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BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS
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In the Matter of) Docket No. 10-HA00129
ANN K. NEUHAUS, M.D.) OAH No. 10-HA0014
Kansas License No. 04-21596)
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Videoconference Deposition of LIZA H. GOLD, M.D.
Washington, DC
Friday, June 24, 2011
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Videoconference deposition of LIZA H. GOLD, M.D., held at the offices of:

PILLSBURY, WINTHROP, SHAW, PITTMAN, LLP
2300 N Street, NW
Washington, DC 20037
(202) 663-8000

Pursuant to K.S.A. 60-230, by Notice, before John L. Harmonson, Registered Professional Reporter, Notary Public in and for the District of Columbia, who officiated in administering the oath to the witness.

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APPEARANCES

ON BEHALF OF THE KANSAS STATE BOARD OF THE HEALING ARTS:
REESE HAYS, ESQUIRE
LORI D. DOUGHERTY, ESQUIRE
KANSAS STATE BOARD OF HEALING ARTS
800 SW Jackson
Lower Level, Suite A
Topeka, Kansas 66612
(785) 296-0961

ON BEHALF OF ANN K. NEUHAUS, M.D.:
ROBERT V. EYE, ESQUIRE
KELLY J. KAUFFMAN, ESQUIRE
BRET JARMAR, ESQUIRE
KAUFFMAN & EYE
123 SE 6th Avenue
Suite 200
Topeka, Kansas 66603
(785) 234-4040
(Present via videoconference)

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APPEARANCES CONTINUED

ALSO PRESENT:
KEITH D. HUDOLIN, ESQUIRE
PILLSBURY, WINTHROP, SHAW, PITTMAN, LLP
2300 N Street, NW
Washington, DC 20037
(202) 663-8000

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LIZA H. GOLD, M.D.,

after having been first duly sworn, was examined and did testify under oath as follows:

EXAMINATION

BY MR. EYE:

Q. Good morning, Dr. Gold. My name is Robert Eye, and I'm one of the lawyers that represents Kristin Neuhaus in this case. We're here today to take your deposition.

Just a couple of ground rules. And probably we need to account for the fact that we're doing this by a videoconference or a video hookup, if you will. And because of that, if the audio is interrupted during my questions, please ask me to repeat it and we'll make sure that it's clear to you. Likewise, if it's interrupted during one of your responses, I may have to ask you to go back and repeat it if that happens.

Additionally, just consistent with that, if I ask you a question that you don't understand, will you agree to ask me to rephrase it so that it is understandable?

A. Yes.

Q. And also to make a good record, and I'm sure you've been deposed many times, but just as much to remind myself as anything, I'll do my best to wait until you complete your response before I ask a question, and if you would do the same in terms of waiting to respond until I finish the question, I'm sure our court reporter will appreciate that in terms of making a good record.

Additionally, if at any time during the course of this deposition you want to take a break, please let us know and we can certainly do that. It's not an endurance test, and I don't want it to turn into one for anybody. So if a break is required, as I say, please let us know.

Dr. Gold, again for the record, you are the individual that provided a report to the Kansas State Board of Healing Arts staff counsel concerning the case that they have filed against Dr. Ann K. Neuhaus, correct?

A. I believe I have filed multiple reports, but otherwise correct.

Q. All right. And when you say multiple reports, what do you mean by multiple reports?

A. Well, they all involve Dr. Neuhaus, but there was a separate report for each case file that I reviewed.

Q. Very well. Do you have your case file on this matter with you today?

A. Yes.

Q. And I would like to -- If you're agreeable, I would like to have that marked as an exhibit and then go through it with you. Then I presume that we can get a photocopy of that before you leave the office there today, and then we can withdraw the original as an exhibit and just use the photocopy, if that's agreeable with you and counsel.

A. Yeah, as long as I get my stuff back, I'm okay.

MR. HAYS: It is, Bob.

MR. EYE: Great. Thank you.

If you would give the case file to the court reporter. And, sir, if you would mark that as

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Exhibit No. 1.

THE WITNESS: It may be more than one piece. These are copies of my reports. And then there's some notes. And there -- Well, that's not really the case file. So this is what I have.

BY MR. EYE:

Q. It consists of the various reports that you prepared related to the charts you reviewed in this matter and some notes; is that correct?

A. Some notes and some office forms that I use as comparative material. So...

MR. EYE: Let's go ahead and have the entire file marked as a single exhibit, and then if we need to break it out into separate parts we can do subparts of Exhibit 1. But let's go ahead and proceed with the entire file at this point as a single unified exhibit.

(Exhibit 1 marked for identification and retained by the witness for copying and distribution.)

BY MR. EYE:

Q. Is your curriculum vitae part of your file?

A. No.

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Q. Do you have it in front of you by any chance?

A. No.

Q. Well, I have it in front of me, so if it's all right, I'm going to ask you some questions about your CV, at least to begin with.

According to your CV that is in front of me, it's dated April 16, 2009. Do you have any significant revisions to your CV since that time? It would be about -- well, two years and a couple of months ago.

A. Yes, probably.

Q. Well, as we go through your CV, if you could let me know any updates that might apply. Let's do it that way.

Are you still a clinical professor of psychiatry at Georgetown University Medical Center?

A. Yes.

Q. And what courses do you teach?

A. I teach a course in writing in forensic psychiatry. I teach a course in assessment of disability, and that's to the forensic fellows. I supervise the fellows when they get disability evaluations, and also certain types of civil litigation evaluations.

And then I also teach the general psychiatry residents in the courses -- they have to do a certain number of hours of forensic psychiatry, didactic lectures, and I give a number of those lectures on various topics, boundary violations, role of expert witness. I'm trying to think of the -- civil litigation issues.

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Q. And in the course of teaching those classes, Dr. Gold, do you ever deal with anything related to provision of abortion services?

A. No.

Q. Now, during the time that you were clinical associate professor of psychiatry, which according to your CV was 2003 to April 2006, were you teaching classes as well in that designation?

A. Yes.

Q. And did any of those classes have anything to do with providing abortion services?

A. No.

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Q. Same question for when you were the clinical assistant psychiatry -- or clinical assistant professor of psychiatry from '98 to 2003. Same question.

A. No.

Q. You were also the associate director of the program in psychiatry in law. It says, according to your CV, that that's been the case from 2001.

Are you still in that role as well?

A. You know, that's kind of defunct at this point because around 2009 Georgetown developed a formal forensic fellowship, so a lot of that got transferred there. So although technically I think I still have the title, I don't think it means anything anymore. I'm pretty sure it's not on my current CV.

Q. Okay. Well, when it was active, or when it was still something that you were engaged in, can you tell us a bit about what your duties or your role was in that capacity?

A. That was more limited to providing forensic didactic lectures to the general psychiatry residents. I organized the lectures. I organized other

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psychiatrists to come and give different lectures in their areas of expertise. There were between -- depending on the year, there were between eight and ten of those lectures a year.

Q. Over the course of an academic year?

A. Yes.

Q. Do you recall whether during the course of your role as the associate director of program in psychiatry in law, whether any of the programs or lectures that you were responsible for arranging, whether they dealt with providing abortion services?

A. They did not.

Q. According to your CV, it indicates that you are the course director for gender issues in psychiatry from 2003 to 2005. Is that correct?

A. Yes.

Q. And can you tell us something about what that entailed, being the course director for gender issues in psychiatry?

A. That was a series of approximately four to six -- I think it was about five lectures for each of those academic years which looked at primarily

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reproductive biological psychiatry, which is evaluation and assessment during pregnancy; postpartum disorders; issues related, for example, to suicide and gender; menopause; premenstrual syndrome; a variety of biologically-related issues.

Q. Did you deliver any of these lectures?

A. Yes. I provided all of them.

Q. Okay. And did any of them deal with evaluating patients for purposes of receiving an abortion?

A. No.

Q. Are you still the course director for writing in forensic psychiatry?

A. Yes.

Q. And although that sort of maybe is self-explanatory, could you tell us exactly what that entails?

A. As part of the fellowship requirements, each fellow is required to do a, quote, scholarly project, unquote. Usually that involves writing something. So I supervise and assist the forensic fellows in developing and writing something that

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hopefully can be published. That's the goal.

Q. And so in that regard, your duties are basically to supervise others who are doing these writing projects?

A. Yes. And edit their material and...

Q. All right. In that regard, have you ever had a student who has prepared a paper for your review or editing that deals with providing abortion services?

A. No.

Q. The next -- Let me ask you this. Since April 2009, are there any additional academic appointments that you have been involved with that we haven't covered today?

A. Not academic, no.

Q. You know, I skipped your board certifications. It indicates in your CV that you're board certified in psychiatry and neurology, and that was since 1991. Is that still an active certification?

A. Yes.

Q. And likewise for the forensic psychiatry

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subspecialty certification, is that still an active certification?

A. Yes. I recertified I believe in 2009. So that's good for another ten years. I'm also on the board, which makes it a little redundant, but that's okay.

Q. Okay. Are there any other certifications that you've received since your April 2009 version of your CV?

A. No.

Q. In regard to the psychiatry-neurology board certification, in the process of receiving that certification did you deal with any issues related to abortions or providing abortion services?

A. I'm sorry, could you repeat that question?

Q. Sure.

In the course of receiving your board certification for psychiatry-neurology, did any of that preparation for taking the examination and getting certified, did any of that deal with providing abortion services?

A. No.

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Q. Same question for the forensic psychiatry board certification.

A. No.

Q. Now I want to go to the areas of expertise that you set out in your CV. The first one that is in the CV that I have in front of me is called areas of expertise, and the first one -- I'm sorry, the first area is "Clinical evaluation, diagnosis and treatment of psychiatric disorders in adults."

Dr. Gold, just in terms of sort of giving us a sense of how this breaks down, what age group do you consider to be an adult? Is there an age demographic that you would apply to, quote, adults, end quote?

A. Well, technically, anyone over 18 is an adult. So anyone over 18 I think I would characterize as an adult, although some are more mature than others and so sometimes there are still adolescent issues even in people over 18.

Q. So it's fair to say that maybe there's not a hard and fast rule in terms of when somebody is an adult and when somebody is an adolescent based on

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developmental or functioning parameters?

A. That's correct. You know, there is a transition and for some people it's earlier, for some people it's later. For legal purposes, 18 is an adult.

Q. Fair enough.

Now, in terms of your areas of expertise, the extent that you specify that it's for evaluation, diagnosis and treatment of psychiatric disorders in adults, do you have an area of expertise that relates to individuals who are not adults; that is, adolescents and children?

A. I see adolescents. I treat adolescents. It is not a specialty area, which is why it's not listed under areas of expertise. In the course of my clinical practice, I have evaluated and treated numerous adolescents for a variety of issues.

In terms of children, if I get a call regarding a child, I typically will refer that to a child specialist because the issues become that much more complicated.

Q. In the -- In the first bullet point

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underneath that area of expertise, it indicates that you have an expertise in the evaluation and psychopharmacologic and psychotherapeutic treatment of post-traumatic affective mood disorders, anxiety disorders and personality disorders.

Does that sound accurate? And I hope I didn't mispronounce anything.

A. That's accurate. And again, the purpose is to highlight the things that I consider I have special expertise in, although in my clinical practice I have treated people with other disorders and evaluated other disorders.

Q. Now, is there anything in that particular evaluation of psychopharmacologic and psychotherapeutic treatment of these kinds of disorders that would bear on providing abortion services?

A. You would have to define what "bear on providing abortion services" means.

Q. Does it -- Well, let me ask you this: Have you ever treated a patient -- or strike that -- evaluated a patient for psychopharmacologic or

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psychotherapeutic treatment, anything that has to do with an abortion?

A. Well, I've had a number of patients with whom I've discussed abortion. I evaluate and treat many, many pregnant women. You know, when people are pregnant, the issue of abortion does arise. Some of them have abortions, some of them do not. Their evaluation and treatment therefore has to include, if that's an issue for them or an option for them, whether or not they want or plan or need an abortion.

Q. And in that regard, do you have any experience in those sorts of evaluations when it deals with adolescents?

A. I've seen a couple of pregnant adolescents.

Q. For purposes of evaluating them for an abortion?

A. Not specifically for purposes of evaluating them for abortion. I evaluate for psychiatric disorders.

Q. All right. The next bullet point is "Psychotherapeutic issues related to the psychological and medical consequences of childhood and adult

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trauma."

Does that have anything to do with abortions in your practice?

A. That's a difficult question to answer because if there is sexual abuse that leads to a pregnancy, then that can be an issue where abortion comes up. Women may have already had abortions before they come to see me. Some women come in crisis because they've become pregnant as the result of trauma and are debating what to do, and one of the options is, of course, an abortion.

So when you work with pregnant women, evaluate pregnant women, inevitably the issue of abortion arises regardless of whether there has been trauma or not trauma.

So that's the best I can answer that question.

Q. Thank you.

The next bullet point indicates that you have an area of expertise in the diagnostic and psychopharmacologic expertise in women's reproductive psychiatry including postpartum disorders, management

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of medication during pregnancy and lactation, premenstrual dysphoric disorder and menopause.

Does that sound accurate?

A. Yes.

Q. I want to look at the first subpart of that, and that deals with women's reproductive psychiatry. Have you evaluated any woman in the course of your practice for purposes of determining whether her mental health would be preserved by virtue of having a late-term abortion?

A. Not a late-term abortion, no.

Q. How about an abortion that's not -- And when we say late term, do you consider that to be the last trimester?

A. Yes.

Q. How about for middle -- the middle trimester? Same question.

A. Possibly a handful. You know, three, four, over the course of 20 years.

Q. And how about a first term abortion?

A. Oh, that's probably a much larger number. Most women who have abortions typically have them in

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the first trimester, so...

Q. In that regard, have you ever generated a report that indicates that an abortion would be consistent with preserving the mental health of the mother?

A. No.

Q. The next bullet point, Dr. Gold, indicates that you have an area of expertise in forensic and independent medical evaluation, including assessment of emotional injury, damages and mental health assessments, including testimony if required.

Have you ever testified in a case that involved providing abortion services? Or strike that.

Have you ever testified in a case that had an issue concerning abortion?

A. No.

Q. Have you ever served as a consultant in a case that involved abortion other than this case?

A. No.

Q. In terms of your forensic and independent medical evaluation work, is that -- does that frequently relate to litigation?

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A. Not necessarily.

Q. What else -- But it would include litigation?

A. It would include litigation, yes.

Q. What else other than litigation would fall under that category, Dr. Gold?

A. I do independent evaluations for disability, workers' comp. Not all of those involve litigation.

I do some criminal evaluations; I guess those by definition involve litigation.

And I do record reviews on occasion which are referred to me by attorneys or insurance companies, and those do not involve -- usually do not involve litigation directly for me. They may involve litigation for someone, but I'm not involved in that.

Q. The next bullet point indicates an area of expertise in psychiatric consequences of trauma and violence.

Does that have anything to do with abortions?

A. Not directly, no.

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Q. How about indirectly?
A. Well, again, a certain small percentage of sexual assault and trauma results in pregnancy, and for those people when you're evaluating or treating the issue of what to do when a pregnancy arises.
Q. In your work have you ever generated an opinion that is consistent with preserving the mental health of the mother if she has an abortion because of a pregnancy that's been caused by a traumatic or violent experience?
A. Can you define generating an opinion?
Q. Sure.
Providing an opinion to either a patient or another physician or an attorney regarding whether preserving a mother's health -- whether an abortion would be consistent with preserving a mother's health.
A. It's not my role to generate such opinions, and I've never been asked to generate such opinions. It's my role to help my patients come to decisions about what's best for them, and that's an autonomous function that I do not -- I actively do not usurp by offering my own opinion unless there is a crisis or

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emergency, and I have not been involved in a case that is a crisis or emergency at that level.
Q. So the answer would be no?
A. I -- I can't explain it any better than I did.
Q. Is it safe to assume that none of your employment litigation consults has anything to do with abortion?
A. That is correct.
Q. I'm now looking at your -- Well, I should ask --
A. Although I would say that a couple of them have had to do with pregnancy.
Q. Sure.
A. Pregnancy discrimination.
Q. Right.
A. But abortion didn't enter into those cases.
Q. Fair enough.
Are there any other areas of expertise that you would consider that should be added to your CV from the April '09 version?
A. I probably would add and probably have

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added employment-related evaluations beyond disability, such as fitness-for-duty, return to work, ADA evaluations, Americans With Disabilities Act. So those types of employment-related evaluations.
Q. Very well.
I'm now looking at the second page of your CV that's dated April 16, 2009. At the top of that page it indicates postgraduate medical training. And the first point is Boston University Psychiatry Residency Training Program from 1986 to 1990.
Does that sound correct?
A. Yes.
Q. In that psychiatry residency training, did any of that training have to do with providing abortions?
A. No.
Q. Did it have anything to do with providing anything that we would consider to be primary care?
A. That's a difficult question to answer. I would have to answer yes in that sometimes patients came in for what they presume was a psychiatric problem and needed really to be seen and treated like

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a primary care patient.
And to the extent that I was able to do so, I did so, but usually in conjunction with referring them to a primary care doctor. But if they needed services immediately that I could provide that were primary care services, I would provide them.
Q. Very well.
It indicates that this residency training program, at least part of it, was conducted at Boston City Hospital. Is that correct?
A. That is correct.
Q. Is that a facility that provides abortions?
A. I don't know.
Q. While you were at Boston City Hospital for the residency training program, do you know whether abortion services were provided at that time, that is between '86 and '90?
A. I don't know.
Q. It indicates some of this training occurred at the University Hospital in Boston, Massachusetts. Is that correct?
A. Yes.

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Q. And is that a hospital that provides abortion services?
A. I don't know.
Q. While you were there, did it?
A. I don't know.
Q. It indicates that some of that training took place at the Edith Nourse Rogers Veterans Administration Hospital in Bedford, Massachusetts. Was that a facility that provides abortion services?
A. Well, it's a veterans hospital, and 98 percent of the population is male, so I doubt it. But I don't know.
Q. And that would be for when you were there and currently?
A. Well, I don't know about currently there. But when I was there, it was 98 percent male, and I can't imagine -- they didn't have an OB/GYN department, so I can't imagine that they provided abortions.
Q. It indicates some of this training happened at the Brockton Hospital in Brockton, Massachusetts. Is that a facility that provides abortions?

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A. Currently, I don't know.
Q. What about then, when you were a transitional intern there?
A. I would have to say I don't know.
Q. The last point under that postgraduate medical training is something that you were evidently designated as a Ginsberg fellow for the advancement of psychiatry, and that was 1989 to 1990.
Could you tell us what that involved, please?
A. Yeah. There is a group called the Group for the Advancement of Psychiatry where they have work groups on active psychiatric issues and some nonactive psychiatric issues, historical issues that are no longer that relevant.
And one of the ways that they actively introduce themselves and recruit members to join is by offering fellowships, free fellowships through residency programs where you participate for two years, you're assigned to a work group, and you go to the meetings. They have two meetings a year in Westchester, New York.

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Q. And is that what you did?
A. Yes.
Q. What kind of work did you do in relation to this fellowship?
A. I was assigned to the work group on managed care, which at that time was a very, very big issue of concern.
Q. I have a vague recollection of when that was going on.
A. Yes.
Q. Did any of that have to do with providing abortion services?
A. No.
Q. Did any of the meetings that you attended in relation to that fellowship have anything to do with providing abortion services?
A. Only tangentially.
Q. In what way?
A. Well, the project that we did, the fellows have to present a project at the end of the two years, and the project that we did was on postpartum disorders. And in the course of that, we talked about

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pregnancy, we talked about abortion, we talked about birth control. We talked about a lot of things. So it did not focus on abortion, but it was tangentially involved in the discussion of postpartum disorders.
Q. Did you in the course of that tangential aspect of abortions deal with evaluating patients for purposes of receiving late-term abortions?
A. No.
Q. The next point on your CV deals with your medical education, which indicates that you graduated from New York University School of Medicine with your medical degree in 1986. Is that correct?
A. Yes.
Q. During the course of your medical education at NYU, did you have any classroom work on abortion services?
A. No.
Q. The next bullet point under medical education indicates that you were the recipient of the Alex Rosen Award for Excellence in Medicine and Humanities in 1986. Is that correct?
A. Yes.

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Q. Did that have anything to do with abortion services?
A. No.
Q. During the course of your medical education, did you have any clinical -- at NYU, did you have clinical experience?
A. No.
Q. Your graduate education --
A. Well, I'm sorry. You asked if I had clinical experience and I said no. That's not true. I had lots of clinical experience.
Can you be more specific?
Q. I surely can. Thank you.
I'm talking about during your medical education at NYU, did you have a clinical component to that medical education?
A. Yes.
Q. And can you tell us whether any of that clinical experience at NYU involved abortion services?
A. It did not.
Q. It indicates that you had graduate education at the University of Cambridge. I assume

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that's in the U.K.?
A. Correct.
Q. And that you received a master of philosophy in the history of medicine in 1983. Is that correct?
A. Yes.
Q. Did you have to write a paper, a thesis or some sort of dissertation in order to receive that degree?
A. Yes, I did.
Q. What was your topic?
A. My topic was -- I'm going to spell this for you, Ignaz, I-g-n-a-z, and the last name is Semmelweis, S-e-m-m-e-l-w-e-i-s, and puerperal sepsis, p-u-e-r-p-e-r-a-l, sepsis is s-e-p-s-i-s.
Q. And did that paper have anything to do with abortion services or abortions?
A. You know, that's kind of interesting because -- well, it was interesting to me, obviously. Semmelweis is considered the person who discovered that if you wash your hands before touching women after they have intentionally or unintentionally have

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given birth or had an abortion, which would be unintentional -- well, I shouldn't say unintentional but not legal at that time in Vienna -- well, yes, I guess it was Vienna where he was, that they didn't get infected and die. The death rate was higher than 50 percent in some of the wards from puerperal infection.
So it revolved around theories of pregnancy, infection, death and Semmelweis's role in elucidating the connections between all of those things. And abortion did come up in that in terms of -- but it wasn't the focus, certainly, of the paper at all.
Q. And it indicates that you received your undergraduate degree from Harvard Radcliffe College in 1981. Correct?
A. Yes.
Q. In the course of your undergraduate education did you have any course work that dealt with abortions?
A. I took a course on medical ethics that talked about abortion in terms of ethical issues.

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Q. Did it have anything to do with evaluating patients for purposes of receiving abortions?
A. No. Just general medical ethics regarding abortions.
Q. Is there anything in terms of your formal education that you should -- that you would need to add to your April 16, 2009, version of your CV?
A. Not formal education, no.
Q. The next section deals with your certifications, and it indicates that you have an active license in Virginia. Is that still active?
A. Yes.
Q. What about District of Columbia?
A. Yes.
Q. And the National Board of Medical Examiners?
A. I have two other licenses also that aren't on there.
Q. Okay. And what are those?
A. And New Jersey and New York.
Q. And when did you receive the New Jersey license?

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A. I think it was late last year.
Q. Okay. And how about New York?
A. It would have been the year before, so it would have been in 2009 but after April.
Q. Do you do any practice in New Jersey?
A. No, I do not.
Q. How about New York?
A. No.
Q. What about District of Columbia?
A. No. I did -- Well, I did consulting work up until about a year or so ago at St. Elizabeth's Hospital, which would probably be considered -- well, it did -- actually I was writing orders, so yes, it was clinical.
Q. Do you still have privileges at St. Elizabeth's Hospital?
A. I'm not sure when the privileges expire. I might.
Q. Is St. Elizabeth's Hospital a facility that provides abortion services?
A. Not to my knowledge.
Q. Do you have privileges at any other

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hospital within the District of Columbia?
A. No.
Q. What hospitals do you have privileges at in the Commonwealth of Virginia?
A. Virginia Hospital Center in Arlington.
Q. Let me just stop with that one. Does it provide abortion services?
A. I don't know.
Q. And then you were going to continue.
A. No, that's the only one.
Q. Do you have admission privileges or practice privileges at any hospital in New York?
A. No.
Q. Or New Jersey?
A. No.
Q. Have we covered all of the hospitals at which you have privileges?
A. Yes.
Q. It indicates that you had licenses -- Well, strike that.
It indicates that you had licenses in New Hampshire from '88 to '92. Is that correct?

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A. Yes.
Q. What were the circumstances for not continuing your license in New Hampshire after '92?
A. My husband and I move moved to the Northern Virginia area, and I wasn't going to be working there anymore.
Q. When you were in New Hampshire did you have admission privileges at any hospital?
A. At a number of hospitals.
Q. Did any of them provide abortion services?
A. I don't know.
Q. Did you ever admit a patient for abortion services at any of the hospitals in New Hampshire at which you had privileges?
A. No.
Q. It indicates that you had a Massachusetts license from '86 to '92. Is that correct?
A. Yes.
Q. Did you have admission privileges at any hospitals in Massachusetts during that time?
A. Yes.
Q. Did any of them provide abortion services?

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A. I don't know.
Q. Did you ever admit a patient in Massachusetts for abortion services?
A. No.
Q. The next section in your CV covers awards. The first one that's -- I should ask, are there any other licenses as of today that you carry that we haven't covered?
A. No.
Q. One thing that I should go back and ask about, you carry a license from the National Board of Medical Examiners and that you've had since 1987, correct?
A. Correct.
Q. What sort of -- What does that license entitle you to do?
A. I'm not sure, but I don't think you can practice medicine unless you get one. So it's a series of three tests. To get the license, you have to pass three stages of tests -- maybe it's two. It was a long time ago. It's two or three stages of tests; the first one after your first two years of

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medical school, the second one I think after your fourth year of medical school, and then the third part is after your internship.

I should know more about it, but at the time they were the hoops you had to jump through and I jumped through them. And you don't have to renew it, so it's there. I have it.

I think it has to do with whether you went to American medical schools or foreign medical schools. I think you -- Yeah.

Q. Well, do you do anything with that license now? I mean, is it something that you actively use in order to practice your craft?

A. I presume that I couldn't practice unless I had it. But I don't know for sure. I think you have to have it in order to graduate from an accredited residency, and if you don't graduate from an accredited residency then you can't practice as a specialist. So...

Q. Now, granted you've had that license since 1987. You took a series of exams to get that license?

A. Yes.

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Q. Did any of that have to do with providing abortion services?

A. Oh, I certainly can't recall.

Q. Do you renew that license periodically?

A. No. It's not required.

Q. Oh, once you have it, you have it?

A. You have it, you have it. That may not be the case anymore. Certain licenses that were lifetime licenses now do require recertification. But if you got them before that happened, then you were grandfathered in. So I don't even know the status of that one. I've never been notified that I need to renew it.

Q. Very well. Thank you.

The next point is awards, and it indicates that you were the recipient of a top doctor award in 2008 in Washingtonian Magazine.

Do you recall that?

A. Yes.

Q. Did that have anything to do with abortion services, that award?

A. Only tangentially.

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Q. And how was it tangentially related?

A. Again, I believe it was related to providing evaluation, consultation and treatment to women who were pregnant, women who had psychiatric disorders or potential psychiatric disorders who were pregnant, and postpartum services and treatment as well. And, of course, in the course of addressing pregnancy, abortion arises on occasion.

Q. Do you know how you were selected to receive that award?

A. I believe that the process is that the magazine polls doctors randomly in the metro D.C. area and asks them to list people they would refer their friends and family to, and I think that that's how they do that.

Q. I see.

Did you -- Did you give a speech when you got that award?

A. No. They -- No, it's not that kind of award. They give it to a number of -- They pick like ten people from each specialty, and they list them in the magazine. And, you know, if you want, you can buy

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a plaque to hang in your office.

Q. I gotcha.

And did they do a little descriptive piece about you when you got your award that appeared in the Washingtonian Magazine?

A. No. They just list your name.

Q. I see. Okay.

A. I think they also list your contact information.

Q. All right. The next award that's specified here is Manfred S. Guttmacher award in 2006, and that was awarded by the American Psychiatric Association -- the American Academy of Psychiatry and the Law.

And do you recall receiving that award?

A. Yes. I just received it again, so I'm also the 2011 recipient of that award as well.

Q. Now, in 2006 you gave a speech when you received that award, didn't you?

A. Well, it's not a speech. It's an academic lecture.

Q. I see. Okay, an academic lecture.

And that was on sexual harassment and

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psychiatric assessment in employment litigation, correct?

A. Well, the book was. The speech wasn't.

Q. What was the speech?

A. It's not a speech. The lecture was on sources of bias in employment evaluations.

Q. That didn't have anything to do with abortion services, did it?

A. No.

Q. And congratulations on being the 2011 recipient.

A. Thank you.

Q. Did you present a lecture in relation to that award?

A. Yes, I did.

Q. And what was the topic of that lecture?

A. It was a model for assessment of disability, of psychiatric disability.

Q. Did it have anything to do with abortion services?

A. No.

Q. In 1997 you were the recipient of the

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Washington Psychiatric Foundation Community Service Award.

Do you recall that?

A. Yes.

Q. And what did that award signify?

A. At that time I was doing -- I was volunteering hours for the local Washington Psychiatric Society hotline for people who would call up with psychiatric questions or needing a psychiatric referral and I would try to help them out. I provided a certain number of hours for I think it was a few years.

Q. So the award recognized that service?

A. Right. It's a community service award.

Q. Did you provide clinical consultations to people who called in on that hotline or whatever it was called?

A. No.

Q. Did you ever refer anybody to a physician for an evaluation to get an abortion as a result of working on that -- in that capacity?

A. No. That would not be an appropriate

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suggestion.

Q. Now, other than the 2011 Guttmacher award that we just talked about a few moments ago, are there any other awards that we should add to this part of your CV?

A. No.

Q. The next page of your CV deals with the summary of your professional experience, and it's arranged in kind of reverse chronological so we'll start with the most current and work our way back.

It indicates in this April 2009 version of your CV that from 2001 to that time you were in private practice in clinical and forensic psychiatry in Arlington, Virginia, since 1992. Is that correct?

A. No. My private practice was in the District of Columbia where I treated inpatients at the Psychiatric Institute of Washington, and I did that from 1992 to 1997 I believe.

And until 2002 my office practice was located in McLean, Virginia, and in 2002 I moved to Arlington, Virginia.

Q. Okay. So if it says since 1992, that was

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probably just a typo?

A. Well, I would have to see it. I mean, if I didn't delineate the locations, I would have to -- I may have delineated them later. I would have to look at the document to see whether it's a typo or just not a clear statement.

Q. All right.

MR. HAYS: Bob, we can show her a copy of it. I have it up on my laptop.

MR. EYE: That would be great. Thank you, Reese.

THE WITNESS: Yeah, I would say it looks like for some reason I put -- well, the part that's correct is private practice clinical and forensic psychiatry since 1992. That part is correct. The Arlington, Virginia, is not correct since I was also in McLean, Virginia. And then I did list St. Elizabeth's.

Yeah, it's a little confusing. I apologize.

BY MR. EYE:

Q. That's all right.

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Doctor, in the course of the private practice that you specify in that section of your CV, I assume that you didn't provide any opinions to either patients or other physicians concerning whether a woman should receive a late-term abortion in order to preserve her mental health?

A. No.

Q. No meaning you did not provide such an opinion?

A. Correct.

Q. Thank you.

It indicates that you were a consultant at St. Elizabeth's Hospital, the John Howard Pavilion, in 2008. Is that correct?

A. Yes.

Q. What did you consult about?

A. Those are -- That's the forensic wards, and those are patients who are being treated and evaluated for things like they've been found not competent to stand trial and they've been committed in order to try to restore competency. Some of them are there for evaluations of whether -- for not guilty by reason of

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insanity evaluations. Some of the more significant or other legal matters that may involve psychiatric issues and evaluations.

Q. I see.

I assume none of that had to do with providing abortion services.

A. Correct.

Q. It indicates that you are on the medical staff of the Virginia Hospital Center, Department of Psychiatry in 2004. Is that correct?

A. Yeah, starting in 2004 to the present. I'm still on that.

Q. Okay. And is the Virginia Hospital Center, is that located in Arlington?

A. Yes, it is.

Q. And does it provide abortion services?

A. I don't know.

Q. And the next designation is that of a court consultant for the Arlington County district and circuit courts, and that's from 2008 to the present. Are you still doing that consulting?

A. Yes. And I've also -- I should probably

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put down Alexandria courts and Fairfax County courts.

Q. And what sort of consultations do you provide in that regard, Doctor?

A. I do court ordered competency to stand trial evaluations and some criminal responsibility evaluations.

Q. Nothing to do with abortions, correct?

A. No.

Q. Is there anything else that we should add to that experience summary from 2001 to today other than what we've already covered?

A. No.

Q. The next time designation is from 1992 to 2000, and recognizing that there may be some overlap there with what you're doing currently, but the first designation is private practice, clinical and forensic psychiatry in McLean, Virginia.

A. Okay.

Q. And I think we covered the locale issue.

A. Right.

Q. Was that just a function of changing the location of your office?

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A. Yes. I moved.

Q. All right. But did the scope of your practice change as a result of moving? I presume it stayed more or less the same.

A. That is correct. There was no significant change.

Q. It indicates that you were attending psychiatrist from 1997 through 2000 at the Columbia HCA Reston Hospital in Reston, Virginia. Is that correct?

A. Yes.

Q. Does the Columbia HCA Reston Hospital provide abortion services?

A. I don't know.

Q. In your work as attending psychiatrist at that facility from '97 through 2000, did you ever deal with patients who were seeking abortion services?

A. No.

Q. Why did you end your affiliation with Columbia HCA Reston in 2000?

A. My role there was I would be called in, often on an emergency basis for a medical or surgical

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patient who was having a psychiatric emergency or crisis, either in the emergency room or on one of the floors. And they did not have any psychiatric infrastructure in that hospital to manage any of that, and so I would be basically having to deal with some of these very complicated, difficult situations without any assistance or backup, and I felt that it was not a good situation.

For me it was very time intensive, very unrewarding, and in the end no one was happy. The patients weren't happy, the doctors weren't happy and I wasn't happy. So they needed a different system.

Q. I understand.

It indicates that during that period of time, that is from 1992 to 2000, you were affiliated with the Psychiatric Institute of Washington, D.C. as the medical director in the day center program, and then it says for the center for post-traumatic disorders. That's a fairly long title. Does that sound accurate?

A. No.

Q. Okay. Well, can you tell me what your --

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Were you affiliated with the Psychiatric Institute of Washington, D.C.?

A. Yes.

Q. And were you the medical director of the day center program?

A. From 1996 to '97, I believe I was.

Q. And is that then distinct from the center for post-traumatic disorders?

A. No. It was a subdivision of that. It was their outpatient day program. So after the inpatient program, many people transitioned through the outpatient day program before complete discharge.

Q. And as the medical director, did you see patients?

A. Yes.

Q. And did you see patients who were seeking abortion services?

A. I wouldn't know. I mean, some of them might have been.

Q. Did you ever -- Let me ask this: I presume that the Psychiatric Institute of Washington, D.C. doesn't provide abortion services.

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A. That is correct.

Q. Is it an admitting hospital?

A. Yes, it is.

Q. And you had admission privileges there?

A. Yes.

Q. Does it deal with any obstetric or gynecological cases?

A. It's a psychiatric hospital. Obstetrical or gynecological issues arise in psychiatric patients, but that's not where you would go to be admitted if your primary issue was an OB/GYN issue.

Q. Dr. Gold, it indicates that from 1992 to 1997 you were an attending psychiatrist at the Psychiatric Institute of Washington, D.C.

Did you see patients in that capacity?

A. Yes.

Q. And if I ask you the same question about anybody seeking abortion services, would your answer be the same?

A. Yes.

Q. You had some affiliation with the center for post-traumatic disorders at the Psychiatric

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Institute. What did that deal with?

A. That dealt with primarily individuals who had undergone trauma or abuse, usually in the context of an intimate relationship as children. Occasionally there was stranger-related violence, but primarily it was trauma and violence, domestic violence, childhood trauma, childhood abuse.

Q. Did any of that have to do with abortions?

A. You know, many of -- the majority of the patients were women. Many of them were women who had had abortions for various reasons. That wasn't the primary reason they were admitted. They were admitted for depression, suicidality, self-mutilation, a variety of anxiety and depression-related problems, dissociative disorders. Some of them were pregnant. You know, a handful were pregnant. Typically didn't have pregnant patients, but some turned up pregnant.

Q. In your work with the Psychiatric Institute of D.C. did you ever evaluate patients for purposes of late-term abortions?

A. No.

Q. How about for abortions that weren't late

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term, that is first trimester or second trimester?

A. Can you define what you mean by evaluate patients for abortion?

Q. Did you ever have an occasion to evaluate a patient to determine whether an abortion in the first or second trimester was consistent with preserving the health of the mother?

A. In the course of treating patients who were pregnant and who may have wanted to consider the option of an abortion, we would discuss the implications of an abortion on their mental health as well as on, you know, social issues, et cetera, that they may have. That's the best I can answer that.

Q. But specifically as to whether an abortion would be consistent with preserving the mental health of the mother, did you do that sort of evaluation?

A. No.

Q. The next time frame that's covered in your CV is from --

A. Let me back up and say that we would discuss what the implications of getting an abortion might be on her mental health. But a formal

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declaration, I'm doing an evaluation to determine whether this is necessary to preserve the mental health, no.

Q. Thank you.

The next time frame is 1986 to 1992. And the first thing that's specified there is an affiliation with the Psychiatric Institute of Catholic Medical Center of Manchester, New Hampshire.

A. I'm pretty sure they didn't provide abortions.

Q. Okay. Thank you for anticipating that.

You were the associate medical director. What were your duties in that capacity, Doctor?

A. It was a smallish inpatient psychiatry unit, and I evaluated and treated about half the patients on the unit, so that would be anywhere between nine and 12 patients, and also provided psychiatric consultations in the rest of the hospital.

Q. Did any of your practice at the Catholic Medical Center have to do with abortions?

A. Oh, unlikely. We weren't even allowed to prescribe birth control pills, so, you know...

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Q. Fair enough.

It indicates that in 1991 to 1992 you were the attending psychiatrist at the Nashua Brookside Hospital in Nashua, New Hampshire. What were your duties in that regard?

A. I believe that was a psychiatric facility only, so I would evaluate and treat patients there.

Q. Did any of your practice there have to do with abortions?

A. Not that I recall.

Q. It indicates that in that same time frame, '91 to '92, you were at the National Memorial Hospital in Nashua, New Hampshire, as attending psychiatrist. I assume that that's a different hospital than Brookside?

A. Yes.

Q. So Nashua, New Hampshire, has two hospitals?

A. Well, I think the National Memorial Hospital was a general hospital that had a small psychiatric unit. Brookside was a separate psychiatric hospital, freestanding psychiatric

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hospital.

Q. I see. And did National Memorial Hospital provide abortion services?

A. I don't know.

Q. Did any of your practice there in '91 to '92 have to do with abortions?

A. I don't recall. Certainly not directly.

Q. It indicates that from 1990 to 1991 that you were the assistant clinical director at the Psychiatric Institute of Malden Hospital in Malden, Massachusetts. Was that another freestanding psychiatric facility?

A. No. That was a general hospital.

Q. I see.

And did it provide abortion services?

A. I don't know.

Q. Did any of your practice as the assistant clinical director have to do with abortions?

A. Again, not directly. It's possible that indirectly -- I don't recall, but if any of the patients were pregnant, it might have come up in the course of treatment.

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Q. In Massachusetts during the '90 to '91 time frame could a woman get a late-term abortion?
A. I don't know.
Q. How about the same time frame in New Hampshire, could a woman get a late-term abortion?
A. I don't know.
Q. It indicates that in '90 to '91 you were a clinical instructor of psychiatry at Boston University School of Medicine. Is that correct?
A. Yes.
Q. And is that affiliated with a hospital?
A. That's affiliated with University Hospital and Boston City Hospital and the VA Hospital in Bedford, Massachusetts. It's affiliated with the residency program.
Q. I see. And do any of those hospitals, that affiliation that you just mentioned, do any of those hospitals provide abortion services?
A. I don't know.
Q. Did they during the 1990 to 1991 time frame?
A. I don't know.

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Q. When you were the clinical instructor in psychiatry from '90 to '91 at the Boston University School of Medicine, what classes did you teach?
A. Well, when it says clinical instructor, it means you're not really doing classes, you're doing clinical instruction. And basically that involved teaching medical students and residents in training who are less experienced than yourself.
Q. I see.
A. So if you're a third year, you teach first year, second year and medical students.
Q. I see. Okay.
And Doctor, did any of those duties involve teaching students how to evaluate patients for purposes of receiving an abortion?
A. No. I don't think there is such a thing.
Q. The next point in your CV is that you were the attending psychiatrist at the Hampstead Hospital, Hampstead, New Hampshire, in 1990 to 1991.
Do you recall that experience?
A. Yes.
Q. Did the Hampstead Hospital in 1990 to 1991 provide abortion services?
A. No. That was a freestanding psychiatric hospital.
Q. So the next point here is as an attending psychiatrist at the Charles River Hospital in Wellesley, Massachusetts, from '88 to 90.
Did Charles River Hospital provide abortion services?
A. No. That was a freestanding psychiatric hospital.
Q. In either Hampstead or Charles River Hospital when you were attending psychiatrist, did any of your practice deal with evaluating women for abortion services?
A. No.
Q. The next section in your CV is "Professional Affiliations," and the first thing that is listed under that is the American Academy of Psychiatry and the Law, 1997.
Is that correct, that you've been affiliated with that since '97?
A. Yes.

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Q. And it indicates that you were elected to the board of governance in 2006 to 2009. Is that correct?
A. Yes.
Q. And is that like being on the board of directors of an organization?
A. I presume so. I mean, it's a nonprofit educational professional organization and you're a voting member of the board.
Q. Has the American Academy of Psychiatry and the Law, since you've been affiliated with it, ever taken a position officially as an organization regarding abortion?
A. No. I'm also -- Just to add for completeness, I'm also vice president elect for the organization at this point.
Q. It indicates in your CV that you were a program chair for the 2006 annual meeting in Chicago.
Do you recall those duties?
A. Yes.
Q. Did any of the program that was presented at the annual meeting in Chicago have to do with

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abortions?
A. I don't recall.
Q. Did you have anything to do with presenting a paper or a program or information during that annual meeting?
A. Yes.
Q. And what was your presentation on?
A. Let's see. I did one on sexual harassment, one on the history of forensic psychiatry, and I participated in a mock trial.
Q. Cool.
A. It was.
Q. I bet.
Did any of your papers or presentations, did it touch in any way on abortions?
A. No.
Q. Did the mock trial?
A. No. The mock trial dealt with postpartum psychosis, but not abortion.
Q. It indicates that in your affiliation with the American Academy of Psychiatry and the Law that from 2005 to 2007 you chaired the task force on

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development of guidelines for disability evaluations.
Do you recall that experience?
A. Yes. Oh, and I had to do a presentation on that also, so that was another presentation.
Q. As chair of that?
A. Yes.
Q. And in terms of just being on the task force, did that have anything to do with abortions?
A. No.
Q. And did your presentation?
A. No.
Q. Is there anything other than what you've already mentioned as far as now being vice president elect of the organization and filling in some other details, is there anything else in terms of your affiliation with the American Association of Psychiatry and the Law that we need to add?
A. I don't think so.
Q. By the way, if you think of something as we progress along, we can always go back and pick it up, so feel free to add if something else comes to mind.
A. Okay.

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Q. You were active in some committees related to that organization as well. One was the newsletter editor search committee in 2008. I assume that didn't have anything to do with abortions?
A. Correct.
Q. Let me just ask you: Did your work in any of the committees have anything to do with abortions?
A. No.
Q. The next organization that's listed is the Chesapeake Bay Chapter of the American Academy of Psychiatry and the Law.
Are you still affiliated with that organization?
A. Well, I'm still a member.
Q. You were president from 2004 to 2008, correct?
A. Correct.
Q. Did the Chesapeake Bay Chapter of the American Academy of Psychiatry and the Law ever deal with abortion issues?
A. I don't know about ever. Not in the time that I was associated with it.

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Q. So not while you've been associated with it?
A. Correct.
Q. The next organization affiliation that's listed is the American Psychiatric Association. It indicates that you were a member of that from 1986.
Are you still a member?
A. Yes.
Q. And you were designated distinguished fellow in 2006. How did you get to become a distinguished fellow?
A. Oh, you have to be nominated and letters of support have to be written.
Q. To your knowledge, does the American Psychiatric Association, does it have an official position related to abortion?
A. Not that I'm aware of.
Q. And you became as opposed to a distinguished fellow, a fellow in 2003. Was the selection process similar to becoming a distinguished fellow?
A. I don't think so. As you go up, fellow,

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distinguished fellow, lifetime fellow, it becomes harder and harder to get those distinctions. So I think for fellow it only required a nomination and a certain number of years in the organization. I don't think you had to have letters supporting why, you know, you would be anything else.

Q. I see.

And did anything in terms of being either distinguished fellow or fellow have any relationship to abortion or abortion services?

A. No.

Q. In 2003 and 2006 you were the chair of the committee of tellers. Can you explain that?

A. Well, every year they have an election for who is going to be president, who is it going to be vice president. And in the olden days the tellers were the people who actually counted the ballots and made the determination. Now they're counted by computer, but the tellers have to go over the computer results.

And there's always a handful of people who don't fill out the ballots appropriately, so you try

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to figure out what the intent of the voters were and whether it was really a hanging chad or not a hanging chad. And then you certify -- And if you can't figure it out, you throw out the ballot, and then you certify the election results.

So they can't announce the results of the election until the tellers sign off on it even though it's mostly done by computer now.

Q. Okay.

A. But in the olden days they counted them by hand, and the tellers did that.

Q. Right.

Dr. Gold, you've served on some committees of the American Psychiatric Association organization. One is on the council on psychiatry and the law, and that was from 2007 to -- it says here 2011. Is that correct?

A. I believe so. It might have been to 2010.

Q. Okay. What did you do on --

A. Oh, it had to be 2010, because this is 2011.

Q. So are you not on that committee anymore?

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A. That is correct.

Q. While you were on that council on psychiatry and the law, did you ever have any -- did you deal in any way with abortions?

A. No.

Q. You were also on a committee on judicial action from 2002 to 2006. Same question. Did any of that have anything to do with abortions?

A. I can't recall. It's possible.

Q. Is there anything that would help you remember whether you dealt with abortions in that capacity? Is there any documentation that you could look at that might refresh your memory?

A. No.

Q. I'm going to skip the next one, the committee of tellers, because you've already discussed that.

The next one is correspondence committee on history and library. That was from 2002 to 2008. Anything to do with abortions in that capacity?

A. No.

Q. The next organization that you list is the

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Washington Psychiatric Association, and you became a member of that in '92.

Are you still a member of that?

A. Yes.

Q. And is that the Washington, D.C. Psychiatric Association?

A. Yes, it is.

Q. And do you hold any offices in that organization?

A. No.

Q. How about are you active in any committees?

A. No.

Q. Does the Washington Psychiatric Association take a position on abortion?

A. Not that I'm aware of.

Q. Abortion services are available in Washington, D.C., aren't they?

A. I presume so, yes.

Q. You don't know?

A. No, I don't know for a fact. I presume they are. I presume they're available everywhere.

Q. Why do you presume that?

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A. Because they're legal, and there is a demand for them, and if something is legal and there is a demand for it, someone provides a service.

Q. So when you say available, you mean someplace within the United States, if a woman wanted an abortion she could find somebody to provide that?

A. No. I presume there are doctors and clinics who provide, among other services, abortions under appropriate circumstances within the legal parameters where that's allowed. And I presume wherever it is legal to do so, there are services available for people who desire to avail themselves of those services.

Q. You've already noted a couple of affiliations that you've had with hospitals that did not provide abortion services, correct?

A. Yes.

Q. Have you ever been affiliated with a hospital that you know of that provides abortion services?

A. Again, I presume, but don't know for a fact, that some of the general medical hospitals that

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I've been affiliated with provide abortion services because those are among standard services provided in OB/GYN surgical departments.

Q. Have you ever had any involvement with those services, that is abortion services, at any of those hospitals that you presume provide those services?

A. No.

Q. You've been a member of the American Medical Association since 2002. Are you still an active member?

A. Yes, I am.

Q. Do you belong to any subgroups of the AMA?

A. I might. I think by virtue of joining the AMA they sign you up for your local chapter. I may be a member of the Northern Virginia -- whatever the local Northern Virginia chapter is, or it might be a Metro D.C. chapter. I don't know.

Q. In your affiliation with the AMA since 2002, has any of that involved abortions?

A. No.

Q. The next thing you list is the American

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Society of Clinical Psychopharmacology, and that's from 1997.

Are you still a member of that?

A. No.

Q. And when did your membership cease?

A. A few years ago, probably.

Q. Any particular reason why you're no longer a member of that particular organization?

A. It was a relatively inactive organization and I wasn't getting a lot out of it, but I had to pay dues to belong to it, and it didn't seem like a useful way to spend money.

Q. When you were a part of that organization, do you recall whether it ever dealt with, as an organization, abortions?

A. It didn't do much of anything, so no.

Q. The next organization you list is Association of Women Psychiatrists. It indicates you joined it in '97.

Are you still a member?

A. Yes.

Q. And does that cover a particular geographic

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area or is it a nationwide organization?

A. That's a national organization. It's an offshoot of the American Psychiatric Association, affiliated.

Q. Okay. And in that organization, does it take a position on abortions?

A. Not that I'm aware of.

Q. Are you actively involved with that organization in terms of serving on committees, for example?

A. No.

Q. Have you ever presented any papers or lectures with that organization?

A. No.

Q. Have you ever attended a meeting of that organization?

A. No.

Q. So you wouldn't know whether at meetings they talk about abortions?

A. No, I would not know.

Q. The last organization you list is the Fairfax County Medical Society, and it indicates you

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joined that in '92.
Are you still a member?
A. No.
Q. And when did your membership cease in that organization?
A. Probably before 2009, so it shouldn't be on there.
Q. And do you still practice in Fairfax County?
A. No. My office is Arlington County, so it would be in Arlington County. I provide forensic services, so I suppose I could rejoin on the basis of my forensic services, but I have not done so.
Q. Are you a member of the Arlington County Medical Society or an equivalent organization?
A. I am not. I don't know that there is an Arlington County Medical Society.
Q. During the time that you were affiliated with the Fairfax County Medical Society, did you ever deal with abortion issues as part of your membership?
A. No.
Q. Do you know whether that organization dealt

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with abortion issues?
A. I don't know.
Q. The next designation deals with committee memberships. The first one is the American Board of Psychiatry and Neurology. It doesn't say when you were -- what time frame that you had an affiliation with that entity.
Can you recall when it was that you were a part of that?
A. I think it was 2008. And it's ongoing.
Q. And what is that? What do you do in relation to that?
A. I'm on the subcommittee for forensic psychiatry. We write the questions that are given as part of the board certification test.
Q. Does that have anything to do with abortions?
A. No.
Q. The next thing that's designated is the Forensic Psychiatry Certification Examination Committee. It indicates on your CV that's from 2008 to 2011.

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Are you affiliated with that committee?
A. That sounds like the same thing to me. I'm not sure where it's there twice.
Q. And if I ask you a question about abortion services, is your answer the same?
A. Yes.
Q. The next thing that is designated deals with public service activities. And the first thing that is noted there is the Commonwealth of Virginia Commission on Mental Health Law Reform.
When was it that you were engaged in that particular activity?
A. Does it not say?
Q. It doesn't.
A. Ah, damn. It was in the year after the Virginia Tech shootings. I think the Virginia Tech shootings were 2008 or 2009. So...
Q. Okay. So those shootings, did that motivate you to get involved in the Commission on Mental Health Reform?
A. The Commission on Mental Health Reform was organized in response to the Virginia Tech shootings.

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Q. Did you volunteer to be part of that commission?
A. Yes, I did.
Q. Did it have anything to do with abortion services?
A. No.
Q. The next designation is the working group on health privacy and the civil commitment process. That was from 2007 to 2008. Is that correct?
A. Yes. That's what I did on the Virginia mental health reform. That was the subcommittee I was on.
Q. Okay, I gotcha. Thank you.
The next designation on your CV deals with academic activities, and the first thing that is listed is CME, LLC, psychiatric congress peer reviewer, 2006 to 2008. I'm going to assume that CME deals with continuing medical education.
A. That's correct.
Q. And LLC, what does that stand for?
A. I don't know. It's the name of their company.

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Q. Okay.
A. Yeah.
Q. So it's a company?
A. Yes.
Q. And what's your activity with that company?
A. Well, they put on programs where doctors can earn continuing medical education. And the programs that they put on, before they -- before someone can present at one of those programs, their presentation has to be evaluated by a peer reviewer, or by a number of peer reviewers. So if the peer reviewers say this is silly and it's not useful, whatever, they won't put it on.
Q. I see. Are you compensated for that --
A. No.
Q. -- peer review?
A. Oh, I'm sorry. I think I am. I think I get like $25 an hour or something like that. It's pretty minimal.
Q. And you did that from 2006 to 2008. Do you do it anymore?
A. No.

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Q. So you actually reviewed programs that were proposed to be offered for CME?
A. Correct.
Q. Did any of them have to do with abortions?
A. Not that I recall.
Q. The next thing that's designated is the American Academy of Psychiatry and the Law program chair for the 2006 annual meeting in Chicago.
Did we already talk about that?
A. Yes.
Q. Is there anything else that you need to add as it relates to abortion services?
A. No.
Q. The next thing that's listed is the St. Elizabeth's Hospital centennial celebration from 2004 to 2005. I'm going to take a wild guess and assume that that didn't have anything to do with providing abortion services.
A. That's correct.
Q. The next thing that's listed, Dr. Gold, is you served as a program director for the educational symposium for something called the role of the public

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psychiatric hospital in the 21st century.
Just to digress a moment, the public psychiatric hospital entity is kind of an endangered species these days, isn't it?
A. Yes. Yes and no, but yes.
Q. In your capacity as the program director of that educational symposium, what did you do?
A. Well, that was affiliated with the St. Elizabeth's sesquicentennial. It was a day-long educational program that I organized in which a number of presenters presented academic lectures available for CME credit for people who attended on that particular topic, various aspects of that topic.
Q. And when you were in that capacity, did you review the presentations that were proposed, or the topics?
A. I didn't review them in detail. I reviewed sort of abstracts or summaries.
Q. Did you have the duty to approve or not approve what was proposed to be presented?
A. It wasn't quite that formal. These were all people who were volunteering for no money to come

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and talk. So...
Q. I understand.
Did any of them present information about abortions or abortion services?
A. No.
Q. The next thing that's listed is to be on the advisory committee for continuing medical education in Psychiatric Times. And that was in 2000. What did that involve?
A. I think that also involved some peer review, but I don't recall specifically.
Q. Did any of that have to do with abortions or abortion services?
A. No.
Q. The next designation on your CV is journal affiliations, and the first one that's specified is an editorial board position with the Journal of the American Academy of Psychiatry and the Law, and that was from 2009 to it says 2011.
Are you still involved with that?
A. I think my involvement ended last month.
Q. Okay. And what did you do as a member of

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the editorial board in that regard, or for that organization?

A. Well, there is a lot of stuff.

Q. Did you review papers that were proposed for publication?

A. Yes, I'm a peer reviewer, but that's separate from being on the board.

Q. Okay. Did the board deal with abortions or abortion services while you were on it?

A. Not that I recall.

Q. As part of the editorial function, did you ever review papers that dealt with abortions or abortion services?

A. Not that I recall.

Q. The next thing that's listed as an editorial board affiliation is Psychiatric Analyst as an editorial review board member from '99, it says to present.

Are you still on that?

A. Yes.

Q. And what are your duties in that regard?

A. Every once in a while they call me up and

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ask me for opinions about various types of issues and whether they might be of interest, et cetera. It's pretty minimal.

Q. Have you ever been asked to provide an opinion about something related to abortions?

A. For that journal?

Q. Yes.

A. No.

Q. The next thing that's listed under your journal affiliations is as a peer reviewer, and the first one is the American Journal of Psychiatry.

Anything in that regard that you've done related to abortions?

A. No.

Q. The next one is Journal of American Academy of Psychiatry and the Law.

Anything that deals with abortions there?

A. No.

Q. You've been a peer reviewer for Obstetrics and Gynecology. Anything that deals with abortions there?

A. No.

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Q. The next one is for Primary Psychiatry. Anything that deals with abortions there?

A. No.

Q. The last one listed is Behavioral Sciences and the Law. The same question.

A. No.

Q. Are there any other peer reviewing activities that you are engaged in that are not listed there?

A. There are. In the last couple of years there have been some other ones. I can't remember specifically what they are.

Q. Did any of them have to do with abortions or abortion services?

A. No.

Q. The next section of your CV is publications. A lot of these I can sort of glean from the title they don't have anything to do with abortions.

MR. EYE: Reese, is it possible that you could give Dr. Gold the CV that's on your laptop and maybe it would expedite going through these.

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MR. HAYS: I can, and she has it.

MR. EYE: Thanks, Reese.

BY MR. EYE:

Q. Page 5, Doctor.

A. Okay, got it.

Q. Let's kind of do it this way. I'm going to assume that the first two, Evaluating Mental Health Discipline in the Workplace and Sexual Harassment, Psychiatric Assessment and Employment Litigation don't have anything to do with abortions.

A. Correct.

Q. The next one is the American Psychiatric Publishing Textbook of Forensic Psychiatry. And you were a co-editor of that, correct?

A. Correct. And that's actually out now in a second edition in 2009.

Q. And were you the co-editor of the second edition?

A. Yes.

Q. And does it deal with abortions or abortion services? Is there anything in that text about abortions?

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A. No.
Q. There is a study guide that I assume that is part of that textbook that's listed right underneath.
A. Correct.
Q. Does it cover abortions or abortion services?
A. No.
Q. The next section is -- well, I should ask: Are there any other books that you've had an involvement with that ought to be listed there that we haven't covered?
A. No. Book chapters are listed in a separate section, so...
Q. Okay. And speaking of book chapters, that's the next section. Gender Issues in Suicide.
Do you see that?
A. Yes.
Q. Did that deal with any aspect of abortions or abortion services?
A. No.
Q. The next is -- and I'm looking at the top

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of page 6. It says -- the title is "Rediscovering Forensic Psychiatry." And you were an editor of that publication?
A. Well, I wrote that chapter and it's in the edited publication.
Q. I see. Okay. And did you cover anything that deals with abortions in that chapter?
A. No.
Q. I'm going to assume that the next one, "The Workplace," didn't have anything to do with abortions?
A. Correct.
Q. The next one is "Ethical Issues in Forensic Psychiatry." Anything to do with abortions in that chapter?
A. No.
Q. The next one is "Psychiatric Diagnoses in Forensic Psychiatry." Anything to do with evaluations for women who seek abortion services in that chapter?
A. No.
Q. I'm going to assume that there is nothing in the sexual harassment chapter that deals with abortion or abortion services. Correct?

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A. Correct.
Q. The next one is "Psychiatric Diagnoses and the Retrospective Assessment of Mental Status." Did anything in that chapter cover abortions or abortion services?
A. No.
Q. You were an honorable mention for the Guttmacher Award for 2002.
A. The book was.
Q. Oh, I'm sorry, the book was.
A. Yeah.
Q. Thank you. Thank you.
I'm going to assume the PTFE employment litigation doesn't have anything to do with abortions, correct?
A. Correct.
Q. I assume nothing in the post-trauma stress disorder employment cases have to do with abortions, correct?
A. Correct.
Q. Any other book chapters that you've been responsible for authoring other than that which is

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covered in this section?
A. No.
Q. The next section is entitled "Articles."
A. And I've had a few more things published since 2009.
Q. As articles?
A. Yes.
Q. Okay. Well, let's get to those -- Well, what are they?
A. I don't --
Q. Has anything published since 2009 had any discussion related to abortions or abortion services?
A. No.
Q. I'm going to assume the articles on "POWs Against their Torturers" didn't have anything to do with abortions.
A. Correct.
Q. Ditto with "Forensic Evaluation of Psychiatric Disability Practice Guidelines"?
A. Correct.
Q. Maybe we could shorten this up. Is there any article that's listed that covers abortions or

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abortion services?
A. No.
Q. The next section, then, and we'll work forward, or working towards the back of your CV I should say. The next section is as an editor. It indicates that you were, I take it, an editor for "Psychiatric Times Special Report on Forensic Psychiatry."
Do you see that?
A. Yes.
Q. Did anything in that regard have to do with abortions or abortion services?
A. No.
Q. You were -- the next section is -- are you -- should there be any other entries under editor?
A. I don't think so, aside from the books. I put this separate because it wasn't a book.
Q. Got you. Okay. As far as editorials are concerned, the first one that's listed there is the American Psychiatric Association honors Dorothea Dix with the first posthumous fellowship.
Who is Dorothea Dix?

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A. Oh, my goodness. Dorothea Dix was a very famous social reformer of the 19th century who was responsible for the founding of approximately 35 public psychiatric hospitals in the United States. She was the head of the informal but moving force behind the building and -- building of asylums and treating psychiatric patients in humane conditions.
Q. Did she deal a lot with indigent patients?
A. She didn't really deal with patients herself. She was a social reformer who mobilized funds and doctors and other things. But yes, I think that she was mostly concerned with indigent people who got very poor, if any, treatment, et cetera.
She was responsible for the founding of St. Elizabeth's Hospital and many other psychiatric hospitals across the United States, some internationally.
And she was not a member of the American Psychiatric Association because in those days they didn't let women become members. So I organized a movement to get her a posthumous membership and was successful.

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Q. Do you have to be a physician to be a member of the American Psychiatric Association?
A. They have honorary type memberships for people who are not psychiatrists.
Q. Dorothea Dix wasn't a physician, was she?
A. No. But she's standing in almost all of the photographs with all of the early members, and at the beginning there were only 14 or 15. So she's there in all the pictures, but she's not a member.
Q. All right.
A. And none of them -- Most of them would not have had jobs were it not for her, which is why she was there.
Q. I'm glad they at least let her in the photographs.
A. Yeah, some of them.
Q. The next one deals with the death penalty. I'm going to assume that doesn't have anything to do with abortions or abortion services.
A. Correct.
Q. Are there any other editorials that you've written since April '09 that ought to be included in this section?

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A. I don't think so, no.
Q. The next section, you've written some book reviews.
A. Correct.
Q. The first one is entitled -- well, it reviewed a book that was entitled "A Physician's Guide: Adverse Events, Stress, and Litigation."
Did any of that cover abortions or abortion services?
A. No.
Q. The next one appeared in the American Journal of Psychiatry, and it was a review of the Clinical Manual of Psychiatry and the Law.
Do you remember that review?
A. Yes.
Q. Did anything in that review have to do with abortions or abortion services?
A. No.
Q. Any other book reviews that you have authored since April '09 that should be included in this section?

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A. No.

Q. The next section is "Invited Presentations," and that covers several pages. Can you look at that list, Dr. Gold, and designate for us or tell us which ones had anything to do with abortions or abortion services.

A. None of them.

Q. One of the things that's listed there is the Guttmacher Award lecture. We touched on that a little bit earlier, the 2006 award.

Is it my understanding that as a recipient of that award you can pick whatever topic you want, basically, to provide a lecture about?

A. Yeah, pretty much.

Q. I looked at the other award recipients over the years and it was a very wide ranging scope of presentations.

A. Yeah.

Q. So were you limited in any way about the topic that you could present on?

A. No.

Q. One of the -- it's at the bottom of page --

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I'm sorry, in the middle of page 11. You gave a lecture on women and depression.

A. Yes.

Q. That was by Glaxo Wellcome Pharmaceuticals?

A. Yes.

Q. Is that a compensated presentation?

A. That one was, yes.

Q. And what about the one right at the bottom, use of psychiatric drugs in treatment of depression during pregnancy. That was sponsored by Forest Pharmaceuticals. Was that compensated?

A. Yes.

Q. And there was -- at the top of page 12 there is one entitled "Interprofession Ethics." Did you go to Jackson Hole, Wyoming, to present that?

A. Yes, I did.

Q. Great. Were you compensated?

A. No.

Q. Other than just getting to be in Jackson Hole?

A. Yeah.

Q. Did you have to pay your own way there?

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A. Yes. And there was another -- There were two presentations in Jackson Hole. I'm trying to find them. The other one was on employment discrimination evaluations.

Q. Okay.

A. Defending emotional injury claims in employment litigation.

Q. Right. But it is the case that at least in that which you have listed in this iteration of your CV, none of these presentations dealt with abortions or abortion services?

A. Correct.

Q. Are there presentations that you have given since April of 2009 that deal with abortion or abortion services?

A. No.

Q. That is the end of the CV as I have it in front of me. Is there any addition to the CV that should be made that we have not covered that you can think of as you sit there today?

A. No. Again, with the caveat that there have been additions since 2009 and I can't recall

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specifically what presentations I've done since 2009 other than the Guttmacher one which was last month.

I have had some more articles published, but I can't recall specifically. I'm certainly happy to provide an updated CV, that's not a problem, I just don't have one with me.

Q. Thank you. I appreciate that. If you give that to Mr. Hays, I'm sure he'll hand it off to me.

MR. EYE: We've been going about two hours. Would it okay to take a ten-minute break at this point?

THE WITNESS: Yes.

(Recess taken.)

MR. EYE: For the court reporter, my colleague Kelly Kauffman, and that's K-a-u-f-f-m-a-n, and Bret Jarmar, J-a-r-m-a-r, are also with me in the room right now. So that should be on the record.

BY MR. EYE:

Q. Dr. Gold, currently in your professional endeavors, about what percentage of time do you spend in a clinical practice?

A. About 50 percent.

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Q. And does that time include time seeing patients in your office and seeing patients in hospitals?

A. I don't see patients in hospitals anymore right now. So it would be all seeing patients in my office.

Q. And approximately what percentage of time do you spend in academic endeavors?

A. Oh, well, okay, let me rephrase that, then. Probably about 40 percent of time in clinical activities, 20 percent of time in academic endeavors including writing and research.

Q. And the remaining 40 percent, how is that spent?

A. In litigation or related forensic activities whether it's litigation or not, the other types I also mentioned.

Q. And is the work that you're doing for the staff of the Board of Healing Arts, does that fall under the category of litigation?

A. Yes. Well, yes, it falls under the category of forensic evaluations.

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Q. For litigation purposes?

A. Yes. I mean -- Yes, now. When it started it wasn't so. I mean, things change and morph over time.

Q. What is your compensation arrangement for this case?

A. $400 an hour.

Q. And what have you billed and collected thus far?

A. You know, I really couldn't tell you. I didn't bring that information with me, and I didn't look at it.

Q. And so your time, for example, today is $400 an hour?

A. That's correct.

Q. Now, I think we've already established that you don't have any privileges at hospitals that perform abortions that you know of?

A. Well, the hospitals may or may not provide abortions. I have privileges at the Virginia Hospital Center. I don't know whether they do abortions or not.

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Q. Now, I think your testimony earlier was that abortion services are available in Washington, D.C., correct?

A. That is my assumption. I assume they're available in Washington, D.C., Maryland and Virginia, New Jersey, New York.

Q. Are you aware of any limitations on expenditure of municipal funds in Washington, D.C. for abortion services?

A. I am not aware, no.

Q. So you're not aware of limitations enacted by Congress in the last year on Washington, D.C.'s ability to use municipal funds for abortions?

A. Not specifically, no.

Q. Dr. Gold, have you ever practiced in the state of Kansas?

A. No.

Q. Have you ever been in Kansas?

A. Not that I'm aware of.

Q. Dr. Gold, do you have any affiliations with advocacy groups that are related to abortion or abortion services?

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A. No.

Q. Do you know who Cheryl Sullinger is?

A. No.

Q. Kathy Ostrowski?

A. No.

Q. Randall Terry?

A. The name sounds familiar, but I don't know who he is.

Q. How about an organization called Operation Rescue?

A. Well, I've heard of them. You know, they're in the news and stuff. But other than that, no.

Q. How about an organization called Kansans for Life?

A. No, never heard of them.

Q. Birthright?

A. No.

Q. Right to Life of Kansas?

A. I'm sorry?

Q. An organization called Right to Life of Kansas.

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A. No.
Q. Have you ever heard of a man named Phill Kline?
A. No.
Q. How about Scott Roeder?
A. I think he's the guy that shot Dr. Tiller.
Q. Have you ever heard of Eric Rucker?
A. I think he's the guy that shot the doctor in Buffalo.
Q. How about Steve Maxwell?
A. No.
Q. Have you ever attended a public meeting of an organization that professes to be opposed to abortion rights?
A. No. Not intentionally for sure.
Q. Do you ever remember an unintentional attendance at such a meeting?
A. No.
Q. Have you ever corresponded with government officials, elected or otherwise, concerning any aspect of abortion rights?
A. No.

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Q. Have you ever testified before any legislative body, state, federal or local for that matter, about abortion?
A. No.
Q. Have you ever provided consultations for Planned Parenthood?
A. No.
Q. How about any other providers of abortion services?
A. You mean as a paid consultant?
Q. Well, let's say paid or unpaid.
A. No.
Q. Do you have personal views or a personal position concerning the propriety of abortions?
A. Of course.
*** Q And what is that?**
A. I'm not going to answer that question.
*** Q Do you -- Do you consider yourself to be pro-choice?**
A. Do I -- I mean, my personal opinions, I don't see how they're relevant. I know you're allowed to ask them, but I don't see how they're relevant, so

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I'm not going to answer them.
Q. Are you refusing to answer those two questions that I just posed?
A. I think so, yes.
MR. EYE: Mr. Court Reporter, would you please note a certification of those two questions for purposes of judicial rulings.
BY MR. EYE:
Q. Dr. Gold, what is the scope of work that you have taken on on behalf of the Board of Healing Arts staff?
A. I was asked to evaluate the records of Dr. Neuhaus in regard to her work with Dr. Tiller's clinic to see if it met the standard of care for psychiatric evaluation and documentation.
Q. And how was the contact made with the staff to you?
A. I believe -- gosh, it was in early 2009, and I believe Ms. Selzler -- I'm not going to say it right, Selzler Lippert contacted me and sent me some paperwork, some files, and asked for a preliminary opinion regarding the standard of care as demonstrated

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in those files. They were redacted files. I had no idea who the doctor or doctors were, who the patients were.
And really it was a question of my assessment in terms of standard of care, evaluation and documentation primarily.
Q. Did you have conversations with Ms. Selzler Lippert in the run-up to actually reviewing the records?
A. Prior to those three that she initially sent me, not really, other than to ask if I thought I would be qualified to look at those records on the basis of psychiatric expertise. And I told her I thought I was.
Q. Did she ask you about whether you had had any involvement with abortions or abortion services in the past?
A. No, she did not.
Q. Now, you mentioned that she sent you three charts?
A. Yes. And I'm not even sure they were complete charts. But she sent me three.

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Q. Of those three that she sent you, did any of those -- were any of those included in the 11 that you discussed in your reports that have been provided to me?

A. I believe so, but I'm not 100 percent sure. I didn't go back and match them page for page. But I believe to the best of my recollection they were.

Q. All together, Dr. Gold, how many patient charts have you reviewed on behalf of the Board of Healing Arts staff?

A. I believe 16.

Q. Of the 16, I take it, then, you selected 11 for inclusion in your reports?

A. No. I was asked to provide reports on 11. I did not select which 11.

Q. Who selected them?

A. Someone at the Kansas board. I don't recall if it was Ms. Selzler Lippert. They've had a few attorneys over the last few years involved in this case, so I can't remember which one specifically selected them.

Q. What criteria were used, if you know, to

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select the charts for you to write about?

A. I don't know.

Q. Did you inquire about the criteria?

A. No.

Q. What opinions were you asked to formulate in this matter?

A. I would have to look at the complaint to refresh my memory and make sure I got all of them, but primarily, without looking at the complaint, opinions regarding standard of care for psychiatric evaluation and documentation. And those are the primary ones.

Initially there were some other questions, I think regarding treatment, but ultimately those were not included, I believe, in the complaint.

Q. Did you -- in the report -- and I think of it as one report with sort of 11 subparts for each chart, so if I use the singular, that's why.

But at any rate, you had a section for "Records Reviewed" for each one of the charts. Do you recall that? Do you have your report in front of you?

A. Yes.

Q. Actually, Doctor, is that part of the file

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that we've marked as an exhibit?

A. Yes.

Q. Okay, fair enough.

Now, in the "Records Reviewed" section, and I'm looking at page 1. Do you see that?

A. Yes.

Q. Now, under the "Records Reviewed" section it says that you got a letter of referral dated June 19, 2009, from Ms. Selzler Lippert.

Do you see that?

A. Yes, I do.

Q. Is that letter referral in your file?

A. No.

Q. Does that letter referral discuss the substance of the opinions that you were asked to render?

A. No.

Q. Can you provide a copy of that letter of referral for me?

A. I hope so. I think it may be in the administrative file, not the case file.

Q. Okay. The next thing that you specify that

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you reviewed was definition of standard of care.

Do you see that?

A. Yes.

Q. And is that a separate document?

A. I don't recall. If I listed it, I believe it would be a separate document, but I don't recall off the top of my head.

Q. Do you know what the document is where you have a definition of standard of care?

A. I presume it's in the administration file.

Q. What is the administration file?

A. Well, the administration file is communication from attorneys and that kind of thing that is separate -- I keep that separate from my working case file because it's not psychiatric notes or, you know, evaluations or interviews. So that's just my standard practice.

Because often -- I don't know if it's the case in this case, but often that communication is purged and so I've just gotten in the habit of keeping it in a separate file, and if it's not privileged I can bring that file in. But if it is privileged, then

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I don't have to worry about accidentally providing something I'm not supposed to provide.

Q. What is the source of the definition of standard of care that you specify in the records reviewed?

A. I don't recall. And it would have been provided by Ms. Selzler Lippert, but I don't recall.

Q. I see. So that definition of standard of care was not something that you formulated but it was provided to you by counsel for the Board?

A. Yes.

Q. The next thing that you specify in the records reviewed is a series of Kansas statutes.

Do you see that?

A. Yes.

Q. And for what purpose did you review those Kansas statutes, Dr. Gold?

A. Well, there is a standard of care which is based upon, you know, what the average practitioner would do or should be required to do as a minimum to provide adequate care. And then there are legal requirements. And the two things may not be the same.

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So typically in a case that's involving any kind of standard of care issue I want to review the legal -- if there are statutes relating to that, I want to review those. Because the legal statutes may not be entirely congruent with the actual standard of care in real life.

Q. I'm sorry. I didn't mean to interrupt you. Are you finished with your answer?

A. I'm sorry. The legal standards may not be 100 percent congruent with the actual standards of practice in real life.

Q. The statutes that you specify that you reviewed, which ones of those set forth standard of care?

A. Standard of care, I don't recall that any of them set forth the standard of care per se. I would have to review them again to see if they did, but I don't recall that they set forth the standard of care.

That's something that isn't established by statute typically. Legal requirements are, but standard of care typically is not.

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Q. Did your review of the statutes that are specified form a basis for your opinions in this matter?

A. I would have to say no in the sense that it's useful to know what the legal requirements are and how they might differ from the standard of care, where they're the same and where they differ.

But if they differ from the legal standard of care -- I'm sorry, I misspoke. If they differ from the legal requirements, they still might not be outside the standard of care. So they really don't form a basis in the sense that deviation from the legal requirements may or may not indicate deviation from standard of care.

Q. Now, the definition of standard of care that you were provided by counsel, did you adopt that definition for your purposes?

A. Yes, I did.

Q. What was the source of that standard of care definition? I mean, I know you got it from counsel, but was it -- was it shown on that where it came from?

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A. I don't recall. I would have to look at the document. And I apologize, I don't have the document with me.

Q. Now, you also say that you looked at K.A.R. 100-24-1, documentation regulation, correct?

A. Correct.

Q. And your purpose in reviewing that was what?

A. Well, again, it's the same thing, to see what the law requires for documentation, because that varies from state to state. All of these statutes vary from state to state. And really, a comparison of what the standard of care would be for your average psychiatric practitioner.

Q. And Dr. Gold, have you in your litigation consultation past, prior to this case, ever done a standard of care analysis for somebody who is providing abortion services or abortion-related services?

A. No.

Q. And have you since this case where you rendered a report, you know, last year basically, a

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year or so ago, have you done any further work related to standard of care in abortion-related matters?

A. No.

Q. So this is your only one?

A. That's correct.

Q. Now, you were -- you were given -- Strike that.

You reviewed a sample report. Do you see that?

A. Yes, I do.

Q. What was that? Do you have it with you?

A. No, I don't.

I don't recall. I'm sorry. The minimum that I recall about it was it was opinions that I was being asked to provide in terms of categories, not the actual opinions. So, you know -- I'm not explaining this very well because I don't recall it very well. But more like an outline of what the report should include.

Q. I see. Sort of a template?

A. Yes.

Q. Okay. Fair enough.

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And did Ms. Selzler Lippert give you that as well?

A. Yes.

Q. Do you have all of the charts that were provided to you for review?

A. Yes, I do.

Q. And did you bring those with you today?

A. Yes.

Q. And is that the totality, all 16 charts?

A. I would have to look. I know it's the first 11.

Q. Would you, please?

A. Okay.

MR. HAYS: And I would object to going into any of the other patients who are not listed within the petition on relevance and also confidentiality. Confidentiality of the investigation pursuant to the statutes.

THE WITNESS: The answer to your question is yes, I do have them.

BY MR. EYE:

Q. Dr. Gold, did you review all 16 of those

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charts for purposes of standard of care evaluations at some time or another?

A. Yes.

Q. Did you render opinions concerning the other five that didn't make it into your report that you've provided?

MR. HAYS: And I would also just reiterate the same objection.

THE WITNESS: I believe I discussed them. Nothing was written.

BY MR. EYE:

Q. Did you reach opinions about those other five regarding standard of care?

MR. HAYS: And I'll renew my objection. It's a continued objection so I don't have to keep on doing it for each question.

MR. EYE: Right.

THE WITNESS: I'm trying to recall whether they were specifically standard of care opinions. I know I had opinions about the cases. I don't recall if they were specifically standard of care.

BY MR. EYE:

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Q. Do you know where those charts came from, that is how the Board of Healing Arts got access to them?

A. No.

Q. Dr. Gold, have you ever had any formal legal training? Let me back up and be a bit more specific.

Did you ever attend a law school class as a student?

A. No.

Q. Have you ever attended a legal education seminar as an interested participant or observer?

A. Yes.

Q. Did any of those that you attended deal with abortions or abortion services?

A. No.

Q. Do you have any other legal training other than either attending a law school class or a continuing legal ed that we just discussed?

A. No. I mean, not formally. In the course of becoming certified or studying forensic psychiatry, one becomes familiar with certain aspects of the law

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as they intersect with psychiatry. So in that sense, yes. But I don't think that that's what you're asking about. But if it is, then the answer is yes.

Q. Fair enough.

In that category, did any of that training have any relationship to abortion or abortion services?

A. No.

Q. Dr. Gold, would you agree with the statement that a patient is entitled to an unimpeded medical judgment from a physician with whom the patient consults?

A. I'm sorry, could you say that again?

Q. Sure. Would you agree that a patient is entitled to the unimpeded medical judgment of a physician with whom the patient consults?

A. I'm not sure I understand what you mean by unimpeded.

Q. No interference from extraneous sources. That is, should the patient have the benefit of a free flow of information and consultation from a physician with whom a consultation is sought?

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A. Within certain restrictions.

Q. What would those restrictions be?

A. Well, if they're discussing child abuse, sexual abuse, any kind of endangerment of a minor, the primary obligation is to report that. If the patient is discussing self-harm or harming others, there is also usually a duty to report and/or intervene.

So there are certain areas where the real world intrudes into what is an otherwise private and confidential relationship. But outside of those, yes.

Q. Would you agree that a patient is entitled to the best clinical judgment of a physician with whom the patient consults?

A. I don't know if entitled is the right word. One would hope that they get the best clinical opinion. What they're entitled to -- I mean, to me, entitled means they have a right to it. I don't know if there is such a right to the best clinical opinion, but certainly one would hope they get it.

Q. Would you agree that the exercise of good faith clinical judgment is done routinely by physicians who consult with patients?

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A. I'm sorry, what do you mean by good faith clinical judgment?

Q. Clinical judgment that's based on the physician's best efforts to understand the presenting problems of a patient and the state of medicine as it bears on those problems that are presented.

A. Again, I would hope that that is the standard of care for everybody, yes.

Q. Would you agree that there can be examples where best medical judgment is exercised in the absence of documentation that you would consider adequate?

A. It's certainly possible.

Q. Would you agree that in the evaluation of a patient for purposes of rendering a medical opinion, that there are both subjective and objective parameters that should be considered?

A. I don't understand the question.

Q. In the evaluation of a patient, are there objective measures by which a patient's condition can be judged or evaluated?

A. It depends on the condition.

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Q. Let's think about vital signs. Are those objective measures of a patient's condition?

A. Yes.

Q. What about subjective evaluations, do those play a role in evaluating a patient's condition?

A. If I understand what you're saying -- Could you define subjective?

Q. Let me give an example. How a patient presents in appearance.

A. Yes.

Q. Is that a subjective evaluation?

A. Yes, it is. It may be a combination of both subjective and objective.

Q. Can you think of any examples of a purely subjective parameter that would be used to evaluate the condition of a patient?

A. Sure. Someone comes in and says, you know, I'm having a bad stomachache. There is no way to really assess that in an objective way. But subjectively, do they appear distressed? Are they doubled over?

Q. I see.

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Now, Dr. Gold, have you ever had, as a practitioner, any clinical primary care experience, where you've taken care of patients as a primary care physician?

A. No.

Q. How about as an OB/GYN?

A. No. Not outside of training in medical school.

Q. What about training outside of medical school?

A. No. Well, that's not true. I guess my first year of residency was -- again, although it was in rotation, some of those rotations were basically primary care medicines. Six months of that.

Q. And I think we established when we were going over your CV that didn't involve any abortions or abortion services?

A. That is correct.

Q. Dr. Gold, what all did you -- Other than that -- Strike that.

Have you reviewed anything in addition to the records that you've specified in the section under

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"Records Reviewed" in your report? Have you reviewed anything in addition to those to prepare for today's deposition?

A. Yes.

Q. And what would that be?

A. I have the inquisition testimony of Dr. Neuhaus from 2006, and I have the testimony, the trial transcript from I believe it was Dr. Tiller's trial in 2009.

Q. What was your purpose in reviewing those transcripts?

A. Well, they were provided for me to review, and I was asked to review them. But they were helpful to me in trying to figure out the process by which patients were evaluated for the late-term abortions that they received.

Q. Did you review those transcripts prior to rendering your reports in this matter?

A. No.

Q. So it's fair to say that those transcripts did not form one of the bases for your opinions?

A. That is correct.

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Q. What else did you review in anticipation of today's deposition?

A. The American Academy of Child & Adolescent Psychiatry guidelines for the evaluation of children and adolescents.

Q. Is that the 1997 or the 2007 version?

A. I have the 1997 version.

Q. How does it differ from the 2000 version?

A. The 2007 version?

Q. Yeah. I misspoke.

A. I think the 2007 version was a specific type of evaluation, if I recall correctly. It wasn't general guidelines. So I didn't want to narrow -- I forget which type of evaluation that one was, but it wasn't -- I believe it was narrow enough so that I don't think it would have been as helpful as the general guidelines.

Q. Is that a document or a source that you keep in your file?

A. Yes.

Q. Do you have it with you today?

A. Yes.

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Q. And so it's part of that which we've marked as an exhibit?

A. No.

Q. Okay. Let's mark it as a separate exhibit. I would like to get a copy of that as well.

(Exhibit 2 marked for identification and retained by the witness for copying and distribution.)

BY MR. EYE:

Q. This is Exhibit No. 2, I presume. Correct?

A. Yes.

Q. In Exhibit No. 2, can you specify the part of Exhibit No. 2 that relates to evaluation of children or adolescents or adult women for purposes of receiving a late-term abortion?

A. There is no section in there that specific.

Q. What about in the 2007 version?

A. I don't have that with me. I don't recall what the specificity was for that one, but I don't think it was about abortion.

Q. Is there other information that you have reviewed in anticipation for today's deposition?

A. Not -- No, no other information.

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Q. Do you know who Allen Greiner, M.D. is?
A. No.
Q. Did you speak with any professional colleagues concerning your agreement with the staff of the Board of Healing Arts to render opinions?
A. No.
Q. Did you review any of the investigation file that was compiled by an investigator for the Board named Clifford Packer?
A. No.
MR. EYE: Let's go off the record for just a moment.
(Off the record.)
MR. EYE: Let's reconvene at the top of the hour.
(Recess taken.)
BY MR. EYE:
Q. Dr. Gold, we'll go back on the record now after our lunch break.
Up to now, have you understood my questions?
A. Except the ones that I said I didn't understand.

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Q. Okay, fair enough. Thank you.
Before we took a break I inquired about your personal views concerning abortion and whether you were pro-choice, and you refused to answer those questions. Is it still your position that you refuse to answer those questions?
A. Yes.
MR. EYE: And counsel, have you advised the witness concerning her obligations to answer questions in that regard?
MR. HAYS: We are not her attorney, so we cannot provide her advice on that.
BY MR. EYE:
Q. Dr. Gold, in the run-up to you actually agreeing to work on this case, I presume you had conversations with Ms. Selzler Lippert?
A. I presume so. I mean, it was a relatively brief process in terms of agreeing to do the file review.
Q. Did Ms. Selzler Lippert ask you about your personal views concerning abortion?

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A. She did not.
Q. Have you ever expressed your personal views about abortion to anybody other than your husband, a clergy person or an attorney?
A. Maybe with friends, but no.
*** Q What did you tell them?**
A. I'm not discussing my opinions.
MR. EYE: Mr. Court Reporter, please note on the record that I would like to have the questions that the witness is refusing to answer certified.
BY MR. EYE:
Q. Dr. Gold, do you in your private practice consult with teenage patients concerning their pregnancies and whether their mental health would be harmed by continuing pregnancy to term?
A. I have consulted with teenage patients. I have consulted with teenage patients who are pregnant. The last part of the question, which is whether their mental health would be harmed if they carried the child to term, is not -- it's not properly a psychiatric question in most circumstances. So the answer would be no.

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Q. Have you ever recommended a termination of a pregnancy for mental health purposes?
A. No.
Q. Have you ever in your medical experience performed an abortion?
A. No.
Q. Have you ever attended an abortion -- an abortion procedure?
A. Possibly. Depending on -- In the course of my training, I did attend what are called D&C procedures. D&C procedures often were -- were done for early term, early stage pregnancies for women who wanted abortions. They were not necessarily called abortions. It was a fuzzy kind of area. And so I attended a number of D&Cs.
Could some of them have been abortions? The answer is yes. I was not necessarily -- as a medical student, I was not necessarily privy to that information.
Q. Have you ever referred a patient of yours to an abortion provider for abortion services or an abortion consult?

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A. In my experience, in my practice, there is no such thing as an abortion consult. If you have a pregnant patient and the patient has issues or problems, you refer them to the appropriate person to help them address those problems.

So for example, if it's an issue with pregnancy and they're not sure about a termination, you might refer them to an OB/GYN. That's not an abortion referral. That's an appropriate referral of a patient with issues about pregnancy to a medical specialist who may be able to assist them.

Q. Have you ever referred a patient to an OB/GYN, for instance, that you later spoke with the OB/GYN about that patient receiving an abortion?

A. No.

Q. Dr. Gold, referencing the specific case today, do you know who the complainant or complainants are in this case?

A. You mean who filed the complaint with the Board of Medicine?

Q. Yes.

A. I believe it was a pro-life activist group.

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I'm not sure which one.

Q. And do you know the basis of their complaint, that is what it is that they complained about?

A. Well, I know what's in the complaint.

Q. You've seen the complaint?

A. Yes.

Q. Is it in your file?

MR. HAYS: I would have her clarify what the definition of a complaint is.

THE WITNESS: Oh, I'm sorry. It's not a complaint. It's a petition. Sorry.

BY MR. EYE:

Q. So you don't have the complaint that was actually submitted by whoever it was that made the complaint?

A. No. I have the Board's petition. Sorry about that.

MR. HAYS: And for the record, I guess if she could clarify what she meant by complaint specifically when she stated that.

THE WITNESS: Yeah. By complaint, I meant the Board's petition.

BY MR. EYE:

Q. Okay, fair enough. Thank you.

Dr. Gold, do you know the purpose or purposes that Dr. Neuhaus was seeing the patients that you evaluated the charge for? Do you know what her purpose in seeing those patients was, or reasons were?

A. I understand that the law in Kansas requires that two physicians certify that an individual needs -- In order to get a late-term abortion, two physicians have to certify that there would be substantial and irreversible consequences, medical consequences, in order for that individual to obtain a late-term abortion.

And so Dr. Neuhaus provided the second opinion, so to speak. Patients would originally contact Dr. Tiller, who I assume provided the first opinion, and her role was to evaluate for the second opinion.

Q. How long did the evaluations in terms of clock time, how long did the evaluations take that Dr. Neuhaus performed?

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A. Well, I know what she testified to and what other people in the clinic testified to. But I have no documentary evidence indicating how long they took.

Q. What was her testimony, as you recall?

A. I think she said they could take as much as six hours but normally they were between 30 minutes and 60 minutes, if I recall correctly.

Q. Depending on the particular case, I presume, or the particular patient?

A. I'm only repeating what she said. That's all the information I have.

Q. Now, you didn't rely on that testimony to write your opinions, though, right?

A. That is correct.

Q. Now, I'm looking at your report for Patient No. 1, and I'm going to go to the top of page 2 of that where it begins with "Standard of Care." It's at the very top of the page in bold face, "Standard of Care."

Do you see that?

A. Yes.

Q. Now, under that you have a designation for

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ordinary negligence and gross negligence, correct?
A. Yes.
Q. Where did you get those definitions?
A. I believe from Ms. Selzler Lippert.
Q. Do you have any independent knowledge as to whether these particular definitions are material to the issues that you have undertaken to evaluate in this matter?
A. No.
Q. In the paragraph underneath the bullet points "Ordinary Negligence" and "Gross Negligence," you say that, quote: "A physician who holds himself out to be a specialist in a particular field of medicine has a duty to practice in a manner consistent with the special degree of skill and knowledge ordinarily possessed by other specialists in the same field of expertise at the time of the diagnosis and treatment."
Do you see that?
A. Yes, I do.
Q. Do I take that to mean that the mental health evaluation of a patient who is being considered

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for an abortion must be evaluated by a mental health specialist?
A. Not necessarily. But it would have to be someone who has the same degree of skill as a mental health specialist.
Q. And how would you determine the level of skill of an OB/GYN who sees patients compared to a mental health specialist who sees patients? How do you make that comparison of skill levels?
A. Well, you either observe them or you ask them what they've done or you look at their documentation of what they've done or any of the above in combination.
Q. As I understand it, you didn't speak with Dr. Neuhaus about any of these cases, correct?
A. That's correct.
Q. So you've never observed her practice, correct?
A. Correct.
Q. So what you have done is look at documentation?
A. Well, and in this case I've also read her

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testimony and the testimony of others.
Q. And were you able to determine what her skill level is as a practicing OB/GYN, for instance?
A. I didn't evaluate her for her skill level as a practicing OB/GYN.
Q. Do OB/GYNs provide mental health evaluations for pregnant women?
A. Some of them do.
Q. Why?
A. Because they're aware that there can be mental health issues surrounding pregnancy in the postpartum period.
Q. So do you believe that it's within the scope of an OB/GYN's skills to counsel patients about mental health issues related to the pregnancy?
A. Sometimes. And sometimes they call me and ask me to see them because it's outside their area of expertise.
Q. And what is typically outside the area of expertise that you're asked to consult on with a pregnant patient?
A. That's a very broad spectrum.

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Q. I understand.
A. Anything from an acute crisis such as the patient is suicidal or psychotic; to the fact that the patient is not responding to appropriate medication treatment; to the fact that the OB/GYN thinks the patient needs to take medication but the patient doesn't want to so they agree to a referral; to concerns about the level of anxiety a patient may be experiencing being above and beyond what might be normal for that person's particular circumstances; to other kinds of issues such as relationship issues that are being negatively impacted by pregnancy and are affecting the mother's mental health. It's pretty broad.
Q. I think those are good examples. That helps me understand better. Thank you.
But as I understand the testimony about your practice, you've never had a patient referred to you for purposes of evaluating for late-term abortion for mental health purposes?
A. No.
Q. Correct?

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A. Yeah.
Q. What I said was correct?
A. What you said is correct. But there is really no such thing. There is no such referral. It's not a psychiatric referral.
Q. What is it? Or what would it be?
A. What would it be? Well, I can think of a couple of situations where it would be a psychiatric referral, let me put it that way. But again, those would fall under extreme circumstances.
Usually it would be a medical referral as to whether the physical health of the mother is in danger. There is really almost no circumstance in which the mental health of a woman is going to be irreparably and permanently or substantially and irreversibly, whatever the language is, damaged by a pregnancy.
Q. What is the basis for that opinion, Dr. Gold?
A. The basis for that opinion is years of treating women who have had wanted and unwanted pregnancies. And the vast literature on postpartum

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psychiatric issues involving women and pregnancy, women with mental health histories, women without mental health histories, there is no category of psychiatric disorder that's related to having an unwanted pregnancy and carrying an unwanted pregnancy to term.
Q. So is it your position that there really is not a justifiable abortion based on preservation of mental health of the mother?
A. No. There can be some extreme circumstances, but they would be really extreme. For example, someone who is acutely suicidal who might be saying, you know, if I have this baby then I will kill myself, period.
Now, to me as a psychiatrist, that would call for psychiatric hospitalization, not necessarily for a late-term abortion. Late-term abortion is not an intervention that any psychiatrist would recommend for any reason other than, I think, immediate medical danger. Because for any suicidal patient, regardless of the answer, you would try to hospitalize them, psychiatrically hospitalize them.

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So I really can't think of too many -- I mean, there is no psychiatric reason I can really think of for which hospitalization wouldn't be an intervention rather than a late-term abortion to preserve the mental health of the mother.
Q. So when you say no psychiatrist would make such a recommendation for a late-term abortion based on mental health, are you purporting to speak for all psychiatrists?
A. No. I can modify the statement and say that I can't imagine a circumstance under which a psychiatrist would do that. An average psychiatrist practicing with an average level of clinical care and expertise. It just doesn't happen. I've never heard of it happening. There is no literature on it happening. There is no research on it happening. It is not a real-world event.
Q. Have you ever undertaken a research project to determine whether there is empirical evidence to support your statements you just made?
A. When you say a research project, have I designed my own research?

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Q. No. Have you ever reviewed the literature to determine whether there is empirical evidence to support the statements that you just made?
A. I have reviewed -- having an issue in gender and psychiatry and reproductive and biological psychiatry, reviewed -- one can't say all because that would be unreasonable, but an extreme amount of the literature regarding psychiatric interventions and problems regarding pregnancy, psychiatric illness during pregnancy, adoption issues, postpartum issues, lactation in postpartum, the effects of maternal illness on pregnancies, on children already born.
There is a huge amount of literature out there and I have reviewed quite a bit of it. I have written about some of it. The late-term abortion issue is not a psychiatric issue.
Q. You haven't written on late-term abortion, have you?
A. I'm sorry?
Q. You've never written anything on late-term abortion?
A. No, I have not written anything on

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late-term abortion.

Q. Or any abortion?

A. Or on abortion as a subject, no.

Q. Would you agree with the following: that a therapeutic abortion is defined as any of various procedures resulting in the termination of a pregnancy in order to save a life or preserve the health of the mother.

A. You know, again, I know there is such a thing as a therapeutic abortion. I know that there are a variety of reasons that people have abortions. I don't know specifically where and how those are defined because that is not an area that comes up in psychiatry under the kinds of circumstances that you're talking about.

Q. Thank you, Doctor.

Let's take a look at page 2 of the Patient 1 report.

A. Okay.

Q. It indicates under "Summary of Events" that Patient 1 is a 14-year-old single white female from New York.

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Do you see that?

A. Yes.

Q. And she was pregnant, right?

A. Correct.

Q. Have you ever treated a 14-year-old pregnant girl?

A. No.

Q. Can you think of any circumstance when it would be advisable for the mental health of a 14-year-old to carry a pregnancy to term?

A. When you're talking about mental health and you're talking about psychiatric disorders, you are talking about two overlapping spheres, but they are not congruent. Okay?

There are all kinds of emotional stress and distress that does not rise to the level of a psychiatric disorder or a psychiatric emergency.

I am highly empathetic to a 14-year-old who wants to get an abortion. I don't think that 14-year-olds having babies adds to the quality of their lives or the babies' lives.

However, a 14-year-old having a pregnancy,

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an unwanted pregnancy, is not in and of itself an indication that they are going to have a major psychiatric disorder or that they have a major psychiatric disorder. And there is no evidence that having an unwanted baby creates an irreversible impairment or substantial impairment that results in a psychiatric disorder.

Q. At least none that you know of?

A. None that I've ever seen reviewed in the literature. And postpartum disorders is something that I have expertise in. Unwanted teenage pregnancy carries a lot of risk to it. Most of them are social risks and medical risks, but they are not acute psychiatric emergencies.

Q. In general terms, does it require an acute psychiatric emergency to meet the standard for a late-term abortion?

A. I don't know in the sense that -- Are you talking about the Kansas standard?

Q. Let's deal with any standard you're familiar with.

A. Okay. Well, the only standard I am

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familiar with the specifics of is the Kansas standard.

Q. Does it require an acute psychiatric emergency under the Kansas standard to justify a late-term abortion?

A. It does not use the words acute psychiatric emergency.

Q. Those are your words?

A. Those are my words.

Q. Doctor, would it be reasonable -- would there be a reasonable relationship between a 14-year-old being pregnant and the onset of an anxiety disorder caused by that 14-year-old's pregnancy?

A. There would be a reasonable relationship between being pregnant and a 14-year-old having an unwanted pregnancy and being anxious, distressed, scared, and maybe even some other things. But of themselves, having those appropriate emotional reactions to an unwanted pregnancy does not mean that those symptoms rise to the level of a psychiatric diagnosis. They don't by themselves meet the criteria needed to cross the line into an actual psychiatric disorder.

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Q. And does it require a psychiatric disorder to justify a late-term abortion in Kansas?

A. The words "psychiatric disorder" are not in the statute. However, they were applied in almost all the cases I reviewed by Dr. Neuhaus. So...

Q. Does it require under the Kansas statute a finding of a psychiatric disorder to justify a late-term abortion?

A. No. I don't know how you would make the connection between a major organ being substantially and irreversibly affected without there being -- without meeting a level for a diagnostic criteria.

Q. Is the brain a major organ?

A. It is. But for it to be substantially and negatively and irreparably damaged, one, you have to get from here to there, and you're not going to get from the brain being a major organ to irreversible damage without crossing that threshold somewhere of meeting a psychiatric disorder.

Q. And you can say that categorically for all patients, correct?

A. There is no evidence that that statement --

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There is no evidence showing it the other way around. In other words, there is no evidence that shows that having appropriate emotional reactions to pregnancy, whether they're good reactions because you want it or bad reactions because you didn't want it, anxious, whatever, results in permanent, irreversible substantial damage to the brain absent some kind of intervening psychiatric disorder.

Q. And you can say that categorically for all patients, correct?

A. In medicine you can't say anything categorically 100 percent. But I can say that there is not any literature that I've seen that would support the position that having an unwanted pregnancy, no matter how distressing it is, leads to substantial and irreversible damage to the brain. It just doesn't exist.

Q. But you're not an abortion practitioner, are you?

A. No, I am not.

Q. You're familiar with the global assessment of functioning, correct?

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A. Correct.

Q. You use it in your practice?

A. Correct.

Q. You do use it in your practice?

A. Yes.

Q. And do you use it to assess the mental functioning of pregnant teenagers?

A. On a few occasions I have.

Q. And what do you use when you don't use the GAF?

A. I meant that I only had a few patients who qualified as pregnant teenagers.

Q. I'm sorry. And did you use the GAF with those patients?

A. Yes, I did.

Q. And do you use any other instrument or battery?

A. For assessing...

Q. Their mental functioning.

A. Well, sometimes I send people for neuropsychological testing or psychological testing.

Q. But not always?

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A. No, not always. But you don't use the GAF in isolation. The GAF is Axis V, meaning there are five categories of assessment in the Diagnostic and Statistical Manual. The GAF is the fifth one. You have to go through the other four before you get to that one.

So even though you use GAF, it's used in conjunction with a significant amount of other data when people use it.

Q. And is that a standard of care?

A. Well, I would say using the GAF -- using the GAF is not always the standard of care. There are plenty of doctors who only do Axis I, II or Axis I, II and III and leave off Axis IV and V all together.

It is certainly not the standard of care to use Axis V alone or alone with an unsupported diagnosis, unsupported Axis I diagnosis. That's not standard of care.

Q. Is the standard -- Can the standard of care for evaluating a patient for a late-term abortion be met without using the GAF?

A. Yes. I mean, I wouldn't do it, but I'm

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sure it can be done.

Q. And meet the standard of care?

A. Regardless of the circumstances, there are many doctors who don't use the GAF to do evaluation -- in their evaluations. They use Axis I, II or Axis I, II, III and stop there.

Q. In fact, that would justify a diagnosis of depression, for example, correct?

A. I'm sorry, what would?

Q. Using Axes I, II, III alone, one could arrive at a diagnosis consistent with the standard of care of, for instance, depression, correct?

A. One could.

Q. And could prescribe and treat accordingly, correct?

A. Assuming -- Yes, assuming that one had done the evaluation to get to a reasonable conclusion on I, II and III, or I and II.

Q. Now, I'm looking at page 4 of your report concerning Patient 1, Dr. Gold.

A. Okay.

Q. I'm looking under the section that says

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"Explanation of Opinion." And you describe Patient 1 as a girl in a, quote, distressing psychosocial situation, specifically an unwanted pregnancy.

What do you consider to be a distressing -- or what are the attributes, rather, of a distressing psychosocial situation?

A. In this specific case or generally?

Q. First of all, generally.

A. Any situation that creates problems in a person's life can be a distressing psychosocial situation. If you have a child who becomes ill, if you have a parent who has to be provided round-the-clock care, if you go through a divorce. There are plenty of life -- if you get fired from a job.

I mean, there are plenty of circumstances in life which create distress that are related to someone's social circumstances and creates emotional distress. That's what a psychosocial distressing situation is.

Q. And can a distressing psychosocial situation, again speaking in general terms, be the

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genesis for a psychiatric diagnosis?

A. Of itself, no.

Q. In any circumstance?

A. It is not -- Well, what do you mean by the word "genesis"?

Q. Origin.

A. Life stressors can result in psychiatric disorders. And certainly an unwanted pregnancy could result in a psychiatric disorder.

Q. Later on in that paragraph, Doctor, you talk about how the medical practice dictates that a referral be made to a mental health professional.

Do you see that?

A. Yes.

Q. What medical practice are you referring to?

A. I guess that would be standard of care.

Q. And what standard of care applies in that situation? I mean, what's the origin of that standard of care --

A. I --

Q. -- that you referred to that tells us what the standard of care is that leads you to say that

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medical practice dictates that referral?

A. That's standard practice, standard training, what doctors are taught to do when they are faced with a clinical situation that is outside their expertise.

And when you have a new -- a presumptively new onset psychiatric disorder in a 14-year-old pregnant girl, that set of circumstances is typically outside the mental health expertise of most practitioners.

And the appropriate referral, especially with a -- if you're diagnosing a new psychiatric disorder in someone who didn't have one on the basis of an unwanted pregnancy, the standard of care for any psychiatrist would be to refer that person to an appropriate child and adolescent psychiatrist for evaluation and an OB/GYN if they didn't already have one.

Q. Is it your testimony that there is no OB/GYN who would be able to make a diagnosis of a mental health disorder arising from an unwanted pregnancy?

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A. It depends on the OB/GYN and what kind of training they've had.
Q. What kind of experience they've had?
A. Experience and training.
Q. Okay.
A. Because it's common even among doctors to mistake distress for disorder. And there is a significant difference between distress and disorder.
Q. And can one go about differentiating between distress and disorder based on objective criteria?
A. Sometimes.
Q. Can one make that differentiation based on subjective criteria?
A. Sometimes.
Q. Do you know whether that differentiation occurred with Dr. Neuhaus's evaluation of this pregnant 14-year-old?
A. Since there is almost no documentation to indicate what kind of evaluation Dr. Neuhaus did, I would have a great deal of difficulty determining how Dr. Neuhaus came to her conclusion.

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Q. So you don't know the answer to that, to my question, do you?
A. Could you repeat the question?
Q. Objective or subjective criteria to make differentiations between a stressor and a mental health diagnosis, correct?
MR. HAYS: Bob, I don't believe she heard the whole entire question. It cut out. I'm sorry about that.
BY MR. EYE:
Q. Did you understand my question, Doctor?
A. I'm not sure that I did.
Q. You don't know what criteria Dr. Neuhaus may have used, either objective or subjective, to differentiate between a distressing psychosocial situation and a mental health diagnosis?
A. I don't know -- I don't know that she used any criteria at all.
Q. Well, you know that she used some objective criteria because the GAF is an objective instrument, is it not?
A. No, it's not.

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Q. It's subjective?
A. It is an assessment based on a combination of objective and subjective data. And the assignment of a score, a number, without any supporting data leaves one in the position of not being able to tell how someone came to that number and whether that number is valid. It's a misuse of the GAF which invalidates the test.
Q. And would that be your testimony as to the standard of care in Kansas?
A. I don't -- I think that the standard of care anywhere is to use a test appropriately in the way it was designed. And I don't have any evidence that the GAF was used that way.
Q. Do you have any knowledge about how practitioners in Kansas utilize the GAF for purposes of assessing the mental health of a patient?
A. I don't have any specific information about Kansas. The DSM is a national and internationally used reference, and the use of the five axes are nationally and internationally accepted, and I can't imagine that Kansas has a different system than what's

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used certainly nationally.
Q. But you don't know?
A. I don't know. But I would hope not.
Q. On page 5 of your opinions concerning Patient 1, the second full paragraph which has the first sentence that begins "These parameters are not rigid guidelines," do you see that?
A. Yes.
Q. What do you mean by that? First of all, are you referring to the practice parameters for the psychiatric assessment of children and adolescents that you referenced in the paragraph preceding?
A. Yes.
Q. What do you mean by them not being rigid guidelines?
A. They represent an expert consensus of best practices but they do not say you have to do this and you have to do that. Practice parameters, even practice guidelines, are not rigid rules. They are an expert consensus of best practices.
Q. And that's why practitioners are expected to use their judgment in making these kinds of

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evaluations, correct?
A. To a degree. Judgment, of course, is used in every kind of assessment. You can't do an assessment without judgment.
Q. Now, the rest of that sentence says: "...nor do they," referencing these parameters, "of themselves establish a legal standard of care."
A. That's my understanding.
Q. Right. So if those don't, what do? What does?
A. Well, you know, that's a -- I don't know how lawyers argue back and forth about how you establish a legal standard of care. My understanding of the standard of care is based on my understanding that it is the average care provided by the average skilled practitioner in a field, whether it's a general field or a specialized field.
Q. And that could also relate to a particular geographic designation too?
A. It could. Although it is fading to some degree, historically there has been some flexibility around the lines that even though 50 percent of states

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do it one way -- I'm sorry, 49 states do it one way, if it's done differently in the 50th state, then there is a local standard of care.
However, in the modern times, so to speak, when people have access to information and practices on a much broader basis than they used to, that among doctors is starting to be less of an issue.
How you do a mental status exam is how you do a mental status exam, in my experience, anywhere in the country. It's not taught differently anywhere. A national board certification, if you have one, means you know how to do it. The boards are national, they're not local. Some of these are becoming less -- the local flexibility, some of it is becoming less and less significant.
Now, could there be areas where it's still significant? Sure, it could. But in psychiatry, my experience has been that it's becoming less significant. Certainly not in the judgment necessarily applied but in the how you conduct an appropriate evaluation. Okay? And these guidelines, these parameters say how you conduct an appropriate

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evaluation.
Now, people can deviate from them, but when you deviate from guidelines, generally there has to be a pretty good reason why you're deviating from them.
Q. And is that -- is that deviation from these guidelines --
A. Or parameters in this case.
Q. Thank you.
These parameters are essentially -- they're not the exclusive means by which a physician can reach a diagnosis of mental health disorder, correct?
A. They represent an expert consensus of the best practices in reaching a psychiatric assessment of disorders in children and adolescents. If there is another way to do it, I'm certainly not familiar with it and it's not endorsed by the American Academy of Child & Adolescent Psychiatrists or the APA or any other professional organization I'm aware of.
Q. But my question is those are not necessarily the exclusive means by which to arrive at a justifiable diagnosis that is consistent with the standard of care, correct?

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A. I don't know that that's correct. I would have to look at it on a case-by-case basis and see if it somehow could be justified to use something else.
Practice parameters are not intended to be exclusive, and I would not state that -- I can't state -- I certainly don't believe that the authors of these parameters would say that they're absolutely exclusive. But you would really have to evaluate what else there is that's being done besides this.
Q. Now, in addition to the GAF, were there other instruments used for Patient 1 to determine her mental health status?
A. I'm sorry, could you repeat the question?
Q. In addition to the GAF, were there other instruments that were utilized to determine the mental health status of Patient 1?
A. No.
Q. What is the DTREE? What is that?
A. That's a good question.
Q. You don't know?
A. I know what it purports to be.
Q. What does it purport to be?

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A. It's a diagnostic algorithm, a computer-generated diagnostic algorithm.
Q. Have you ever used it?
A. Nobody uses it.
Q. Nobody uses it?
A. As a standard of care, no, nobody uses it. They were very popular in the 1980s because everyone thought you would be able to turn over diagnostic assessment to computerized algorithms. It turned out not to be as a validity or reliability, and they were for the most part abandoned.
It's not considered an instrument the way a psychological test would be considered an instrument. It's not a rating scale. It's -- I don't know what it is other than to say it's a computerized algorithm for establishing a diagnosis that has no validity or reliability.
Q. It has no validity or reliability?
A. That's correct.
Q. And is it your testimony that use of the DTREE is a deviation of the standard of care?
A. Not the use of it in conjunction -- If

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you're doing a complete psychiatric evaluation and you want to use something like this in conjunction with that, you can. But the use of it as an instrument upon which to base a psychiatric diagnosis, that is not standard of care.
Q. At least not by itself?
A. Certainly not by itself.
Q. In conjunction with other means and methods, is it a deviation from the standard of care to utilize the DTREE?
A. They're not used, so in the sense that they're not used by psychiatrists, I would say it is a deviation from the standard of care of psychiatrists. But it's not of itself problematic except if it's used as the basis of a diagnosis.
Q. Meaning not problematic meaning it's not uncertain, or it's not invalid to use it in conjunction with other means or methods to arrive at a diagnosis concerning mental health?
A. It's not invalid to use it as a guide to collecting information in a variety of ways. It's sort of like a cheat sheet of things that you need to

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explore. But to have an algorithm where if yes then A, if no then B, which is basically what it is, taken directly from the Diagnostic and Statistical Manual criteria, that is the basis of psychiatric diagnoses is a deviation from the standard of care.
Q. Dr. Gold, in your evaluation of Patient 1, is it your opinion that the DTREE was the only means that Dr. Neuhaus could rely on to arrive at her conclusions concerning the mental health status of Patient 1?
A. The only documentary evidence that I had for Patient 1 was the DTREE, computerized, unsigned, not even clear that Dr. Neuhaus completed it herself, but for the sake of argument we can say she did. And a computerized GAF report, ditto, with no specific symptoms, examples of impairment, examples of dysfunction, nothing to justify the DTREE report or the GAF report.
And that was all there was in the file except for a letter referring this patient to Dr. Tiller, saying that she would suffer substantial and irreversible impairment.

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Q. My question was: Is the use of GAF and DTREE as a means, or as two means by which to assess the mental health of a patient, a deviation from the standard of care?
A. Well, the DTREE is, just because --
Q. That's your opinion?
A. Well, yeah, I'm here giving my opinions. It's not used. It's not used. It's not relied upon. I've never even seen a research protocol which relies upon it.
The GAF is standardly used. But certainly the documentary evidence presented here of an unused and unvalidated diagnostic algorithm and a GAF with no specifiers specific to the patient, that's the only information I have about what Dr. Neuhaus reportedly did to conduct an evaluation in this case.
So that's all the information I have.
Q. Now, I understood your testimony just a minute ago that using a DTREE in conjunction with other means or methods was an acceptable methodology to arrive at a diagnosis or a conclusion about mental health of a patient.

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A. I wouldn't call it a methodology. I would call it sort of a cheat sheet where it might have things to remind someone, oh, I should ask about this, I should ask about that, because basically it lists DSM criteria that you should ask about. Okay?

But there is no evidence here of what the data was put in. In other words, it's the data that is important. It's not the algorithm that is important. And the evaluation is what gets you the data. Okay?

So the algorithm by itself, you know, there is, like I said, no validity, no reliability, nothing that says that if you put the data in in a certain way, you're going to get a true positive a certain amount of the time. There is just no data about that. It's not there.

So it doesn't hurt to use cheat sheets, okay, to remind yourself to ask about symptom A or symptom B. But there is no evidence here that it was used as a cheat sheet. It appears to have been used as a diagnostic tool.

Q. But you don't know?

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A. I don't know why anyone would want to use one for a reason other than to be a cheat sheet. There is no -- There is no science behind it. So I don't know why else you would use it.

Q. You mentioned a moment ago that the DTREE includes DSM criteria; is that correct?

A. That's correct.

Q. Does the DTREE originate with the DSM or was it the other way around?

A. Well, I presume that the DTREE originated with the DSM, because the DSM has been around since the turn of the century in one form or another. The turn of the last century.

Q. And the DSM is a reliable source upon which to -- that practitioners use to help arrive at diagnoses and conclusions, correct?

A. Correct.

Q. And you restate in the third paragraph under "Explanation of Opinion," you say twice that termination is not a treatment for any psychiatric disorder. You first say abortion is not a treatment for a psychiatric disorder, then you later on say

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termination is not a treatment for any psychiatric disorder.

A. I'm sorry, where are you?

Q. It's on page 4 under "Explanation of Opinion," the third full paragraph.

A. Correct.

Q. Now, is there a literature cite that you can point to that essentially states that abortion is not a treatment for any psychiatric disorder?

A. Well, I can't cite something -- you know, you're asking me to cite proof of a negative, which of course you can't do. I mean, no one would ever do a study. How could you possibly do an ethical study of whether abortion is a treatment for a psychiatric disorder?

Q. So that study has never been done?

A. No, of course that study has never been done. I mean, it would constitute human experimentation. Maybe the Nazis did it. But you couldn't do that kind of study.

Q. What is it that you base your statement that it's not a treatment for a psychiatric disorder?

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A. Because there are many, many, many treatments for psychiatric disorders including all the psychiatric disorders in the patients that I reviewed, and it -- it's not done, it's never been done. No one would refer someone with an adjustment disorder for an abortion. It's just not a treatment. I don't know how else to say it.

There are no signs to support that kind of treatment. There is no experience, there's no clinical judgment, there's no science. Whereas someone with an adjustment disorder, there is tons of evidence to support, assuming that you're going to treat an adjustment disorder, counseling, medication, psychosocial support. There is a variety of interventions. So there are many interventions. But an abortion is not one of them.

Q. Have you ever referred a patient for an abortion?

A. It would not be my place to refer a patient for an abortion.

MR. HAYS: Objection; asked and answered earlier.

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BY MR. EYE:
Q. Is it within the standard of care for a psychiatrist in some instances to refer a patient for an abortion?
A. I wouldn't think so, no. I wouldn't think so.
Q. Have you ever spoken with any psychiatrist about that question, or something akin to it?
A. No. It doesn't come up because it doesn't happen. You don't talk about stuff that doesn't happen.
Q. And you're not a member of any professional organization that deals with abortions, are you?
A. No.
Q. You've never attended a conference that deals with abortions, have you?
A. No.
Q. You don't subscribe to literature, medical journals that is, that deal with abortions, do you?
A. Not directly.
Q. On page 8 of your report concerning Patient 1, under No. 3 you list four subpoints, A through D.

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Are those essentially summations or repetitions of what you said earlier in your report?
A. I believe so.
Q. Okay. Now, that raises another question. You've got your report laid out in a question and answer colloquy kind of format, correct?
A. Correct.
Q. Who gave you the questions that you answered?
A. I believe that was -- when I testified earlier about the sample report being categories, I think that's what that was.
Q. But you formulated these questions, correct?
A. No. That's what I'm saying. Those were the questions that were in the sample report saying, please respond to these questions.
Q. And they were general enough that you could have them apply to the question that you were dealing with?
A. Well, I think I made -- What I did was I got very specific about them. So they opened the subject and then I specifically said what I could say.

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Q. All right. Let's take a look at No. 4 on page 8 of your report concerning Patient 1. You referenced the DSM-IV, correct?
A. Correct.
Q. What part of the DSM-IV did you rely on?
A. Well, in a sense, you rely on all of it. But there are sections of it that talk about the appropriate use of the DSM in terms of coming to diagnostic conclusions.
Q. Did you actually open up the DSM and look at those sections as you wrote the report concerning Patient 1?
A. No.
Q. We've already talked about D&C, correct? That's the '97 and 2007 versions of those practice parameters?
A. Correct. Oh, okay. So the 2007 is specifically for anxiety disorders.
Q. All right.
A. Okay.
Q. And it's your testimony that neither B nor C have any particular specific applicability to pregnant teenagers?
A. No, that's not my testimony.
Q. Well, tell me how the practice parameters set out in either the '97 or the 2007 versions relate to the assessment of a pregnant teenager.
A. They are the general guidelines for assessing any teenager, and they do not specifically -- well, the anxiety -- the 2007 one talks about anxiety disorder specifically. But you can have an anxiety disorder in a pregnant teenager, an anxiety disorder in a nonpregnant teenager. The evaluation is, generally speaking, the same. There would be no difference in the psychiatric evaluation other than explorations of the circumstances of the pregnancy similarly to if the teenager was in the process of parents divorcing versus parents not divorcing.
Of course, it's a circumstance that you're going to explore because it's unique to that teenager. But the general guidelines remain the same. There are no separate guidelines for evaluating children who

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have diabetes and children who have a brain tumor and children whose parents are divorcing and children who are pregnant. The guidelines are the same.

Q. You reference under 4 at letter D a work by Cohen and Novak were the editors. Can you tell me exactly what it was in that reference that you relied on?

A. Well, that's a book that documents the variety of disorders and treatments available to women who have psychiatric problems during pregnancy and postpartum period.

Q. It talks about women?

A. Women -- I mean, they don't necessarily differentiate between wanted and unwanted pregnancies. Women have unwanted pregnancies, children have unwanted pregnancies. But when I say women, I'm referring to anybody who can get pregnant.

Q. Females?

A. Females, thank you.

Q. What about the Yonkers reference?

A. Same thing. And they're actually more recent. I can update those also if you want more

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recent.

Q. Now, Yonkers deals with management of psychiatric disorders in pregnancy?

A. Correct.

Q. Does it deal with the assessment of mental health of a person who's pregnant?

A. No. I mean, in the sense that Yonkers, the assessment of a female who is pregnant, now if you want to use adult women, is the same assessment that you would do for anybody following the general practice guidelines of assessment of adults published by the American Psychiatric Association.

So the guidelines remain the same regardless of the individual circumstances. The circumstances dictate things that you may need to explore further, but it doesn't change the guidelines.

Q. Do you agree that children are frequently more vulnerable than adolescents or adults when it comes to issues like unwanted pregnancies?

A. Vulnerable to what?

Q. To being influenced about the decisions they should make concerning that pregnancy.

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A. I'm not sure how to answer that question.

Q. Well, let me ask it in a different way, then. Do you consider it to be valid that children are more vulnerable to extraneous influences than adolescents or adults?

A. Generally speaking, yes.

Q. Would you say that children generally compared to adolescents and adults lack the same level of maturity when it comes to decision-making?

A. Certainly.

Q. And would you agree that children usually require a higher degree of parental involvement or adult involvement, if you will, that's not a parent, in terms of making decisions about something like pregnancy?

A. I would say they require it around pretty much anything.

Q. And so would you use the same diagnostic methodology to evaluate a child as you would an adult?

A. No. That's why there are different practice guidelines for children and adolescents than there are for adults.

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Q. And so in Yonkers, did they differentiate between adults and adolescents and children?

A. I would have to go back and look but I doubt it.

Q. How about in Cohen?

A. They might have, but I would have to look. And part of the purpose of those references, there's two issues. Well, there's more than two issues. But there's the evaluation issue, which I think is more or less covered by the general parameters. Okay?

And then there's the treatment issues, which are more what I relied on D and E for, those two tests.

And these are the standard -- I shouldn't say standard. These are some of the most respected researchers in these two fields and clinicians in these fields. And when you talk about treatment and the question of whether abortion is a treatment, nowhere in this respected literature is found the idea that somehow abortion is a treatment for the common and even the uncommon disorders associated with pregnancy and the postpartum period.

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So I don't know how much evaluation material there is in Cohen and Yonkers, but the evaluation is covered by the guidelines.

Q. Doctor, were you asked to render an opinion about treatment in this case?

A. I think originally, although I understand it did not become part of the petition. So...

Q. That's a gratuitous opinion on your part, isn't it?

A. Well, at the time it wasn't, but it's not useful now. So I wouldn't call it gratuitous. That's kind of negative.

Q. Were you asked to render an opinion in this case concerning the propriety of abortion as a treatment?

A. Not specifically in those words, no.

Q. Were you asked to give that opinion in any words?

A. I was asked about the standard of care regarding treatment.

Q. Really?

A. Well, initially the question was about --

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MR. HAYS: Objection; argumentative.

THE WITNESS: Standard of care and documentation. And treatment was potentially an issue at that time.

BY MR. EYE:

Q. So was it suggested to you by counsel for the Board that they were going to contest the abortions as treatment, or they were going to contest the evaluation that led up to the recommendation for abortion?

A. Counsel did not suggest to me what they were going to do with my reports. They wanted the report, and they wanted me to be -- to address all of these different aspects. I was never included in any discussions about what they were going to do with the reports.

Q. In the letter of referral, does it ask you to render opinions about propriety of treatment?

A. The word propriety I know for a fact was never used.

Q. Does it ask you to render an opinion about treatment?

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A. I would have to look at the letter specifically to recall.

Q. Would you do so, and would you provide an answer to that question under oath in a separate writing to supplement this testimony?

A. Sure.

Q. And would you provide a copy of that letter?

A. Yeah. I think I already said I would do that.

Q. Very well.

MR. EYE: And counsel, I'm going to reserve the right to reconvene this deposition depending upon what is specified in that letter or anything else that's produced subsequent to this deposition today.

MR. HAYS: If you want to go off the record real quick, I can tell you. I can expound on this a little bit.

MR. EYE: Can you do it on the record?

MR. HAYS: Sure.

I'm looking at what I believe is a final draft of the letter, and I believe we provided it in

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discovery but I'm going to have to check on that.

MR. EYE: I don't remember seeing it.

MR. HAYS: Okay. And it states: "Once you have reviewed the records, please prepare a separate written report for each of the patients regarding Licensee 2's care and treatment of the patients."

BY MR. EYE:

Q. So you weren't asked to render an opinion about whether abortion was a proper referral, correct?

A. Well, it appears -- That specific question was not asked. But no specific question was asked, is medication an appropriate referral, is therapy an appropriate referral, is abortion. I was asked about treatment and my opinions about the treatment.

Q. And what treatment was Dr. Neuhaus responsible for giving in the course of this evaluation?

A. Well, a referral for an abortion. Without which -- Without her letter, I don't know if you would call that letter a referral letter. I think it says I am referring -- Let me see what it says.

The letter says: "I am referring the

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above-named patient to your organization." It doesn't say for abortion, but it says "for consultation regarding her unwanted pregnancy. The patient would suffer substantial and irreversible impairment of a major physical or mental function if she were forced to continue the pregnancy."

I saw that, rightly or wrongly, as a referral under these circumstances for an abortion.

Q. Was there treatment that Dr. Neuhaus provided Patient 1?

A. No. Other than the referral, no.

Q. Was there care that Dr. Neuhaus provided Patient 1?

A. Again, other than the referral, no.

Q. Look at Patient 2. It's fair to say that the records that you reviewed there other than the specific chart of Patient 2 were the same, correct --

A. Correct.

Q. -- as Patient 1? All right.

Now, Patient No. 2 was a ten-year-old incest and rape victim, correct?

A. Yes.

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Q. She was pregnant, correct?

A. Yes.

Q. Is it your opinion that the ten-year-old should carry that pregnancy to term and not experience any life impairing mental health problems?

MR. HAYS: Objection; compound question.

MR. EYE: All right, I'll break it down.

BY MR. EYE:

Q. Do you understand the question, Doctor?

A. I thought I did, but now I've forgotten it.

Q. I'll break it down.

Is it your opinion that a ten-year-old is able to carry a pregnancy to term without having adverse mental health consequences?

A. I don't have enough details -- Are you asking me about this specific one or generally?

Q. I'll ask generally first.

A. Generally it's possible. Anything is possible.

Q. How many pregnant girls have you counseled? Any?

MR. HAYS: Objection; argumentative.

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THE WITNESS: There is no accepted axiom or literature within the mental health profession that says that any adverse circumstance is going to result in permanent mental harm, injury or psychiatric disorder. One cannot simply state that because somebody is going through a horrible experience that they will be psychologically brain -- irreversible brain damaged for the rest of their life on the basis of a psychiatric disorder.

It's hardly optimal for any child to be pregnant, never mind have to carry a pregnancy to term. Could a specific child develop severe emotional problems from that or psychiatric problems? Sure, a specific child could. Can you say generally that every child will? No, you can't. The same way you can't say that every concentration camp survivor had a psychiatric disorder at the end of that horrible experience, even though every one of them would have told you it was an adverse horrible experience.

BY MR. EYE:

Q. How many ten-year-old pregnant girls have you counseled, Doctor?

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A. None.

Q. How about 11-year-old pregnant girls?

A. None.

Q. What is the youngest pregnant girl you've ever counseled?

A. 16.

Q. Now, in Patient 2 there was a GAF report. Did you review that?

A. Yes, I did.

Q. Do you think that it was reasonable to infer from the GAF score that the patient had an impairment in several areas including thinking and mood?

A. I don't -- I can't infer anything from the GAF report other than the number because there is no data to say how that number was arrived at.

Q. And in your clinical judgment, then, would it have been in the case of a ten-year-old pregnant girl, would the subjective assessment of that girl play a more prominent role in her evaluation than, let's say, the quantitative methods that GAF or other quantitative instruments might yield?

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A. I don't have any data about this particular girl to allow me to come to a conclusion one way or another. That's part of the difficulty or the problem, which is that the data is not documented. And so a conclusion -- an outside person who knows nothing about the case specifically could not come to an educated reasonable opinion on any of these questions that you're asking.

Q. Well, what are the data that you would look to to assess the mental health functioning of a pregnant ten-year-old?

A. I would look at the data that one would use for any child of that age and then explore further whether the pregnancy is an additional impairment factor. One would assume that it is, but one is not supposed to make assumptions when you're doing the evaluation. You're supposed to get the data.

Data can be objective, data can be subjective. There is no documentation of either objective or subjective data in Dr. Neuhaus's GAF report.

Q. And what are those data that you would look

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to and expect to find?

A. Okay. I would refer back to the practice parameters. You know, if you want me to, I can read through all the different things that they tell you you're supposed to collect.

But there is a huge amount of data that should be collected in order to reach not only a GAF, which is only part of the diagnostic assessment, but the whole diagnostic assessment. Some is objective, some is subjective. They don't make a distinction because you do use both. It's just not documented.

Was it collected? It may very well have been collected, I just don't know. And so I can't say.

Q. And those parameters that you just referenced a moment ago, those are not standard of care, are they?

A. They do not represent a legal standard of care.

Q. Thank you.

A. They represent best practices and expert consensus of best practices of the American Academy of

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Child & Adolescent Psychiatry.

Q. Which is still not a standard of care, correct?

A. No. They are -- It's the expert consensus of best practices.

Q. But you would agree that that's not a standard of care?

MR. HAYS: Asked and answered.

MR. EYE: No. The record is confused.

BY MR. EYE:

Q. Do you agree that that is not a standard of care?

A. It is not a -- It does not establish a legal standard of care.

Q. Thank you.

Take a look at Patient No. 3. Patient No. 3 is a 15-year-old pregnant girl, correct? Look at page 2.

A. Yes, correct.

Q. And this is still younger than anybody you've ever treated that was pregnant, correct?

A. Correct.

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Q. Now, in this instance there was an MI statement. What's an MI statement?

A. It's a document that was drawn up, presumably by Dr. Tiller's clinic. My understanding of it was that it was filled out by a member of Dr. Tiller's staff, often by telephone interview.

Q. But it was based upon an interview of the patient?

A. By a nonmental health professional, but yes.

Q. And what do you know about the qualifications of the person who did that interview?

A. Only the testimony that they were not mental health professionals.

Q. Did they have any training in using an MI statement?

A. Well, that MI statement is an idiosyncratic document. They drew it up, so I don't know how you could have training in it other than the clinic used it as a standard document. It's not a -- at least from a psychiatric perspective. Maybe it's a standard document in other types of practices, but it's not a

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standard tool for psychiatrists or psychologists.

Q. Do you have any objection to it, or do you have any professional objection to the MI statement being used to help evaluate the mental health status of a patient that was seeking abortion services?

A. Not as a -- Not as a screening instrument for further evaluation by someone who was a mental health professional.

Q. Do you ever rely on assessments that are made by somebody else to help you evaluate a patient? In other words, a patient referred to you by a general practitioner, do you sometimes look at that practitioner's records?

A. Well, if I get records sent to me, I look at them regardless of who has generated them. But the weight that I give the assessments vary depending on the qualifications of the individual.

Q. Did the MI statement that you looked at ask relevant questions, in your judgment?

A. Yes and no.

Q. Go ahead.

A. It was more geared towards determining why

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the individual wanted an abortion but there was some mental health information -- there was some information gleaned about the person's emotional status. I wouldn't even call it mental health information because it wasn't specific enough or nuanced enough to be mental health. But it certainly did ask them about their emotional state.

Q. Is the motivation to seek an abortion a relevant consideration in judging the mental health status of the patient?

A. It can be.

Q. Are you familiar with the -- and I'm not exactly sure how to pronounce it but it's the acronym SIGECAPS?

A. Yes.

Q. I've heard it pronounced various ways. SIGECAPS?

A. SIGECAPS, yeah.

Q. Are you familiar with that?

A. Yes.

Q. Do you ever use it?

A. No.

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Q. Is it beyond the standard of care to use it, or outside the standard of care to use it?

A. No, in the sense that it is the minimum information you would want to know to screen for depression.

Q. And what about the SIGECAPS parameters that it examined, why are those relevant parameters to consider in evaluating the mental health status of a patient?

A. Because they are symptoms that can -- they are potentially symptoms that could indicate -- could indicate a diagnosis.

Q. And what does SIGECAPS stand for?

A. Oh, I knew you were going to ask that. It's a pneumonic. And let's see. I think S is sleep. I is -- no, that wouldn't be right. Okay. Suicide, insomnia, guilt, energy, concentration, attention. I'm not sure what the P is, and S is for I think self-esteem. A might be for appetite, I'm sorry, concentration and appetite.

Q. Is SIGECAPS used by -- Strike that.

Was SIGECAPS something that got presented

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during your psychiatric training?

A. No. Well, maybe. It's an acronym to help teach medical students and really first-year trainees how to remember to ask for the most significant symptoms associated with depression. So it is the tip of a -- it is the tip of a screening tool. And the reason I don't -- the reason I don't use it or remember specifically is because my evaluations go into much more than just this, so that this pneumonic is not particularly useful to me because I go past it. And hopefully most psychiatrists would go past it.

Q. And is SIGECAPS, the use of it to assess the mental health of a patient, is that within or outside the standard of care?

A. It's within the standard of care if it's used as a screening tool for further assessment.

Q. And does SIGECAPS give any treatment by practice parameter for assessment and treatment of children that we've referenced, this '97 or the 2007 versions?

A. I'm sorry, is the SIGECAPS mentioned in the practice guidelines, is that the question?

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Q. Right.
A. No, it's not mentioned in the practice guidelines.
Q. And same question for the --
A. Well, let me go back. SIGECAPS is not a formal diagnostic tool or screening assessment. It's a pneumonic that is taught to people to get them to ask specific questions. All of those questions are referenced in the practice parameters in one way or the other, they're just not referenced as SIGECAPS, because SIGECAPS is sort of the minimum information you would want to get.
And in the guidelines regarding best -- expert consensus of best practices, they're not telling you to get the minimum that you can get. Okay? So you're not going to find a specific reference to SIGECAPS.
Q. So you wouldn't want to get anything less than what SIGECAPS would yield?
A. If you are a mental health professional, that would be sort of the lowest amount, the least amount of information that you should ask to do a

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competent assessment.
Q. Now, Doctor, in your review of those Kansas statutes, did it specify that the assessment to determine whether a woman is going to have -- whether a female is going to have impairment for mental health from carrying an unwanted pregnancy, does that have to be done by a mental health professional or like you, a psychiatrist? Is that a requirement?
A. I don't think it specifies. I don't recall. I would have to look at the statutes. I don't recall.
Q. Now, with Patient 3, it was more than the SIGECAPS that was used, correct?
A. Well, there was this narrative MI statement.
Q. Okay. And what else? DTREE, right? Even though you've sort of been critical of the DTREE, it was one of the --
MR. HAYS: Objection; argumentative.
THE WITNESS: Yes, there was a DTREE.
BY MR. EYE:
Q. And there is a GAF?

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A. And a GAF.
Q. Now, with all of those together, do you believe that that forms a basis of information in addition to a face-to-face consultation that would allow a practitioner to arrive at a diagnosis related to a mental health impairment?
A. No.
Q. And what else would be required?
A. A mental health evaluation, which none of this is.
Q. What else would be done in a mental health evaluation that wasn't done here?
A. You would have to get a significant amount of information regarding symptoms, length of symptoms, intensity of symptoms. When I say length I mean how long they have been present. Impairment, whether they're causing any impairment. With someone who is 15 years old, again, with children and adolescents they are often not the best source of information. You want to get some collateral information from somebody else if possible. Family history, psychiatric history, social history, medication

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history. You know, there's a variety of information including, but most importantly, specificity of symptoms and specificity of impairment of functioning to come up with a diagnosis of -- with a psychiatric diagnosis.
And it's hard to imagine that all of that information, since some of it is dated -- I mean, it's hard to know -- The dating on this makes it even more difficult to understand how this was an adequate evaluation. The DTREE was documented on the date of the appointment for the abortion. There is a duplicate with a different date. There's -- Let's see.
The MI statement was on 7/31. The appointment, presumably for the abortion, was on 8/5. The DTREE is dated 8/5. And the GAF is dated 8/5.
So presumably no information was collected other than the MI, which was again presumably a telephone conversation with a nonmental health professional for which the SIGECAPS I guess is part of that.
So there is one telephone conversation and

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then two documents, computer documents generated with no specific information in them on the same date as the procedure.

And how that would constitute a thorough psychiatric evaluation or a minimally adequate psychiatric evaluation is very difficult to understand, because there is no evidence of other information collected.

Q. What is the standard of care related to Patient 3 and the evaluation that she underwent for mental health purposes?

MR. HAYS: Objection; compound question.

BY MR. EYE:

Q. You may answer.

A. I'm sorry, can you repeat the question?

Q. What is the standard of care related to the mental health evaluation for Patient No. 3?

A. It would be a -- It would be the standard of care for the evaluation of an adolescent, which includes obtaining not only face-to-face information from the adolescent but collateral information from other individuals including, for example, parents or

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involved adults, evidence or descriptive evidence of functioning or changes in functioning, symptoms, plus an extensive what's called a psychosocial history.

Perhaps -- perhaps -- I mean, I could come up with any number of reasons of why this girl was distressed about her pregnancy that have nothing to do with having a major depressive disorder. I just don't know.

And an evaluation that results in a diagnosis should be able to provide the data that says, oh, I understand how you got from the fact that she's upset about her pregnancy to a psychiatric diagnosis. And that's not present.

Assigning a GAF without specifying what that GAF is based on is not standard of care. The DTREE we have already discussed is not standard of care in any way, shape or form.

And if the only information relied upon was an MI statement which was a telephone screen for initial eligibility by a nonmental health professional, then that's certainly not standard of care either.

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Q. The standard of care that you've just -- You said that those things aren't the standard of care. Where do you get the standard of care that you just applied?

A. From the practice of -- the average practice of a prudent practitioner who, upon seeing a patient that they have never met before, would do an evaluation that would cover the information that I suggested.

Q. And that's an average psychiatrist?

A. Yes. This would not be acceptable as a mental health evaluation, I think, for the average psychiatrist. If you handed the average psychiatrist this information and said, okay, go ahead and treat this patient, that doctor would not rely on this information despite the fact that there is a diagnosis listed in there to go ahead and treat that patient.

Q. Would you agree that practitioners make diagnoses of depression, for example, and prescribe treatment for it that don't necessarily do everything that you just specified?

A. They may not on occasion.

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Q. Is that beneath the standard of care?

A. Well, the standard of care is what the average doctor would want. Average means there are people who do more and people who do less. So the fact that there are people who would do less doesn't defeat the standard of care.

Q. And is it the situation of people who do less may be using their good faith judgment of what is required in a particular set of circumstances? That would be consistent with the standard of care?

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

Q. Again, you agree that based upon your review of the pertinent information, it doesn't require a psychiatrist to do what Dr. Neuhaus is doing here, correct?

A. I don't understand that question either.

Q. Does the law in Kansas require that a psychiatrist do this mental health evaluation that's part of the second opinion for a late-term abortion?

A. I'm not an expert on the law in Kansas. I'm not aware of it, but I'm not qualified to talk

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about the law in Kansas.

Q. Well, what about practice in Kansas, medical practice in Kansas, does it require a psychiatrist to do this evaluation?

A. I think it would require someone with some mental health expertise and training at the very least. And again, that would be the very least. When you're making a diagnosis of a new onset psychiatric disorder in a young person which can have profound implications for the rest of that person's life, typically you're going to get a referral for a good evaluation, especially if you are going to do an extreme intervention.

If you're not going to do an extreme intervention, you can certainly take your time and gather information here and there and however you want to do it, and that might meet the standard of care in some places.

You know, my daughter doesn't like to do her homework. Okay, you sort of collect information over time and come up with an intervention on how to get your daughter to do her homework.

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If you're talking about a major surgical intervention in a new onset psychiatric diagnosis, by definition someone with a new onset psychiatric diagnosis that has never been treated is potentially unstable, and a surgical intervention at that moment in time is something that would be considered potentially even more destabilizing for a person. Okay?

So if you have a new onset psychiatric diagnosis and you're going to perform a surgical intervention, you are certainly going to want someone with the experience and expertise to be able to talk to you about that person's stability and the appropriate treatment for the mental health problem.

Q. What do you know about Dr. Neuhaus's experience and expertise?

A. Only what I read in her testimony.

Q. Do you know anything else? That's the extent of it?

A. Yeah, only what I read in her testimony.

Q. And what did you read about? What did you read in her testimony?

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A. That she -- Oh, gosh. She took every psychology course that there was in Kansas State University. That she thought about becoming a psychiatrist. That she's read the DSM front to back twice. That she has on occasion prescribed antidepressants, although she doesn't like to prescribe medication and uses that as a last resort, which is perplexing.

Q. Is it beneath the standard of care to use that as the last resort?

A. Certainly not. I'm sorry, could you repeat the question?

Q. Is the decision to use medicine necessarily -- not using it until it's a last resort, is that a deviation of the standard of care in all cases?

A. Nothing is a deviation in all cases every single time. But she was speaking of a general philosophy of not wanting to use medication except as a last resort, which a mental health -- you know, a mental health professional looks at all of the options and decides which one is most appropriate without a

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priori assuming that one is less good than another in any individual case.

So especially -- especially under the present circumstances where there is tons and tons of evidence for the use of medication as a treatment for anxiety and depression during pregnancy and zero evidence for the use of abortion as a treatment for the use of depression during pregnancy. That's why I'm very perplexed by that statement.

I think she said she considered becoming a psychiatrist. She reads articles about psychiatry. And she undertook her own research on pregnancy, informally on pregnancy.

Q. Does that suggest to you that she didn't appreciate the gravity of her task in evaluating these patients?

A. I can't speak to Dr. Neuhaus's state of mind. I don't know whether she appreciated it or didn't appreciate it.

Q. Fair enough.

MR. EYE: I need to take about a five-minute break. So reconvene here in about five

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minutes.
(Recess taken.)
BY MR. EYE:
Q. Doctor, let's go to Patient 4, please.
A. Okay.
Q. I think I can speed this up a little bit. The records reviewed is the same for all 11 patients, isn't it?
A. That is correct. Well, with the exception of the obvious medical records themselves; obviously they differ for each patient. Anything that's not a medical record was the same.
Q. Thank you.
Patient 4 was a 15-year-old single African American female who was pregnant, correct?
A. Correct.
Q. And in this instance there was a DTREE, correct?
A. Yes.
Q. And GAF, correct?
A. Yes.
Q. And SIGECAPS?

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A. Yes.
Q. And did an MI get used in this instance?
A. Well, you know, the MI and the SIGECAPS are often the same document.
Q. So they're kind of structured as far as following the same general line of questions?
A. Yes.
Q. All right. Now, over on page 7, the part related to Patient No. 4, there is a paragraph that's marked Roman numeral IV.
Do you see that?
A. Yes.
Q. Now, you're not saying that that observation and assessment of those particular parameters wasn't done; you're simply saying you didn't see documentation of it?
A. That's correct.
Q. All right. Now, I would like to ask a question that I think actually has some applicability to other patients but it shows up here in Patient 4. Over on page 8 it would be Roman numeral X.
A. Okay.

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Q. Do we agree that the purpose of Dr. Neuhaus seeing these patients was for an evaluation concerning whether there was a mental health impairment that would justify a late-term abortion, correct?
A. I'm sorry, could you repeat?
Q. Sure.
The purpose of the evaluation -- I'm sorry.
The purpose of Dr. Neuhaus evaluating these patients, really all 11 of them, was to determine whether there was a mental health justification for a late-term abortion?
A. That's my understanding.
Q. And that was the scope of her evaluation, correct?
A. Yes.
Q. Now, in Roman X you talk about how a physician providing an assessment and referral for consultation and treatment -- that there should be some provision for after care. I'm sorry, it's the very first sentence of that Roman X.
A. Yes.
Q. Now, an evaluation that is done to meet the

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statutory requirements for late-term abortion, does that require a provision for after care?
A. Does the statute require it?
Q. Right.
A. I don't -- again, I would have to look at the statutes, but I doubt it.
Q. Does an evaluation require a treatment plan?
A. Yes and no. It depends on the nature of the evaluation.
Q. You do evaluations for disability and workers' comp and so forth, don't you?
A. Yes, I do.
Q. And when you do those evaluations, do you have a treatment plan that goes along with them?
A. It's a recommendation for treatment. It's not a personal treatment plan. But almost always I'm asked for treatment recommendations.
Q. Well, when you're not asked for treatment recommendations, do you provide them anyway --
A. If --
Q. -- for a patient for a disability claim,

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for example?

A. If I think that there is a need for it, I will do it. If I think that someone is receiving inappropriate treatment or inadequate treatment or potentially harmful treatment, I will absolutely make a recommendation regarding treatment.

Q. So if an insurer comes to you with a case file of a person who is seeking a disability benefit and you evaluate that file for that purpose, do you make a recommendation for treatment?

A. I will if I'm asked to. Or if not asked to, I will if it seems important or indicated. In other words, if I see something that really jumps out at me and says, oh, this is not good, then I make the recommendation.

Q. And you do that without ever laying eyes on the patient, correct?

A. When it's a file review, sometimes. There are some -- Yeah, there are some things that are so obvious that you don't necessarily need to actually see the person to know that they need a different kind of treatment than they're getting.

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Q. So in those instances you don't rely at all on subjective considerations, correct?

A. Well, in the file there is going to be some subjective information. It's inevitable that there will be in any file. The question is how much weight you put on it, and that depends on the source of the information.

Q. Does it depend on whether the subjective considerations would be consistent with what you would have drawn based upon the same, say, ability to assess the patient in person?

A. Well, the file review is limited by not having access to the individual. So the treatment recommendations that I would give for a file review would be limited to something very general. For example, the individual is being treated with medication for depression by his primary care physician and hasn't gotten better in two years. I think it's probably time for this person to be referred for an evaluation to a psychiatrist for treatment.

So it's a very broad treatment

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recommendation, and you're not really going to do much more than that on a file review for someone that you haven't seen.

Q. And does it make a difference how the person presents physically?

A. Well, once you see the person, once you do a face-to-face interview, of course then you have a wealth of data that you observe and that the person can report to you in addition to the collateral sources, the other information that you get about their status from other providers or from family members or from employers or whatever.

Q. I guess I just want to make sure about your opinion here, Doctor. I take it that you consider the failure to provide an after care treatment plan as a deviation from standard of care that Dr. Neuhaus should have met. Is that correct?

A. Not necessarily that she would make arrangements for after care but that she would be discussing -- at least discussing after care with Dr. Tiller, and that there would be some evidence that somebody was thinking about after care, particularly

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given the circumstances of this cases where almost every one was a new onset psychiatric disorder who was being again in a potentially inherently -- and I say potentially unstable because none of them except one was receiving treatment for their psychiatric disorder, who is being referred for a surgical intervention, which again this is my assumption, was supposedly the treatment for the psychiatric disorder because that's what they were doing.

And if that treatment didn't work a week or two later and that patient still had depression or acute distress disorder or whatever they had, who was going to be looking at that?

So if Dr. Neuhaus is going to take the step of referring for a therapeutic abortion for a psychiatric disorder, a medical intervention for which there is no evidentiary basis, then I think that there has to be some discussion somewhere of, gee, if this doesn't work, what is going to happen to her next in terms of the psychiatric disorder that's been discussed. The pregnancy has been taken care of, but what about the psychiatric disorder.

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MR. EYE: I'm going to move to strike based on that it's not responsive.
BY MR. EYE:
Q. My question is: Is it a deviation from the standard of care when a doctor is asked to evaluate a patient that they do not provide -- for purposes of a late-term abortion that they don't provide a plan for after care?
A. It can be.
Q. And are you familiar with the after care routine that Dr. Tiller's office engaged for each one of these patients?
A. No, I am not.
Q. Let's move to Patient No. 5, Dr. Gold.
A. Okay.
Q. Again, some of these questions just because they happen to relate to Patient 5, they actually are common to others as well, but as appropriate they would likely apply.
But at any rate, over on page 2 for Patient No. 5, the middle of the page there is under "Review of Licensee 2's Records," there is Paragraph No. 2 and

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it says that -- in the middle of that paragraph there appear to be a set of initials at the lower left side of Bates No. 3.
Do you see that?
A. Yes.
Q. Now, if those initials were Dr. Neuhaus's, is that enough to show that she's reviewed this?
A. It would certainly show that she had access to it. You would have to ask her if she reviewed it.
Q. All right.
A. In other words, there is no note anywhere that says reviewed MI statement. So I don't know but she would have had access to it if she wrote her initials on it.
Q. Now I would like you to go to the next page, page 3. About the top fourth of the page under Paragraph 3 it references Bates pages 6 and 7.
I want you to look at the paragraph just underneath that. And there is some discussion there about dates having been crossed out and dates being handwritten.
A. Yes.

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Q. What was the significance of that as to whether the standard of care was met in the evaluation of the patient for purposes of a late-term abortion?
A. Well, if you're going to do an evaluation for referral, then the evaluation should take place prior to the procedure for which the person is being referred. And it's not clear when the dates have been changed.
The procedure apparently was on 8/12. And the report date -- and I could look at the document itself, but based on my report, one date was crossed out and 8/13 was written in. That's after the procedure. 8/7 was crossed out and 8/12 was written in. That's the date of the procedure.
So if there was an evaluation, when exactly did it take place becomes unclear. And obviously if it took place after the procedure, then that's a deviation from the standard of care.
Q. Other than this, you know, typed date and handwritten date and all that, do you have any information to indicate that any evaluation that Dr. Neuhaus did occurred after an abortion procedure

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had already been performed?
A. Other than the change in the date, no.
Q. Is it your opinion that an evaluation occurred after an abortion procedure had already been performed?
A. No.
Q. Again on page 3 there is a paragraph that's numbered 4 and it references Bates page 8. There is a recapitulation that you cite in here, and it's a quote I believe from the GAF. "The patient has been unable to function in almost all areas, e.g., she stays in bed all day, has no job, home or friends."
Are those clinically significant findings related to the mental health status of Patient No. 5?
A. I don't know. It's just a quote from the GAF scale. It says nothing specific about Patient 5 at all. It doesn't say whether she's unable to function or she has no harm -- I mean, it's a statement with no specific reference to Patient 5 at all.
Q. Does staying in bed all day tell you anything clinically about the mental health of a

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patient?
A. It can. If that's true, then that can tell you something about a patient's mental health. It can tell you something about their physical health. It can tell you a lot of things.
Q. What about in conjunction with the fact that she doesn't have a job or friends?
A. I don't know that that -- I mean, are you asking me to assume that that's true?
Q. Well, do you assume -- Well, let me ask you this. Do you think that the information that was derived in the GAF was false?
A. I don't know what information was derived for the GAF. It's not documented.
Q. The GAF information that you quoted here, that was documented.
A. That's not about Patient 5. That's just what the rating scale says the score means.
Q. Does that have clinical significance, that score?
A. Not as presented, no.
Q. Would it be useful in conjunction with

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other information?
A. With other information it could be, yes.
Q. Was other information utilized in that regard?
A. Well, there was no other information -- I'm just looking before -- The only clinical information was the SIGECAPS that was done by the nonmental health screener, telephone screener and does not indicate what the specific problems are except that they're associated with an unwanted pregnancy rather than a primary psychiatric diagnosis.
So, you know, you've got a bunch of -- you've got a lot of smoke but I can't find the fire. I'm not sure what the problem is by looking at the GAF score. There is no data supporting -- A GAF score of 25 means that that person is in acute crisis and needs immediate psychiatric hospitalization if that score is accurate. Okay? That is a person who is either dangerous to themselves or so nonfunctional that they can't take care of themselves.
I don't see anything here that would correlate with that. Staying in bed all day by itself

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does not give you a score of 25. So there is no information to support that score. In fact, the information that is there doesn't support the score.
I don't know how the score was derived at, so I can't say that it's significant based on the information that I have. If there's other information, I'm happy to consider it.
Q. That score of 25 wasn't just based on the report that the patient stays in bed all day, correct?
A. There is no report. I mean, I don't know that there is a report that she stays in bed all day. That is a quote from the GAF rating scale. It does not say Patient 5 says that she stays in bed all day.
Q. What about the MI, did you review that?
A. Well, I'll be happy to look at it specifically. The MI, as I summarized it, says that there is a problem with sleep but it doesn't say what that problem is. I'm happy to look at the original document and tell you what it says.
Do you want me to look at the document?
Q. No, let's move on.
A. Okay.

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Q. Dr. Gold, is it permissible for Dr. Neuhaus to rely on documentation that was gathered in Dr. Tiller's office related to the mental health of these patients?
A. As a screening and a starting point, yes.
Q. And it's your opinion that then she should have done more?
A. Yes.
Q. And you're not sure what else she did do?
A. Well, I'm not sure. Obviously, if she did things and didn't document them, then I have no evidence of what she did actually do. So she could have done any number of things but I wouldn't know because there is no documentation.
Q. I beg your pardon, Doctor. I've lost my place here.
A. That's okay.
Q. Just give me one moment here.
Doctor, let's review Patient No. 6.
A. Okay.
Q. Now, Patient 6 was a 14-year-old pregnant girl, correct?

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A. Correct.

Q. And what was the documentary basis that you reviewed that was relied on to arrive at the recommendation that Dr. Neuhaus made to -- or I should say the referral that she made to Dr. Tiller?

A. Well, again this is an assumption, and I'm happy to be corrected if I'm wrong, but that the information that's in Dr. Neuhaus's file is the information she relied upon, and what was in Dr. Neuhaus's file was an intake form, an MI statement, a statement -- which included a statement from the mother. A statement describing some chaotic living situation circumstances, including SIGECAPS screen.

I note that there is no way to determine who performed this evaluation or prepared that document. And again I am presuming it was the screening from Dr. Tiller's office.

There was the DTREE. There was the GAF report. And that's it.

Q. Who gathered the information -- Strike that.

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Is information from the parent a useful tool in making --

A. I'm sorry, you got a little garbled at the end. Could you repeat that?

Q. Sorry about that.

Is getting information from the parent or parents, depending on how many parents show up, is that a useful tool to make assessments of the mental health of these patients?

A. It can be.

Q. And is that something that you do, is get information from parents?

A. It depends on the circumstances.

Q. It's appropriate to seek that -- at least in these patients was it appropriate to use that information?

A. I think so.

Q. Did you review the records to determine which patients had parents' input and which ones didn't?

A. I didn't specifically review for that information. What I did review was to see whether

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there was any indication that Dr. Neuhaus had gotten that information as opposed to relying on information generated by a nonmental health professional doing an initial screen.

Q. Is it a deviation of standard of care to rely on that nonmental health professional to do the initial screening and rely on that information for purposes of doing an evaluation?

A. Yes, I would say so.

Q. Okay. Why?

A. Because first of all, you don't know -- you don't know what information that person considered significant and not significant when they wrote it down. Because nontrained individuals may assign more significance to something that is psychiatrically less significant. For example, someone crying frequently over an unwanted pregnancy could be easily construed as a sign of depression when it's really just appropriate sadness. You have to distinguish between those two things. All right?

And they may under -- they may not put enough weight on other things that they hear. So for

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example, what jumps out at me just from this minimal amount of information is it would be very hard to figure out, and I would want to do a lot of questioning if I was evaluating this patient based on the information in the MI about who is more invested in getting this abortion given that the patient lives with the mother, has multiple siblings in the home, it's a precarious financial situation, there may not be enough food for everyone.

Is the mom really the force behind this or is the 14-year-old the force behind this? And I would want to know. It doesn't have to be either/or, they could both be doing it. But a parent's agenda is not always in the child's best interest, unfortunately.

And that is something I would want to know about this, and I would not want to rely on someone else's evaluation or statement just to know that. I would want to do my own evaluation.

Q. Okay. And you don't know whether that was done or not?

A. Well, I have no information that Dr. Neuhaus did or did not do her own evaluation in

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this case. There is no documentation to indicate that she did.

Q. Over on page 5 of your report for Patient No. 6 -- I'm sorry, page 5 of Patient 5.

A. I'm sorry? Page 5 of Patient No. 6?

Q. Correct. I'm sorry.

A. That's okay.

Q. Page 5 of Patient No 6. About the middle of the paragraph -- or the middle of the page there is a paragraph that says: "There is no doubt that Patient No. 6 was distressed in finding herself pregnant."

Then you say: "However, it is beyond any psychiatric or psychological theory or evidence that an unwanted pregnancy after sexual assault," which didn't occur in this case, "could be construed as a traumatic stressor that could result in acute distress disorder."

That's a categorical no exception kind of statement as I read it. Is that how you intended it to be read?

A. You could add a couple more qualifiers to

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it. But basically the way acute distress disorder is defined is that there has to be a traumatic stressor. That is the gatekeeper criterion for this diagnosis.

A traumatic stressor would be an assault, a rape, an earthquake, a car accident, something not just distressing but traumatic. So almost by definition this is a diagnosis that excludes anything that doesn't meet that gatekeeper criteria.

Q. And there are no circumstances where an unwanted pregnancy could cause trauma? Is that your testimony? It could be a traumatic event?

A. An unwanted pregnancy is not a traumatic event, it's a distressing event. And there is a psychiatric meaning. A traumatic stressor is a term of art, and the fact that the word "trauma" is frequently used to describe an upsetting experience has created a lot of confusion, generally speaking.

But a traumatic stressor is defined in the DSM, and the studies that support the diagnoses of acute stress disorder, post-traumatic stress disorder, which are traumatic stress-induced disorders, clearly identify and define what a traumatic stressor is. And

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it's not an unwanted pregnancy. And they give numerous examples of what such trauma could be.

Q. Like an assault or living through an earthquake?

A. Right. Which is not to say that it's not incredibly upsetting and distressing to find yourself pregnant when you don't want to be pregnant under these circumstances or other circumstances.

I have no doubt that, you know, these -- I have no doubt that all of these young women and children were in acute distress, but that's a very different thing from saying accuse distress disorder. So as close as you can get, there are a couple of caveats, unless she had a previous psychiatric history of trauma, previous traumatic assault, et cetera, unless her mother was beating her because she got pregnant, there could be other trauma that's not being directly addressed, she could have acute stress disorder because of those. But the unwanted pregnancy by itself would not result in acute stress disorder. By definition that could not happen.

Q. Irrespective of the age of the patient?

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A. Irrespective of the age of the patient.

Q. Can the age of a patient be taken into account in determining whether a mental health impairment could result from an unwanted pregnancy?

A. Well, there is no evidence that I'm aware of that links those three things, age, unwanted pregnancy, mental health impairment. There is just no evidence to suggest. You know, females have pregnancies, unfortunately, or fortunately, at all ages, from, you know, I think eight might be the youngest or seven to now 60. And there are mental health consequences of pregnancy for everybody.

I mean, it's a big deal to get pregnant and to either have a baby or to terminate a pregnancy. It's a big deal. There is no linkage of which I'm aware that would say a mental health impairment is related to an unwanted pregnancy and it is more likely if you're a child or a teenager or you're 60 years old.

Q. And in that regard, the vulnerability of a child doesn't make any difference in terms of their developmental -- at what developmental stage they are

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in life?

A. It, of course, makes a difference on an individual case-by-case basis with an evaluation that takes all of that into account. But if you're asking generally does the age of a child make a difference, there is no evidence to suggest that as a general rule the age of a child having an unwanted pregnancy is linked to a mental health impairment.

If you have a child that already has a mental health impairment and that child becomes pregnant and now you can build all kinds of circumstances onto to that and say yes, that could be a problem. Right?

But as a general statement, you can't make that. There is no evidence to support that kind of general statement. I think everybody can agree that an unwanted pregnancy in a seven or eight-year-old child not only is horrifying but is usually criminal. So it's not a good thing, and I'm not trying to suggest that it's a good thing. But not every bad thing leads to a permanent or irreversible mental health impairment. Some people have more resilience,

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some people have less.

Q. You mentioned a seven or eight-year-old. I presume that you would say the same thing about the typical 14-year-old, it's not exactly a great idea for them to be pregnant?

A. Correct. Yes. Generally speaking, both medically and psychosocially, it is not a good idea in our society, in our culture, for 14-year-olds to be pregnant.

Q. And that causes psychosocial distress, correct, or it can?

A. Yeah, it often does, and can lead to some very unfortunate things happening like babies being abandoned and dying in garbage cans and other bad things that I think we would all agree are bad.

Q. Do you remember reading in any of the MI documentation here that some of these girls were worried about that very thing, about the inability to take care of a child or that they might harm a child if they carried the pregnancy to term? Do you remember seeing anything like that?

A. I don't recall specifically about harming

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the child intentionally; that I don't recall. And I'm happy to look at the documents again if that's present.

I do think some of them were appropriately concerned about their ability to care for the child -- for a child.

Q. And the psychosocial distress that can result from an unwanted pregnancy for a teenager, it's your testimony that that cannot cause a psychiatric disorder?

A. No. I said that that of itself does not constitute a psychiatric disorder.

Q. Is it your testimony that it can cause a psychiatric disorder? Be a contributing cause?

A. Any adverse or distressing event, whether it's an unwanted pregnancy or a parent's divorce or illness in a sibling can be a contributory cause to the development of a psychiatric disorder such as depression or anxiety or might even trigger an underlying genetically coded more severe disorder. But of itself it's not equivalent to a psychiatric diagnosis.

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Q. Right. But as far as an underlying cause of a psychiatric disorder, it could serve that function?

A. I would not say underlying cause. I would say it could be a contributory factor to the development of a psychiatric disorder. There could already be a psychiatric disorder present. I mean, you have to do the evaluation to know.

Q. In some of these patients' evaluations there was the mention of possible harm to the patient in terms of them committing suicide or having suicidal thoughts. Is that a significant finding?

A. Certainly it's a significant statement when someone tells you that they're thinking of killing themselves.

Q. What is the significance of it?

A. It's different -- It's different for each individual. To go all the way from an extreme, it can mean someone who is intent, has a plan, has a lethal plan, has the means to carry out that plan and has it ready to go. Okay? To someone -- One extreme.

To the other extreme is someone making a

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dramatic statement using those words to convey to other people how upset they are but with no intent, no plan, no lethality, et cetera. So you can run the spectrum.

Q. In the situation where a patient says that they had suicidal thoughts but they don't express necessarily a plan that implies lethality, can you discount the statement that they were thinking about it?

A. Certainly not. Certainly not. You have to explore it. You have to find out what it means, and you have to find out what it means not only in the context of the immediate circumstances but in the context of the patient as a whole person, not just in the context of an unwanted pregnancy but in their whole life story.

Q. Now, on page 6 of your report related to patients, the top of that paragraph, the first full paragraph, you talk about the incidence of suicide among women who have just given birth is one of the lowest rate demographics in the United States. That's a statistical probability analysis, correct?

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A. Yes.

Q. And so is it permissible for an individual practitioner to rely upon the statistical incidence of a particular event to determine whether that is or isn't going to happen with a patient that's sitting across from them?

A. No.

Q. So why did you include that paragraph in your report?

A. Because it is a piece of data that would inform an evaluation. When you do a risk assessment of someone, a suicide risk assessment, there is a lot of different data that you have to consider that contributes to or mitigates the risk of suicide. And although that's a general statistical piece of data, it's certainly one that you want a person who is doing a risk assessment to be aware of.

Now, again, how much weight it would carry in that specific evaluation, a different issue. But you would want to be aware of it because it would be a really uncommon thing for a woman who was pregnant or who within the first year of giving birth to commit

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suicide. It would be a very uncommon occurrence.

So does that mean it wouldn't happen here? No. But it means that -- What it means is if you put it together with other data that indicates, for example, that it's just a statement of distress, then you can be a little more comfortable with your assessment that it's a statement of distress as opposed to if it you take that and put it together with someone who says, oh, no, I've been saving up drugs and I've got them out in the car and the second I walk out of here, you know, that's going to happen.

I'd say okay, that statistical data goes out the window because I have someone whose clinical evaluation indicates that that statistic is not the most weighty fact here.

Q. So a probabilistic risk analysis, which is kind of what this paragraph infers --

A. Uh-huh.

Q. -- is not something that you would apply in a case-specific situation?

A. It is a piece of data that I would consider and then based upon the clinical evaluation, I would

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give it the weight that it seems to merit based on the clinical evaluation.

Q. Now, have you ever sat across from a patient and sensed that there may be suicide that's a possibility even though more objective indicators might tell you otherwise?

A. You mean --

Q. Sort of an intuitive sense, if you will, in assessing a patient and determining whether they might have the capacity or the intent to harm themselves.

A. You know, really a risk assessment is not an intuitive thing. It's based on the collection of, again, a lot of data. So, you know, could someone have all kinds of data that says they're at pretty high risk and then sit across from me and tell me, oh, I'm not planning on killing myself? I don't know that I would call that intuition. I would say I have enough data to suggest to me that you are planning on killing yourself even though you're telling me that you're not.

Q. Let's not call it intuition. Let's call it subjectivity.

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A. Well, there are plenty of people who will say to your face but that they're not planning on killing themselves when they are. But again I would not say that it's an inference or it's a subjective thing.

Usually there is enough information that you've gathered from other things that they have said or that you have gotten from the history or from a collateral source that would lead you to believe that they might not be telling you the truth and, in fact, might be lying in order to get out so that they can kill themselves. So...

Q. All right. Let's take a look at Patient No. 7, Dr. Gold.

A. Okay.

Q. How old was this patient?

A. 15.

Q. And did she express concern that carrying this pregnancy to term would cause her to be harmed mentally?

A. Yes.

Q. Does that have clinical significance?

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A. Yes.

Q. How?

A. What I'm struggling with here is trying to find a way to explain that there is no question that having a baby when you're a teenager and going through with the pregnancy and keeping the child is not a life altering event and not necessarily a life altering event for the better. Okay?

But mental harm is a much more nebulous concept in the sense that if you call being upset and having your life path diverted "mental harm," then there are all kinds of things that you can call mental harm. If you're in a car accident and you end up in traction for 12 months, is that permanent mental harm?

Q. Is it?

A. Is it? I mean, it's a good question. It's distressing. It's certainly going to cause problems. It may create circumstances that alter the path of your life that cannot be altered back. But I don't know that that would qualify, you know, as a psychiatric disorder. I don't know what -- mental harm is sort of a laymen's term. Doctors talk about

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psychiatric disorders and -- You know, every adverse event causes mental harm if you use the term generically that way.

So yes, is this girl concerned about the effect that this is going to have on her life, on her relationship with her parents? Absolutely. Is that appropriate? Absolutely. She's spot on. Her insight is good, her judgment is good. Her understanding that -- her feeling that her parents wouldn't trust her anymore, her guilt, all of that is appropriate to the circumstances. Okay? Because she knows her parents would be upset and hurt and she feels guilty that she would be the agent of upsetting and hurting them.

All of that is absolutely legitimate and so it's clinically significant. But it doesn't establish the basis for assuming permanent mental harm or irreversible harm.

Q. Not by itself?

A. No, it doesn't.

Q. Now, would it, in conjunction with reported problems with sleep and interest and guilt and energy,

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appetite and increased fatigue?

A. Maybe.

Q. Okay.

A. Maybe.

Q. All right. And would it in conjunction with, for example, the GAF score?

A. Well, you practically have to be dead to have a GAF score of 15. I mean, you have to be, you know, practically have to be holding a gun to your head to get a GAF score of 15. That's a pretty -- That's almost as low as you get without being in a coma from malnutrition from not eating.

So there is just no way that someone with this kind of good insight and judgment has a GAF score of 15. Those two things right there are contradictory.

Q. And that's your conclusion based on the Patient 7's own concern about mental health issues and the SIGECAPS?

A. Without the benefit of being able to do further evaluation or having other information, I would say that -- I would say that this is a case of

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mistaking her profound distress with a psychiatric diagnosis based on the information I have available to me.

Now, if there is other information, I'm happy to consider it. But there is no other documented information. This unfortunate 15-year-old is extremely upset about being pregnant and she doesn't want to be pregnant anymore. And I empathize. I do.

Q. Fine.

Doctor, let's take a look at Patient No. 8. How old was this girl?

A. 13.

Q. And what's the significance that she reported -- and I'm reading at the bottom of page 8 of your report where Patient 8 said she didn't think she was going to make it through, she didn't think she would live through this, that she thought that either it, I guess that refers to baby, or I will die. I think I would die or I would kill myself. I would neglect the child or beat it senseless. And she says, I've been very depressed.

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Are those kind of self-reporting information, does that have clinical significance?

A. Of course.

Q. Why?

A. Well, again, it's the patient's own report of her own condition. You can't do an evaluation of someone's emotional or mental or psychiatric status, or it's much more difficult to do, if they can't communicate it to you in some way.

So this girl is very clearly communicating her distress and she's communicating it in words that you have to take very seriously.

Q. And then on the following page, the second paragraph from the top, you say, quote: "Patient 8 in responding to questions about suicide stated, 'I did think that. I thought at first slitting my wrists and then falling down stairs.'"

And then you say: "There is no indication she took any action to harm herself."

In that last sentence of that paragraph, are you essentially dismissing her verbalizations of harming herself or others?

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A. No.

Q. She didn't take any action to harm herself?

A. No. That's part of the risk assessment, is that people can have thoughts, and then it's a higher risk if they take actions. And then if they take actions, the risk becomes higher if you consider that those were high intent, high lethality. It's part of a spectrum of risk assessment.

So you follow it up -- So in other words, if she had taken an action, let's say she had taken an aspirin and she thought she was taking an overdose, I would say took -- actually did something. But then my next sentence might be, if I was doing the risk assessment or trying to figure out the risk assessment based on someone else's documents, this was a nonlethal attempt and -- with low intent, for example.

So you go through the risk assessment until you start getting negatives, because that tells you how significant the statements and the behaviors are. It's not an invalidation of what went before it.

Q. Okay. Now, when she expresses these thoughts about suicide, is that a fair way to

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characterize what she was doing, she was thinking about suicide?

A. Sure. Yes.

Q. And would it be fair to say that she was thinking about harming the baby?

A. Possibly, yes.

Q. If you couple those self-report -- that self-report information with the SIGECAPS, can you begin to form a clinical judgment about whether there is a psychological impairment that might result from carrying this pregnancy to term?

A. No.

Q. If you combine that with a face-to-face evaluation that essentially validates those findings in the MI and that validates the self-report about harming herself or others, does that get you to a point where you can arrive at a conclusion about the mental health of this person and the likelihood that carrying a pregnancy to term with that mental health would be impaired?

A. No.

Q. And that's a standard of care question?

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A. Well, you asked me if I could arrive at that conclusion, and I said no.

Q. And why not?

A. Okay. Because you're talking about a 13-year-old child who presumably has adult care. Someone has brought her to this clinic from New Jersey, so there is someone involved in taking care of her.

I don't see any assessment of her support system. I don't see any assessment of her -- I don't see any consideration of treatment interventions or options.

Let's say this child does have an episode of acute depression. Let's say she meets the criteria for depression. There are treatments for depression. People recover from depression even if that depression has been triggered by adverse circumstances like an unwanted pregnancy.

So to go from even a diagnosis, let's say she meets the diagnostic criteria, to say irreversible mental harm, you cannot conclude that. You cannot reasonably conclude that, even with a complete

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evaluation. How could you conclude that in someone who hasn't had any intervention?

Q. Even with a complete evaluation, one that would satisfy Dr. Gold's standards, you still couldn't get to that conclusion, correct?

A. To the irreversible mental harm?

Q. Yes. Is that your testimony?

A. No, you can't. Because that would be saying that -- again, just for the sake of argument, that there is no treatment for this child's depression, that no intervention -- if she were to have this baby, there is no intervention in the world that could cause her depression to get better. And I don't see how any physician could say that about anything without attempting treatment.

Q. Dr. Gold, in the standard in Kansas that is supposed to be determined whether the late-term abortion is justified or not, is it required that the physician who does the evaluation consider alternative treatments to abortion? Is it specified that way?

A. I don't -- Again, I'm not an expert on the Kansas statute. I assume it doesn't. But because

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that's a medical imperative that you consider treatment options. There is never only one option. It's below the standard of care to wed yourself to one option and not consider anything else.

Q. What was the purpose of this evaluation, again, towards this patient and the others? Was it to determine treatment alternatives or was it whether there was the possibility of a substantial mental impairment that might result from carrying this pregnancy to term?

MR. HAYS: Objection; compound question.

BY MR. EYE:

Q. You may answer.

A. My understanding is that these referrals to Dr. Neuhaus were to determine -- was for her to determine whether on the basis of a substantial and irreversible mental harm these females qualified for a late-term abortion.

Q. Right. So she was not obligated by that standard to consider treatment alternatives, correct?

A. I guess not legally obligated.

Q. And under the standard of care for that

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evaluation's purpose she wouldn't have been required to consider those alternatives, correct?

A. I would disagree with that. I would disagree on the basis that one starts with the least -- when one thinks about an intervention, which is what she's being asked to consider, one thinks about medical training, everybody's medical training. You consider the least invasive -- again, risk assessment, least invasive, most invasive, least risk, most risk, least complication, most complication. If you wed yourself to only one treatment intervention, then you are not doing your duty, so to speak, to that patient.

Now, just because that patient comes in referred for that thing, if I think something else is going to be better, in that patient's better interest, then it's my obligation as a physician to say, you know what, I know you came in for this but I think it's in your best interest that you consider that. Okay?

So to not do that, I just don't see how that can be justified medically even if it's not

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written into the Kansas statutes.

Q. And would you agree that to do these additional evaluations that you would suggest are appropriate would require additional time?

A. Well, certainly additional -- well, I don't know how long Dr. Neuhaus spent, but it certainly does not appear that there was an effort to collect a lot of other information that might have been available. So that's time that it takes to collect and review that information. So to that degree I would say yes.

Q. And if you were to refer these patients to other alternative mental health professionals, let's say, it's a fair assumption that that would build time into the process as well, right?

A. One would assume, yes.

Q. And would you agree that that then impinges on the capacity of these girls to have a safe procedure if too much time passes?

A. That --

Q. I think you're not really qualified to answer that question.

A. I'm sorry?

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Q. Are you qualified to answer that question?

A. Could you ask the question again? I'm sorry.

Q. If you allow enough time to pass while additional evaluations are done and alternative mental healthcare professionals evaluate these patients, wouldn't that impinge on the capacity of these girls to get a safe abortion? In other words, additional time passing.

A. I don't even know how to answer that question because these are not emergency procedures. And they're coming from various places, and there's time involved in doing that. And I presume that there are psychiatrists, child social workers, mental health professionals in Kansas City -- I'm assuming, I could be wrong -- that in Kansas there is not an inability to access as there would like in a rural area. I think there are three psychiatrists in the whole state of Idaho or something like that. You know, there may not be a child person there.

So if they have time to make appointments and let's say they're urgent evaluations but not

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emergency evaluations, then there theoretically would be time to collect their medical records and get them sent on ahead. There would be time on the other end in Kansas to get them to set up an appointment with the child person the same way that Dr. Neuhaus was recruited to be available to do evaluations. One would presume that appointments could be made with other people.

I don't understand -- I don't think that lack of time is a factor in a non-emergent surgical intervention. If it's life-threatening, then yes. But I did not see any evidence that these were life-threatening surgical -- interventions done for physical life-threatening circumstances.

Q. All right. Let's take a look at Patient No. 9.

A. Okay.

Q. This girl was 15 years old, correct?

A. Yes.

Q. And if I remember your testimony, you've actually treated 15-year-old pregnant girls?

A. I think I said I had one 16-year-old.

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Q. I'm sorry, I beg your pardon. I misspoke.

A. That's okay.

Q. Now, in this instance what was the documentary evidence that you saw that was the underpinning for the conclusion Dr. Neuhaus reached in this case?

A. The documentary evidence consisted again of an intake form, an MI indicators form which included some narrative as well as the SIGECAPS evaluation or screening. I guess there was another MI indicators form in this chart.

I would have to look at the records because it's puzzling. I've got MI and SIGECAPS twice. I don't know if two were done or if I've made an error in this report.

Q. Yeah, that was sort of the genesis of my question.

A. Okay. Well, I would have to take a look. Do you want me to go ahead and do that?

Q. I think that's probably a good idea.

A. Can I take a quick break and -- I don't know if anyone else needs to.

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MR. HAYS: Can we go off the record?
MR. EYE: We're off the record then.
MR. HAYS: For about ten minutes?
MR. EYE: Yeah, that's fine.
(Recess taken.)
BY MR. EYE:
Q. Have you had a chance to look at the chart for Patient No. 9?
A. Yes.
Q. And we have a better sense for what the documentary evidence is in that chart?
A. Yes. There are actually two documents labeled MI indicators. The first one is correct, Bates 2 to 3. And the second one is also correct, Bates 6 -- yeah, just Bates 6. So it is actually correct as indicated in the report.
Q. All right. And as far as -- does the information -- Is information on the two MI indicators the same? Does it look like the same document to you?
A. Not exactly. No.
Q. All right. Did you compare the two to determine whether together they form a more complete,

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more clinically complete picture as far as what this person's condition was?
A. No. The first one, Bates 2 to 3, is really minimal.
The second one, Bates 6, has a little more information but still -- again, is a screening with a little bit more information in it and more information about the pregnancy issues.
Q. All right. And as far as the one that is more complete, which I believe is probably Bates 6 --
A. Correct.
Q. Of the two that is more complete. Is there information there that would -- Again, I'm not assuming that it's standing alone, but it would be an indicator of a mental health impairment?
A. Any of the information provided could be an indicator of a mental health impairment. You know, absent a complete evaluation, it's hard to know the significance of any of it. Just sleep. It says: "Some nights I can sleep, some I can't." You know, first of all, pregnant women sleep less. So how much of that is physiological, how much is psychological?

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Then she adds: "This is on my mind. I feel I let everyone down." So is she staying awake at night turning these thoughts over and over in her head? That might be more of an indication of a psychological issue, and you would need to go through not only these symptoms but additional symptoms, intensity, frequency, duration, et cetera.
If you look at the context around here, for example, she doesn't play basketball as much. "Everything I do is slower. I run slower, I'm not as quick, my game is off." Well, you know, she's 25 and a half weeks pregnant. So yeah, I'm sure that's true. But I'm not sure that's an indicator of a psychiatric problem.
And then the context around the bottom and the outside of the page is all about, you know, again -- it's about the pregnancy. So, you know, how much of it is psychiatric, I don't know.
Q. How about her self-report that she's sad all the time?
A. I'm sure she is. She's pregnant and she doesn't want to be, and she doesn't want people to

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know.
Q. Are pregnant women expected to be sad all the time?
A. If it's an unwanted pregnancy and she's a teenager and she knows that it's going to be a real big problem, you bet they're all sad. They're not happy. But that's appropriate to the circumstance. It's not necessarily an indicator of a psychiatric problem. It's appropriate to the circumstances in which she finds herself.
And again, when you look at things like insight, judgment, guilt, even -- you know, even the suicide question in this patient, "I just feel if I weren't here, I wouldn't hurt my mom as much," is the kind of statement you would expect from someone who finds themselves in a very bad situation, what they perceive to be a bad situation, and they say, gee, I wish I had never been born, then this problem wouldn't have happened.
It's much more frequent in less mature individuals to hear that kind of stuff but you see it in adults too. I'm getting loose now because I've

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been going.

Q. I understand.

You mentioned earlier that pregnant women sleep less. That's sort of a general condition of pregnant women?

A. Yes. Especially as they get towards the end, physiologically they just sleep. They may be more tired but they sleep less. They spend less hours in sleep.

Q. And not necessarily with this Patient No. 9, but I'm sure that you saw other MIs where it indicates that some of these girls were sleeping more?

A. Well, and again, it's hard -- it's very hard to know what they mean, what changes have there been. What does more mean? Does more mean that they're sleeping an hour a day more? Does it mean they're sleeping five hours a day more?

In the early parts of pregnancy it is more common to sleep more. They're all in third trimester. It's more common to sleep less. But if they're not going out, if they're not doing the stuff they normally do, if they're teenagers who are used to

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being out and about and active, perhaps they are staying home and napping more often because they're not doing stuff.

Are they still going to school? I mean, I don't know -- Some of these are in the summer but some of these are not. Are they still going to school? Are they still participating in extracurricular actives? What is going on? How are their grades? There is a lot more information you would want to get. When someone says sleeping more, I don't know exactly what that means.

Q. All right. And the other documentary evidence that you found related to Patient No. 9 in addition to the two MI documents was what?

A. Well, there was the DTREE report and the GAF report.

Q. All right. Now again, you don't know whether in Kansas the standard of care would be met by relying on MI, GAF and DTREE, correct?

A. I would hope it would not be.

Q. But you don't know?

A. If it is, then Kansas deviates from

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practice that's accepted nationally. I don't know if Kansas does or not, but I would hope not.

Q. Let's take a look at Patient No. 10, Doctor.

A. Okay.

Q. Patient 10 is an 18-year-old, right?

A. Yes.

Q. And she had a pre-existing diagnosis apparently, correct?

A. Correct.

Q. And that was what?

A. Apparently it was anxiety disorder.

Q. Does that have any clinical significance?

A. Of course.

Q. What is it?

A. She has an anxiety disorder.

Q. Does that have any significance related to the evaluation to determine whether she was a candidate for a late-term abortion?

A. Well, again, there is a connection that I have the difficulty with, which is that any psychiatric disorder makes you a candidate for a

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late-term abortion. No. So no, it has no relevance as to whether she's a candidate for a late-term abortion.

Q. Is an anxiety disorder something that can impair a person's mental functioning?

A. At times it can. Not typically all the time unless it's very, very severe or untreated.

Q. And is prescribing Paxil indicative of an anxiety disorder that is less than -- that is more serious than just an irritant?

A. Well, it means that somebody -- and again, I have no other information besides the fact that she has anxiety attacks and is on Paxil. But it means that somebody somewhere made an assessment that her symptoms met the criteria for an anxiety disorder and that she might benefit from treatment with medication. And apparently she does because she keeps taking it. Usually when people take a medication that doesn't help them, they stop taking it.

Q. And does the diagnosis of an anxiety disorder, which presumably triggered the prescription for Paxil, in your judgment that diagnosis of an

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anxiety disorder doesn't have anything to do with determining whether this person would be a candidate for late-term abortion; is that correct?

A. Yes. Because I don't think there is a way to connect any psychiatric disorder with the intervention of a late-term abortion, except under extraordinary unusual circumstances.

Q. Is that your interpretation? You said that a number of times. That's your interpretation based on what?

A. On the fact that a late-term abortion is not a treatment or intervention for any psychiatric disorder under any circumstances. It's not -- It's not how you treat these disorders. Even if you think that someone is severely psychiatrically ill, you don't perform abortions, you don't perform sterilizations, you don't perform lobotomies.

There has been no surgical intervention ever found, unless someone has a brain tumor. Again, I'm talking about these extreme circumstances that can cause psychiatric problems like a brain tumor that will prevent or treat a psychiatric disorder.

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Q. Now again, that's not necessarily -- Is that consistent with what the standard is in Kansas?

A. Well, I mean, again I can't speak to what the statute says in Kansas. The evidence in Kansas is the same as the evidence in Virginia and Washington, that there is no psychiatric disorder that's treated by a surgical intervention, I don't care what kind of surgical -- Well, that's not true. See, you say stuff and it's not true.

Every once in a while people are still doing brain surgery on people with severe psychiatric symptoms. But surgical interventions like abortions, hysterectomies, sterilization, lobotomies, there's no evidence for using any of those kinds of surgical interventions to prevent harm from a psychiatric disorder. It's not going to happen.

Q. Okay. So in your judgment, the fact that the law anticipates a mental health reason to get an abortion is just what, superfluous?

A. No. I can imagine some unique circumstances where it might become an emergency on the basis of psychiatric circumstances that someone might need a late-term abortion. Extreme circumstances.

And extreme circumstances happen. I mean, everything once in a while. But they only happen once in a while. It's not routine.

This is routine. These are routine psychiatric disorders, anxiety disorder, depression, they're treatable with medication, if someone is suicidal you put them in the hospital. You don't hear someone suggesting abortion as an intervention for this.

So when you ask the question is it significant in terms of mental impairment justifying a late-term abortion, there is an assumption of a connection that I disagree with.

Q. And is there anything in the Kansas statute that requires an emergent situation to justify a late-term abortion based on mental health reasons, the condition that you have interjected?

A. No. From what --

MR. HAYS: Objection. Not qualified to answer that question. It's a legal question.

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THE WITNESS: Yeah, from what I understand, the Kansas statute isn't written to indicate emergency. But that doesn't change the medical fact.

BY MR. EYE:

Q. Didn't you just say it should be an emergent situation to justify a mental health, a late-term abortion?

A. I said I could imagine circumstances that constituted an emergency that might justify mental health basis for a late-term abortion. I didn't say it would have to be an emergency, and I'm not trying to reinterpret Kansas statutes.

I'm just trying to explain the basis for why I think that having a pre-existing psychiatric disorder like an anxiety disorder in this specific patient does not make any difference in terms of whether they would or would not qualify for a late-term abortion.

Q. Standing alone? Well, strike that.

So do you know of any legal or policy that -- legal reason or policy reason that says you have to have an emergency to justify a late-term

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abortion based on mental health considerations?
MR. HAYS: Objection; calls for a legal conclusion.
THE WITNESS: Yeah, I mean, I'm not an expert in all the state statutes and policies regarding late-term abortions, so I don't know.
BY MR. EYE:
Q. Are you an expert on any of those?
A. No.
Q. And you don't consider yourself to be an expert on standard of care in Kansas, correct?
A. Only in the sense that Kansas is part of the United States of America and I believe that there is a national standard about doing evaluations regardless of whether someone is pregnant or not. So if things are done differently in Kansas, then no, I'm not an expert in Kansas.
Q. And you've never undertaken an inquiry to determine what the standard of care is in Kansas, correct?
A. No. I have operated on the assumption Kansas does what everybody else does in regard to

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psychiatric evaluations.
Q. That's an assumption?
A. It is an assumption.
Q. Take a look at the Patient No. 11 report.
A. Okay.
Q. This is a 16-year-old pregnant girl, right?
A. Yes.
Q. And just to kind of clear up my own use of nomenclature here, is a 16-year-old a girl or an adolescent?
A. Both.
Q. Okay. All right. But not an adult, at least in terms of legal age of consent kind of things, correct?
A. Correct. Well, it depends on what you're talking about. Consent is not blanket for everything.
Q. Well, consent to get an abortion, for example?
A. I don't know what the legal age is for that.
Q. All right, fair enough.
A. I think in some places -- I think in some

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places you can get an abortion if you're 16 without parental consent.
Q. But you've not undertaken a determination of that either?
A. No, no.
Q. In the GAF report it indicates that the patient has been in some danger of hurting herself?
Do you see that down at the bottom of page 2 of that?
A. I see that that was written there. But there is no information that that was true in the case of this patient.
Q. And the GAF score there is 15. I think earlier that 15 is just barely above comatose?
A. Well, that might be a little bit of hyperbole but only a little.
Q. In terms of clinical description, what would it reflect?
A. When you see a GAF score of 15 you're thinking immediate psychiatric hospitalization.
Q. Okay.
A. Either because the person is completely

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unable to care for themselves up to and including not being able to eat or drink or come in out of the freezing cold and might die of exposure, or they're imminently dangerous to themselves and others.
Q. And what role did this girl's family history play in her assessment of her mental state to justify getting a late-term abortion?
A. I don't know from looking at the report. I would have to look at the records.
Q. Did her family situation, based on the report, was it a contributor to the finding that she was suffering a major depressive disorder?
A. I can't tell from the report.
Q. All right. Down at the bottom of page 3 --
A. I'm sorry. Okay. All right, okay.
Q. Would this be an example of a pre-existing condition aggravated by an unwanted pregnancy?
A. Well, bereavement is not considered to be a psychiatric disorder. Bereavement is a normal reaction to loss and death. There is such a thing as complicated bereavement where the bereavement sort of morphs into depression. And it's not clear whether

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that was the case with this girl or not.

It's certainly clear that this family's emotional resources were already taxed to the limit and that another adverse life circumstance was more than they could handle. That's clear.

Q. Would you consider that this unwanted pregnancy was an exacerbation of the bereavement or grief that she was feeling?

A. How do you mean?

Q. Did it aggravate the pre-existing -- Before she was pregnant, evidently she was experiencing grief because of the loss of her father. Is then the unwanted pregnancy, is that something that can aggravate that feeling of grief or the dealing with grief?

A. Well, the loss of the father is an adverse event. Right? The unwanted pregnancy is another adverse event. There is no -- There is no evidence presented that the cumulative -- even the cumulative effects of these adverse events rose to the level of diagnostic criteria for major depressive disorder.

So I mean, just common sense wise,

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obviously if someone -- you know, if the family has suffered one major blow and now they have another major blow, it's going to be very, very upsetting, and more upsetting perhaps in the context that they've already had one major blow. But even so, it doesn't mean that there is a psychiatric disorder.

Q. Did you in the process of reviewing the information for Patient No. 11 rule out a major depressive disorder?

A. How could I possibly have done that? I didn't evaluate the patient.

Q. I'm just asking if that's something you did.

A. It's not possible. So no.

Q. And it's not possible partly because you didn't evaluate the patient?

A. A, I didn't valuate the patient; B, if I was going to do a record review to see whether that diagnosis was justified based on the information collected, I wouldn't be able to do that because there is no documentation available.

Q. And that would be your answer if you were

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asked that question for the other ten charts as well, correct?

A. Yeah. I would have to say yes.

MR. EYE: I am close to being wrapped up, I think. It would probably be useful if I could have like just ten minutes to go back over things. If there is anything more that I want to cover, I'll do it. I could probably do it in a more expeditious way if I can have a few minutes to review what I've already got.

MR. HAYS: Okay.

MR. EYE: So in about ten minutes we'll reconvene.

(Recess taken.)

BY MR. EYE:

Q. Doctor, we've just had an off-the-record conversation about how we're going to handle getting a copy of your file to us. And what we've agreed is that one of the counsel for the Board will do a count of the number of pages, we'll enter that into the record, we'll withdraw the exhibit, hand it back to you, and then you'll make a copy for us, us meaning

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the lawyers for Dr. Neuhaus.

A. What I'll do is I'll make a copy and send them to the Board and then I'll trust you guys to distribute them to whoever. Is that okay?

MR. HAYS: We can do that.

BY MR. EYE:

Q. That's great. Thank you.

A. Okay.

*** Q The only other thing I want to do, Doctor, is give you one more opportunity to answer the questions to which you've objected earlier, and that is about your personal views concerning abortion.**

MR. HAYS: Asked and answered. Objection.

THE WITNESS: I still don't want to answer them if that's the question. Is that the question?

BY MR. EYE:

* Q If that's your answer.

And the other question is: Do you consider yourself pro-choice?

A. I'm not going to answer any questions about my opinions regarding abortion.

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*** Q Do you consider yourself anti-choice?**

A. I decline to answer.

MR. EYE: Okay. Then I think that would conclude the questions I have. I thank you, Doctor, for your cooperation today.

MR. HAYS: And I just have a couple of follow-up questions.

EXAMINATION

BY MR. HAYS:

Q. Dr. Gold, you spoke about transcripts that you reviewed after making your report.

A. Yes.

Q. Have those transcripts changed your opinion?

A. The transcripts made me -- my degree of certainty regarding my opinion stronger in the sense that they validated what appeared to be the inferences that I made. When I wrote the report, for example, I had to infer that certain documents were generated by Dr. Tiller's office. When I read the transcripts, it became clear that they were generated by Dr. Tiller's

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office. So...

Q. Do you recall what documents those were?

A. The initial phone screening, the MI, the SIGECAPS, all of those were not done by Dr. Neuhaus herself but by someone screening in Dr. Tiller's office, and usually by phone. And a nontrained mental health professional.

So not only was it not done by Dr. Neuhaus, but it was often done by phone and always done by a nontrained mental health professional.

Q. And how -- Strike that.

And you spoke about the dates of evaluations that you gleaned from dates on the documents.

A. Correct.

Q. Do you know, was that evidence of when those evaluations actually occurred?

A. It's hard to say what it's evidence of. People can do evaluations and then document it days later. So it's hard to know whether the evaluations were done later or whether there was an error in the date and someone just corrected it to reflect the

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correct date or whether the evaluation was done at the appropriate time but the document was generated later.

Q. And to direct your attention to the standard of care, there were several questions on standard of care in Kansas. Let's talk about the standard of care itself.

There are certain guidelines that you referenced in your report from the American Academy of Child & Adolescent Psychiatry. And what does that form the basis of?

A. Those guidelines are a consensus of experts about the best practices for the evaluation of children and adolescents.

Q. Would that form the basis of someone determining what the standard of care would be?

A. It would be contributory information. It's not the basis. The standard of care is based on what the average practitioner, skilled practitioner, based on knowledge and clinical experience and usual and customary practice would actually do.

So you can have guidelines that describe best practices but not everybody is going to do all of

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that -- all of the things that are in the practice guidelines. And they may not all be indicated in every case.

Q. Are there practice guidelines for other specialties also?

A. Absolutely.

Q. And are there certain guidelines that are standard across the entire United States?

A. Well, the American Academy of Child & Adolescent Psychiatry is a national organization. The APA is a national organization, the American Academy of Psychiatry in Law. These are all national organizations.

They are the ones who generate -- Usually when guidelines are generated, they are generated using people from all parts of the country so that they form a consensus of national practice.

Q. Are there basic standards of care that apply throughout the United States?

A. It depends on what you're talking about. That's very broad.

Q. To give an example, treating a strep throat

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with antibiotics, that would be basic standard of care throughout?

A. Well, I would have to say that I assume so, but since I don't do that, I don't know. Let me give you a different one. It is always below the standard of care to have sexual relations with your patients when you're a psychiatrist. I don't know about other doctors, but for psychiatrists that's a national standard, the breach of which is always wrong, and it doesn't matter if all the psychiatrists in your community do it, it's still wrong. Even if it's usual and customary practice, it's still wrong.

Q. And are these types of standards of care taught in medical school?

A. They're taught -- I mean they are gleaned. Standard of care is not directly taught. It is a legal term. Medical schools and psychiatry residencies teach medical and psychiatric, and other specialties teach their specialty. Standard of care is gleaned from best practices, experience, usual and customary practices and review of literature and knowledge gained academically.

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So one hopes that people learn what the minimum standard of care is just because you want people to be trained to be good doctors.

To answer that a little bit differently, when doctors learn it, it's ethics and obligations as opposed to being called standard of care.

Q. Okay. And just to go back to when we first started and talked about your CV, did you also get awarded the top mental health doctor in 2009 also?

A. I think it was only one year.

Q. Only one year?

A. I thought it was 2009, but I don't have my CV in front of me. It could have been 2008, it could have been 2009. I don't remember. But it was only once.

MR. HAYS: That's all I have.

MR. EYE: I'm sorry. Were you done, Reese?

MR. HAYS: Yes, that's all I have.

MR. EYE: I've just got a couple of follow-ups on that.

EXAMINATION

BY MR. EYE:

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Q. I just want to make sure that I understand a couple of things that you just testified about, Doctor.

Guidelines are not standard of care, correct?

A. Correct.

Q. And is it the case that the standard of care that relates to a child might not be the same standard of care that relates to an adolescent?

A. Yes.

Q. And it would be true that the same standard of care that relates to a child would not necessarily relate to an adult?

A. In certain aspects, yes.

Q. Okay. So it's not a one size fits all?

A. No. That's why there are subspecialties, because one size doesn't fit all.

Q. And you have acknowledged that the standard of care may actually have some potential regional or community variations. So you may disagree with what it is, but you acknowledge that that may be the case depending upon, as I say, regional or community

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variations?

A. Yes. Historically that's always been the case.

Q. When you got top mental health doctor in 2009, I am assuming it didn't have anything to do with providing abortion services or abortion consultations?

A. No, it did not.

Q. You were asked about reviewing the transcripts and whether it changed your opinion, and you said it made your conclusions stronger, I believe was how you characterized it.

Was that the totality of the effect on your opinions having read the transcripts?

A. Pretty much, yes. I mean, there wasn't new information about the patients in there. It was really about the process and procedures. So...

Q. And as far as the process and procedures are concerned, you've never been affiliated in a professional way with any institution or facility that has included you in the process of evaluating patients for purposes of late-term abortions, correct?

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A. Correct.

MR. EYE: That's all I have.

MR. HAYS: My co-counsel has a count for the documents.

MR. EYE: Great. And what is that, Lori?

MS. DOUGHERTY: This is Lori Dougherty for the board.

Exhibit 1, 16 pages, eight double-sided, titled "New Patient Evaluation."

There is a second one called "Mental Status Exam." It's two pages, one double-sided.

The final part of Exhibit 1 is Gold's notes. There are six pages, and those are single-sided.

Exhibit 2 contains 11 attachments -- excuse me, 12. The first is "Practice Parameters for Psychological Assessment of Children and Adolescents." That's 17 pages single-sided.

There is the report for Patient 1, which is nine pages single-sided; the report for Patient 2, which is nine pages single-sided; Patient 3, nine pages single-sided; Patient 4, ten pages single-sided;

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Patient 5, nine pages single-sided; Patient 6, ten pages single-sided; Patient 7, nine pages single-sided; Patient 8, eight pages single-sided; Patient 9, ten pages single-sided; Patient 10, 11 pages single-sided; and Patient 11, nine pages single-sided.

MR. EYE: Very well. Thank you for doing that.

MS. DOUGHERTY: You're welcome.

MR. EYE: You probably know that you can read your transcript or you can waive reading it. We should probably determine which you're going to do here.

THE WITNESS: I'll read.

MR. EYE: I'll let you make arrangements with the court reporter or counsel as to how you get that transcript in hand.

Is there anything else that needs to be put on the record, counsel?

MR. HAYS: I'm good if you are.

MR. EYE: I think we're good on this end.

Again, thank you for your cooperation today, Doctor.

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THE WITNESS: Thank you.

MR. EYE: We're off the record now. Thank you.

(Signature having not been waived, the videoconference deposition of LIZA H. GOLD, M.D. was concluded at 5:15 p.m.)

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ACKNOWLEDGMENT OF DEPONENT

I, LIZA H. GOLD, M.D., do hereby acknowledge that I have read and examined the foregoing testimony, and the same is a true, correct and complete transcription of the testimony given by me and any corrections appear on the attached Errata sheet signed by me.

_____ _____

(DATE) (SIGNATURE)

REPORTER'S CERTIFICATE

I, the undersigned Registered Professional Reporter and Notary Public, do hereby certify that LIZA H. GOLD, M.D., after having been first duly sworn by me to testify to the truth, did testify as set forth in the foregoing pages, that the testimony was reported by me in stenotype and transcribed under my personal direction and supervision, and is a true and correct transcript.

I further certify that I am not of counsel, not related to counsel or the parties hereto, and not in any way interested in the outcome of this matter.

SUBSCRIBED AND SWORN TO under my hand and seal this 7th day of July, 2011.

My commission expires November 14, 2015.

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NOTARY PUBLIC IN AND FOR
THE DISTRICT OF COLUMBIA

ERRATA SHEET

IN RE: Ann K. Neuhaus, M.D.

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