. EYE: It's beyond the scope of direct.

PRESIDING OFFICER: It is beyond the scope of direct. Where are we going?

BY MR. HAYS:

Q. Now, you spoke about attending a residency program. Did you attend a psychiatric residency?

A. I did not.

Q. Now, you spoke about the DSM. Do you know how many editions of that DSM there's been?

A. We're on the fourth now and the fifth is coming out soon according to Doctor Gold.

Q. And do you remember testifying previously about you describing the DSM as an encyclopedia of psychological diagnoses?

A. I believe that was in the transcript. I just -- I didn't have access to those for a long time, but I did review and I believe that was in there, something with that -- if you could show me the exact line, maybe I could say more accurately, but it soundd vaguely familiar. So if you could

please show me the line and tell me which transcript.

Q. You were asked if you read through this book twice in the course of your education and you answered yes. Do you remember that?

A. May I see that, please?

Q. If -- if --

MR. EYE: Would you please show the witness the transcript, Counsel?

MR. HAYS: Well, let's flip to it in Neuhaus 992.

THE WITNESS: Okay. I don't even see a copy. I don't want to say something that I can't look at.

MR. EYE: Doctor, until a question is posed, please do not respond.

BY MR. HAYS:

Q. Do you want to read lines 10 through 13?

A. Do you want me to read it out loud?

Q. Yes.

A. Okay. Question: Is this -- and I think some context is in order possibly.

Q. Just read the question.

A. I can't say who I was talking to.

Q. It's in the Tiller trial. Just read the

question.

A. In the Tiller trial?

Q. Would you agree it says, this is widely regarded as sort of a bible of psychiatric --

THE REPORTER: I'm sorry. Slow down.

MR. HAYS: I'm sorry.

THE REPORTER: Would you agree?

BY MR. HAYS:

Q. -- is this widely regarded as sort of a bible of psychiatric and psychological diagnoses? And your answer was, yes, more like an encyclopedia than a Bible, yes.

A. Yes. I did say that.

Q. Do you agree with that?

A. I -- I -- I agree that's in the transcript and I probably said it.

Q. Do you agree that you said it?

A. More than likely.

MR. EYE: I think that's been asked and answered.

PRESIDING OFFICER: She said I probably agree with it.

A. Well, I said I probably did say that, yes. I don't remember saying it.

PRESIDING OFFICER: Okay.

BY MR. HAYS:

Q. Was that testimony taken under oath?

A. It was.

Q. And were you sworn --

A. I was.

Q. -- to tell the truth?

A. I was.

MR. EYE: This is redundant. If it was under oath, she was sworn.

PRESIDING OFFICER: Sustained.

A. Yeah. So I -- I -- mostly likely, I did say that.

PRESIDING OFFICER: Doctor Neuhaus, there is no question.

MR. EYE: Right.

PRESIDING OFFICER: Stop.

BY MR. HAYS:

Q. Now, a referral is when one physician asks another physician to evaluate a patient, correct?

A. Generally. Yes.

Q. And the reason why you performed your evaluation was for purpose of being in compliance with the state law, correct?

A. That's correct.

Q. But you'd also do more than just perform the evaluation for the purpose of being in compliance with Kansas law, correct?

A. Can you be more specific by doing more? I mean, what do you mean? I'm sorry.

Q. Can you turn to Exhibit No. 46. Right there, just flip. Would you flip to page 257.

MR. EYE: Is that Bates 257 or transcript --

MR. HAYS: No, the transcript page 257.

PRESIDING OFFICER: 357?

MR. HAYS: 257.

A. There is no 257.

PRESIDING OFFICER: I don't have it.

MR. HAYS: It's Bates 889.

A. I have that.

MR. HAYS: I'm sorry. Bear with me, sir.

BY MR. HAYS:

Q. Lines 8 through 20 in which you stated, I'm here to doing -- I am here doing this act for purposes of being in compliance with this law, but once I am there, my own priorities are always first and that is that. I make sure that I do the best of my ability, evaluate the patient and a person's entire life -- life situation and to the

best of my ability, I offer the best guidance that I can, the best medical information that I have and the best medical judgment that I can use. Because ultimately, can I be rude. I don't give a -- a crap what Phil Kline thinks. What I care about is a patient that I am -- whose trusted is invested in me during the consultation period, so my first priority is the patient. And my second priority is to make sure that I'm doing best that I can in being in compliance with the law. Is that your testimony during that inquisition?

A. It is, and it also is what I remember saying, as well. And there was no judge there.

Q. That was not a question.

A. Okay. So --

Q. But you were --

A. I --

Q. -- sworn?

A. Yes. I just wouldn't have sworn if there was, that's all.

Q. And you had an attorney there present with you?

A. I did.

Q. That could make objections?

A. He was there --

MR. EYE: Objection, that calls for a legal --

A. -- I don't know -- I don't know what --

MR. EYE: -- conclusion.

A. I know his capacity was --

MR. EYE: Kris, when I make an objection, please stop. Okay?

THE WITNESS: Hmm.

MR. EYE: Thank you. I think the objection was sustained, Your Honor?

PRESIDING OFFICER: Yes.

MR. EYE: Thank you.

BY MR. HAYS:

Q. Now, you mentioned about receiving other patients records that were faxed to you?

A. Yes.

Q. And you put those patient records in -- into your patient record, correct?

A. I did.

Q. And you would have other patients' record available?

A. You mean Doctor Tiller's?

Q. Doctor Tiller's record, correct.

A. Yes.

Q. And you did not put any of the patient

records that you reviewed from his patient record into yours, correct?

A. Not his record, no. Sometimes I would copy them and add them.

Q. But you wouldn't put the copies into -- or strike that. You did not do that in Patient 1 through 11, correct?

A. I did not.

Q. Now, let's talk about the DTREE module -- the portion of the PsychManager Lite. It comes with a cautionary statement on it, also?

A. The -- the only knowledge I recall of that was from the testimony the other day but, yes, yeah, it was there and I saw it.

Q. And it cautions the proper use of this program requires specialized clinical training that provides for a large body of knowledge in clinical skills?

A. We did read that. Yes.

Q. The accuracy of the output is strictly limited by the --

THE REPORTER: I'm sorry. The accuracy of output?

BY MR. HAYS:

Q. -- is strictly limited by the quality of

the clinical observations that are used in addressing the DTREE questions?

A. Yes.

Q. And you testifed that it was a diagnostic tool, correct?

A. Well, probably, but, I mean, I don't -- I don't see that specifically so I can't verify that from my memory.

Q. Is -- is the DTREE a diagnostic tool?

A. It can be used, I guess, in that capacity.

Q. But that's not the way that you used it?

A. I used it to document. If it had been absent, it wouldn't have mattered, I just have the book.

Q. Let's take a look at Patient 1. Could you flip to your Patient 1 record, please. I believe it will be Exhibit 23. Now, you spoke about being able to have Patient 1's -- or Doctor Tiller's patient record available to you, correct?

A. Yes.

Q. Is there any indy -- any indy -- strike that. There's no indication within that patient record that you looked at Doctor Tiller's record, correct?

A. Within my record?

Q. Correct.

A. There is not.

Q. Let's take a look at the patient records documented or the -- strike that. Let's take a look at the patient record of disclosures, Bates page No. 2. Now, the purpose of that record is to record any of the disclosures that you would have made, correct?

A. Yes.

Q. Are there any disclosures made or -- strike that. Are there any recordings of any disclosures being made within this patient's record?

A. No.

Q. The --

A. The reason for that is that it never occurred to me that I should do it on the day of, and I only use that when I subsequently released information.

Q. But you did disclose this patient's information to Doctor Tiller, correct?

A. I did.

Q. And that's not documented within this document?

A. No. And I notice it's not in his either to me, so neither of us had done that.

Q. Now, let's take a look at the DTREE report. You saw this patient on July 21st, 2003?

A. No -- well --

Q. Well, let's just look at the DTREE report. Because that's your report, correct?

A. It is.

Q. And it's indicates the rating date of 7-21-2003?

A. It does.

Q. And that would indicate the day that you saw this patient, correct?

A. It would.

Q. So this would -- July 21st, 2003 is the day that you saw this patient, correct?

A. It is, supposedly. It wasn't though, it had to have been the 22nd.

PRESIDING OFFICER: I can't hear you.

A. It must have been the 22nd. I don't remember being down the day before. So the date was wrong, but the computer I was using for that, I was also using to do some old things that were --

BY MR. HAYS:

Q. I don't believe I asked that question.

A. Okay. But I had had to change the date on it few times on my computer.

Q. I didn't ask that question.

A. All right. Sorry. So I'm --

Q. From your record, can you tell me what that patient's history was?

A. No, not specifically, other than the things that are included in the record.

Q. Can you tell me what the specific symptoms that patient presented with?

A. This is just a positive -- no, not specifically, no.

Q. Can you tell me what the patient's family history was from your patient record?

A. No, I cannot.

Q. Can you tell me what the impact of the family relation -- relationships were from your record?

A. Well, from the GAF, I could give some information about that.

Q. Can you tell us specifically what the patient responded?

A. No.

Q. Now, this indicates that there's a

diagnosis of anxiety disorder NOS, correct?

A. That's correct.

Q. Can you tell us what the diagnostic criteria for anxiety disorder NOS is?

A. Well, since even Doctor Gold doesn't have this memorized, may I refer to the book --

Q. Go ahead.

A. -- and then I will be happy to read them to you.

Q. Do you need to refer to the book?

A. Just as she did, I would prefer to, so that I don't misrecollect one or two of them.

Q. Well, I won't have you read it. However, can you tell me how this patient -- and if you need to refresh your memory in the book -- can you tell me how this patient met the diagnostic criteria for anxiety disorder from your record?

A. As I was inputting the information that I had from my recollection and whatever record was available, I would have selected those items from the algorithm.

Q. There are no notes taken within your patient record, correct?

A. There are none that are included here, that I see anyway. But as we pointed out before,

these records --

Q. You don't have a question.

A. Never mind.

Q. Can you tell me what the patient's physical appearance was?

A. Well, she was five-foot-two, 150 pounds. Other than that, I don't recall.

Q. Can you tell me whether she was tired looking?

A. I cannot.

Q. Can you tell me whether she was crying?

A. No.

Q. Can you tell me whether she was disheveled?

A. No.

Q. Can you tell me the patient's affect and mood?

A. Not from this, no.

Q. From any documents within your patient record?

A. No.

Q. Can you tell me the patient's motor behavior?

A. No, I cannot.

Q. Can you tell me your -- the -- the

patient's content and form of thought?

A. That would have been normal or I would have noted it somewhere.

Q. Do you know that for sure, though?

A. Yes.

Q. You would --

A. Because it would have gone into another algorithm.

Q. Can you tell me how the patient's speech and language was?

A. Not insofar as it wasn't positive. As far as something abnormal. If it was abnormal, it would have been noted.

Q. Can you tell me what the patient's judgment and insight was?

A. It must have been normal. It's -- all of that's in the GAF.

Q. Your name is not on the DTREE report?

A. I was the only one that had it. So I didn't think to sign it.

Q. Your initials are not on the DTREE -- DTREE report?

A. No. But I'm a licensed owner of it and there aren't very many. They're probably none other in Kansas so I didn't think it was

necessary.

Q. Just answer yes or no.

A. No, they are not.

Q. The DTREE has not been authenticated by you in any way, correct?

MR. EYE: Objection.

A. Personalized, no, it hasn't been personalized.

MR. EYE: Do you mean signed?

A. Signed, no.

BY MR. HAYS:

Q. The GAF report also does not have your name on it, correct?

A. No.

Q. It does not have your initials on it, correct?

A. No.

Q. It has not been signed, correct?

A. Correct.

Q. And that record does not contain a referral letter that you created for Doctor Tiller, correct?

A. It does not.

Q. Now, you testified earlier today that outside, there could have been a lot of yelling,

screaming, things like that that would have been stressing to the patient?

A. That's right.

Q. And would that have -- or strike that. That would have caused some kind of stress to be placed on that patient?

A. Yes.

Q. Can you indicate within your patient record or any of your patient records where you addressed that stressor and how it was not affecting how they were presenting by that day -- or how they were presenting that day?

A. Are you asking me to -- to explain that their symptoms were solely due to the protesters, their entire psychopathology or whatever it was that brought them there were -- are you asking me to differentiate that?

Q. I'm asking you -- I'm asking you whether you ruled out or whether you indicated ruling out the stress that they were under by being pregnant and coming into that office before making your diagnosis?

A. Well, in order to filter that out, I would have to assume that none of their reasons for being there had anything to do with the --

their pregnancy. So I don't know how I can answer that, really. I mean, other than sending them home, having the protesters cleared out and have them come in on another day and see if their affect and behavior are different on a day when the protesters aren't there. I mean, you're asking me to conjecturize there.

Q. Is there --

A. If I just asked them, okay, is all your stress that you're experiencing due to the protesters, would I get an accurate answer? Probably not. So trying to differentiate something like is that really not very useful, I mean, and it doesn't even seem possible. So I don't -- I don't know how to answer that. You know what I mean. They have --

Q. Now, can you explain the difference between psychosocial symptoms and symptoms of psychiatric illness?

A. Well, psycho -- psychosocial is not a symptom, it's a -- it's a factor. Psychosocial factors are things like your family dynamics, your relationship dynamics, the -- the factors available in your community as far as support, the availability of jobs, opportunities, the country

you live in, the kind of tax structure, all of those things impact on a person's health, but they're not individual symptoms within an individual. They're more like symptoms of society in that sense. So I think, you know, thinking back on Doctor Gold's testimony that psychosocial stressors don't cause mental illness, they can simply contribute to it. To me, I mean, even though I'm a lowly GP with no fancy credentials or academic standing, it -- it seems quite evident to me from the evidence that people living in psychosocially stressed areas have higher rates of heart disease, cancer, any number of -- of physiological manifestations that are directly correlated and considered to be contributors to not only mental illness, but physical illness. So I don't know if that answers your question, but I would say that mental health is -- is the property of an individual and psychosocial health is the property of -- of the community that that individual resides within.

Q. So your psychosocial stressors does not include the stress that was involved with being pregnant?

A. Oh, absolutely that is one. Because it

-- it -- the individual is not an isolated being. If that individual lives within a family and has relationships, lives in a community, goes to school, goes to work, all of those things impact on the person's health. And that's what we're supposed to be assessing, as I understand it from Doe v Bolton, is that the person's economic, educational and other sociological attributes are allowed to be considered when trying to project the impact of -- of pregnancy on their health is projected into the future, which is basically what we're asked to do, is to have a crystal ball and see into the future based on whatever limited factors that are available to us to make that assessment.

Q. Did you rule out the psycho -- strike that. Is there any record or indication within your patient records that you ruled out psychosocial stressors in coming to your diagnosis?

A. I wouldn't have ruled them out as -- as a factor in making the referral. In fact, those would have been --

Q. Is there --

A. -- but insofar as coming to the

diagnosis, let's say I just -- I -- I happen to disagree on that.

Q. Yes or no?

MR. EYE: Hold on. She -- she's trying to answer the question, Counselor.

A. You know, I -- I did not attribute pregnancy-related symptoms to vegetative symptoms of depression so I certainly would not have fallen into that trap. But, you know, the fact that someone's dad had just died or they were living with, you know -- having their family distributed all over the place, do I consider that as being a potential cause of psychological symptoms, well, I wouldn't want to filter that out because they're relevant. To me, and I'm, just like I said, a lowly GP and I don't have all these fancy degrees and whatnot in -- in that, but I understand that someone who's just gotten divorced, doesn't have a job, can't pay the bills, is going to experience stress and maybe depression over that. So, no, I would not have filtered those out specifically if I felt that they were contributing to their state.

BY MR. HAYS:

Q. Did you document any of your reasoning of how you differentiated or used those psychosocial

stressors within your diagnosis?

A. I did not.

Q. Now, let's look at page No. 5 of Patient 1. It indicates that this patient has presented with a serious impairment of social, occupational or school functioning. Does this record indicate whether it was social?

A. This was over the past week and it would have been primarily to do with social and school.

Q. Does it --

A. It doesn't indicate --

Q. Does this record indicate whether this was social?

A. No, simply one of the above.

Q. Does it indicate whether it's occupational?

A. Well, presumptively, no --

Q. Yes or no?

A. -- but she didn't have a job so -- she did not have a job. She's like 15 or something, so, no, it doesn't specifically.

Q. So there's no clinical significance in that entry?

A. I -- I disagree. I think that one of those is present and that that's clinically

significant.

Q. But you did not document which one of those was present, correct?

A. No, I didn't feel the need to do that, no. It wouldn't have mattered as far as getting the rating.

Q. You don't have a question.

MR. EYE: She's trying to explain her answer.

MR. HAYS: You'll have an opportunity on redirect for her to explain her answer.

MR. EYE: Thank you.

BY MR. HAYS:

Q. And your referral letter that you wrote to Doctor Tiller, not present in any of your patient records?

A. Not at this point in time, no.

Q. And that's because you were not putting your patient referrals within your records at that point in time, correct?

A. I wasn't making a copy, right.

Q. So you were not putting one in your patient record, correct?

A. Correct.

Q. Okay. Let's move on to Patient 2 of your

record. You did not document the patient's medical history within your record, correct?

A. No, other than this front page.

Q. And that's not your documentation, correct?

A. No, but it's in my record.

Q. There's no record of psychiatric history being taken in this record by you?

A. No. Other than what's on the cover sheet.

Q. And you did not fill out the cover sheet, correct?

A. No.

Q. So there is no record of a psychiatric history?

A. There's no written record of it, that's correct.

Q. And the next page in that record is authorization -- well, let's move on to page 3 of the patient's record. That's another copy of the patient record of disclosures?

A. Yes.

Q. And that one does not indicate any disclosures that may have been made, correct?

A. It does not.

Q. And you did disclose a portion of this record to Doctor Tiller, correct?

A. I did.

Q. Now, let's take a look at the GAF report. There's no information documented within this -- strike that. There' no specific patient record information documented on this document to indicate how the patient responded to your questions, correct?

A. Well, I'm not sure that that's the way it's meant to be used. My understanding is that this is a categorical thing for clinician to use. And that the specific -- well, the -- no. So I guess to answer your question, could it identify that patient particularly? No.

Q. But you were using this as a documentation of your global assessment of the function of the patient, correct?

A. Right. Of their functional level. Which to -- to me, it didn't matter which of the factors it was, it was just the functional level.

Q. So the specific patient information that you used to come to this conclusion wasn't important?

A. It was important in the overall judgment,

not in the obtaining of the number.

Q. But it wasn't important enough to document, correct?

A. I think I elucidated why I didn't identify a lot of personal material earlier, but if you'd like me to repeat it, I will.

Q. It wasn't -- it wasn't important that -- to document, correct?

A. It was important that I documented what was necessary to comply with the reporting standards -- or not reporting -- recording standards, what I perceived those to be.

Q. And those recording standards you speak about are underneath the Kansas Administrative Regulations, correct?

A. Yes.

Q. And you're subject to that because you're a licensed physician in Kansas, correct?

A. That's correct.

Q. And underneath that Kansas Administrative Regulation, it requires you to document pertinent and significant information concerning the patient's condition, correct?

A. Yes. Which I felt that I was doing. It doesn't say every shred of it, it just said

pertinent and relevant, which I did.

Q. But there's no information specific to this patient, correct?

MR. EYE: Asked and answered.

PRESIDING OFFICER: As to this patient?

MR. HAYS: I believe it was Patient 1.

PRESIDING OFFICER: That was Patient 1, I believe.

MR. EYE: I think that's -- we -- who we were --

MR. HAYS: No, we're on Patient 2.

MR. EYE: I beg your pardon.

A. Can you ask the question again, please? Sorry.

BY MR. HAYS:

Q. There's no in -- there is no specific patient information on this document, correct?

A. Well, I mean, now, I think we're going to have to get into the semantics of that. Specific, what do you mean exactly by specific?

Q. Well, the first statement is, the patient has had major impairment in several such and I'll quote it --

A. That was a typo.

Q. -- as judgment, thinking or mood --

A. I would say that that --

THE REPORTER: Hold on. One at a time.

BY MR. HAYS:

Q. -- is using an "or" statement specific?

A. Well, I mean, it's semantics. To me, it's specific, but it may not be as specific as if there wasn't an or.

Q. Well, with this patient, was it the patient's judgment?

A. My understanding of this tool was --

Q. Was it --

A. -- rating --

Q. -- the patient's judgment?

A. No. It would have been mood.

Q. Is there any information located within this patient record that indicates that?

A. Yes.

Q. Documented by you?

A. Yes. The -- the DTREE report.

Q. And that is documented where specifically for that patient?

A. 6 and 7.

Q. And the specific information that is directed at Patient No. 2?

A. That there was a -- that there was a

period of markedly diminished interest or pleasure in all or almost all activities with a duration of at least two weeks in which the diminished interest lasted most of the day, nearly every day.

Q. So let's take a look at this. Was it a diminish -- diminished interest or was it diminished pleasure?

A. It was a depressed mood -- or diminished interest or pleasure would have been probably both, because they usually are --

Q. Well, then there's or right there. Why would or be there if there was both?

A. Once again, the diagnosis is not diminished regardless of which --

Q. No.

A. -- one it is.

Q. Just answer the question that's been asked.

A. What was your question again, please?

Q. Which one was it, was it diminished interest or diminished pleasure?

A. Well, it was one or the other. And the reason I wouldn't be particularly concerned which one about recording it is because it takes one or the other to meet the criteria. And it's very

likely that both were present. Because usually, when people are depressed, they have both symptoms.

Q. Then if both were present, wouldn't there be an and there instead of an or?

A. That's -- the reason that I quit using this thing was because it wasn't flexible at all. You had no control over it, there was no editor ability with it. So I would have had to go back and edit it by hand, I guess. But from my perspective, as long as one of them are present that -- that was significant.

Q. Now, you stated that it was because of mood, correct --

A. Yes.

Q. -- that the GAF?

A. Correct.

Q. Is there any evidence on this document that the patient had a depressed mood?

A. Well, the vegetative symptoms of depression, many of them were present including a -- in -- in addition to that, there was also a some feeling of worthlessness or inappropriate guilt. Which a lot of that, you know, I would have probably remembered just from reading that

other record.

Q. Does it document whether there was a dome -- depressed mood, yes or no?

A. Yes.

Q. Where at?

A. The totality of it met the criteria.

Q. Now, if this -- there is an option within this DTREE for it to document depressed mood, correct?

A. Well, it's not an option. It -- I mean, there's a setting where you can have it print out all the -- the negatives or just the positives. But, I mean, it's not an option to have it do something.

Q. Major depression -- depressive disorder has a gatekeeper symptom, correct?

A. Well, I know you're calling it that, I've never heard it called that before. But there is some criteria that have to be present before you can make that diagnosis.

Q. And what's the first criteria that must be present?

A. Well, there has to be this two-week period of -- of, you know, every day, most of every day, whatever. Well, let me -- I'll just

read it, I guess, so I don't have to look it up out of there. But there has to be a period of at least two weeks duration in which there's a depressed mood or the symptoms of anhedonia, this diminished interest or pleasure. And in this case, she must not have had the depressed mood because it would have put that, but it -- it defaulted down to the next potential, what you called gatekeeper criterion, which was the anhedonic symptoms of diminished pleasure and interest in all activities which with a duration of at least two weeks most of the day, nearly every day. And I believe that's straight out of the DSM.

Q. Is there a reason why you keep on checking your phone?

A. This is the first time I did. But because I got a page and I have a son who's diabetic, so I'm concerned about his health and that's why I just checked it.

MR. EYE: Is there an objection?

MR. HAYS: Well, I don't know what communication's being -- going on. I -- with the phone.

THE WITNESS: Would you like to have my

phone and then you can tell me if I get a message from my husband? I'm sorry. I got a text from my husband and I was concerned it might be something to do with my son. I'm sorry if I'm being rude.

MR. HAYS: Could I have one minute, sir?

BY MR. HAYS:

Q. Let's take a look at one of the exhibits here -- let's take a look at Exhibit No. 91. Now, that's -- that's criteria for the major depressive disorder, correct?

A. Yes.

Q. And five or more of the following symptoms have been present during the same two-week period and represent the change from the previous functioning. At least one of the symptoms is either depressed mood or loss of interest or pleasure. Correct?

A. Yes.

Q. Is that the gatekeeper --

A. Well --

Q. -- has to be either depressed or loss of interest?

A. Yes.

Q. So there's no indication on your DTREE of there being a presence of a depressed mood,

correct?

A. Well, it's the other one, it's the second criteria, loss of interest or pleasure, the anhedonia symptoms.

Q. Correct.

A. Right. I mean, the -- the way that it's printed out.

Q. You don't know --

A. It says the criteria --

Q. Wait until you have a -- wait until you have a question.

A. -- have been met. I'm sorry.

Q. Now, within Patient 2, there's no documentation of you observing or assessing the patient's physical appearance, correct?

A. There's no documentation of it, no.

Q. There's no documentation -- strike that. There's no documentation of you observing the manner of relating to --

THE REPORTER: I'm sorry. Observing the?

BY MR. HAYS:

Q. -- manner of relating to yourself. Correct?

A. That's correct.

Q. There's no documentation as to the

patients affect and mood, correct?

A. No documentation of the affect and mood, no, other than --

Q. What --

A. -- mood. Well, there is. The mood is in here.

Q. Anything specific to "them"?

A. Yes -- well -- well, probably not specifically.

Q. Any documentation of their content and form of thought?

A. By virtue of its absence, then, yes. But it's not documented as a positive, so it wouldn't have been there.

Q. What about their speech and language, is that not documented?

A. If it was -- because it wasn't present, then it's not documented.

Q. How about their overall intelligence, that's not documented?

A. Once again, I did not document a negative finding. And so it would have been -- I would have -- I would not have put it down there unless it was abnormal.

Q. Any documentation on how their pregnancy

relates to their diagnosis?

THE REPORTER: I'm sorry. Any documentation on how?

BY MR. HAYS:

Q. -- their pregnancy relates to their diagnosis?

A. Not specifically, no. Other than the -- the letter, which isn't in my record.

Q. Now, on Patient No. 2's GAF, page 4 of your patient record. Are you on Bates page 4?

A. Yes.

Q. On the bottom under GAF ratings, not in the range of 21 to 30 because of the following criteria. It's states, the patient has not been suicidal or in danger of intentionally hurting herself. Correct?

A. Yes.

Q. And let's flip to page -- Bates page 6, the DTREE positive report. And the last entry on that states, there have been -- there have also been recurrent thoughts of death, not just fear of dying, but current suicidal ideation without a specific plan or a suicide attempt or a specific plan for -- and it goes on to page 7 -- and ends with committing suicide.

A. And is this where? Ends with what?

Q. Committing suicide.

A. Oh, yeah, yeah. Right.

Q. So the GAF document indicates that the patient is not suicidal, correct?

A. Right. Which means that --

Q. And the DTREE indicates that they are suicidal, correct?

A. Well, people can have thoughts of death without having suicidal ideation.

Q. It indicates that they're suicidal, correct?

A. It indicates that it could have been one of the considerations that would have -- so one of those things were present. But by the GAF rating, I would've not felt her to be significantly suicidal. Just having thoughts of death is a -- is a very low -- a low level indicator, but would not be an active suicidal ideation.

Q. Is there is any indication within the patient records, documentation why it indicates they're suicidal on one report and not suicidal on the next report?

A. Yes. Should I read it out all out again so that maybe I can make it a little clearer?

Okay. So one of -- one of these was present. They are either recurrent thoughts of death, not just fear of dying or -- I'm putting the "or" in there, so that I distinguish these separate potential possibilities -- recurrent suicidal ideation without a plan or a suicidal attempt or a specific plan. So that's a whole continuum of risks for suicide, with the recurrent thoughts of death being on the low end and a plan for carrying it out being on the high end. So that's a range of potential suicidal behavior. But when I did the GAF rating, I must have thought that her -- whatever thoughts of death were not significant indicators of suicidality, so that's why I wouldn't have. Because it would have been in her interests if I really thought that she was suicidal, to rate it higher, and I did that on other patients, but I didn't on this one because at the time, it didn't seem to be an imminent suicidal ideation, it must have just been thoughts of death, which is a very low level indicator.

Q. You're just assuming that, correct?

A. From the record, yes.

Q. Because you can't tell what --

A. Specifically, no, I can only tell by --

by -- I can only deduce it from the two records.

MR. EYE: Doctor, wait until he's done with his question and -- so the court reporter can get this down accurately.

BY MR. HAYS:

Q. So there's not enough pertinent and significant information concerning this patient's condition to come to the determination of how suicidal they may or may not have been?

A. No, I disagree.

MR. EYE: Object -- objection, it's argumentative.

PRESIDING OFFICER: Do you want to ask that question or rephrase it?

MR. HAYS: Okay.

BY MR. HAYS:

Q. So is there enough information to come to a determination within this patient's record on where they fall on how suicidal they are?

A. Yes.

Q. So how suicidal are they?

A. Very low level, but, I mean, there's some thoughts of -- recurrent thoughts of death, which is, you know, of concern, but it's not as urgent as the other levels indicated on the --

Q. There's no indication within this patient's record whether there has been a recurrent thoughts of death, not just fear of dying, or recurrent suicidal idealization (sic) without a specific plan or a suicide attempt or a specific plan for committing suicide, correct?

A. Well, I wouldn't have chosen --

MR. EYE: Objection. Objection, it's compound and it's also argumentative.

PRESIDING OFFICER: It is compound and it's also argumentive. Rephrase.

MR. HAYS: I'll move on.

BY MR. HAYS:

Q. The DTREE report doesn't have your name on it, correct?

A. It does not.

Q. It does not have any of your initials on it, correct?

A. No.

Q. And the GAF does not have your name on it, correct?

A. No.

Q. And it does not have your initials on it?

A. No.

Q. And neither documents are signed,

correct?

A. They are not.

Q. But your document -- your record does contain a record from another physician, correct?

A. It does.

Q. Let's move on to page 3. Page one of your Patient 3 is Doctor Tiller's record, correct?

A. It is.

Q. And the MI Statement is also his record, also correct?

A. It is.

Q. And the next MI Statement of Bates 4 is also --

A. Yes, it is.

Q. -- Doctor Tiller's record, correct?

A. It is.

Q. Is the date of your appointment recorded in this document?

MR. EYE: In the --

BY MR. HAYS:

Q. In the record, in the patient's record?

MR. EYE: Okay.

A. I guess it is not, not that I can see.

BY MR. HAYS:

Q. And let's go back to Patient 2's record

real quick. Is your appointment date documented within that patient record?

A. Patient 2?

Q. Correct. Which is Exhibit No. 24.

A. Yes, it is.

Q. Where's it documented at?

A. On the authorization to disclose PHI.

THE REPORTER: PHI?

A. Yes. Protected health information. And also on the patient record disclosure.

BY MR. HAYS:

Q. Okay. Let's look at the patient protected health information. Is there a date that has been placed on that document by you?

A. That may have been the patient's mom because I -- that's was -- that part was normally filled out by them.

Q. So you did not document the patient's date of appointment in this record?

A. Well, I mean, I -- I did it at the time of the appointment, so I obtained that date. I didn't -- I don't know that that's my writing there, it doesn't look like it.

Q. Are your signature -- or strike that. Is your signature on this page?

A. No. It wouldn't normally be anyway, but it is not.

Q. Let's go to patient record disclosures. You didn't -- you did not write that date on that document either, correct?

A. It looks like the same handwriting and so it's probably the mom or parent.

Q. And your name does not appear on that document, correct?

A. It does not.

Q. Okay. Let's move back to Patient 3's record, Exhibit No. 25. And a copy of your referral letter is not contained within this document, correct?

A. It is not.

Q. And there's no indication within your patient record that you relied upon any other physician documents that were not created -- that were not contained within your patient record?

A. There is no indication, other than the -- well, there isn't.

Q. And this patient was also diagnosed with major depressive disorder, single episode?

A. That's correct.

Q. And let's go to Bates page No. 7. Are

you there?

A. Yes.

Q. And it also has an entry, there has been a period of markedly diminished interest or pleasure in all or almost all activities with a duration of at least two weeks --

A. Yes.

Q. -- in which the diminished interests lasts for more than a day, nearly every day.

A. Yes.

Q. And that's the same entry as you wrote -- you -- you --

A. It's -- it's a -- it's part of that module. And it was selected because that was present.

Q. Can you wait until -- wait until I ask my question until you finish?

A. Sorry.

Q. That's the same language that is found on Patient No. 2's DTREE, correct?

A. It is.

Q. Is there any differentiation between Patient 2 and Patient 3 contained within the documents?

MR. EYE: Objection, that's -- we're

going to relevancy now. I mean, we're talking about two different patient charts. The fact that there happens to be a coincidence of the same language doesn't necessarily mean that there's any relevance that it shows up in one and the other. I mean, it's -- these are patient-specific charts. And it's kind of like the coincidence that was raised the other day that was subject to an objection, that it would -- that there was the same diagnosis that occurred in a number of charts. And I objected to that on the basis of relevance and --

MR. HAYS: It -- it goes to the --

MR. EYE: -- I would lodge the same objection.

MR. HAYS: -- it goes to the pertinence of that entry within a patient's record. If it's the same entry in every patient record, then how is that a pertinent entry within that record?

A. Well, it isn't the same.

PRESIDING OFFICER: Just a minute, please.

MR. HAYS: And I'm just asking about that one entry, not the entire document.

A. Oh, I'm sorry. That one entry --

MR. EYE: Hold on, Kristin.
PRESIDING OFFICER: Wait, wait. You're asking about what?
MR. HAYS: That one entry that I quoted, not the entire document.
MR. EYE: I still object on the grounds of relevancy.
PRESIDING OFFICER: Are you talking about the GAF or the other one?
MR. HAYS: The DTREE positive reports, Bates 6 in patient -- in Patient No. 2 and Bates 7 in Patient 3. And it would be the -- underneath the heading that starts off with 296.3. It will be the one, two, three, fourth entry on both documents.
PRESIDING OFFICER: I'm losing where we're at. The question -- your question was what?
MR. HAYS: Are those two entries exactly the same?
PRESIDING OFFICER: And your objection is?
MR. EYE: Well, I -- well, I don't object to that. It was to -- the question that I objected to was his -- that -- that there was no differentiation between the two of them, or a

question similar to that. I don't remember exactly what it was. But I don't object to whether the entries are the same.

MR. HAYS: And then there are -- and then the next follow-up question was the differentiation between those two patients' entries.

MR. EYE: Which I do object to the relevancy on -- of that question.

PRESIDING OFFICER: Ask the first question and then ask the second so I can follow.

BY MR. HAYS:

Q. Are those two entries exactly the same?

A. The paragraph, there has also been, that also appeared in that one?

Q. Correct.

THE REPORTER: I'm sorry. There has been also?

A. Oh, I was trying to make sure I had the right paragraph. The paragraph that starts, that there has also been a period of markedly diminished interest. So, yes, those two paragraphs are the same.

BY MR. HAYS:

Q. Is it -- is there anything within the two

patient records that indicates how those patients met that criteria?

A. Yes.

Q. And what is that?

A. Well, the --

Q. Specific information --

A. -- this is the record --

Q. -- to the patient --

A. -- this is it --

THE REPORTER: Hold on.

MR. EYE: You guys need to -- boundaries here a little bit. Kristin, I can only direct you to wait until counsel was -- finishes his question. That's -- that's the limit of what I can do here. But please try to do so.

MR. HAYS: I'll strike that question and we'll start anew if that will be easier.

BY MR. HAYS:

Q. That entry goes to one of the -- the first two symptoms underneath major depression, correct?

A. Yes.

Q. And the patient has to meet one or the other symptom before they can go further within the major depression -- depression criteria,

correct?

A. That's correct.

Q. And both of these patients met markedly diminished interest or pleasure, correct?

A. That's correct.

Q. And both patients, there's not a differentiation between how they met that specifically --

A. Correct.

Q. -- within their patient record by you?

A. Yes, correct.

Q. Let's move on to the GAF. That document -- strike that. I've already asked those questions. There's no documentation within this patient record as to the specific symptoms this patient was describing to you, correct?

A. Well, I mean, if -- if I'm saying the person is not suicidal, that's certainly a documentation that I didn't think that she was suicidal. And suicidal is a symptom, so I'd have to disagree with that statement.

Q. Is there any documentation within your record that shows a specific answer to support any of the positive findings?

A. Well, yes. This -- this is the

documentation.

Q. Is there any notation as -- strike that. There is no notation within your patient record as to what the patient responded to your questions?

A. I couldn't have filled this out if they didn't, so, no, I can't possibly agree with that.

Q. Are there any quotes located within your patient record of what the patient said?

A. I'm not aware that quotes are necessary.

Q. Is there a summarization of what the patient told you?

A. Yes, this is it. This is not the whole totality, but this is certainly part of it. This is the part that I documented.

Q. So let's take a look at the first entry of the GAF, the patient has reference -- has presented with major impairment in areas such as work or school, family relations, judgment, thinking or mood. That's the entry, correct?

A. Yes.

Q. There's no indication whether it was work.

A. Well, I mean, I'm not looking at this from a long-term therapy standpoint, I'm looking at it as a snapshot of the patient now.

PRESIDING OFFICER: That is not a question.

BY MR. HAYS:

Q. There is no indication whether the patient presented with work or school, correct?

A. Not from here, no.

Q. And there's no indication whether the patient presented with family relations or judgement, correct?

A. That's correct, from this paragraph.

Q. And there is -- and there's no indication whether the patient exhibited thinking or mood impairments, correct?

A. There's no indication whether they had that?

Q. There's no indication whether it was thinking or mood?

A. Oh, oh, as to differentiating, no, there is not.

MR. HAYS: We have been going for a little bit, sir. Can we take a recess?

PRESIDING OFFICER: Yeah. And when we come back, I'll ask the question of how long you wish to go this evening.

MR. EYE: Well, if -- I -- I can say now,

I --

(THEREUPON, a recess was taken.)

PRESIDING OFFICER: Back on the record. And when we were off the record, we had a discussion and I believe both sides want to adjourn at this point.

MR. EYE: That's correct, Your Honor.

MR. HAYS: Yes, sir.

PRESIDING OFFICER: Tomorrow morning at 8:30?

MR. EYE: That's fine, Your Honor.

MR. HAYS: Yes, sir.

PRESIDING OFFICER: Files left here?

MR. HAYS: Fine.

(THEREUPON, the hearing concluded for the day at 4:55 p.m.)

.

.

.

.

.

.

.

.

CERTIFICATE

STATE OF KANSAS

ss:

COUNTY OF SHAWNEE

I, Cameron L. Gooden, a Certified Shorthand Reporter, commissioned as such by the Supreme Court of the State of Kansas, and authorized to take depositions and administer oaths within said State pursuant to K.S.A. 60-228, certify that the foregoing was reported by stenographic means, which matter was held on the date, and the time and place set out on the title page hereof and that the foregoing constitutes a true and accurate transcript of the same.

I further certify that I am not related to any of the parties, nor am I an employee of or related to any of the attorneys representing the parties, and I have no financial interest in the outcome of this matter.

Given under my hand and seal this day of , 2011.

_____

Cameron L. Gooden, C.S.R. No. 1335