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BEFORE THE KANSAS STATE BOARD OF HEALING ARTS

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IN THE MATTER OF Docket No. 10-HA00129

Ann K. Neuhaus, M.D.

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Kansas License No. 04-21596

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VOLUME III

TRANSCRIPT OF PROCEEDINGS

taken on the 14th day of September, 2011, beginning at 8:31 a.m., at the Shawnee County District Court, 200 Southeast 7th Street, in the City of Topeka, County of Shawnee, State of Kansas, before Edward J. Gaschler, Hearing Officer.

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APPEARANCES

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ON BEHALF OF THE PETITIONER:

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ALSO PRESENT:

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Ms. Kathy Moen

Ms. Hester Jay

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INDEX

WITNESS

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MR. EYE: I've just informed the hearing officer that we're ready to proceed. I expect Doctor Neuhaus to be here shortly.

PRESIDING OFFICER: And you're -- it's acceptable to you to proceed without Doctor Neuhaus being here?

MR. EYE: It is at this time, yes, sir. Thank you.

PRESIDING OFFICER: Mr. Hays.

MR. HAYS: Yes, sir.

DIRECT EXAMINATION (cont.)

BY MR. HAYS:

Q. Doctor Gold, if I could direct your attention to Patient No. 10. Do you have your expert report in front of you for Patient 10?

A. Yes.

Q. What exhibit number is that?

A. 77.

Q. And do you also have Doctor Neuhaus' record for Patient 10 in front of you?

A. Yes, I do.

Q. And what exhibit number is that?

A. 32.

Q. And do you have Doctor Tiller's patient record for Patient No. 10?

THE REPORTER: I'm sorry. Do you have?

BY MR. HAYS:

Q. -- Doctor Tiller's patient record for Patient No. 10? Sorry.

A. Yes, I do.

Q. And what's the exhibit number for that?

A. 43.

Q. From your review of the records, could you please describe Patient 10?

A. Patient 10 is an 18-year-old single female from Kansas who became pregnant as a result of consensual sex with her boyfriend and she is 25-plus weeks pregnant.

Q. How many pages consist of Patient 10's records for Doctor Neuhaus?

A. 10 pages.

Q. And without being told that record came from Doctor Neuhaus, would it be possible to tell who's physician record it is?

A. No.

Q. Why is that?

A. Because there is no clinical information or acknowledgement of review of information in the chart that could specifically be assigned to Doctor Neuhaus. There is on one page some

initials, but it's hard to determine what those would mean.

Q. And can you tell from the patient record what date and time the patient's appointment was with Doctor Neuhaus?

A. No, I cannot.

Q. Do you know whether Doctor Neuhaus came to a diagnosis for Patient 10?

A. Yes, I do.

Q. How do you know that?

A. There is a positive DTREE report.

Q. And what does that diagnosis -- or what does that report indicate?

A. Acute stress disorder, severe.

Q. So let's take a look at patient number -- or that document, the DTREE document. What Bates page is that?

A. 8.

Q. And what do the numbers refer to that are on that document?

A. The -- there's a code number next to the diagnosis, 308.3, that's the DSM code for that -- numerical code for that diagnosis.

Q. And where does that numerical code come from?

A. The DSM.

Q. And what is the rating date and time for that document?

A. The date is November 13th, 2003, 1302.

Q. And what is the report date and time?

A. 11-13-2003, 1306.

Q. And can you tell us what the significance of the -- of this report is for this patient?

A. I'm -- I'm sorry. Can I -- there's a second diagnosis on this patient, as well.

Q. Okay. And what is that diagnosis?

A. Anxiety disorder NOS, not otherwise specified.

Q. And --

A. In -- in partial remission, is the -- modified.

Q. And what does in partial remission mean?

A. It means it's not -- it's partially resolved, it's decreased or gone away from its most maximum symptomatic state.

Q. And what's the significance of this document within this patient's record?

A. Well, it indicates that Doctor Neuhaus, using the DTREE program, computer program came to a -- a diagnosis of acute -- a severe acute stress

disorder on -- on this patient.

Q. Can you tell from Doctor Neuhaus' patient record for Patient 10 how Patient 10 met the diagnostic criteria to support a diagnosis of acute stress disorder?

A. No, I cannot.

Q. And you spoke about yes -- yesterday that -- the gatekeeper criteria. Can you indicate from that record what the -- that criteria was?

A. No, I cannot.

Q. Is there any information within the document about the event that threatened death or serious injury?

A. No, there is not.

Q. What about one that threatened physical -- or was a threat to the patient's physical integrity?

A. There's no indication that this person felt that either or underwent that.

Q. Is there any information that would support the criteria for finding a diagnosis of anxiety disorder within her patient record?

A. This is a patient with a -- a psychiatric history who was being treated with an anti-depressant/anti-anxiety medication for, I

believe, panic attacks.

Q. And where did you get that information from?

A. That information came from the intake sheet in Doctor Tiller's clinic that is included in Doctor Neuhaus' record.

Q. And how much information did it provide about that anxiety disorder?

A. It says Paxil, P-A-X-I-L, which is the medication, 40 milligrams, one a day: Anxiety attacks. And my interpretation of that is used for anxiety attacks. And underneath, there's another sentence or -- or phrase that says, last anxiety attack was six months, presumably meaning six months previously.

Q. Is that enough information to come to a diagnosis of anxiety disorder NOS?

A. No. Especially not without a review or a ver -- with a patient -- this patient is 18 years old and presumably could tell you more about that history or review of some medical record from the doctor who's been prescribing that medication. Especially in light of the fact that an acute stress disorder has been diagnosed. They're both anxiety disorders. Acute stress disorder and

anxiety disorder NOS are both anxiety disorders and you would need to -- anxiety disorder NOS is a -- is a diagnosis of exclusion, so it's not -- it -- it implies that there's a history of anxiety disorder NOS, but she's been treated, so one would think there must be more diagnostic information somewhere. And that would be relevant to the diagnosis of acute stress disorder, which is another anxiety disorder that would be a second anxiety disorder on top of the first one. So you would really want to know that history.

Q. Is there any indication from the file that a review of that occurred?

A. No, there is not.

Q. Is there any information in the file that indicates that this was discussed further with the patient?

A. The previous an -- history of anxiety disorder, no, there is not.

Q. Well, let's talk about the GAF. Is there one present in this patient's record?

A. Yes, there is.

Q. And what is the GAF to this patient, according to that report?

A. 25.

Q. And what's the significance of this document for this patient?

A. Well, it -- it indicates a -- a relatively low level of functioning due to psychiatric symptoms. The general statement associated with this diagnostic range which appears on the GAF form is, the patient has been unable to function in almost all areas, e.g., she stays in bed all day or has no job, home or friends. There are some negative findings. Not suicidal, not violent or aggressive, not -- judgement not significantly impaired. And then the positive finding is able to maintain minimal hygiene.

Q. Is there any information contained within this record that could serve as a basis for that determination?

A. Well, some of the information in the MI statement could support some of the -- some of the findings. For example, the MI Statement, the patient says she did not have suicidal thoughts. The GAF rating generic statement says there are no suicidal thoughts. You know, a negative finding is, generally speaking, a negative finding. So one -- that negative finding supports the other

negative finding. There's really not anything in here that --

Q. And which MI statement are you looking at?

A. I'm sorry. There are two MI statements. One is typed and that's Bates 2 and 3. And one is handwritten and that's Bates 4 and 5.

Q. And before I interrupted you, you were speaking about the MI Statement and its relationship to the GAF.

A. Again, other than some of the negative findings, there really is nothing in here that would indicate that this person is overwhelmingly impaired in her function to rate on -- on the basis of psychiatric symptoms to rate a GAF of 25.

Q. Why is that?

A. Well, the GAF itself doesn't have any specific clinical data for -- upon which this finding is based, but the examples it gives which are, again, taken directly from the DSM are, stays in bed all day or has no job, home or friends. There is no indication, you know, that this patient stays in bed all day or has no job, home or friends. She -- she says, I try to be busy. She's only known she's been pregnant for a week.

So that would imply certainly that she's not staying in bed all day. She goes to school. She doesn't have a job, she's 18, she goes to school. It -- you know, for the week that she's known, she says she can't concentrate at school, which means that she's still going to school, or implies. She has a boyfriend. So no job, home or friends, she at least has a boyfriend and she has a home, she lives with her parents. So I don't know -- you know, she's clearly very upset, but that's not of itself enough. And it has a number of -- of situational stress symptoms, but that of itself is not enough to support a generic statement, the patient has been unable to function in almost all areas of functioning.

Q. Now, does -- is there any information about a job on Bates page 4?

A. It -- at the bottom under the typed -- the prompt of guilt, it says, I've been offered a job in my hometown which will help. I -- so that's -- she's been offered a job. It doesn't state more than that.

Q. Now, is there any other in -- information contained within that -- those two MI statements -- I guess they're both entitled MI Indicators --

that would either support or not support the GAF?

A. Well, theoretically, if they were related to a psychiatric disorder, but it does not seem from the min -- MI Indicator statements that this patient has even had a -- a recurrence of her previous anxiety disorder because she's not reporting a recurrence of panic attacks, which were apparently the symptoms that she was having treated with the Paxil. So she -- she certainly has situational stress and she's certainly extremely upset in a variety of ways. That -- that upset is being expressed in a variety of emotional and behavioral ways, but of itself, these do not support a diagnosis of acute stress disorder.

Q. So how would a physician utilize this information?

A. Well, again, this would be -- these kinds of evaluations performed by a nonpro -- non-mental health trained person are screening examinations. And they are certainly used in places everywhere around the country where someone who's not necessarily a -- a mental health professional or trained in mental health assessments can be trained to ask the questions that are on their

standard screening -- that are part of their standard screening or Doctor Tiller's standard screening questionnaire, but the -- if - but if it comes up positive, the physician who is doing the assessment needs to expand and develop that information further through a standard mental health evaluation, including a mental status examination, and determine whether these are actually symptoms of a diagnose -- diagnosable psychiatric disorder or related to situational stress or related to a medical condition. Just, for example, when we go to the doctor, we go to our internist or whatever, the nurse takes our blood pressure, right? The doctor relies upon that blood pressure. And if it's normal, the doctor rarely takes another blood pressure unless there's some complaint that would cause him or her to do so. However, if the nurse's blood -- blood pressure reading is extremely high, it's very likely that not only the nurse will repeat it, but the doctor will repeat it and they will investigate the possible causes of why you've shown up with that high blood pressure and try to determine that. They may not be able to determine it that day, they may follow along, et cetera, but

you're not going to rely on one blood pressure. If you're the physician, you're not going to rely on one abnormally high blood pressure reading taken by your nurse to diagnose and treat the possible medical reasons for a high blood pressure in that patient. It's not going to tell you what they are and it's not going to tell you what the appropriate treatment is.

Q. So is there any evidence within this file that indicates that further examinations or evaluations were performed to determine whether it was situational stress or psychiatric symptoms?

A. No.

Q. And going back to the GAF real quick, can you tell me what the rating date and time was for that document?

A. 11-13-2003 --

Q. And --

A. -- and 1306 is the time.

Q. -- that was a rating date and time?

A. Yes, for the GAF.

Q. Okay. And the report date and time?

A. 11-13-2003.

Q. And what's that time difference?

A. I'm sorry. The time is 1307 and the

difference is one minute.

Q. Now, using Doctor Tiller's record, can you determine whether 11-13-2003 was a possible date for this patient's appointment with Doctor Neuhaus?

A. I -- I suppose it could have been a date for the appointment for Doctor Neuhaus.

Q. Well, can you tell me when the termination of the pregnant began?

A. Well, the post-abortion checkout exam was 11-7-2003, so it was prior -- prior to 11-7.

Q. What does the appointment date on Doctor Tiller's intake page indicate?

A. Doctor Tiller's intake appointment date is 11-4 of '03.

Q. So if 11-13-2003 is a correct -- is a correct appointment date, that would have been before or after the termination of pregnancy?

A. Well, if the appointment was 11-13, that would have been after the termination. But it is possible that the appointment occurred before and the printout was done after.

Q. So there's no --

A. That date is the date of the report and printout and not necessarily the date of the

appointment.

Q. So is there any evidence within this record that shows what the date and appointment of Doctor Neuhaus was?

A. No.

Q. Now, if you consider the information listed on the DTREE and GAF reports as evidence of Doctor Neuhaus' performance of an evaluation of behavioral or functional impact of Patient 10's condition and symptoms, do you have an expert opinion as to whether she met the standard of care in performance of that evaluation?

A. Unfortunately, I -- yes, I do. And --

Q. And what is it?

A. -- unfortunately, I would have to say she did not.

Q. Why?

A. Because there's no evidence of the clinical evaluation and mental status exam with positive findings to support the diagnosis or rating assessment that she concludes.

Q. What is there evidence of?

A. Well, there's evidence that she did -- this patient checked into Doctor Tiller's clinic. There's evidence that she was administratively

processed through Doctor Tenners -- Tiller's clinic. There's evidence that one week after -- based on Doctor Tiller's documents that are in Doctor Neuhaus' chart, there's evidence that one week after discovering she was pregnant, she contacted this clinic and two weeks later came for -- for the procedure, and that she was extremely distressed to find herself pregnant. There's also indications of a preexisting psychiatric disorder for which she is receiving treatment, 40 milligrams of Paxil. None of -- none of that information was -- all of that information is obtained through a review of Doctor Tiller's record. And finally, there is, you know, a positive telephone screening and in-person screening of -- for possible mental health disorder.

Q. Now, you mention there's evidence that this patient was distressed. Is that evidence or is that -- is being distressed a symptom of these diagnoses?

A. Well, it can be.

Q. How?

A. Well, usually, if someone has an active psyc -- psychiatric diagnosis, there are evident

active symptoms, so being agitated, upset, weeping, things that you would consider distress, too nervous to sit, physically uncomfortable and mentally uncomfortable symptoms constitute distress. And you would say or -- and people would say, I am -- if you had to describe it, that one word to describe those kinds of symptoms is distress. The issue is, it doesn't work the other way around. People who are distressed do not necessarily have a diagnosable psychiatric disorder. And distress, especially distress that is appropriate to an adverse life event is a normal human behavior reaction and not a sign of pathology. Could it become or could it -- could it be a sign of pathology? It could, but of itself, does not indicate pathology and needs further evaluation.

Q. If you consider the information listed on the DTREE and GAF reports as evidence of Doctor Neuhaus' performance of Patient 10's mental status examination, do you have an opinion as to whether she met the standard of care in her performance of that mental status examination?

A. I do.

Q. And what is it?

A. An -- unfortunately, she did not.

Q. Why?

A. There's no indication that Doctor Neuhaus performed a formal or informal mental status examination. There are negative findings con -- on the GAF that would be consistent with the patient's -- with the -- some aspects of a mental status examination, but there is no positive clinical findings to indicate the positive mental status findings that would be consistent with this diagnosis or GAF score.

Q. Now, if you consider the information listed on the DTREE and GAF reports as evidence of Doctor Neuhaus' performance of Patient 10's mental health evaluation, do you have an expert opinion as to whether she met the standard of care in her performance of Patient 10's mental health evaluation?

A. I do.

Q. And what is it?

A. She did not.

Q. Why?

A. There's no evidence of Doctor Neuhaus conducting a clinical evaluation, reviewing current and past history, psychiatric history,

medical history. In a patient who is in treatment for a psychiatric disorder, it would be common practice to at least attempt to review the treating physician's records or contact or verbally discuss the patient with the treating doctor. There's no evidence of -- there's certainly no evidence that it -- that such a record review happened. There's no evidence of an attempt to contact the doctor. So in this patient, there's an added element because there is a -- a history given which adds to what a standard evaluation would encompass. And then, you know, a med -- formal medical examination -- I'm sorry -- a men -- for -- formal or informal mental status examination and consideration of the effects of an unwanted pregnancy on her emotional presentation and/or her prior -- her preexisting psychiatric disorder.

Q. And why are those important things to do?

A. Well, Doctor Neuhaus is diagnosing an acute stress disorder, a new onset acute stress disorder, which is a type of anxiety disorder, in a patient with a preexisting anxiety disorder who's acutely distressed. I don't know how you could do that without doing at least a standard

clinical evaluation and a review of -- of her previous psychiatric history. And she's still taking medication, which means someone's still prescribing the medication, which means there's a doctor who, theoretically, knows what her history is and has diagnosed her with a disorder for which he or she is prescribing this medication. And at least theoretically, that doctor could be contacted by telephone and presumably would know this patient and be able to give you some history that would be relevant, especially if she's a -- presenting for a surgical or intervention.

Q. Is there any evidence in the file of who that other physician is?

A. No.

Q. Is there any evidence in the file of her attempting to contact that physician?

A. No.

Q. Is there any contact information for that physician in the file?

A. No.

Q. Is there any indication -- strike that. Do you have an expert opinion as to whether Doctor Neuhaus met the standard of care in documentation in regards to this patient's record?

A. Yes.

Q. And what is your opinion?

A. I would, again, say unfortunately, she has not.

Q. Why?

A. Doctor Neuhaus' file does not appear to contain any specific clinical information about this patient generated by Doctor Neuhaus. The GAF report and the DTREE report are not signed. They contain no specific clinical information. It's not possible to recreate her -- to understand the process of evaluation by which she came to these diagnoses and conclusions, nor the specific clinical data that support the diagnosis and -- and GAF conclusion.

Q. And why are those important to do for this patient?

A. Well, this is a patient who -- I mean, it's important for all patients, but in this particular case, this is a patient who presumably will be going back to treatment with her -- at the very least, with the doctor who has continued -- who has been prescribing medication for her panic attacks. And it would be very significant for that doctor to know that his patient has been

diagnosed with an acute stress disorder and what the basis for that diagnosis is -- is for to him continue providing effective patient care for her.

Q. Let's move on to Patient 8. Do you have your expert report for Patient 8 in front of you?

A. Yes, I do.

Q. Do you have Doctor Neuhaus' patient record for Patient 8 in front of you?

A. Yes, I do.

Q. And do you have Doctor Tiller's patient record for Patient 8 in front of you?

A. Yes, I do.

Q. From a review of the records, could you please describe Patient 3?

MR. EYE: Could you -- which one?

MR. HAYS: Oh, sorry. Patient 8.

MR. EYE: Thank you.

A. Patient 8 is a 13-year-old girl from Englewood, New Jersey who became pregnant at age 12 after consensual sex with a 15-year-old and was 25 weeks pregnant at the time of evaluation in Doctor Tiller's clinic.

BY MR. HAYS:

Q. And without being told who that record came from, could you determine whose physician

record it is?

A. No.

Q. Why is that?

A. Because Doctor Neuhaus' name appears in only one place on this form, on -- in this -- on these five pages and it's at the top of the Patient Intake Form. It's handwritten in by someone. It doesn't indicate why her name is there. Doctor Tiller's name is also on that form, so -- typed in. Again, the name appears -- it -- it does not appear to have been written by Doctor Neuhaus. So it -- it -- again, you know, out -- outside the Authorization to Disclose Information typed form, which we've discussed previously, it's -- it's not personalized by Doctor Neuhaus in any way nor does it contain clinical information generated by an evaluation by Doctor Neuhaus.

Q. Do you know when Doctor Neuhaus had the appointment time and date for this patient?

A. No, I do not.

Q. What was the diagnosis that's documented within this record?

A. There is no diagnosis documented within this record.

Q. What is the GAF that's documented within

this record?

A. There is no GAF documented in this record.

Q. Do you know whether Doctor Neuhaus came up to a diagnosis for this patient?

A. I do.

Q. And how do you know that?

A. Through her inquisition testimony.

Q. Where is it at in her inquisition testimony?

A. It be -- page -- Bates number is -- I can't read the Bates number -- 887. And that's the transcript of the inquisition and there's four pages on each page and it's page 248.

Q. And what does she say on that page?

A. Doctor Neuhaus testified that she diagnosed her with a, quote -- diagnosed her with, quote, suicidal ideation and acute stress disorder.

Q. And how were you able to identify that Patient 8 was the one that she was talking about in that transcript?

A. Well, she was identified in the transcript as 13-year-old from New Jersey, 25 weeks along viable pregnant. And this is a

13-year-old from New Jersey with a 25-plus weeks of viable pregnancy, so I -- it is an assumption on my part that it is the same patient.

Q. Were there any other descriptions about that patient's symptoms in that transcript?

A. No.

Q. What diagnostic information or what possible diagnostic information is contained within Doctor Neuhaus' record?

A. Again, there is the MI screening form on Bates 4 and 5.

Q. And what information does it contain?

A. This is -- this states that the patient has known for about a week that she was pregnant. She states that she doesn't think she -- she thinks that she might die from this pregnancy. That she thinks her life -- she states that she would kill herself or die if she couldn't get an abortion, or if that didn't happen, I would neglect the child or beat it senseless. And then there is the screening information with the screening questions for depression.

Q. And are there any indicators within that screening for depression?

A. Indicators for?

Q. Any diagnoses?

A. Potentially, yes.

Q. And what are those indicators?

A. Well, there's -- there are positive findings under a number of symptoms. The issue is that you're talking to a -- what sounds like a very young 13-year-old who has only known for a week that she is pregnant. And so a clinical assessment would have to tease out whether this is age-appropriate or developmentally-appropriate communication, what this really means, what these statements really mean. Is she really serious that she would neglect a child or beat it senseless or kill herself or die? And those are -- again, when -- especially -- she's on -- you know, without seeing this patient, it's hard to know where she is in a developmental scale, but she's either a very young teenager or still developmentally, you know, a -- a child -- child. And there's all kinds of indicators on here that -- but it's -- it's hard to know what they mean without further evaluation. And -- and you know, again, this is a week's duration that she's known she was pregnant, so --

Q. Is there any evidence within Doctor

Neuhaus' patient record that any of that follow along clinical assessment had occurred?

A. No.

Q. What about any clinical assessment by Doctor Neuhaus herself?

A. No.

Q. Is there any evidence within that file that indicates Doctor Neuhaus followed-up on the suicide issues?

A. No.

Q. Can you tell me how many pages this file is for patient record?

A. It's five.

Q. And that's Doctor Neuhaus' patient record for this patient?

A. That's my understanding.

Q. From the record, can you determine whether a evaluation of the behavioral or functional impact of the patient's condition occurred?

A. I'm sorry. Could you repeat the question.

Q. From the record, can you tell -- can you determine whether an evaluation of the patient's behavioral or functional impact of the patient's

condition occurred with this patient?

A. By Doctor Neuhaus?

Q. Correct.

A. I cannot determine that, there's no record of it.

Q. What would need to be documented?

A. There would need to be some indication of an appointment, a date, how long this evaluation took. This is another complex evaluation where, you know, there would be a question about referring to a specialist in child psychiatry given the age and presentation of this child. Again, I don't have enough information to know if there are other complicating factors, but just based on the MI Screening, this appears to be someone who's at least talking about killing herself or killing the baby if she should have it. But there would have to be in the record some documentation of an appointment, and evaluation, including the mental status examination, including a review of psychiatric -- current and past psychiatric history, social history, psychosocial history with -- the child's caretakers would need to be involved. There would need to be some documentation of all the elements -- some

documentation of any -- of elements of a comprehensive evaluation. It wouldn't have to be every single element of a comprehensive evaluation, but there would have to be something. There is, as far as I can tell, nothing in this chart generated by Doctor Neuhaus, not even the computer programs -- or the computer program reports.

Q. Now, based upon Doctor Neuhaus' testimony describing how she generally performed mental status examinations, do you have an expert opinion as to whether she met the standard of care in the -- in performing a mental status examination of this patient?

A. Doctor Neuhaus was -- did not describe a mental status examination specifically for this patient.

Q. What about mental health evaluation?

A. Doctor Neuhaus testified generally about conducting mental health evaluations on all these patients, but there's nothing specific here. She acknowledges that she remembers the patient based on the history, presumably the MI Statements, and the fact that she was so young, but did not refer specifically to her own evaluation of this

patient, acknowledges that the -- that she didn't have any notes to go off of for herself specific -- no specific information of her own.

Q. Do you have an expert opinion as to whether Doctor Neuhaus met the standard of care in documentation in regards to this patient record?

A. Yes.

Q. And what is that expert opinion?

A. Unfortunately, she did not.

Q. Why is that?

A. There is no documentation in this chart generated by Doctor Neuhaus that would indicate an evaluation or a diagnosis of this patient.

Q. Why is it important to document that information for this patient?

A. That was why the patient was referred to Doctor Neuhaus for a consultation, for a mental health evaluation. So if -- if she hasn't documented a mental health evaluation, it's not -- she hasn't performed the task with which medically, psychiatrically, she was undertaking by agreeing to see the patient. And this is potentially a very serious situation that would need -- based on the information I have available, that would need even a specialist evaluation to

determine whether there's an underlying psychiatric disorder and what the appropriate treatment would be for it.

MR. HAYS: I have no further questions for this witness. If we can take a short break in-between so the witness can -- because she may be on the stand for a little bit longer.

PRESIDING OFFICER: How long are you going to be, do you have any idea? And I'm not holding you to it, but how long?

MR. EYE: It's -- it's going to be awhile.

PRESIDING OFFICER: Do you want a break before he starts?

THE WITNESS: Sure. Thank you.

(THEREUPON, a recess was taken.)

CROSS-EXAMINATION

BY MR. EYE:

Q. Doctor Gold, you maintain your private practice, correct?

A. Yes.

Q. In psychiatry?

A. Yes.

Q. And you spend about 40 percent of your time currently seeing patients, correct?

A. Currently, yes.

Q. And you spend about 40 percent of your time in litigation or forensic-related activities, correct?

A. Correct.

Q. And you spend about 20 percent of your time in academic pursuits, correct?

A. Teaching and writing, correct.

Q. Now, it's accurate that you've never seen a pregnant adolescent for the purpose of evaluating her for an abortion, correct?

A. I don't quite understand the question.

Q. It's correct that -- that you've never professionally counseled a -- an adolescent girl to determine whether she was a suitable candidate for an abortion, correct?

A. There is no kind of specific psychiatric category for assessing whether someone is suitable for an abortion, so it's not possible to do that. It's not a real world event, so, no.

Q. In fact, you've never evaluated any woman in the course of your practice for the purpose of determining whether her mental health would be preserved by virtue of having a late-term abortion, correct?

A. I'm sorry. Could you repeat the question?

Q. Sure. In your practice, since -- or since you've been out of medical school, you've never val -- evaluated any woman for the purpose of determining whether her mental health would be preserved by virtue of having alert -- late-term abortion, correct?

A. A late-term abortion is not a treatment or intervention for any psychiatric disorder, so it would not be -- those two things are not connected. So, no.

MR. EYE: Okay. Well, I'm going to move to strike the part of her answer that preceded the no, Your Honor -- Your Honor, as being unresponsive to the question.

PRESIDING OFFICER: Sustained.

BY MR. EYE:

Q. You would agree that of the 11 patient charts that we've covered -- that you've covered during your direct examination, all of those dealt with children or adolescents, save for one, correct?

A. Yes. The -- except that the one is 18 years old and technically still counts as an adolescent, although legally, 18 is an adult. So

for psychiatric purposes, I would consider that person still an adolescent.

Q. And so for purposes of your review, did you consider any of the -- the 10 patients that were under 18 years old as women?

A. Well, they're all women.

Q. In the female sense. How about in the developmental sense?

A. Well, if by women, you mean adults, then, no, none of them are, psychiatrically speaking, adults in a developmental sense.

Q. You've never testified in a case that had anything to do with abortion, have you?

A. No.

Q. Other than this one?

A. Correct.

Q. And other than this case, you've never been a consultant for -- in a litigation context that involved abortion, correct?

A. Correct.

Q. In -- in a nontestifying capacity?

A. Correct. Well, ex -- except more -- except broadly in the sense that when patients -- when women and adolescents find themselves pregnant, the question of abortion can arise.

And, so in the general treatment, it may come up for a discussion with a patient, but not specifically as a specific focus of treatment.

Q. In your capacity as a part-time clinical professor of psychiatry at Georgetown, you've never dealt with anything related to abortions, correct?

A. That is correct.

Q. And you have been a -- a course director for writing in forensic psychiatry, is -- is that correct?

A. At Georgetown, yes.

Q. Yes. And you've never had an -- an occasion to review or edit a paper, a professional paper that dealt with abortion services, correct?

A. That is correct.

Q. You would agree that at no time during the process of you receiving a board certification in psychiatry or neurology, did you deal with anything that related to abortions, correct?

MR. HAYS: Objection, relevance.

MR. EYE: Well, we're going to the weight that should be afforded this witness' testimony, Your Honor. Your Honor has admitted her testimony and I believe even counsel for petitioner

acknowledged that it would be up to you to determine what weight to get it -- to give that testimony and that's the reason for these questions.

PRESIDING OFFICER: Objection overruled. You may answer the question if you know the answer.

THE WITNESS: Could -- could you repeat the question? I'm sorry.

BY MR. EYE:

Q. In the process of getting your board certifications, you didn't study about abortions, did you?

A. No.

Q. And you weren't tested on that either, correct?

A. Correct.

Q. It -- it -- it's correct that you are -- that you don't consider yourself a specialist in the evaluation of -- of psychiatric disorders in adolescents or children, correct?

A. That is correct.

Q. And you don't consider yourself a specialist in the diagnosis of disorders in adolescents or children, correct?

A. Correct, I -- I don't consider myself a certified subspecialist in those areas.

Q. And you don't consider yourself a specialist in the treatment of psychiatric disorders in adolescents or children, correct?

A. Correct.

Q. And you went to Boston U, Boston University for residency training, correct?

A. Correct.

Q. And nothing in that training dealt with abortions, correct?

A. Correct.

Q. And you were designated as a Ginsberg Fellow, correct?

A. Yes.

Q. And that's a -- that's a -- a -- a credential, isn't it?

A. Yes.

Q. But that credential doesn't have anything to do with providing abortion or abortion-related services, correct?

A. Correct.

Q. When you were at medical school, you didn't have any class work that dealt with abortions, did you?

A. Not that I can recall specifically. It -- there might have been, but I can't recall it.

Q. There was a clinical component in your medical education, correct?

A. Correct.

Q. And none of that involved abortions or abortion services, did it?

A. It -- it might have, but only tangentially.

Q. Do you remember your deposition being taken on June 24 of this year?

A. Yes.

Q. Do you recall being asked a question about during your medical education at New York University, did you have a clinical component to that medical education, and do you -- you recall your answer being yes?

A. Yes.

Q. And then do you recall the question, and can you tell us whether any of that clinical experience at NYU involved abortion services, and do you recall your answer was, it did not?

A. Not -- yes. Not -- I -- I thought I had also said that during the course of an OB/GYN rotation, there were a number of D & Cs performed.

Sometimes, those D & Cs, they're -- D-- capital D and C -- sometimes, those are actually abortion procedures that the medical students would not be privy necessarily to the fact that they were early -- you know, first trimester abortions. I thought I said that somewhere. So -- so that's what I meant by tangentially.

Q. You observed some of these D & C procedures?

A. Correct.

Q. But you didn't -- but a D & C procedure can be done for purposes other than termination of a pregnancy, correct?

A. Yes, yes.

Q. And you don't know whether any D & C procedure that you observed was for purposes of terminating a pregnancy, correct?

A. Correct.

Q. You had privileges at hospitals in New Hampshire at one point, correct?

A. Correct.

Q. And you never admitted a patient for any abortion-related services at any of those hospitals, did you?

A. It would be inappropriate for a

psychiatrist to admit a patient for an abortion-related service.

MR. EYE: Move to strike as being unresponsive.

PRESIDING OFFICER: Sustained.

A. No.

BY MR. EYE:

Q. And when you had privileges in Massachusetts, you didn't ever admit a patient for abortion services, did you, at any hospital there -- in Massachusetts?

A. No.

Q. At no time in the course of your private practice have you ever provided an opinion to a patient concerning whether she should receive a late-term abortion in order to preserve her mental health, correct?

A. Correct.

Q. And you've never provided any such opinion to any other physician, correct?

A. Correct.

Q. You are an attending psychiatrist at Columbia HCA Reston Hospital, correct?

A. I -- I was.

Q. And that's in Virginia?

A. Yes.

Q. In the course of being an attending psychiatrist -- or when you were an attending psychiatrist there, you didn't deal with an -- any patients who were seeking abortion services, correct?

A. Correct.

Q. In fact, at no time during your work with the -- with a -- a -- strike that.
You have a relationship with the Psychiatric Institute of District of Columbia, correct?

A. I did. I don't -- well, it's the Psychiatric Institute of Washington.

Q. I'm sorry.

A. That's okay. And I don't any longer, but I did.

Q. All right. And during the course of that relationship, you didn't have any occasion to evaluate per -- patients for purposes of late-term abortions, correct?

A. Correct.

Q. And in the course of your entire practice, you've never evaluated a patient to determine whether an abortion would be consistent with preserving the mental health -- health of a

mother, correct?

A. Correct.

Q. And you've never done an evaluation to determine whether an abortion would preserve the physical health of a mother, correct?

A. Correct.

Q. A little geography lesson here, I guess. Nashua is in New Hampshire, correct?

A. Correct.

Q. And so we already asked about your New Hampshire hospitals and you didn't admit patients for abortions or any abortion-related services there, correct?

A. Correct.

Q. And Hampstead, is that in Massachusetts?

A. No, that's in New Hampshire.

Q. Okay. And so we've already answered that question, correct?

A. Correct.

Q. Charles River, that sounds like a Massachusetts geographic location if I remember my rivers in Boston correctly?

A. That is correct.

Q. And you had -- you were a -- designated as an attending psychiatrist at Charles River

Hospital, correct?

A. Correct.

Q. And you didn't do anything related to abortion services with patients at Charles River Hospital, correct?

A. Correct.

Q. Now, of all the hospitals that you've been affiliated with, you don't know whether any of them provided abortion services, do you?

A. I -- I assume that some of them did not, because they were Catholic hospitals. Other than those, I don't know whether they did or did not.

Q. So it'd be fair to say that in terms of your professional affiliations, you've never had any relationship with an institution or health care facility that is included -- as far as you know, included anything -- strike that. You've never had a relationship with any institution or facility --

MR. HAYS: Objection, asked and answered.

MR. EYE: I'd like to ask the rest of the question perhaps.

PRESIDING OFFICER: Fine. Ask the question and then we'll see.

BY MR. EYE:

Q. In terms of any facility -- I mean, we haven't listed every institution or facility that you've ever been affiliated with, have we?

A. No.

Q. Okay. Of all the institutions and facilities that you've had an affiliation with, you've never done anything professionally that would have related to the evaluation of patients for purposes of late-term abortions, correct?

A. Correct.

Q. You have a long list of articles that you have either authored or been a coauthor on in your CV, is that correct?

A. Well, I have --

Q. Relatively long?

A. -- I have a list, yes.

Q. All right. None of those deal -- none of those writings cover abortions or abortion services, correct?

A. Correct.

Q. You have -- or had, and perhaps you still do, editorial work for Psychiatric Times Special Report on Forensic Psychiatry?

A. Well, that was a one-time edition, but I did that whatever year it says I did it.

Q. Okay. Would it be 2000 -- and strike that. I'm not sure exactly what year it was. But --

A. Yeah.

Q. -- none of that had anything to do with abortions or abortion services, correct?

A. Correct.

Q. You've reviewed a number of books in the course of your professional life, correct?

A. I've reviewed some books, yes.

Q. And none of those covered abortions or abortion-related services, correct?

A. Correct.

Q. You were invited to do presentations at various programs and symposiums, correct?

A. Correct.

Q. And you've never done a -- a presentation, an invited presentation that had anything to do with abortion or abortion-related services, correct?

A. Correct.

Q. And in the totality of your writings, you've never -- other than related to the reports in this case, you've never had an occasion to produce any material related to late-term

abortions, correct?

A. Correct.

Q. In the course of your practice in any capacity, you've never recommended a termination of a pregnancy for mental health purposes, correct?

A. Correct.

Q. You've never performed an abortion, correct?

A. Correct.

Q. And before engaging this matter, you've never done a standard of care analysis for some -- for a physician who was providing abortion services or abortion-related services, correct?

A. Correct.

Q. Now, as I understand it, the -- the -- the definition of standard of care that you applied in this case was something that you didn't develop on your own, correct?

A. Correct.

Q. It was provided to you, correct?

A. Correct.

Q. Did you do anything independently to determine whether that standard of care that was provided to you accurately reflected the standard

of care in Kansas?

A. No, not independently.

Q. You've never practiced medicine in Kansas, have you?

A. No, I have not.

Q. You were provided a series of Kansas statutes by counsel for the Board of Healing Arts, correct?

A. Correct.

Q. And in re -- did you use those statutes as a basis to determine what you believe is the standard of care in Kansas?

A. As -- legal statutes, I don't know how to answer the question yes or no. Legal statutes inform the medical standard of care, but do not establish the medical standard of care. So I've used the statutes to understand what the legal requirements are for the -- the elements of medical care that were covered by those statutes, but of themselves, they -- so they inform my opinion, but they were not the basis of my assessment of standard of care.

Q. You've never had a patient referred to you from another physician or healthcare provider for purposes of evaluating that patient for a

late-term abortion related to mental health reasons, correct?

A. Correct.

Q. You would agree that the -- after having reviewed the materials that were provided to you for standard of care related to late-term abortion, does not refer or require the finding of an acute psychiatric emergency to justify a late-term abortion, correct?

A. Well, the material provided to me didn't specify the standard of care for a late-term abortion.

Q. My question was: Did it refer to or require a finding that a patient was suffering from an acute psychiatric emergency in order to justify a late-term abortion for mental health purposes?

MR. HAYS: Objection, relevance.

PRESIDING OFFICER: Overruled.

A. I would have to look at the statute to refresh my memory, because I don't think it mentioned mental health at all, but I could be wrong. As a matter in fact, it says, for substantial and irreversible impairment of a major organ.

BY MR. EYE:

Q. Is -- is it your understanding that that would include a mental health under -- a mental health reason for performing an abortion?

A. I understand that it was interpreted that way. I don't know what the intent or the under -- of the law was.

Q. And you were told that it's been interpreted that way by counsel for the board?

A. No. It's -- it's clearly been interpreted that way by reading through Doctor Tiller's and Doctor Neuhaus' records.

Q. So you relied on that to -- to determine that mental health -- preserving the mental health of a woman can be a reason for obtaining a late-term abortion, correct?

A. I -- I inferred from that, that Doctor Neuhaus and Doctor Tiller considered it to meet the definition that was provided in the statute.

Q. And -- and you don't have any reason to differ with that, do you, as a -- as a -- an expert witness in this matter?

A. Differ with what specifically?

Q. That mental health -- preserving the mental health of a woman can be a reason for

performing a late-term abortion?

A. I'm not -- I mean, in rare situations possibly, but it would be extremely rare and unusual. I -- I -- it's very hard to come up with circumstances that would -- of a mental illness for which a late-term abortion or any kind of abortion would be a treatment.

Q. In your opinion?

A. In my opinion.

Q. Does the statutory -- do the statutory provisions that you look at talk about abortion as a treatment? In the statutes that you referred to?

A. In the statutes, they do not refer -- refer to abortion as a treatment or an intervention for a mental illness.

Q. You've never counseled or -- or dealt professionally with a 10-year-old pregnant girl, correct?

A. That is correct.

Q. You've never counseled professionally an 11-year-old pregnant girl, correct?

A. That is correct.

Q. In fact, the youngest pregnant girl you've ever counseled was 16 years old, correct?

A. That is correct.

Q. And that was not for the purposes of seeking an abortion, correct?

A. That is correct.

Q. You referenced in your direct testimony, practice parameters generated by the American Academy of Child and Adolescent Psychiatry, do you remember that reference?

A. Yes, I do.

Q. Those are not a standard of care, correct?

A. They do not by -- of themselves establish a standard of care. They inform it, but do not establish it.

Q. Now, it's your opinion that even with a complete psychiatric evaluation, a mental -- strike that.
A healthcare provider could never conclude that there was irreversible mental harm that would be caused by carrying a pregnancy to term, correct?

A. I'm sorry. Could you repeat the question?

Q. Sure. It's -- it's your opinion that even with a complete evaluation, a healthcare provider could never conclude that irreversible

mental harm would result from carrying a pregnancy to term, correct?

A. Mental harm from a psychiatric disorder, no, it could not.

Q. All right. Okay. I want to make sure our -- that -- that our record is clear here.

A. Okay.

Q. Do -- do you agree that -- that your position is that even with a complete evaluation, a healthcare provider could never conclude irreversible mental harm that would result from carrying a pregnancy to term?

A. Yes.

Q. You agree with that?

A. Yes. Sorry.

Q. It's all right. No, it's --

A. I got confused.

Q. -- sometimes the record gets a little bit unclear and I just want to make sure --

A. Uh-huh.

Q. -- that we do our best to clarify. It is your opinion that a late-term abortion is not a treatment or intervention for any psychiatric disorder under any circumstances, correct?

A. That is correct.

Q. And, your view is it even if a healthcare provider concludes that a patient is severely psychiatrically ill, an abortion would not be recommended, correct?

A. Well, an abortion might be recommended, but not for the psychiatric disorder. If -- if that woman had a -- or girl had a, you know, physical life-threatening condition in addition to a psychiatric disorder, then somebody might recommend a late-term abortion, but it wouldn't be for the psychiatric disorder.

Q. My question was strictly the psychiatric part.

A. Okay.

Q. And you would agree that your position is that even if -- even if a physician concluded that a patient was severely psychiatrically ill, an abortion would not be, in your judgement, an abort -- an abortion would not be recommended?

A. It would not be recommended as a treatment for psychiatric illness or disorder.

Q. And, you -- in -- in your view, there is no significance in terms of determining mental impairment -- strike that.

You're not an expert in any state statutes or policies regarding late-term abortions, correct?

A. That is correct.

Q. And you are not an expert on the standard of care in Kansas, correct?

A. Standard of care for what?

Q. Anything. Medical practice in Kansas.

A. Nonpsychiatric medical practice?

Q. Let's start with the global. Are you an expert in the standard of care for any aspect of medical practice in the state of Kansas?

A. I believe -- well, psychiatry is a subspeciality of medicine. I believe I am an expert in the practice of psychiatry.

Q. Do you remember your deposition testimony on June 24, 2011 where you were asked the question, quote, so do you know of any legal or policy -- legal reason or policy reason that says you have to have an emergency to justify a late-term abortion based on health -- mental health considerations, and your response was, yeah, I mean, I'm not an expert in all the state statutes and policies regarding late-term abortions, so I don't know. Do you remember that testimony?

A. Yes.

Q. And then the question that followed up was, are you an expert on any of those, and your answer was no. Are you -- do you stand by that testimony?

A. Well, the -- my understanding of the word "those" was statutes and policies. So if -- if that is what those refer to, then I do stand by that.

Q. And you -- then you -- the next question was, and you don't consider yourself to be an expert on standard of care in Kansas, correct? And your answer was 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. Do you remember that testimony?

A. Yes.

Q. And then the following question was, and you've never undertaken an inquiry to determine what the standard of Kansas -- standard of care is in Kansas, correct? And your answer was no. Do you remember that?

A. Yes.

Q. So you -- you are not an expert on the standard of care in Kansas, correct?

MR. HAYS: Objection, misstates the testimony.

PRESIDING OFFICER: Well, I -- I don't know that it misstates it, but it doesn't -- it doesn't include all of it.

BY MR. EYE:

Q. Do you consider yourself to be a -- an expert on the standard of care in Kansas?

A. Insomuch as that there is a national standard of care for the conduct of psychiatric evaluations regardless of what the purpose of the evaluation is. And Kansas is part of the United States. So I believe that I am in that sense.

Q. But you've never done an -- an inquiry specifically to determine how practitioners in Kansas perform mental health evaluations, correct?

A. My -- I have never done an inquiry into that.

Q. You've never done any research period into that specific question, have you?

A. Not into that specific question. Board certification, training practices, residency

requirements are the same everywhere in the United States in terms of their being national standards that must be met.

Q. Is there a national standard of care that applies to doing a mental health evaluation for a late-term abortion, that you know of?

A. There -- there is no such specified entity and therefore, there can't be a standard of care for that kind of specific evaluation.

Q. Would you agree that 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 as they're presented constitute clinical judgment?

A. I'm sorry. You're going to have to repeat the question.

Q. Would you agree that clinical judgment is 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 as they're presented?

A. Not exclusively, but that would be part of it.

Q. You would agree that there are examples

where best medical judgment is exercised in the absence of documentation that you would consider to be adequate?

A. It's possible that it could be.

Q. You would agree that in the evaluation of -- of a patient for purposes of rendering a medical opinion or a medical judgment, that there are both subjective and objective parameters that should be considered?

A. Correct.

Q. Would you agree that in doing a mental health evaluation for purposes of determining whether there would be substantial and irreversible harm to the mental health of a female by carrying a pregnancy to term that both objective and subjective standards come into play?

A. They would come into play in any mental health evaluation.

Q. So the answer is yes?

A. Yes.

Q. Now, when you wrote the reports related to the 11 patients in this case that you've testified about the last day or so, you wrote those without consulting the testimony of -- of anybody, particularly Doctor Neuhaus, that derived

from the inquisition or the criminal trial of Doctor Tiller, correct?

A. Correct.

Q. And so when you testified earlier in this proceeding that those materials had some bearing on your opinion, you didn't take that into account when you wrote your reports, correct?

A. Correct.

Q. And so those transcripts did not form a basis for your medical opinions in this case -- or the information in those transcripts, I should say?

A. Didn't form a basis for the opinions in the reports, that is correct.

Q. You referenced a -- as we discussed earlier, the American Academy of Child and Adolescent Psychiatry and -- and the -- the guidelines that were generated by that body, correct?

A. Well, they're -- they're actually called practice parameters, but I think it's the same.

Q. All right.

A. For all intents and purposes, it's the same thing.

Q. Now, those practice parameters as they

were -- the -- the latest version of that -- of those parameters is 2007, correct?

A. No.

Q. What's the -- what's the most recent?

A. The most recent general parameters are 19 -- were 1997. The 2007 parameters were for the assessment -- or evaluation of anxiety disorders.

Q. Now, in -- in the compendium of -- of those parameters, there's no attempt, is there, to provide guidance to a professional, a -- a healthcare professional as to how to conduct a -- an evaluation for purposes of determining whether carrying a pregnancy to term would cause substantial and irreversible health to the female, correct?

A. In -- in a general guideline, you would not expect to see such a thing and there is not such a thing.

Q. So we couldn't pull those parameters and find guidance on how to conduct such an evaluation, correct?

A. We could.

Q. That specific kind of evaluation for those specific purposes?

A. Well, yes, I think that they would still

be relevant.

Q. Is there anything in those parameters that -- that cites the late term abort -- or -- or rather, doing an evaluation for purposes of determining whether carrying a pregnancy to term would be -- would cause substantial and irreversible harm to the mental health of the female?

A. It does not cite that specific very extraordinarily narrow circumstance. There are general guidelines that are there to be adapted for whatever specific circumstances as per the clinical judgment of the individual. They are a starting point, not a -- not a finishing point.

Q. Now, you would agree that whether a patient's mental health would be harmed if they carried a pregnancy to term is not properly a psychiatric question in most circumstances, correct?

A. Yes, it's not properly a psychiatric question as framed by that language.

Q. You would agree that the late-term abortion issue is not a psychiatric issue, correct?

A. I don't know that I -- can you rephrase

the question?

Q. You would agree that the late-term abortion issue is not a psychiatric issue, correct?

A. I -- I don't know that I can answer that question as asked.

Q. Again, in your deposition of June 24, 2011, do you recall the question that says, have you ever reviewed the literature to determine whether there is empirical evidence to support the statements you've just made, and that statement was, you've never heard -- or there's no research on a circumstance when a psychiatrist would make a recommendation for a late-term abortion? Your answer continues, quote, 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 -- 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. Do you remember that testimony that you gave?

A. Yes.

Q. Do you agree that the late-term abortion issue is not a psychiatric issue?

A. It's -- it's not a psychiatric -- it's not a focus of psychiatric practice or research, no.

Q. Would you agree that 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. Yes, I think that is the definition of a therapeutic abortion.

Q. But you would agree that as far as your practice of psychiatry, that's not an area that comes up in your practice, that is, the area of the -- the question about therapeutic abortions and their efficacy?

A. Well, it can -- the question does come up because pe -- women occasionally undergo -- or more than occasionally, therapeutic abortions and that becomes a mental health issue for them, but

not the reverse. It is not a customary practice to conduct a therapeutic abortion for mental health reasons.

Q. You would agree that the law authorizes such to happen however, correct?

A. I'm not an expert in the law and I don't know whether it authorizes it or not.

Q. So you proceeded through this entire case without any idea about whether -- whether there is a right to a therapeutic abortion for -- to preserve the mental health of a mother?

MR. HAYS: Objection, relevance.

MR. EYE: It -- it -- it goes to the whole question of -- of how she analyzed this case.

PRESIDING OFFICER: Well, I'm not sure it does, so the objection is sustained.

BY MR. EYE:

Q. Do you recall this testimony? Question: 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 a mother? Answer: 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. End quote.

Do you remember that testimony?

A. Yes.

Q. And is that an accurate statement of your view?

A. I've -- I've become quite confused about what we're discussing at the moment.

Q. Was that your testimony, that --

A. That -- you're reading it, I -- I'm assuming you're reading it correctly, it was my testimony.

Q. And you had a chance to review this transcript, didn't you?

A. Yes, I did.

Q. And you made some changes in it, didn't you?

A. Yes, I did.

Q. But you didn't make any changes in that, did you?

A. Well, but I'm not sure out of -- I'm not

sure what you're referring to by that.

Q. When I -- when we took your deposition, we made an agreement up front in that deposition if there was a question I asked you that you didn't understand, you would ask me to repeat it and make it a -- and make it understandable, correct?

A. Yes.

Q. And you didn't ask me to repeat that question, did you?

A. No. And I'm not asking you to repeat it now, I'm asking you to repeat the question you just asked me, not the question from the deposition. I've become lost as to what you are asking me.

Q. Well, just answer the questions that I -- that I -- that I ask you.

A. I'm trying. I -- I've lost the question.

Q. Now, you -- in your view, there is no such thing as a psychiatric consult that would relate to an abortion, correct?

A. No.

Q. It -- it -- I'm sorry. You -- you -- you believe that there are psychiatric consults that relate to abortions?

A. There could be.

Q. Your -- in your deposition testimony, I asked you a question. It said, have you ever referred a patient of yours to an abortion provider for abortion services or an abortion consult? And your answer is?

A. No.

Q. Quote, in my experience, in my practice, there is no such thing as an abortion consult. Do you remember that testimony?

A. Yes.

Q. So is that the case, that there's no such thing as an abortion consult?

A. Didn't that question say referred to another practitioner for an abortion consult or did it say --

Q. Have you ever referred a patient -- this is the question.

A. Okay.

Q. Have you ever referred a patient of yours to an abortion provider for abortion services or an abortion consult? And your answer was, in my experience, in my practice, there is no such thing as an abortion consult. If you have -- if you -- you say -- if you have a pregnant patient and the

patient has issues or problems, refer them to the appropriate person to help them address those problems. Have you ever referred a patient for purposes of getting a consultation about an abortion?

A. Not specifically about an abortion.

Q. Okay.

A. But about concerns regarding a pregnancy and an abortion may arise as an intervention that's necessary.

Q. But you've never done such, a -- a con -- a re -- a -- a referral for that purpose, correct?

A. It's hard -- I -- not specifically for an abortion.

Q. Now, in your work on this case, you came to it with a -- a view that the question about the -- the appropriateness of a late-term abortion is not a psychiatric issue, correct?

A. Again, I -- I don't know -- when you say appropriateness, I'm not sure what you mean.

Q. Whether an -- an abortion would be a -- a -- a -- an appropriate intervention?

A. It's not a -- it's not a therapeutic intervention for any psychiatric disorder or diagnosis. It is not a standard intervention in

-- for those reasons.

Q. But you would agree, wouldn't you, that a woman has the right to choose an abortion if she meets the legal requirements for such, correct?

A. As a choice, certainly.

Q. It's just not something you personally would recommend, correct?

A. It's not -- it's not a -- a -- a psychiatrist's place to recommend a specific course of action for any individual.

Q. Such as to get an abortion?

A. Yes. That it -- it would be highly inappropriate to -- as a doctor, direct someone who is puzzled about what to do to specifically an abortion, outside a discussion of all of the possible options of -- of how to address their issues about their pregnancy.

Q. I think we covered this a moment ago, but I -- I want to make sure that the record's clear. Would you agree that an unwanted teenage pregnancy carries a lot of risk with it?

A. Can you define risk?

Q. Would you agree with the statement that unwanted teenage pregnancy carries a lot of risk?

A. Can you define risk?

Q. Can you answer my question?

A. Not as presented.

Q. Do you remember your deposition testimony when you were asked, quote, 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? And your answer was, when you're talking about mental health and you're talking about psychiatric disorders, you're talking about two overlapping spheres, but they are not congruent. Okay? You continue, there are all kinds of emotional stress and distress that does not rise to the level of a psychiatric disorder or a psychiatric emergency. You continued, 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, an unwanted pregnancy, is not in of itself an indication that they're 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. And the question then followed, at least none you know of? And your answer, none that I ever -- have 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. Do you remember that testimony?

A. Yes.

Q. So you were able in -- in that testimony to articulate that teen -- unwanted teenage pregnancies carry risks?

A. Well, I defined the categories of risk and I differentiated between them.

Q. So unwanted teenage pregnancy doesn't carry any psychological -- risk of psychological harm, is that your testimony?

A. In the sense that it is not a risk factor for the development of psychiatric disorders. In the sense that it creates problems for an individual and problems cause distress, yes. If you define it as distress, yes. It's distressing, but it doesn't cause a psychiatric disorder typically, it's not a risk factor.

Q. Would you agree that a medical risk can be the cause of a mental health impairment?

A. It would be -- I don't know that I could agree with that statement, you'd have to be much more specific.

Q. I believe we've established that -- at least, that the standard of care that you're familiar with in Kansas, that there is no requirement that there be an acute psychiatric emergency to justify a late-term abortion, correct?

A. I understand that the statute does not require that. I don't know if the statute creates the legal standard of care, but the statute doesn't require it.

Q. In your work in this case, did you come at it with the presumption that late-term abortion could only be justified on mental health grounds if there was an acute psychiatric emergency?

A. No.

Q. So there are other reasons other than acute psychiatric emergencies that would justify a late-term abortion, correct?

A. Psychiatric reasons?

Q. Yes.

A. Possibly.

Q. All right. In terms of doing mental health evaluations for purposes of determining whether the -- carrying a pregnancy to term would cause substantial and irreversible harm to a woman -- to a female's mental health, would you agree that to do those evaluations, at least in your opinion, it requires somebody that has the same degree of skills a mental health specialist?

A. I think to do any complex psychiatric or mental health evaluation, you need the same degree of skill as a mental health specialist would bring to a set of unique circumstances that constitute a complex evaluation.

Q. So is -- is your testimony that a -- an internal medicine specialist does not have the same degree of skill as a mental health specialist?

A. They could if they had the appropriate clinical training and experience.

Q. And in terms of doing a comparison of those skills, you would agree that in order to make that comparison, you would either observe that physician or ask the physician what they've done or look at the documentation or some

combination of -- of two of those three or all three, correct?

A. Not -- no.

Q. Do you remember your testimony in your deposition when you were asked, 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? And your answer was, quote, 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 combin -- of -- of the above in combination. Do you remember that testimony?

A. Yes, I do.

Q. And doesn't that testimony imply that you would have to do at least two of those three in order to assess the skill level of a physician who is conducting a mental health evaluation for purposes of determining whether a woman is an appropriate candidate for a late-term abortion?

A. Whoa.

MR. HAYS: Objection, misstates her previous testimony.

MR. EYE: Well, I'm asking a question,

it's -- it's not quoting her testimony.

PRESIDING OFFICER: Ask the question again.

A. You -- you went a little too fast for me to follow.

BY MR. EYE:

Q. Would you agree that in order -- that -- that in your view, to evaluate the skill levels of a nonmental health specialist, a psychiatrist, let's say, but whose -- but that nonmental health specialist, let's say an OB/GYN, is cast in the role of doing a mental health evaluation. You would agree that in order to come -- to determine whether that person's skill levels, the nonspecialist health -- mental health specialist, that is, were appropriate, you would either observe them or ask them what they've done or look at their documentation or any of the above in combination? The above being those three factors.

A. Yes, that -- that was not a complete answer.

Q. That was the answer you gave though, wasn't it?

A. That -- that is correct.

Q. And you had an opportunity to review this

transcript, didn't you?

A. Yes, I did.

Q. And you didn't make any changes to that part of the transcript, did you?

A. No, I didn't.

Q. And you read the transcript?

A. Yes, I did.

Q. And I think we've already -- I think it's -- it goes -- I think we -- we know, but I think for purposes of the record, we need to establish that you never spoke with Doctor Neuhaus about any of these 11 patients that -- whose charts you've reviewed, correct?

A. That is correct.

Q. And you've never observed her practice, correct?

A. That is correct.

Q. So you evaluated her practice related to these 11 patients by considering only one of the three parameters that you cited as a way to determine whether her skills were adequate, correct?

A. That is correct as stated, but the answer was not correct -- not complete.

Q. And you didn't evaluate her for her skill

level as a practice -- that is, Doctor Neuhaus as a practicing physician as a obstetrics and gynecologist person, correct -- practitioner?

A. I'm sorry. Can you repeat that again?

Q. You -- you didn't evaluate Doctor Neuhaus' skills as -- as an OB/GYN, did you?

A. No, I did not.

Q. And do you -- you agree that physicians who practice in obstetrics and gynecology do provide mental health evaluations for pregnant women, correct?

A. At times, they do.

Q. And so you would agree that it's within the scope of an OB/GYN's skills to counsel patients about mental health issues related to pregnancy, correct?

A. It -- it can be.

Q. The -- all the -- the patient charts that you reviewed came from 2003, correct?

A. Correct.

Q. Do you happen to recall how many times Doctor Neuhaus went to Women's Health Care Services in Wichita to do consultations in 2003?

A. From her testimony?

Q. Yes, or whatever source, but I presume

it's from her testimony.

A. Yes. I think she said 40 to 50 times and I think people pretty much settled it at approximately once a week, and there may have been some weeks she didn't go.

Q. And that at each time that she went there on the average, she would evaluate five or six patients? Again, on the average.

A. I thought it said seven or eight, but that's --

Q. Okay.

A. -- we're in the ballpark.

Q. All right. Now, you -- it's your position that there is really not a justifiable abortion based on the preservation of the mental health of the mother, except in extreme circumstances, correct?

A. I'm sorry.

MR. HAYS: Asked and answered.

PRESIDING OFFICER: I --

MR. HAYS: It's been a while back, but he already went through this.

MR. EYE: I -- I don't think we got into the circumstances that she would -- that she would make such a recommendation. I don't think I -- I

think I carved that part out.

PRESIDING OFFICER: Overruled.

A. I'm sorry. Could you ask the question again?

BY MR. EYE:

Q. Sure. It's your position that there's really not a justification to an -- to do an abortion based on preservation of the mental health of the mother, correct?

A. Again, there would have -- have to be extreme circumstances.

Q. Now, that's -- that's your view as a psychiatrist, correct?

A. I am a psychiatrist and that is my view.

Q. But it's ultimately the female's choice or in consultation with her physician, and if it's the case of a minor, with her parent or guardian, correct, whether to have that procedure?

A. If she's legally entitled to it, she, you know -- for whatever reason, if she's legally entitled, she should be able to have it.

Q. And it's just not something you personally recommend?

A. As --

Q. Ever?

A. -- as an intervention or treatment for a psychiatric disorder, no.

Q. Nor to preserve the mental health of the mother, correct?

A. Well, you would have to define that on a case-by-case basis as to what exactly the intervention would be pre -- be averting or creating. What does preserving the mental health mean? And that is going to be very specific on a case-by-case basis. So --

Q. So case-by-case is -- is -- is your -- is your testimony, that you'd have to evaluate these on a case-by-case basis?

A. You -- you -- yes.

Q. Do you remember your deposition testimony in response to this question? So is it your position that there really is not a justifiable abortion based on preservation of mental health of the mother? Your answer, no, there has can be some extreme circumstances, but they would be really extreme. For example, someone -- someone who is acutely suicidal who might be saying, you know, if I have this baby, then I will kill myself, period. Then you continue, now, to me as a psychiatrist, that would call for psychiatric

hospitalization, not necessarily for 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. Then you continue, so I can't think of too many. You say, then, 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. Do you remember that testimony?

A. Yes.

Q. So that's -- that sounds pretty categorical in terms of when you say you can't really think -- you can't really think of any psychiatric reason that would be justified to do a late-term abortion rather than hospitalization, correct?

A. The circumstances that I can think of as I was thinking through that answer, constitute a psychiatric emergency. I -- I can't think of any circumstances, absent a psychiatric emergency.

When someone has a psychiatric emergency, the typical intervention is to consider hospitalization. So as I try to think of circumstances which -- for which you would refer somebody for a late-term abortion to preserve their mental health, the first thing I come up with over and over again is psychiatric hospitalization. So, I -- I mean, I don't know how to answer it better than that.

Q. Yeah. How about this? That's really a choice of -- of treatment modalities, isn't it, between referring a patient for a late-term abortion or hospitalizing the patient, correct? That's a choice that --

A. For --

Q. -- that a physicians would -- would recommend or would posit to a patient?

A. No, I can't imagine.

Q. So not withstanding the fact that there's -- if you accept the premise that a woman has a constitutional right to a late-term abortion under certain circumstances, you wouldn't ever find it psychiatrically justified, correct?

A. No. I -- I would be willing to consider any given set of circumstances, I just can't think

of one. But if I were to evaluate someone and it became clear that the only intervention that would avert permanent harm or damage was an abortion, I would certainly think about that as an intervention. I just can't think of what those circumstances might be. I -- I'm not categorically denying that there might be some set of circumstances out there in the world.

Q. Because you're certainly not omniscient on this --

A. Correct.

Q. -- in this, correct? Okay.

MR. EYE: Your Honor, I apologize. I -- I've -- I've managed to lose my place and I'm -- I'm attempting to -- to track back and -- and find it. I -- and I apologize for the delay. I'll --

BY MR. EYE:

Q. Doctor, would you agree that an unwanted teenage pregnancy has the potential to cause harm to the female who's pregnant?

A. It's a -- it's a very broad term, harm. Can you --

Q. I -- I -- I just -- the -- the -- in -- in a general sense, would you agree that an unwanted teenage pregnancy has the potential to

harm the mother?

A. Any pregnancy has the potential to harm a mother, so, yes.

Q. Let's deal with the -- some of the evaluation techniques that were used on this -- on -- on many of the patients that -- that you reviewed the charts for in this case. Let's start with the -- the global assessment of functioning, the so-called GAF or GAF.

A. GAF.

Q. Okay. You use the GAF in your practice, don't you?

A. Yes, I do.

Q. And the GAF is not used in isolation, it's used as a -- as a part of other -- or as a part of evaluation techniques, correct?

A. Correct.

Q. Or assessment techniques?

A. Correct.

Q. Now, is the DSM that we've referred to -- or DSM-IV, does that axis system that you've described, does that set out a standard of care?

A. It informs a standard of care, it does not of itself create or set a standard of care.

Q. And it would be your opinion that the

standard of care for evaluating a patient for a late-term abortion can be satisfied without using the GAF, correct?

A. Correct. The standard of care for a psychiatric evaluation of any kind can be satisfied without using a GAF.

Q. And you recognize that there are physicians who do mental health evaluations who don't use the GAF at all, correct?

A. Yes, I -- I'm sure there are.

Q. And you testified about that in your deposition, correct?

A. Yes.

Q. And in terms of looking at the -- or using the -- the axes in DSM, one could arrive at a justifiable diagnosis by using only Axis I and II, correct?

A. I'm sorry. When you say justifiable diagnosis, can you --

Q. A -- a -- a diagnosis that's supportable?

A. A supportable diagnosis, you could.

Q. I'm sorry. What?

A. Yeah. I mean, you could. It would not -- depending on the circumstances that might or might not meet the standard of care, but you

could.

Q. And you could prescribe -- you could prescribe medicine for a psychiatric disorder or illness using only Axis I and II to arrive at a diagnosis, correct?

A. Well, you could, but that definitely might not meet the standard of care.

Q. But one could do that?

A. One can do anything, but it doesn't necessarily mean it's a good idea.

Q. But it would be within the standard of care?

A. It depends on the circumstances.

Q. And a practitioner could use Axes I, II and III and not do any further evaluation other than just what -- what would apply under those three axes, correct, and arrive at a supportable diagnosis?

A. Okay. Well, the axes are the conclusion, they are not the assessment tools. So that the way you're asking the question implies that you're only using Axis I, II -- or I, II and III. The way it works is, you do the evaluation and then you document your assessments using -- the assessments are your -- the diagnoses and the axes

are your conclusions and -- and often the support for those conclusions can be notated there. So the way you're asking the question assumes a process that doesn't actually happen.

Q. Well, in -- in terms of evaluating a patient from the perspective of Axes I, II and III, using whatever assessment techniques would be -- whatever techniques might be used to assess a patient for Axes I, II and III, one could do those assessments under those three axes and arrive at a supportable diagnosis, correct?

A. The evaluation doesn't preclude -- the evaluation is the same regardless of how many axes you fill out, it's just that some people don't bother or it's not necessarily relevant to use the other ones to describe a psychiatric disorder. But you could not, for example, get to a diagnostic conclusion about the presence of a psychiatric diagnosis without some assessment of functioning, even if you didn't actually document it with the GAF rating. So I'm not quite with you.

Q. I guess the point of my question is that irrespective of whether one makes an attribution to DSM, if the functional purposes that are

anticipated to be evaluated under those various axes, if they're done, even without saying, this is pursuant to DSM, that's really consistent with the standard of care, isn't it, in doing an evaluation for, in this case, a late-term abortion?

A. I'm sorry. I -- I don't understand your question.

Q. Well, let's move on. You agree that a distressing psychosocial situation can create a situation where a person could develop a psychiatric disorder, correct?

A. It's possible.

Q. In fact, you agree that life stressors can result in psychiatric disorders, correct?

A. Typically, they contribute, they can contribute to the development of the disorder. There are only certain disorders where there's a direct causal relationship. But they certainly can contribute to the develop -- development of disorders.

Q. And you would agree that an unwanted pregnancy could result in a psychiatric disorder, correct?

A. It could. A wanted pregnancy could

result in a psychiatric disorder.

Q. My question was: An unwanted pregnancy could result in a psychiatric disorder, correct?

A. Any disorder can, so any -- any pregnancy can result in a psychiatric disorder potentially, so, yes.

Q. But in your view, treatment of that psychiatric disorder is not -- it -- it would not be -- it would not be consistent, in your view, with standard of care for a late-term abortion to be performed because there's a psychiatric disorder that has had its genesis, its org -- its origin from an unwanted pregnancy, correct?

A. That is a -- an abortion of any kind, late term or not, is not a psychiatric treatment for any psychiatric disorder regardless of it's genesis. An abortion that resolves distress related to a pregnancy is a situational intervention for a situational problem, but not necessarily a psychiatric disorder.

Q. But it could be a psychiatric disorder --

A. It --

Q. -- that's being addressed?

A. Not by an abortion.

Q. So the fact that a -- a woman seeks an

abortion to preserve her mental health, if a practitioner agrees that that should be done, you would consider that to be outside the standard of care?

A. Again, I am open to considering circumstances on a case-by-case basis. I simply cannot think of the circumstances that would lead to that chain of events as you describe them.

Q. We deviated from the GAF for a moment, but let me resume that. Would you agree that the GF -- GAF has both objective and subjective data that are a -- a part of it?

A. Yes.

Q. Have you acquired any knowledge in the course of working on this case or any other source, for that matter, about how practitioners in Kansas utilize the GAF for purposes of assessing the mental health of a patient?

A. Not specific to Kansas, no. The -- the GAF is in the DSM. The DSM is the same DSM in Kansas as it is anywhere else.

Q. Would you agree that a physician can diagnose and treat a psychiatric disorder without relying on the DSM-IV for purposes of treating a patient?

A. Could you say that again?

Q. Sure. Would you agree that a -- a physician can make a diagnosis of a psychiatric disorder and treat, including prescribe drugs for that, without specifying that their diagnosis relates back to the DSM?

A. You mean without actually citing the DSM?

Q. Well, let's -- let's do that first, without actually citing the DSM?

A. Okay. You don't have -- you don't have to cite the DSM as a reference for every time you make a diagnosis, no.

Q. And, in fact, a -- a physician could, based upon subjective evaluation of a patient, arrive at a -- at a supportable diagnosis based on subjective factors, arrive at a diagnosis of a psychiatric disorder and treat it accordingly, correct, based on subjective data alone?

A. They could, but typically, that would be outside the standard of care.

Q. And it would be your position that that would have to be augmented by some sort of objective data, such as blood pressure and body temperature and vital signs, correct?

A. Well, in subjective data, it refers

primarily to what the person tells you and not to what is observable or reported or documented by other people. So for someone to come in and say, doctor, I'm depressed, and for that person to say, okay, based on you're what you're telling me, I diagnose a major depression and prescribe a medication, that would not be a psychiatric evaluation or a supportable diagnosis and should not form the basis of treatment. That's subjective information only --

Q. Right. And --

A. -- without consideration of any other factors that might be contributing.

Q. So in your view, it would require at least some inquiry from the physician to the patient to essentially determine the nature of the symptoms to determine whether they are consistent with the diagnosis of, let's say, major depression?

A. Well, as a starting point, they would have to be consistent or -- they -- should be consistent for -- to come up with a diagnosis as a starting point.

Q. Is it your view that the standard of care is based on what the average practic -- what the

average skilled practitioner in the field does, whether it's in a general field or a specialized field, average care?

A. My understanding of the standard of care is that if you undertake a certain type of medical practice, that the standard of care is that you have to perform that practice with the degree and skill of a specialist if it's a specialized area of care.

Q. Do you remember testifying, quote, 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? Do you remember that testimony?

A. Yes, that is true.

Q. And you agree with that?

A. I do agree with that.

Q. The DTREE tool, for lack of a better description at this point, had you had any experience with it at all prior to this case?

A. No, I'd never seen it.

Q. And the DTREE, as I understand your description of it, has its origins or the authors

of the -- the DSM-IV have some -- have had some role in developing the DTREE as well, correct?

A. It appears so, yes.

Q. And you would consider that the authors of the DSM-IV are competent, I presume?

A. Yes.

Q. And so if they develop the DTREE as a diagnostic tool, does that affect your -- your opinion about its usefulness as a -- as a technique of analysis for mental health disorders?

A. The fact that they are the authors of it, does that affect my opinion of it?

Q. Yes.

A. No.

Q. And at any rate, you've never used the DTREE in your practice, correct?

A. No.

Q. It's a teaching tool -- and I think you described it as a teaching tool?

A. Well, it can be either used for teaching or as an mnemonic device to help people remember the kinds of questions they're supposed to ask.

Q. And in -- in that regard, as a mnemonic device, it does have the capacity then to cover parameters of information that would be useful in

arising at a diagnosis, correct?

A. Yes.

Q. And the -- the DTREE is an algorithm, correct?

A. Correct.

Q. And it can then be used to help rule out certain indications of a diagnosis, correct?

A. If -- if the -- if the answers are accurate to the yes or no questions.

Q. Accurate meaning truthful?

A. No, just accurate meaning correct.

Q. Accurate meaning correctly recorded by the practitioner as to the binary yes or no?

A. They have to be accurate, I don't know how else to say it. I mean, these are not really yes or -- I mean, the way they're put in there is as a yes or no question, but they're not really yes or no questions clinically. Because just to use a typical example, a question with the conjunction "or" in it is not ultimately a yes or no question except in the broadest sense.

Q. Your view is that a person that has a diagnosis of a psychiatric disorder should be treated with, for example, counseling?

A. Possibly.

Q. Medication?

A. Possibly.

Q. Psychosocial support?

A. Possibly.

Q. Is it your view that if the diagnosis that -- that is made that a -- a practitioner would make has in -- includes the consideration of carrying a pregnancy to term would have adverse consequences for the mother and so that an abortion would be recommended, is that a -- in that circumstance, would the -- would you view a late-term abortion as a reasonable intervention or as an appropriate intervention?

A. I'm sorry. Could you re --

Q. Sure. In the instance when a practitioner determines that the carrying -- that carrying a pregnancy to term would have an adverse effect -- let's be more specific -- would have an irreversible substantial adverse consequence to a mother's mental health, would you agree that in that circumstance, an abortion would be an appropriate and reasonable intervention?

A. If -- if who determined that?

Q. A practitioner, a -- a medical practitioner.

A. Again, it would depend on the circumstances and -- and the -- and the qualifications and the -- and the training, et cetera, of the practitioner. I mean, by virtue of -- of practice, that doesn't make one's recommendation necessarily reasonable. Again. It really depends on the circumstances. So it possibly -- it's possible.

Q. Is it your view that you don't believe that it is within a standard of care for psychiatrists in some instances to refer a patient for an abortion?

A. It's not within the standard of care for a psychiatrist to direct a patient to any course of action, whether it's an abortion, a divorce, a marriage, cosmetic surgery, anything.

Q. It's still up to the patient to choose, if the patient's competent to do so, correct?

A. Correct. It is the psychiatrist's obligation to help the patient think through and consider the options that are available to them. Those options might be an abortion, might include an abortion and the patient might choose to pursue that option. But to use one's standing as a doctor to recommend a life-altering action, a

wedding, marriage, divorce, giving up a child for adoption, having an abortion, undergoing an elective surgery, et cetera, it would be inappropriate to use your role as a care provider to influence someone in that way by saying, I'm referring you for an abortion, I'm referring you for cosmetic surgery, because you have an issue that you don't like the way your nose looks, I'm going to refer you for cosmetic surgery. You discuss what their issues are and what their options are and what they'd like to do about it and discuss the pros and cons of cosmetic surgery in the context of all the other options they might have.

Q. Let's not talk about other cosmetic surgeries, let's talk about abortions.

A. Oh, okay.

Q. You've never advised a patient that it would be medically recommended that an abortion would be a treatment option, correct?

A. Not for a psychiatric disorder.

Q. In other words, a mental health reason?

A. Correct. Mental health, meaning on the level of a psychiatric disorder and not on the level of a psychosocial or situational stress.

Q. Well, but we've already established that you agree that psychosocial stressors can -- can include an unwanted pregnancy, correct?

A. It can include a wanted pregnancy.

Q. We established -- my question is: It includes an unwanted pregnancy, correct?

A. A -- an -- an unwanted pregnancy is certainly almost by definition a psychosocial stressor.

Q. And a -- a psychosocial distress -- stressor can cause a psychiatric disorder, correct?

A. No. Typically, it can contribute to the development of a psychiatric disorder, except in -- except in, again, very unusual circumstances. I shouldn't say very unusual, but absent a direct -- a direct -- for example, a -- an assault by a parent, okay, that's a psychosocial stressor, but it also includes an assault, okay?

Q. Do you remember this testimony at your deposition? You said, quote, life stressors can result in psychiatric --

THE REPORTER: I'm sorry. Psychiatric?

BY MR. EYE:

Q. Sure. Quote, life stressors can result

in psychiatric disorders, and certainly an unwanted pregnancy could result in a psychiatric disorder, end quote. Do you remember that testimony?

A. Yes. And I -- I think I repeated it. It could.

Q. Let's talk a little bit about Patient 2 for -- at this point. Patient 2 is a 10-year-old girl, correct?

A. Is it okay if I --

Q. Oh, absolutely.

A. -- refer --

Q. Of course.

A. -- somewhere?

THE WITNESS: Would it be okay if we took a quick break before we dive in?

MR. EYE: Yeah, that's fine with me.

(THEREUPON, a recess was taken.)

BY MR. EYE:

Q. Doctor Gold, we -- just before we broke, we were looking at the characteristics of Patient 2. You would agree that Patient 2, at the time in 2003 when evaluated by Doctor Neuhaus, that Patient 2 was a 10-year-old and had been the victim of incest and rape, correct?

A. That is what her record indicated, yes.

Q. Speaking of records, digress for a moment. Do you know where these records that -- that you looked at for this case, where they originated?

A. Well, I got them from the Kansas board.

Q. Do --

A. Beyond that, I don't know their providence, so to speak.

Q. So you don't know how it came to pass that the -- the charts that you reviewed were selected?

A. No, I do not.

Q. Or how they were obtained by the Board of Healing Arts?

A. No, I don't know what their process is for obtaining records.

Q. Or anybody else who may have obtained these records properly or improperly, correct?

A. I -- I don't understand that last part.

Q. Yeah. Do you know whether there was any -- whether there were any improprieties associated with acquisition of these particular records that you've reviewed?

MR. HAYS: Objection, outside the scope

of direct.

MR. EYE: Well, we're dealing with -- we're dealing with records generally, so I think --

PRESIDING OFFICER: Overruled.

BY MR. EYE:

Q. Do you -- are you aware of any improprieties associated with these records as to how they came to be known to anybody outside the practitioners that were dealing with these patients?

A. No, I'm not aware of anything.

Q. Again, Patient 2. And I apologize for the -- for the break in that. Would you agree that -- that a 10-year-old carrying a pregnancy to term carries with it the risk of substantial and irreversible damage to that child's mental health?

A. I -- I cannot categorically agree to that, although I -- I mean, it's clearly a -- a horrifying situation. I cannot categorically agree that carrying the child to term causes irreversible and substantial harm to their mental health.

Q. With a 10-years-old?

A. Of -- if 10, 20, 40, 50.

Q. No, I'm just -- I'm just talking about the 10-year-old in this case.

A. Yes. Categorically, I cannot state that. There's a -- a high possibility, but I cannot absolutely cat -- is it a good thing? No. But that doesn't mean that it's the same thing as substantial and irreversible harm to their mental health.

Q. You would agree that a specific child could develop severe emotional problems from -- a 10-year-old child as a result of carrying a pregnancy to term, correct?

A. It's -- it's certainly possible.

Q. And you've never had an occasion to treat a 10-year-old pregnant girl, correct?

A. I would not undertake such a -- a patient. It requires a level of skill that -- and -- and clinical training that I don't have.

Q. But --

A. In this particular case, the rape and incest is -- is at least equally, if not more likely, to be damaging than the pregnancy, which adds a level of complexity to the evaluation and treatment of this patient, aside from her age.

Q. And the rape and -- and incest that

caused this 10-year-old girl to be pregnant, would there -- would that be a so-called gatekeeper incident or event?

A. It -- it could be, depending -- yes, I mean, it -- it could be, without question.

Q. And you would agree that -- that in some cases, a 10-year-old child carrying a pregnancy to term would cause substantial and irreversible harm to her mental health?

A. It's possible.

Q. I want to talk a little bit about the -- the MI and -- and again, sort of general terms here.

A. Okay.

Q. The purpose of the MI is to survey various categories of behaviors to determine whether any of those indicate that there might be abnormalities in a person's mental health, correct?

A. Well, I've never seen this MI screening previously, but my understanding of what this particular format is is that it is a screening tool that can be used in person or by phone by a member of Doctor Tiller's staff who is not a trained mental health professional to screen for

symptom -- for -- I shouldn't say symptoms -- for changes in emotional or behavioral functioning that could represent symptoms of a psychiatric disorder.

Q. And you would agree that -- that not necessarily in isolation, but in conjunction with other techniques of analysis, that the use of the SIGECAPSS -- again, it's an mnemonic device, but --

A. Correct.

Q. -- surveying those particular categories or parameters, that that would be within the standard of care to rely on that information to help form a diagnosis, correct?

A. Well, rely depends on one's own evaluation.

Q. In other words, if -- if the SIGECAPSS were used by the practitioner, and I -- and I'm -- I'm going to assume the SIGECAPSS was completed by one of the staff people -- that document is handed off or record is handed off to practitioner, Doctor Neuhaus, that that would be -- it would be within the standard of care for her to utilize that in conjunction with other methods to arrive at a supportable diagnosis, correct?

A. It could be, yes.

Q. And that's within the standard of care?

A. That could be, yes.

Q. And, in fact, the SIGECAPSS covers the minimum level of information that you would need to know to screen for depression, correct?

A. As a screening tool, yes.

Q. And then the practitioner can use the SIGECAPSS record as a means by which to conduct a face-to-face interview or evaluation?

A. Well, it -- one's own -- whether there was a SIGECAPSS or not, that information should be reviewed in a mental health evaluation anyway. But because one has some clues in terms of directions to follow, one would then expand upon the SIGECAPSS information in conjunction with all of the other information that you would get in an evaluation.

Q. Now, as I understand your testimony, a proper mental health evaluation would include a -- a -- obtaining or reviewing a history of a patient, correct?

A. Current and past history, yes.

Q. Right. Well, history assumes a retrospective view, correct?

A. Well, yes, but you can have a history of their current problems started last week and includes this, and then a past history, I had this problem once before two years ago. So there's a current history that's the problem under -- that -- that's brought that person in for treatment or evaluation and then there is their past history, and the two are not necessarily the same.

Q. All right. So a history broken down into --

A. Right.

Q. -- past and the history of any present presenting problems?

A. Correct.

Q. And it would require in addition to the history -- well, what -- in addition to the history, what would it require, Doctor?

A. The history, the psychosocial circumstances, family, social functioning, medical history, mental status examination, medical records or treatment records and information from care providers, which becomes increasingly -- which is critical in the evaluation of children and adolescents.

Q. And conceivably, all of that information

can be derived through a face-to-face interview?

A. I mean, potentially.

Q. Okay.

A. Again, one of the issues with evaluating children and adolescents is that their developmental levels often preclude getting the kind of good verbal information that you might need to form an opinion. They're often not the best describers, for a variety of reasons, of their own emotional state or mental history.

Q. So one would rely on the observations or information from an adult who had familiarity with the child?

A. One -- one might and one -- it -- it frequently does, and after assessing the agenda of the adult to the extent possible.

Q. And when you say assess the agenda of the adult, I presume you mean to -- to try to detect whether there are ulterior motives for presenting the child for an evaluation --

A. Correct.

Q. -- for abortion?

A. Cor -- well, presenting a child for any evaluation.

Q. But in this case, for an abortion?

A. In -- in --

Q. That's what we're talking about here, isn't it?

A. Yes, but -- yes, so it -- when I say ulterior, I don't mean ulterior motives in terms of something nefarious, but just parents sometimes have an agenda that's not always in the child's best interest, unfortunately, and you want to make sure that that's not necessarily the case. Or there are other problems going on and the child becomes an identified patient, as they say, when the problems are really elsewhere.

Q. So if a -- if a parent determines that it's in the child's best interest to obtain a therapeutic abortion based on a mental health evaluation that's been done, would you be deferential to the parent's choice in that regard, even though you don't consider it to be an appropriate intervention?

A. If peop -- if someone is legally entitled to an abortion, then whether they are children or adults, they are entitled to the abortion. And the reason -- if they're legally entitled, they're legally entitled, that's -- that's it. I -- I wouldn't have an opinion in such a case.

Q. No medical opinion at all?

A. I don't know about a medical opinion. There might be a medical opinion that -- in terms of psychiatric opinion --

Q. Okay. Psychiatric opinion?

A. Would I have -- okay -- I'm -- maybe I'm confused and don't understand the question. Could you repeat it?

Q. Would you be deferential to a parent who would choose to have an abortion performed for a minor child subsequent to a mental health evaluation that indicated that carrying the pregnancy to term might cause substantial and irreversible harm to the child's mental health? Even though you don't believe --

A. Would I be deferential --

Q. -- abortion is --

A. -- to the parent? I mean, it's ultimately, if -- if it's a minor child, then a decision is ultimately a parent's decision and I would have no -- they're the legal decision-maker. I don't understand about -- about the deferential part.

Q. Even though you might disagree with that choice?

A. It -- it's not a question of disagreeing with the choice. It's do -- my opinion would -- if I was involved psychiatrically in that case, which I would say typically, I would not be because such a case requires evaluation by a specialist in the evaluation of children, my opinion would be based on such an evaluation and if there are circumstances in that case that indicate that that's one of those extreme cases, then that -- my opinion might support that, might support a late-term abortion or an early abortion or whatever. But again, the -- these generic -- you know, an age by itself doesn't indicate anything, a diagnosis by itself doesn't indicate anything. You have to have the specific circumstances.

Q. That can frequently be drawn out during the face-to-face interview?

A. Often, not always. But, and, again, depending on the communication skills and the developmental level of the child or adolescent, but typically, you need somebody else.

Q. And -- and I think that you've testified and I think you would agree that -- that the face-to-face interview can yield a wealth of

information about a patient's mental health status, correct?

A. Correct.

Q. And the face-to-face interview is, in large measure, an exercise in subjectivity or -- or judging subjective parameters of -- of -- that the patient presents, correct?

A. Well, there's some subjectivity in -- involved in it, there's some objectivity involved in it. Someone -- just to use an extreme example, someone's not maintaining their personal hygiene, that, you know -- and you can smell, you know, body odor, et cetera, that would be, I think, an objective type of observation, an example of an objective type of face-to-face observation. If they can't sit still. There are -- there are certain objective elements to it.

Q. Of course, sitting still is -- is sort of in the eye of the beholder, isn't it? Some people would judge conduct as sitting still, others would -- would not, correct?

A. Well, yes, but if you're talking about a psychiatric evaluation, you're not just talking about necessarily someone whose more or less sitting still, you're talking about someone who's

agitated, has extreme psychomotor behavior, can't stop moving, tapping, et cetera. It's not -- it's not -- the observations are not supposed to be for subtle signs necessarily, that kind of stuff.

Q. Let's clarify the nomenclature here for just a moment. Do you use synonymously psychiatric evaluation and mental health evaluation?

A. Yes.

Q. And is it your view that a psychiatric evaluation is necessary under the standard of care in Kansas to justify a late-term abortion?

A. My understanding of the statute is that it -- it does not say that a psychiatric examination is necessary, that's the statute.

Q. In order to -- to meet the statutory requirements?

A. No, it's not necessary.

Q. All right. Let's -- let's go back to the mental health evaluation. During the -- a -- a clinical interview, there is no specific time that it -- that it must last in order to be considered within the standard of care, correct? I mean, there's no hard and fast rule that says a -- a clinical inter -- the clinical interview must have

a specific duration to be within the standard of care?

A. That is correct.

Q. And would you agree that some clinical interviews will be longer because of the complexity of issues or the -- the amount of information that's -- that's required to be covered in order to arrive at a diagnosis?

A. That would be correct.

Q. And some could be appreciatively shorter?

A. Within certain reasonable limits.

Q. And -- and you've never specified a minimum time that's required in order to do an -- an adequate clinical interview, correct?

A. Correct.

Q. And there is no specific time that's designated as a minimum for conducting a proper clinical interview, correct?

A. There is no specific numerical designation of a time, no.

Q. Thank you. In -- in terms of the history that is part of the medical -- or the -- the medical health evaluation rather, that would include a -- social characteristics, correct?

A. Correct.

Q. Pertinent medical considerations or medical history?

A. Correct.

Q. School or academic involvement if you're talking about a school-age girl?

A. Correct.

Q. Interactions with family members, is that part of the history?

A. Yes.

Q. And if it's a person who works, their occupational characteristics or their functioning in their occupation?

A. Yes.

Q. And there may be other categories, but those are representative of the kinds of things that -- that would be covered during the course of a typical mental health interview that's being done to cover the history of a patient?

A. That is correct.

Q. And the history really is broken down into medical and nonmedical, correct? In other words --

A. Broad --

Q. -- if certain -- and I'm sorry. Go ahead

A. -- broadly.

Q. All right. And then the fourth category would be a mental status evaluation, correct?

A. It's technically a mental status examination, but --

Q. Okay.

A. -- yes.

Q. Mental status examination.

A. Yes.

Q. And that's broken into two subparts, the psychiatric aspect and the cognitive aspect, is that --

A. More or less correct, yes.

Q. And it is the case that in terms of -- and I think we've already discussed that medical history is something that can be derived through the interview, correct?

A. Assuming that you have someone who can communicate that information.

Q. And because it's the case that physicians frequently do mental health interviews without the benefit of the -- of the -- all the medical records that are -- records that have ever been generated regarding a certain patient, correct?

A. That is correct.

MR. HAYS: Objection, assumes facts not

in evidence.

MR. EYE: I'm just asking in terms of the general, almost kind of a hypothetical, I suppose.

PRESIDING OFFICER: Overruled.

BY MR. EYE:

Q. That's the case, isn't it?

A. That is the case. Depending on the evaluation and what the evaluation is going to be used for, the standard of care may require at least an attempt to access those records, even if that attempt is unsuccessful.

Q. Otherwise, it's permissible to rely upon the verbal recapitulation of a patient's medical history in order to complete the mental health evaluation?

A. It depends on the quality of -- of the -- of the clinical information you're getting. If you're just not getting the information you need, then, no, it would be below the standard of care to rely on it exclusively.

Q. Now, in terms of the mental status evaluation -- or examination -- I'm sorry --

A. Yes.

Q. -- mental status examination, the -- the psychiatric aspect of that, is that part of the

face-to-face interview process that one can -- can do the psychiatric aspect of that mental status evaluation during a face-to-face interview?

A. Yes.

Q. And likewise, with the cognitive aspect, isn't that something that can be covered during the face-to-face interview?

A. Yes.

Q. Because the cognitive aspect would include questions regarding whether a patient is oriented times three, correct?

A. That's one question that's asked.

Q. And orientation times three means what?

A. That they know their name, their date and -- name, date and where they are, I believe.

Q. And that could be derived pretty quickly in terms of understanding whether the -- the patient is cognizant of their current place and time and -- and their identity, correct?

A. Correct.

Q. And if the cognitive function that the physician observes, Doctor Neuhaus observes, is -- does not reflect any abnormalities, there would not be a necessity to document those negatives, correct?

A. I don't know that that's true. A -- a standard evaluation and documentation documents significant positive and negative findings. Again, when you're dealing with children and adolescents, because there's always going to be a question of their developmental level and stage, you need to document the positive finding that show their cognitive capacity, as well as what their cognitive impairments might be. Now -- now, orientation is pretty basic, but it also goes on to ask some other --

Q. Was it your testimony under direct that -- that you don't document negatives?

A. I don't think so. Negatives can be just as significant as positive findings.

Q. True. But in terms of determining that there was no -- in a particular patient, no cognitive impairments, would it be necessary to document -- to -- to use words to the effect, there were no cognitive impairments observed?

A. Right. But --

Q. That would be a co --

A. That would be adequate documentation assuming there was some evidence of a clinical evaluation that you could under -- you could

understand what that -- no -- no cognitive impairments is a conclusion. You need at least some data to understand how the physician arrived at that. So if you stopped at just orientation and the person could give you person, place and time, you could write, no cognitive impairments, but you haven't really done a full evaluation and the person reading the document would not know that.

Q. And you agreed, I think, earlier, that standard of care for mental health evaluation and exam -- or examination can be met in the absence of adequate documentation, correct?

A. Anything is possible and the absence of -- as they say, the absence of documentation isn't the documentation of absence, so, yes.

Q. Right.

A. People can do things and not write down that they did them.

Q. Correct. Thank you. It's permissible for Doctor Neuhaus in the course of doing mental health examinations, to rely upon the observations of other physicians of a particular patient that's being evaluated, correct?

A. It depends what you mean by rely upon.

Q. Re --

A. She can are rely upon them to inform her own evaluation, but she could not necessarily rely upon them as a sole basis for her diagnosis.

Q. Can she use them as a sort of a corroborative tool?

A. Yes.

Q. All right. So if in the course of doing a mental health evaluation, it would be permissible for Doctor Neuhaus to review, for example, Doctor Tiller's mental health evaluation and use that as a means by which to conduct at least part of the face-to-face interview?

A. One -- one would hope that if Doctor Tiller had done such an evaluation, that Doctor Neuhaus would be able to review it.

Q. Because that's part of the history, isn't it?

A. Well, it -- it's part of the record review and it's a recent evaluation from a -- a physician. And you want -- and that would be part of what you would want to review, yes.

Q. Okay. Doctor Gold, in -- in reviewing the statutes that you were provided, in terms of performing a -- an evaluation as to whether or not

a patient would qualify for a late-term abortion, that statute doesn't require that the evaluation be done by a psychiatrist, does it?

A. No, it does not. I don't think it specifies anything about evaluation, it only specifies a certain conclusion.

Q. And there's no specification as to how that conclusion is reached in the statute?

A. That is correct.

Q. From the perspective of an average prac -- practitioner that we were talking about earlier in terms of evaluating standard of care or establishing standard of care, an average practitioner, would you agree that practitioners, medical practitioners that are not psychiatrists make diagnoses of depression that are the product of a face-to-face interview with a patient?

A. I -- I'm not sure I understand the question.

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've specified that would be required in a mental health evaluation?

A. Yes.

Q. And would you -- do you know whether that's the practice in Kansas?

A. I would assume that it is. It's --

Q. And that's --

A. -- not uncommon among -- I'm sorry -- it's not uncommon among family practitioners, primary care practitioners, OB/GYNs.

Q. That aren't necessarily specialized in psychiatry?

A. That -- that is correct. They -- yes.

Q. And they can do that and still be within the standard of care?

A. Up to a point, yes. And the more complex the evaluation becomes and the less they adhere to established guidelines for those kinds of evaluations or for general psychiatric evaluations, the further away from standard of care they're running the risk of moving.

Q. But it -- it really is left up to the practitioner's clinical judgment during the course of the face-to-face interview to determine whether a patient -- whether a -- a --a diagnosis of a mental health problem is justified, correct?

A. I mean, if they're make -- if they're doing the assessment, then it is their -- they can

do their own assessment. And those categories of doctors and perhaps some others off -- will often do that.

Q. So it would be within the standard of care?

A. Again, it depends on the particular evaluation. The more complicated the patient is, the more the standard of care -- you know, standard of care also requires that you don't treat things that you're not qualified to treat. And that's broadly pretty much everywhere and there are exceptions for things like if you're the only doctor within, you know, 1,200 miles, you may be called upon to do things that a specialist would do if that person -- patient were in an urban area and had easy access to an emergency room. But absent resource issues, the standard of care typically requires that if you're not qualified or trained or have the expertise to treat something, you refer it to somebody who does. Okay? So something that's relatively simple and straightforward, you could do an assessment and not be outside the standard of care. And something that's very, very, complicated would almost de facto put you outside

the said -- standard of care if it requires an expertise that you don't have and you don't refer it.

Q. Doctor, what is your -- it -- it -- it is the case that patients that Doctor Neuhaus evaluated, the 11 patients that -- whose charts that you reviewed, they were there to determine whether or not they could obtain a late-term abortion, correct?

A. They were where?

Q. At the -- at -- at -- present in front of her at Women's Health Care Services in Wichita?

A. The -- my understanding was that they were there in order for Doctor Neuhaus to provide a second opinion regarding whether they would suffer -- suffer substantial and irreversible harm to a major organ.

Q. So that was a -- that -- that's a fairly specific kind of objective in terms of the evaluations that Doctor Neuhaus was doing, correct?

A. Correct.

Q. And you do evaluations for things like disability, correct?

A. Correct.

Q. You do evaluations as far as determining whether somebody's competent to stand trial, correct?

A. Correct.

Q. And those are fairly focused kinds of evaluations, the disability and competency, correct?

A. Sometimes.

Q. Yeah. I mean, you go into it with the idea of you're judging a patient -- or not necessarily a patient --

A. Yes.

Q. -- but a person to determine whether or not they have or don't have a disability, for instance?

A. Well, based on a psychiatric problem. So determining -- people can have impaired functioning or lack competency for all kinds of reasons. My job is to determine whether those reasons are psychiatric. And if they're not, to say, gee, move on to something else.

Q. Would it be the case that you use the same evaluation techniques to determine the competency of a person to stand trial as you would to determine whether somebody has a disability

related to a psychiatric disorder?

A. To some degree, but of course, it's not exactly the same.

Q. There are some overlaps, but there are some distinctions as well, correct?

A. That is correct.

Q. And would it be the case -- although you've never done a mental health examination for purposes of determining whether a -- carrying a pregnancy to term would cause a substantial and irreversible harm to a -- a female's mental health, would it be reasonable to expect that that kind of evaluation might have some common ground with other kinds of mental evaluations -- or examinations rather, but would also have some specific characteristics?

A. Yes.

Q. Although you've never done them?

A. Yes. I -- any evaluation is tailored to the circumstances of the evaluation, particularly a consultation.

Q. And you've never received any training about how to conduct an -- a mental health examination for a woman who -- or for a female rather, whose pregnancy carried to term might

cause substantial and irreversible harm, correct?

A. No.

Q. You've never been trained on that?

A. I -- I -- I don't know anyone whose ever been trained on that.

Q. You've never consulted with -- you never knew Doctor Tiller, of course, did you?

A. No, I did not.

Q. And you didn't review any of the materials that he developed in the course of his practice to help provide some guidance in that regard, correct?

A. That is correct.

Q. And you've never consulted an attorney, for example, to determine exactly what would be required under a standard of care to make a -- a justifiable conclusion regarding whether carrying a pregnancy to term would cause substantial and irreversible harm to a female's health, correct?

MR. HAYS: Objection, relevant -- relevance.

MR. EYE: Goes to the basis of her knowledge.

PRESIDING OFFICER: Overruled.

A. No, I've never consulted an attorney for

that reason.

MR. EYE: Your Honor, this is probably as good a time to break as any for -- for me, at least.

PRESIDING OFFICER: Okay.

(THEREUPON, a recess was taken.)

BY MR. EYE:

Q. Doctor, a -- a couple of items that I'd like to talk -- ask you about concerning Doctor Tiller's mental health examination that he did and that you testified about -- or -- or some of the ones that he did you testified about. It was your opinion that the ones that you at least were asked about, met the standard of care, correct?

A. Yes.

Q. Okay. And the -- the standard of care in terms of those meant the -- the recordation, the documentation of the -- the mental health examination. Does that include determining the duration of the examination, duration of time?

A. Not specifically.

Q. Okay. Because it's the case that Doctor Tiller's don't specify the duration of time that those mental health examinations that he did required, correct?

A. That is correct.

Q. So any inference that there's a requirement for documentation purposes that it include the duration of time that a mental health examination took is not part of the standard of care, correct?

A. No.

Q. So it is part of the standard of care?

A. I'm sorry.

Q. I -- let me start over. It -- you said that Doctor Tiller's examinations, mental health examinations met the standard of care, correct?

A. Correct.

Q. And you could go back and look at the ones you testified about, but my review of them indicated that they did not include a specification as to the duration of time that the mental health examination required.

A. That is -- that is also my recollection.

Q. Right. And yet, in spite of the absence of that, that report -- or his reports, I should say, met standard of care?

A. Yes.

Q. So would we -- we infer from that, that there is no standard of care requirement that

there be a documentation as to the duration of time that a mental health examination requires?

A. No. There -- there's a requirement as to content, which implies that enough time has to be given to obtain that content, but it doesn't specify how much time it's going to be because that's obviously going to differ.

Q. My question was though as far as the documentation is concerned, not necessarily that there's a preconceived idea that, you know, a -- a mental health examination takes a particular amount of time. My question's about the documentation aspect of it. You don't have to record the duration of time that the mental health exam took in order to meet standard of care for documentation, correct?

A. No. Not -- not if the content reflects that an adequate examination was undertaken. In -- in response to your previous question, for example, if someone documents that they spent an hour evaluating the patient, but then doesn't document specific clinical information, there is at least an inference that's -- that they spent that time talking about clinical information.

Q. An inference that they did take that time

or that they spent the time speaking about clinical information?

A. That's correct.

Q. Okay.

A. But if there is --

THE REPORTER: Hold on. If they spent the time speaking?

BY MR. EYE:

Q. -- about clinical information?

A. Right. But if there's no specific clinical information and no documentation about the amount of time spent with the patient, then there's no way even to tell that an actual clinical evaluation occurred.

Q. Well, there's a difference between whether one occurred and the duration that -- that one required, correct?

A. Correct.

Q. Okay. And I -- I'm -- I'm not dealing with whether one occurred or not, I'm dealing simply with the standard of care required to documenting the duration of time that these exams took.

A. Okay.

Q. And there is no standard of care to

record the dur -- duration of time that these exams took, because Doctor Tiller didn't do that?

A. No.

Q. And yet, you found his to be within the standard of care?

A. Correct.

Q. In terms of the process that was used in Doctor Tiller's office to evaluate parents -- parents -- patients for purposes of -- of abortions, is it your understanding that the -- that the intake was handled by nonmental health trained staff?

A. Yes.

Q. Is it also your understanding that they were directed to ask the questions from the SIGECAPSS and then record the responses that they got from patients or patients' guardians and parents?

A. Well, the outline indicator also had some other questions on it besides the SIGECAPSS, but it's my impression, understanding that they were basically directed to ask these questions and record the answers.

Q. Was it your understanding that they were required to record the answers verbatim or as

close to verbatim as they could get it?

A. That, I don't have an understanding.

Q. And to the extent that this was the routine that Tiller's staff engaged as far as asking those questions and then writing down responses in a verbatim way, is -- is reliance on the MI and the SIGECAPSS reasonable to use as a part of a mental health examination?

A. At -- yes, as -- as a document to review and draw your attention to areas that need further elucidation.

Q. Let's talk a little bit about the aftercare aspect of your opinions. Is -- is it your opinion that in order to meet after -- in order to meet standard of care, that Doctor Neuhaus was required to make referrals to other health care providers when she concluded that there was a mental health diagnosis or a mental health-based diagnosis?

A. Not necessarily.

Q. So it was a judgment call as to whether there would be a recommendation for follow-up by Doctor Neuhaus?

A. No. If one is diagnosing a psychiatric disorder, and especially if there is a question of

it being something of a urgent, emergent or crisis issue, it -- which it is if the con -- if the idea of suicide arises, then even as a consultant, one is obligated to make certain that somebody is following up. Now, that may not require a specific referral to a specific counselor, but there has to be some follow-up of the psychiatric care.

Q. Now, when your deposition was taken back in June of this year, I believe you testified that you were not familiar with the WHCS aftercare provisions?

A. WH --

Q. Women's Healthcare Services, the -- the -- the George Tiller clinic.

A. I was not.

Q. Have you familiarized yourself with any of -- with anything related to the Women's Healthcare Services process or procedures for follow-up care since your deposition?

A. And when we're talking about follow-up care, we're talking -- I'm referring to follow-up psychiatric care.

Q. I'm -- I'm -- my question is -- right now is generalized to any follow-up care.

A. Okay. There -- there is in some of Doctor Tiller's records, a form that discusses aftercare for the patients. And usually, that is -- or -- or when that form is present, that's exclusively OB/GYN care follow-up for the abortion. So there is nothing in Doctor Tiller's charts about follow-up psychiatric care.

Q. Is -- is -- is it your understanding that in the -- in the hierarchy of treatment as related to the 11 patients that -- whose charts you reviewed, that Doctor Tiller would have been the primary caregiver or primary treater in that circumstance?

A. Not really, because he's a -- he is not going to be following -- he's performing the procedure, so he's the primary caregiver for that.

Q. And that's what I was referring to.

A. For -- for the procedure.

Q. Right.

A. But not necessarily the primary caregiver for these young ladies, some of whom come from other parts of the country and --

Q. The world?

A. Yes.

Q. Right. But as to Doctor Neuhaus and

Doctor Tiller, Doctor Tiller was the primary treater of those -- of -- of those two physicians?

A. That would be correct. However, the standard of care would still require that the consultant advise, ensure, particularly if it's a question of life and death, suicide, that there is going to be some follow-up care. You can't simply send a patient back to someone and say, I think there's a risk of suicide and not ensure that something is going -- somebody -- some professional is going to be following up on that, and it could be Doctor Tiller and it could be somebody else.

Q. Do you know of any process or procedure that was in place that would have put the burden for follow-up care, of whatever variety, on Doctor Tiller rather than the consulting physician, Doctor Neuhaus?

A. Well, the burden would have been on -- on both of them. The burden of one doesn't obviate the burden of -- doesn't remove the burden from the other one. They both, as doctors of someone with a potential life and death situation are required to ensure that the appropriate steps are taken. Now, Doctor Neuhaus' obligation may only

have extended to ensuring that Doctor Tiller was going to follow up on it.

Q. Right.

A. But she still had an obligation.

Q. That -- that was the essence of my question, is it --

A. Okay.

Q. -- is it -- is that something that can be, on a collaborative basis essentially, Doctor Tiller's responsibility by agreement or by process and practice as it developed within his clinic?

A. It -- it could.

Q. All right.

A. But again, it -- it would have to be -- it could not be implicit. That would not meet the standard of care. It -- it would have to be explicit.

Q. Does the fact that Doctor Tiller's clinic had a form that was specific to each patient that related to follow-up care be indicative --

MR. HAYS: Objection, facts not in evidence.

MR. EYE: Well, his records are in evidence and it includes follow-up care.

MR. HAYS: In what form are you talking

about?

MR. EYE: Well, there's -- there are forms in his records that indicate follow-up care.

PRESIDING OFFICER: Did she testify that she saw them?

MR. EYE: Right.

PRESIDING OFFICER: Doctor, did I misunderstand your testimony?

A. Yes. There -- there's a one-page form that says aftercare.

BY MR. EYE:

Q. Is that indicative to you of Doctor Tiller's clinic realizing that the provision for aftercare was something that they would be responsible for? Is that a manifestation of that obligation?

A. I can't really -- it's not psychiatric aftercare, so I don't know if there's a division of labor. There can be after -- you know, again, it just is -- generally says aftercare and it's focused on the surgery, so clearly, they felt an obligation to do that. I don't know if you could extend that to include an obligation to -- for aftercare for the psychiatric problems since that's not addressed.

Q. Did it -- did it exclude psychiatric aftercare in the -- as -- as a matter of the after -- the follow-up care?

A. What do you mean by exclude?

Q. Did it explicitly say that this does not in -- cover psychiatric care or mental health?

A. No, but it excluded it by omission. I mean, it didn't say, we're not going to do it and so someone else has to do it. It said -- it just simply didn't address it, which doesn't tell you whether they understood what their obligation was or not.

Q. If the Women's Healthcare Services staff or Doctor Tiller, for that matter, didn't follow-up on aftercare, you know, for mental health purposes, it -- and they were the -- the office that was responsible for follow-up care in a global sense for these patients, wouldn't it be reasonable for Doctor Neuhaus to rely on Women's Healthcare Services to do referrals or follow-up care as necessary?

A. It depends on the case and the circumstances. When you have a question of suicide, it is not the standard of care to assume that somebody else is going to take care of it.

Q. All right.

A. Even as a consultant.

Q. Let's talk a little bit about the -- you would agree that the term "mental harm" is a nebulous concept, correct?

A. Correct.

Q. And that mental harm is, essentially, a lay person's term, correct?

A. Yes.

Q. But it has -- and when you use -- or when you hear the term mental harm, you have a -- a constellation of things that it would include, correct?

A. Correct.

Q. And that that would include an impact or -- or symptoms that would have a significant impact on life combined with -- or strike that. It would have a significant impact on life and it could be the basis for a psychiatric disorder, that is, what is commonly nermed -- termed in the lay world as a mental harm?

MR. HAYS: Objection compound.

BY MR. EYE:

Q. Could that also refer to a psychiatric disorder, mental harm?

A. Yes. I -- I assume as -- in the same way that the term "nervous breakdown" can refer. It -- it's -- it is very nebulous.

Q. All right.

A. It certainly encompasses, I think, to the lay understanding, more than the presence of a psychiatric diagnosis.

Q. And whether a person -- whether a -- female qualified for a late-term abortion because it could -- because carrying a pregnancy to term could carry substantial and irreversible consequences to the health of the woman -- strike that. I'm not -- I've forgot exactly where I was going with that question, so never mind. Would you agree then that there is a role for subjectivity in doing these mental health examinations?

A. To some degree, there is, yes.

Q. And that it is also the case that social factors can play a role in determining whether a diagnosis of a -- of a mental health problem exists, correct?

A. That is correct.

Q. And that to a certain extent, even statistical probabilities of -- of -- that bear on

a particular patient situation can inform a diagnosis?

A. Up to a point, yes.

Q. You testified in relation to Patient 7 that you did not have a basis to -- to disagree with the GAF score of 15. Do you remember that testimony?

A. Not specifically.

Q. Well, yeah, it's patient-

A. Oh.

Q. -- Patient 7.

A. Okay. I'm on 8, so this would be -- okay.

Q. Do you have a basis to disagree with the GAF of 15 in the case of Patient 7?

A. There's no specific clinical data for me to agree or disagree with the GAF gathered by Doctor Neuhaus --

Q. And --

A. - in the assignment of this --

Q. Sorry.

A. -- number.

Q. And would -- would that be your testimony as to all the GAF scores that you looked at for these patients? I guess there would be 10 of

them.

A. Well, there's -- yes, there's 10 of them. I would think so. And without going through each one specifically, broadly, I would say, yes. As a general rule, there is no data collected by Doctor Neuhaus to indicate how she arrived at her conclusion of the GAF rating scale.

Q. At least no data that are -- that are reported?

A. In the record, that is correct.

Q. Those data may have been gathered, but they are not reported?

A. That -- that's always a possibility.

Q. And would the same -- would the same hold true for the DTREE process?

A. To the extent that -- well, yes, it would -- it would hold true.

Q. Okay. Is the -- in relation to Patient 8, as I recall your testimony, that there was some indication in the MI -- and I'll let you get to that.

A. Yeah, I'm there.

Q. -- in the MI, that there was a -- that the patient disclosed enough information to indicate that there was the potential for harming

herself or the baby if -- if the pregnancy was carried to term, correct?

A. That is correct.

Q. Is that information, that she would harm herself or possibly the baby, that's clinically subjective, correct?

A. Certainly, yes.

Q. And it's something that you would take seriously?

A. Yes.

Q. And it's indicative of a patient who is extremely distressed, isn't that a fair --

A. That would be a fair statement.

Q. And that -- is -- is it also fair to extrapolate from that that the distress has its origins in the unwanted pregnancy?

A. Well, it certainly would appear so and you'd probably be right, but it -- it could be something else and you wouldn't know unless you dug around.

Q. And that digging around is what may happen during the course of the face-to-face interview or evaluation?

A. Correct.

Q. Between physician and patient?

A. Correct.

MR. EYE: May I, Your Honor?

PRESIDING OFFICER: (Nods head.)

BY MR. EYE:

Q. Once a clinician understands in the case of Patient 8 that there -- that there is fairly specific suicide thoughts or ideation, I guess is the proper term, would that be sufficient to conclude that there was a mental health disorder with the patient as it was pre -- as the patient was presented that day?

A. It would be enough to conclude that there was a -- no, is -- is the answer, as unlikely as that sounds.

Q. So that by itself, in your judgment, would not be sufficient to conclude that continuation of the pregnancy to term might have a substantial and irreverse -- irreversible harmful consequence to the patient?

A. That is correct. Tomorrow, she might feel differently.

Q. Is it your -- is it your view that the mental health examination that Doctor Neuhaus performed for the patients that -- whose charts you reviewed was to determine treatment

alternatives?

A. I'm not -- I'm not sure I understand the question.

Q. Is it your understanding that when patients consulted with Doctor Neuhaus, that her purpose was to determine treatment alternatives for whatever problems might be presented to -- to her from a patient?

A. My -- well, my -- patients -- doc -- my understanding is Doctor Tiller referred patients to Doctor Neuhaus for the evaluation of whether there would be significant and irreversible harm on the basis of mental harm, psychiatric disorder, whatever term the statute -- you -- you know, irreversible harm of a major body organ. In this particular case, the implicit or explicit object of that evaluation was the mental health.

Q. So I --

A. So -- so the answer to the question is that it -- it was an eval -- it was a mental health evaluation in terms of severity and permanence of a mental harm. It's -- it's hard to understand how a mental harm would be severe -- is significant and irreversible if it didn't rise to the level of a psychiatric disorder. If it's a

psychiatric disorder and it's an urgent matter, then treatment alternatives would not necessarily be part of that evaluation. But if it's an urgent or emergent matter, again, the standard of care requires that there be an intervention directed towards that urgent or emergent matter.

Q. And the nature of that intervention could range from -- or could include -- not necessarily would range, but could include hospitalization?

A. Yes.

Q. Pharmaceuticals, drugs could be part of that intervention?

A. Possibly.

Q. Psychotherapy?

A. Possibly.

Q. Could be abortion? You don't think so?

A. I -- I don't think so, no. It's not a treatment for a psychiatric disorder or an intervention for a psychiatric disorder. And it could include referral to a specialist, a child and adolescent eval -- mental health specialist to further elucidate the nature of the -- of the problem. I mean, there could -- again, there could be circumstances. There was nothing I saw in the 11 charts that I evaluated that indicated

that a late-term abortion would be a treatment for a diagnosis of major depression or acute stress disorder.

Q. But you went into the evaluation of these charts with the idea that -- that abortion wouldn't be a treatment in -- in -- in any event, correct, except in the -- kind of the outlier situation where you get --

A. Well, based on my clinical training and experience in the diagnosis and treatment of psychiatric disorders, generally, in psychiatric disorders in pregnancy, the medical standard of care generally does not acknowledge that abortion is a treatment for any psychiatric disorder, it's just more intervention, except under extraordinary circumstances.

Q. And so if a woman chooses to get an abortion after going through the mental health evaluation process, if she chooses to -- or a female chooses to get an abortion, it would not necessarily have to comport with or -- or hurt -- her condition would not necessarily have to be such that it would require intervention by another healthcare provider, a follow-up? In other words, she could still get the abortion without the

necessity of -- of other kinds of intervention?

A. You've lost me. I'm sorry.

Q. A woman could still get an -- after going through the evaluation process and determined to be qualified to -- to get an abortion --

A. Competent to agree.

Q. -- competent to agree, meets the requirements that --

A. Right.

Q. -- that -- that are set out in -- in the records and so forth, and the abortion occurs, there's not a, per se, requirement that would have that woman necessarily be followed up by another physician, correct?

A. Followed up for what?

Q. For anything?

A. The woman herself -- the patient is not required to do anything. It's the physicians who are required to do something. So the burden of -- of action, so to speak, is on the physicians providing care, not on the patient. Any patient can choose to do or not do anything they want to do, regardless of how many doctors recommend that they do it, you know, that they follow certain health procedures. So if you have a woman --

let's take the mental health out of it -- who has an abortion and the doctor says to her, you really should -- you know, you're going back home, you're going to be somewhere else, you should see your regular OB/GYN two weeks from now to follow up to make sure that, you know, everything's okay, there's nothing that says that she has to do that, that's her choice.

Q. All right?

A. You know. But the physician has to tell her to do it. There is a burden on the physician to provide guidance regarding aftercare treatment. And to ensure that if she chooses to avail herself of it, that aftercare treatment is available to her.

Q. Is there any assumption about capacity to -- to be able to afford that aftercare treatment?

A. Not in the standard of care, no.

Q. Because you dealt with -- or you covered some charts of people I think we -- your testimony was that they were obviously -- I mean, you know, in sort of an objective sense, pretty poverty-stricken.

A. There was one chart, yes, where that was clearly a consideration.

Q. So follow-up care in that instance would have been problematic in terms of being able to afford it absence of some sort of state support or -- or state payment of -- for that care?

A. That, I could not answer directly. Whether the patient can afford it or not, again, doesn't relieve the physician of taking the appropriate steps regarding aftercare.

Q. Now, you used the term a little while ago, emergent situation or emergent condition. Would that be, in your judgment, if a patient presented with an emergent condition, that that would justify a late-term abortion based on mental health reasons?

A. It's possible. Again, the -- the -- I -- the circum -- the mental health circumstances that would create a situation of significant and irreversible harm, I -- again, I can't -- I have not been able to come up with those cir -- those circumstances. That may be a failure of imagination on my part. I would like to believe that I could recognize them when I see them.

Q. But you don't really have any experience in that anyway, do you, in terms of evaluating women for abortions?

A. No, I don't have any -- it's -- it's -- it's not a -- a real life event in the practice of psychiatry.

Q. Well, it's a real life event in the -- the patients who went to Women's Healthcare Services in Wichita, correct, to be evaluated for an abortion, correct?

A. It was a real life event to be evaluated for significant and irreversible harm of a major body organ -- or a body organ, but it didn't specify that it was mental or brain or neurological.

Q. Well, if -- if it's a case that a -- that that has been -- that statute has been interpreted by -- including the United States Supreme Court to include preservation of the mental health of a woman, would that be enough to --

MR. HAYS: Objection, facts not in evidence, and it's also not relevant.

MR. EYE: Well, the -- the facts are in evidence in terms of the statute that was provided to the -- to Doctor Gold.

PRESIDING OFFICER: Objection overruled. You better reask the question, I don't think the doctor followed it. I don't.

BY MR. EYE:

Q. Does the -- the reality that late-term abortions are available for mental health purposes, as the statute -- and I won't belabor the term again -- but as the statute K.S.A. 65-6703 specifies, is the fact that there's a legal right to that procedure to prevent permanent irreversible -- rather irreversible and substantial harm to the woman, does that matter to you from a medical standpoint?

A. Well, that's what I'm saying. I mean, I'm -- I -- I can't imagine that there could be circumstances where irreversible harm could occur, but it's not possible to say that there is irreversible harm absent treatment. So if you're talking about a psychiatric disorder or mental disorder, the standard treatments for those which have been found to be in many, many people effective, would imply that it's not a permanent or irreversible harm to develop depression or anxiety, or even a posttraumatic distress disorder, people recover from those.

Q. But it's the -- the patient's choice -- or the patient and their parent or guardian, in the case of a minor, it's their choice as to what

treatment modality to choose?

MR. HAYS: Objection, relevance.

MR. EYE: Well, we've been talking about --

PRESIDING OFFICER: Well, I -- I -- we plowed that field.

MR. EYE: May the witness answer that question, though?

PRESIDING OFFICER: She's answered it before.

MR. EYE: All right.

BY MR. EYE:

Q. In the case of Patient 11, Doctor Gold, you couldn't -- based on what you reviewed, you couldn't rule out a major depressive disorder, correct?

A. No, I could not rule out a major depressive disorder.

Q. And that was partly because you didn't evaluate the patient, correct?

A. I'm not sure how to answer that. I -- I -- that's not -- I mean, I suppose if I had evaluated the patient myself, I would have an opinion as to what diagnoses to rule in or rule out, but that's not the basis for my opinion, that

I couldn't rule it in or rule it out.

Q. I -- I -- I'm just asking the question. You couldn't rule it out based upon what you reviewed?

A. That is correct.

Q. Is it accurate to characterize the DTREE as a rule-out process or can -- can it be used as a rule-out process?

A. It -- it can be used as a diagnostic aid in a variety of ways.

Q. And -- and one of them is to rule out some --

A. Yes and no.

Q. It -- so, yes, it -- it --it can be used that --

A. It could be used that way. Again, it depends on the accuracy of the data that -- of the data that's being entered.

Q. Assuming the data are accurate, it could be used as a rule-out process, correct?

A. With medical certainty, within in a reasonable degree of medical certainty?

Q. Well, that kind of depends on, again, the data.

A. Yeah.

Q. Okay.

A. But I -- I -- I -- I have a -- it's -- I really don't think it can be used to rule in or rule anything out in and of itself regardless of the accuracy of the data.

Q. It -- it -- it's part of the overall -- it's part of the evaluation, it's not any one definitive part of the evaluation, it's just a -- one of the components of the evaluation?

A. The DTREE?

Q. The questions that are asked from the DTREE that -- that yield responses? I believe your testimony was that it could be used as an evaluation tool?

A. Tool, or an assist, yes. But that doesn't -- a tool or assist doesn't lead to a definitive rule-out of anything.

Q. No, but it's assists in -- it -- it's one way to get to a rule-out?

A. In the context of a broader evaluation, yes.

Q. Which the rule-out process, whether it's done using DTREE and other methods or GAF and other methods, that's another way of -- of arriving at a differential diagnosis, isn't it?

MR. HAYS: Objection, compound.

A. Well --

MR. EYE: Okay. I'll just go with it.

BY MR. EYE:

Q. Using the DTREE and other methods, like the face-to-face interview, is a way to arrive at a differential diagnosis, correct?

A. I would say that's correct. The object of any evaluation is to -- is to arrive at a differential diagnosis, what -- regardless of what tools you use.

Q. When you -- when you reviewed the -- the charts for purposes of writing your opinion, you kept track of your hours, didn't you?

A. I did.

Q. Okay. And that was so that you could bill for your services, correct?

A. That is correct.

Q. And there wasn't any other reason you kept track of your hours, was there?

A. No.

Q. And while I'm at it, what is your fee?

A. It's $400 an hour.

Q. Is that for anything that you do on the case?

A. Yes, anything and everything.

Q. I want to make sure I get some of these loose ends. You've never had any experience as an office practitioner in primary care, correct?

A. Not outside my medical school and internship, no.

Q. Same question for a family physician, which may be very close to the same thing --

A. Yeah.

Q. -- but just --

A. Yes. Medical school and internship.

Q. You've never been in an office to practice that on a day-to-day basis?

A. No.

Q. All right. And you've never practiced as an OB/GYN?

A. That is correct.

MR. EYE: Your Honor, may I have just a few moments to --

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

MR. EYE: That concludes my cross examination, Your Honor. Thank you, Doctor Gold.

THE WITNESS: Thank you.

PRESIDING OFFICER: Any redirect?

MR. HAYS: Yes, sir. And I'm just going --

REDIRECT EXAMINATION

BY MR. HAYS:

Q. Doctor Gold, for the review of the patient records for Doctor Neuhaus, could you tell us what her purpose was that was documented in there for doing that mental health evaluation for each patient?

A. No, I could not.

Q. Is there any reference to a referral for a late-term abortion located within those records?

A. In the MI Statements, sometimes there are references to obtaining an abortion and also references to how far along the pregnancy is. That's as close as it gets.

Q. What about any information documented within those patient records about her referring those patients to anyone?

A. There is no -- there is no information regarding referrals from Doctor Neuhaus to anyone.

Q. Now, for a re -- strike that. What is the difference between the mental health evaluation that is documented within Doctor Neuhaus' patient records and any other mental

health evaluation?

A. Any other? I mean, they all differ from each other to some degree.

Q. Are there basic requirements that need to be met in order to meet the standard of care?

A. Well, there are basic elements that should be present. They can vary -- in other words, it -- you don't need to have necessarily all of the elements that would comprise a -- a mental health evaluation present to indicate that the standard of care has been met, but you have to have at least some of them. And so it varies from doctor to doctor what they choose to document. The reason Doctor Neuhaus' failed to meet the standard of care is because, essentially, she doesn't have any of them. But Doctor Tiller's, for example, also don't have all the elements necessarily, but he has enough of them so that looking at his documentation, it would meet the standard of care. But it certainly doesn't have all of them that you would see in a fully, you know, comprehensive mental health evaluation, and it's not required to, to meet the standard of care.

Q. Now, would it be appropriate for a

psychiatrist to admit a patient for an abortion?

A. Patients who are admitted for abortions are usually admitted to an OB/GYN service through a medical doctor such as an OB/GYN or a general practitioner or a surgeon. Psychiatrists would never be in a position, again, absent any other resources, medical resources in the area of admitting a patient for a surgical procedure that -- again, just not --

Q. And is that why you have not admitted a patient for an abortion?

A. Yes. If I was an OB/GYN, I probably would have admitted a patient for an abortion. I'm a psychiatrist, psychiatrists don't do that, it's not part of their practice. So I've also never admitted a patient for an appendectomy or a brain tumor removal.

Q. Is there any indication within Doctor Neuhaus' patient records that she admitted these patients in for abortions?

A. That she?

Q. That she admitted these patients in for abortions?

A. Admitted them into a hospital?

Q. Or admitted them anywhere for an

abortion?

A. These are not admission records, no, there's no evidence of an admission for a medical procedure.

Q. Are any of patient -- are Doctor Neuhaus' patient records pertaining to mental health evaluations?

A. Where the records exist, they are pertaining to mental health evaluations.

Q. Now, let's talk about the standard of care just briefly. You spoke about the standard of care for the mental health evaluation being national. Why is that?

A. Because the resource -- because the training programs are nationally accredited and must meet national standards. Every training program has to meet the same standards to be accredited. They're all based on training and use of the DSM, which is a national and international resources -- resource. Board certifications are nationally administered examinations. There may be regional differences along the lines, for example, of having certain minority populations or cultural populations for whom slightly different -- or adaptations of the standard process may be

required. But, generally speaking, the elements of a mental health evaluation are relatively standardized across the United States at this point.

Q. And do you have an opinion as to whether Kansas would be different for any reason?

A. I know of no reason that Kansas would be different and -- and I would hope it wouldn't be unless there was a really good reason.

Q. Now, taking the standard of care out of the mental health evaluation portion and generally speaking about it, why would a standard of care be different in some other -- in one locality in comparison to another locality?

A. The primary reason these days is access to medical resources. So, for example, in an urban area, presumably, there are going to be specialists in various types of medical and surgical practice. If you go out to a very rural area, even in Kansas, that there might be -- not be an OB/GYN and babies might all be delivered by family practitioners, for example. But in rural areas, again, even in Kansas, there should be access to various kinds of medical specialists and practitioners. So presumably, there are

psychiatrists in Wichita and even child psychiatrists or psychologists if you want to use a psychologist or social workers in -- in Wichita who could, theoretically, perform these evaluations. Whereas, out in the middle of a very rural area, there might not a psychiatrist for, you know, hundreds of miles. So that would -- that would affect the standard of care.

Q. Now, you spoke about using the transcripts of the trial and also the inquisition. How did you use those transcripts in your review?

A. Well, I had already reviewed the records before I had read the testimony transcripts, but the testimony transcripts strengthened and -- and my opinions by deepening my understanding of the process that seemed to have occurred. Excuse me.

Q. And through those transcripts, what did you get a deeper understanding of?

A. Of -- of the -- of how an evaluation might be conducted when referred to Doctor Neuhaus from Doctor Tiller's clinic. So, based on Doctor Neuhaus' records and even on Doctor Tiller's records, how the referral came about and what kinds of evaluations were -- what the nature of the evaluations were was not a hundred percent

clear, the testimony made that much clearer, and also clarified the -- well, let me just stop there -- I'm going to just say it made it much clearer.

Q. Now, were you made aware of Doctor Neuhaus' training?

A. Yes, I was.

Q. And how did you become familiar with that?

A. I, at some point, reviewed Doctor Neuhaus' CV and I also read her testimony where she delineated her training in -- well, her -- her --her mental health training, the CV included all of her training.

Q. Now, how would you go about determining a doctor's qualification to perform a mental health evaluation?

MR. EYE: Objection, I think it's beyond the scope of cross.

MR. HAYS: I believe he went into the comparison of skills of a surgeon and mental health specialist and went down that road and had her actually try to make a difference between those two abilities and I believe he even asked her this very question.

MR. EYE: I -- I don't recall that, but

--

PRESIDING OFFICER: I don't recall it. Do you recall approximately when and where?

MR. HAYS: It was when he was doing the comparison of the skills of the surgeon and the mental health specialist. That's about as close as I can get now, Your Honor.

MR. EYE: I don't really remember him using a surgeon as a comparison, but --

PRESIDING OFFICER: I'm sorry. I -- I don't -- ask your question again. And, Mr. Eye, jump in if you need to.

MR. EYE: Okay.

BY MR. HAYS:

Q. How would you go about determining a doctor's qualification to perform a mental health evaluation?

MR. EYE: I'm going to object on the basis it's beyond the scope of cross.

PRESIDING OFFICER: How -- again, how do you claim that this is --

MR. HAYS: It's when he went into you either have to observe, talk to or review the records of the physicians to be able to determine how to evaluate how they -- how well they perform

their mental health.

PRESIDING OFFICER: That was her deposition testimony that she gave three things you do.

MR. HAYS: And he asked questions of -- based off that, correct?

PRESIDING OFFICER: And he -- and that she only did one of these things.

MR. HAYS: It was the -- the observe, speak to or review doc -- documentation.

PRESIDING OFFICER: And -- and then you're claiming Mr. Eye went where?

MR. HAYS: Well, that goes to how you would evaluate a performance of a physician's qualification of a mental health evaluation.

MR. EYE: No. Sir, the -- the genesis of that -- I'm sorry -- I don't -- the --

PRESIDING OFFICER: The objection is sustained.

MR. HAYS: Okay.

BY MR. HAYS:

Q. From your experience, what type of mental health evaluations do OB/GYNs perform?

A. Relatively basic evaluations. Generally, they will die -- evaluate and dying -- do an

evaluation to diagnose for depression and anxiety. And if they think there's anything else going on, they will refer for a consultation. Or if they begin treatment for those disorders and the patient doesn't respond or continues to have -- to -- or -- or worsens, again, they will refer to a psychiatrist.

Q. And why do they refer out?

A. Because generally, their training and expertise limits them to very basic mental health evaluation and treatment and they are not comfortable providing anything more in-depth. And if they feel their patient needs it -- needs something that's more complex than just the basic straightforward evaluation and treatment for depression and anxiety or they provide that and it's not yielding the desired results, then they refer out. They -- they just don't feel that they have the expertise and training to do it.

Q. Now, let's talk about Patient 2. What was Patient 2 diagnosed with?

A. Major depressive disorder, single episode, severe without psychotic features.

Q. And does that diagnosis have a gatekeeper requirement?

A. It does. You have to have one of the first two listed criterion in the DSM in order to make -- make this diagnosis for a major depressive episode.

Q. Let's look at that patient's MI Statement. Is there not one located within there?

A. I don't -- we're talking about Patient 2?

Q. Correct.

A. No, I don't see one.

Q. Okay. Let's talk about the MI Statements generally.

A. Okay.

Q. Was there any evidence of Doctor Neuhaus using those MI statements within her mental health evaluations for any of the patients?

A. Some of them had initials on them which I interpreted to be not Doctor Neuhaus' possibly, giving her the benefit of the doubt, since they were in what's purported to be her file. Which would indicate that she -- usually, when a doctor initials something, it means that they've read it.

Q. Do you know whether the initials, in fact, were Doctor Neuhaus'?

A. I do not, but I assume they were.

Q. Now, let's talk a little bit about

documentation. Why would you want to document the positive and also the negative implications or indications within a patient's record?

A. Because both positive and negative findings can be significant, so -- and can inform a diagnostic assessment and a -- and a -- treatment issues.

Q. Would it -- no, strike that. Can you tell me what ANO times three means to you?

A. Alert and oriented in -- to person, place and time.

Q. And how do doctors normally document that?

A. Well, again, it varies, but at a minimum, you see a notation ANO times three, and usually, it's in either handwriting or on a signed document. So the signature implies that -- that the evaluation was done. And if it's handwritten in, that implies that the evaluation was done. So you ask the person their name and what the date is and what the time is and --

Q. Is it usually documented --

THE REPORTER: I'm sorry. What was the end of that?

A. I'm sorry. Time of year or -- or

something along that line.

BY MR. HAYS:

Q. Is it usually documented if they were alert and oriented times three?

A. If you are formally documenting a mental status examination, then, yes, it is. If you're not formally documenting it, then not necessarily.

Q. Now, in the course of a mental health evaluation, how can a physician rely upon another physician's records?

A. Well, if they form an -- an element of the data that's being reviewed, it can figure in in a variety of ways. One is it can direct a physician to -- if there have been positive findings in the other physician's evaluation, it can direct the current physician to look for those problems and perhaps evaluate them further, expand upon them. If there are none, then it might be an indication that if the new physician -- or the current physician is finding problems, it's new, which isn't a significant piece of information. If the for -- physician's records document an evaluation and then also document treatment and now the new physician is evaluating it and the person's better, there's an implication that the

treatment was effective. If they're not better, it -- there's an implication that the treatment was not effective. So there are many ways that you can rely upon that documentation. But the -- the significant thing -- the significant caveat about relying on anyone else's documentation, whether it's a physician or not a physician, is that that was an evaluation at that moment in time, whether it was yesterday or a week ago or a year ago. You're seeing that patient today, and what happened yesterday or a week ago or a year ago may not be what's going on with that patient today. And so you need to do your own evaluation because people's mental status change, their physical status change. Pregnancy, by definition, is a changing -- a rapidly changing physiological state in a variety of ways.

Q. Does relying upon those -- of the first physician's evaluation relieve the second physician's duty to document their mental health evaluation?

A. No.

Q. Why not?

A. For the reasons I just explained, that evaluation was good for, you know, that time of

that day. Even if it was an hour ago, it may or may not have changed.

Q. And in Doctor Neuhaus' records, could you determine what patient records of Doctor Tiller's she reviewed?

A. In -- in her testimony, Doctor Neuhaus stated that she would review what Doctor Tiller's clinic provided to her, which was if -- typically, if -- the intake sheet and the MI Statements. She also testified that she reviewed other physician's records if they were available and accompanied the patient. However, she also testified that when she reviewed records, she would copy them into her file. And although there are copies often of Doctor Tiller's -- you know, there's always -- I think all of them have an intake form and most of them have at least one MI form, none of them have a copy of -- of any other physician's records.

Q. Is there any documentation within any of her patient records how she used those documents?

A. No, there is not.

Q. Now, you also indicated that a mental health evaluation would be tailored to a specific situation. Why is that?

A. Because every evaluation is done for a

purpose and if you don't tailor the evaluation towards that purpose, you may miss the significant elements relevant to the goal of the evaluation.

Q. So how would you tailor a mental health evaluation for a specific purpose?

A. It depends -- it very much depends on the purpose.

Q. How would one be tailored for the Patients 1 through 11?

MR. EYE: I -- I would object, it lacks foundation because this witness doesn't have the requisite experience or training to establish that she would know what the mental health examination for a late-term abortion would consist of.

PRESIDING OFFICER: I believe that's correct. The doctor has testified she has no experience -- correct me, Doctor, you tell me if I'm wrong -- she basically has no experience of any type of counseling for abortions and so forth.

THE WITNESS: That is correct, I mean, in the --

BY MR. HAYS:

Q. What is the purpose of -- indicated within the patient records of that mental health evaluation was performed for?

A. In the patient records, there is no indication of the purpose of the evaluation.

Q. Are there diagnoses in that patient record?

A. Yes, there are -- in all of them, but one.

Q. Now, how would you tailor a mental health evaluation to come to a diagnoses for each one of those patients?

MR. EYE: Same objection as I stated before just a few minutes ago, lacks foundation and no qualifications.

MR. HAYS: Sir, the patient records that are included within Doctor Neuhaus' patient records are specifically the only evidence you have as to diagnoses. There is no referral indication within those, there's no purpose of what is occurring in those patient records?

PRESIDING OFFICER: Correct.

MR. HAYS: So I'm asking her what the mental health evaluation, the -- how to tailor a mental health evaluation to come to the diagnoses that are present within those patient records.

THE REPORTER: I'm sorry. How to tailor a mental health evaluation?

MR. HAYS: -- to come to the diagnoses that are present within those patient records.
MR. EYE: Same objection.
PRESIDING OFFICER: How to tailor her?
MR. HAYS: How you would tailor a mental health evaluation for the purpose of coming to diagnosis.
MR. EYE: Well --
PRESIDING OFFICER: I --
MR.EYE: I'm sorry.
PRESIDING OFFICER: I don't think you do that. Do you tailor your mental health evaluation so you can get a specific diagnosis?
THE WITNESS: Sometimes you -- well, not to get a specific one, but to come to a diagnostic conclusion, sometimes you do.
PRESIDING OFFICER: Well, of course, a conclusion.
THE WITNESS: Yeah.
MR. HAYS: But for the specific purpose to come to a diagnosis.
MR. EYE: Then I would object on the basis that it's -- I think it's so vague that it -- it doesn't really go to a point that is at issue.

PRESIDING OFFICER: Yeah. Can you rephrase it, because I'm not following you a bit here. I'm sorry. Maybe I'm just --

BY MR. HAYS:

Q. For every mental health evaluation that's performed, do you have to come to a diagnosis?

A. No.

Q. Now, if you were going to perform a mental health evaluation to come to a diagnosis, how would you tailor that mental health evaluation?

MR. EYE: Objection, it's vague, it doesn't go to anything in particular related to this case. And if it's intended to address the mental health evaluation for a late-term abortions, then I'd renew my objection that I made a few minutes ago concerning foundation qualifications.

PRESIDING OFFICER: I'm sorry, Mr. Hays, I still don't understand where we're going here.

MR. HAYS: Well, the mental health evaluations were for the -- if you take a look at the record, there's no indication that the mental health evaluations were for the referral. The indication is that they were for a diagnosis.

MR. EYE: I think he's free to argue that, but I don't know that it forms the basis for a proper question.

PRESIDING OFFICER: Objection sustained. Move on.

BY MR. HAYS:

Q. Now, does an attorney set the standard of care by which a doctor must meet?

A. No.

Q. Now, you spoke about Doctor Tiller's mental health evaluation. Was your opinion that he met the standard of care only for documentation?

A. Yes.

Q. And do you have an opinion whether he met the standard of care in the performance of his mental health evaluation?

A. I do not.

Q. To meet the standard of care for documentation, would any aftercare provisions need to be documented?

A. It depends.

Q. What does it depend on?

A. It depends on the purpose of the evaluation and the -- the level of urgency of the

need for care.

Q. Now, you also spoke about aftercare being documented within Doctor Tiller's record. What type of aftercare was documented within his record?

A. Follow-up OB/GYN type care.

Q. Could you turn to page 85 of Patient 1's record for Doctor Tiller.

A. Patient 1, yes.

Q. And was that an aftercare document that you were talking about?

A. That's one of them. I saw -- I -- I saw another one also that was different from this one.

Q. Do they contain the same information?

A. I -- I'd have to look. I mean, I'm -- I'm happy to look and see.

Q. Go ahead.

A. All right. So this is Patient 1. If you -- let me just double-check before I say. Okay. If you look at Patient 2, Bates 48 --

MR. EYE: Ma'am, is this from Doctor Tiller's record?

THE WITNESS: Yes. I'm sorry. This was the other type of document I was referring to, which is -- it says at the bottom, final checkout

exam, the date, the time, the findings and -- and some handwritten notes at the bottom, reviewed breast care, uterine massage, DVT prophylaxis, I can't read the second thing, something -- A-something, A, and then call referral source. So that's -- that's not quite an aftercare plan that one would provide for the patient, that's one for the medical documentation of the last visit. So I -- so that was the other document I was thinking of.

BY MR. HAYS:

Q. Is there any document within Doctor Tiller's record that specifically pertains to psychiatric care, aftercare?

A. No.

Q. Now, why would the presence of suicidality not be enough to conclude a patient has a mental disorder?

A. Because people can have extraordinarily strong brief reactions or temporary reactions to adversity up to and including impulsive suicidal thoughts and acts. Most psychiatric -- to qualify for a psychiatric diagnosis such as the ones that are in these charts, one would have to -- there's a minimum amount of time that that reaction has to

be present or that -- that suicide -- that -- that the distress, because suicidal thinking rarely occurs in the absence of other kinds of distress if, you know -- it would have to be present for a longer time. Now, it certainly is an emergency and it may even be an emergency that would qualify for involuntary psychiatric hospitalization to protect that person's life, but it doesn't necessarily infer a standing psychiatric disorder. You know, situational stress can be very, very severe. And if a person is impulsive as children and teenagers often are, can lead to very unfortunate outcomes involving suicidality, even though yesterday they may have been okay.

Q. Now, let's talk about the DTREE and the GAFs a little bit. Do you know how Doctor Neuhaus was using those programs?

A. Doctor Neuhaus stated in her testimony that she was using them to document her evaluations because it was faster and more thorough. The automated process made it faster and also, she said it was more thorough.

Q. Was she using it as a diagnostic tool?

A. There is one point in the testimony where she seems to say that she is, but generally

speaking, she is emphatic about saying that she was using it to document her own evaluation.

MR. HAYS: I have no further questions.

RECROSS-EXAMINATION

BY MR. EYE:

Q. Doctor Gold, I want to ask just a -- a couple of questions about documentation. I think that in your direct testimony from yesterday, you mentioned that there wasn't any national or -- that you weren't trained on in med school on documentation. I think it was something like you learned by fire. I think maybe it's like trial by fire?

A. Yeah. You learn when you screw it up.

Q. Okay. Right. Well, trial by fire?

A. Right, that's what I said.

Q. Yes. I mean, that's -- that's the learning experience.

A. Right. The QA people come and get you.

Q. And in that regard, since it's not formally taught as a subject in medical school, there is at least a possibility for variation from practitioner to practitioner in terms of what documentation should be required in a particular circumstance?

A. And -- and there is variation.

Q. And to the extent that there are variations, do you have an -- you haven't undertaken to determine what variations might apply in Kansas?

THE REPORTER: I'm sorry. I'm sorry.

MR. EYE: That's all right.

THE REPORTER: And to the extent that there are variations --

BY MR. EYE:

Q. You haven't undertaken any sort of inquiry to know what variations might be present in Kansas as far as documentation for -- for instance, a mental health evaluation?

A. Well, it's a -- the variations in my experience in evaluating charts from -- and documentation from all over the country are more variations from doctor to doctor rather than from region to region. So I would not be aware of a regional variation in Kansas.

Q. More practitioner to practitioner variation?

A. That -- that would be correct. But the use -- but -- but the lack of specific clinical data gathered by the doctor conducting the

consultation or evaluation is -- would not qualify as a variation.

Q. And that actually brings it to my next question --

A. Okay.

Q. -- about the -- you mentioned that there were formal and informal documentation or could be formal, could be informal. And I presume just by the use of those terms, a formal anticipates a more expansive documentation and informal assumes a less expansive?

A. It -- it's not necessarily so much expansive as it is how you collect and then document it. So that, for example -- let me try to give you an example. You can include information about -- that -- information that would be found or elicited in a mental status examination in a formal way, you could write alert and oriented times three, speech normal, behavior normal, and go through every single element and formally list positive and negative findings. Or you could write a brief couple of statements saying, no evidence of hallucinations, delusions, patient was oriented, mood appeared good. That would be informal. The information that you

collected, theoretically, should be approximately the same. You could, for example, on cognitive testing write, not formally tested, but grossly within normal limits. So that would let someone know that, you know, you didn't feel the need to go through a whole process of cognitive testing because I'm talking to you, you clearly did not appear to be suffering any kind of impairment. But that would be an informal report.

Q. I just want to make sure that I understand. Your testimony from yesterday was, at least in some instances, there -- the necess -- there was not a necessity to document negative findings. There were some instances where negative findings are not necessary to be documented, correct?

A. I would have to see what the context of that was -- I -- I -- of that particular statement was and what I was responding to.

Q. Okay. So you wouldn't necessarily agree that in -- that in some instances, a negative finding doesn't require documentation?

A. A negative finding that's relevant to the substance of the evaluation would require documentation.

Q. Documentation. Okay.
And the -- whether it requires documentation is a judgment that has to be made as the evaluation is proceeding?
A. Or afterwards. But, you know, I mean, documentation -- what you choose to document is always a matter of -- of judgment. But relevant to standard of care, certain things should be documented. Again, and what those things are depends upon the type of evaluation that you're doing and how complex the presentation is.
Q. We were looking at Patient 1 records page Bates 85 in Doctor Tiller's compilation. Could you refer to that again, please.
A. Yep.
Q. That's the -- I think we referred to it as a follow-up care or an aftercare note.
A. Correct.
Q. In this instance, right, I think you -- you mentioned that this appeared to you that she's -- perhaps it was the other record we looked at -- that it was being directed to an OB/GYN or that she was being -- it was recommended that she follow-up with her OB/GYN, correct?
A. Well, it could be an OB/GYN, it could be

a -- it's a medical doctor --

Q. Oh.

A. -- as opposed to a psychiatric doctor. And it's directed both towards the doctor and towards the patient.

Q. Okay. And if the patient is compliant and follows up and has a mental health problem at that point, that's something they could take up with a physician pursuant to this follow-up, correct?

A. Depends on the problem.

Q. But they could present the problem, at any rate?

A. If they haven't already killed themselves, for example.

Q. For example?

A. Yeah.

Q. If they --

A. Or if they haven't already done something else to harm themselves in the interim, short of suicide or -- or developed another medical problem relative to their psychiatric status.

Q. Now, you can't hold a physician responsible for every time somebody commits a suicide after an abortion, correct?

A. Absolutely not, no.

Q. Okay. Thank you.

A. But this form just is -- is, I will have a pregnancy test one week and three weeks after my abortion. So that implies a time span of at least one week. And it does not suggest when the follow-up doctor should be there if -- should see her if there's a one-week -- in someone who's acutely suicidal or who might take other action because the abortion did not resolve the situational stress. So, for example, the family was still rejecting the adolescent even though she had had an abortion simply because they still were unhappy with her. A week is a long time to go without follow-up, psychiatric follow-up in an emergent or urgent situation.

Q. Is there any -- for this patient, Doctor, was there any indication she was suicidal -- or the Patient 1?

A. Patient 1, let's see.

Q. You might -- let me just direct -- maybe we can shorten this up a little bit -- direct your attention to Bates 5 in Doctor Neuhaus' record, that the -- the GAF. And underneath the GAF rating is not in the range of one to 10 because

the following --

THE REPORTER: I'm sorry.

MR. EYE: I'm sorry.

THE REPORTER: Underneath the GAF rating?

BY MR. EYE:

Q. -- the GAF rating is not in the range of one to 10 because of the following criteria. And one of those criterion is, it says, the patient has not been suicidal or in danger of intentionally hurting herself.

A. Well, I -- I -- I would rather -- I'm splitting hairs, I suppose, but I would rather base it on Doctor Tiller's evaluation. And in Doctor Tiller's evaluation, there is no indication of suicidality in this particular patient.

Q. So for the chart as a whole between Doctor Neuhaus and Doctor Tiller, suicide wasn't an indication of concern, correct?

A. As far as I can tell in Patient 1.

Q. Now, back on page 85 again, could you just flip to that?

A. Yes.

Q. Thank you. Down in the -- the lower left-hand quadrant of the page, there are a number

of foils with initials next to them. Do you see those?

A. Yes.

Q. Do you see the one for MHC consult?

A. Yes.

Q. Would that be -- that initial there, would that be consistent with the other initials you saw that you were giving the benefit of the doubt that were Kristin Neuhaus'?

A. Yes.

Q. And MHC, is it reasonable to advance the idea that that relates to the mental health consult?

A. Yes.

Q. And this would be evidence that she performed it, correct? It'd be some evidence of it, correct?

A. It -- it would -- it -- it -- yes. I mean, it would be -- it doesn't say what the consult consisted of.

Q. Right. But just that it was done?

A. Just that something was done that was described as a mental health consult.

Q. You mentioned that standard of care is a legal concept, correct?

A. Well, the -- well, there's a -- no, there is a -- a medical standard of care.

THE REPORTER: I'm sorry. There is or isn't?

A. Is -- I'm sorry -- a -- let me stop for a second, because I'm a little --

MR. HAYS: Do you need to take a break?

PRESIDING OFFICER: Mr. Eye, how much longer?

MR. EYE: Oh --

THE WITNESS: Yeah.

MR. EYE: -- I don't have a lot of recross remaining --

THE WITNESS: Okay. Let me --

MR. EYE: -- but if this is a time --

THE WITNESS: -- let me -- no, let me -- if -- if we're going, we'll go. Standard of care is a legal concept. It can also -- there are statutes which define what is legally required, which inform a medical standard of care, which is what the average practitioner does when they perform a general examination and a specialist does when they perform a specialty examination or when a general practitioner performs a specialist evaluation or examination, they're held to what

the average specialist would do. And, determining what those are are medical determinations, but the concept of standard of care is a legal concept.

BY MR. EYE:

Q. And, did your review of the statutes help in -- the statutes that were provided -- provided to you from the staff counsel for the petitioner, did those help inform your idea of stand -- standard of care in this -- in this case?

A. Well, they provided what the legal requirements are for documentation and the legal requirement for a late-term abortion. And the documentation one is -- is certainly congruent with reasonable standard of care documentation.

Q. And is what you're referring to for the -- this statute for documentation, was that actually the Kansas Administrative Regulation 100-24 dash -- I can't --

A. 100-20 --

Q. 2?

A. 100-20 -- well, I have 100-24-1.

Q. Okay.

MR. HAYS: Well --

BY MR. EYE:

Q. So -- so that helped inform your idea of

what the standard of care for documentation would be?

A. No. It told me what the legal requirements were in Kansas. I understand from years of training and personal trials by fire and witnessing trials by fire, et cetera, and also risk management training that doctors receive in terms of adequate documentation, what is the standard of care for documentation. A -- again what's listed legally -- what's listed in the legal statute is not necessarily everything the average practitioner does even though they may be legally required to do it, they don't always do it. And the average practitioner is what -- the practices of the average practitioner establishes standard of care.

Q. So that's actually kind of an experienced based standard of care --

A. Well, it's clinical --

Q. -- aspect?

A. -- well, it's clinical training, it's experience and it's teaching and supervision of residents and fellows. So it -- it's not only experiential, but experience is the best teacher. And, you know, the trial -- being either involved

in or witnessing other people's problems with documentation is often one of the best teachers.

Q. The -- I -- I believe in -- in your redirect, there was a question that -- that -- posed to you that was about the purpose for the referral. Did you understand that question to be the purpose for Doctor Tiller sending a patient to Doctor Neuhaus, was that your understanding of the question?

A. That was my understanding, yes.

Q. And did you find in Doctor Tiller's records, a -- a correspondence that was attributed to Doctor Neuhaus reporting her recommendation for patients that she had evaluated?

A. Well, there was a letter from Doctor Neuhaus, I don't recall whether it was in every single file, but it was in -- if not in every single one, then it was in almost all of them. It was --

Q. And in that letter, you could certainly, at the very least, infer the purpose that Doctor Neuhaus was carrying out for her evaluation of these -- of these patients? Let's take a look at one.

A. Yeah. I have one from -- that's in

Exhibit 37, Bates page 4. Will that do?

Q. Tell us which patient that's for.

A. Patient 4.

Q. Thank you. Hold on a second here. And it was Bates 4?

A. Bates 4.

Q. And that letter carries a -- I mean, this is a letter from Doctor Neuhaus to Doctor Tiller, at least on its face, that's what it indicates, correct?

A. Yes.

Q. And it refer -- references a specific patient, correct?

A. Correct.

Q. And says, Dear Doctor Tiller, I am referring the above named patient to your organization for consultation regarding her unwanted pregnancy. The patient may suffer substantial and irreversible impairment of a major physical or mental function if she were forced to continue the pregnancy. Do you see that?

A. Yes.

Q. And it's signed by Doctor Neuhaus.

A. Correct.

Q. Is it reasonable to infer from the

verbiage in this letter that Doctor Neuhaus had evaluated the patient for purposes of determining whether the patient would suffer substantial and irreversible impairment of a major physical or mental function if the pregnancy were to continue?

A. Yes, that is the maximum that you could infer from this, but, yes.

Q. All right. You were asked about the data that were supplied for the -- we'll take it one for one -- one by one. GAF, do you remember on redirect being asked about the origin of the data that were in -- in -- inserted into the GAF --

A. I no longer remember it, sir. I'm sorry.

MR. HAYS: Objection, I don't believe that was in redirect.

BY MR. EYE:

Q. You -- you were asked questions about the data for the GAF, correct?

PRESIDING OFFICER: She was asked about the GAF and the DTREE and how Doctor Neuhaus was dealing -- was using it. Doctor Neuhaus said the way to document the evaluation of --

THE REPORTER: I'm sorry, Your Honor.

PRESIDING OFFICER: I'm sorry.

THE REPORTER: Doctor Neuhaus said?

PRESIDING OFFICER: The way to document her evaluation, it was faster and more thorough using as a diagnostic tool.

BY MR. EYE:

Q. The -- do you have any information one way or the other that would tell you that the data that were used to plug in to the GAF originated with something other than interviews that were conducted by Doctor Neuhaus? I'm -- I guess I'm asking you, do you have any information to lead you to believe that those data were falsified?

A. I -- well, I -- I -- falsified in the sense of --

Q. Made up?

A. I -- I don't -- I don't think they were necessarily made up or fabricated, but I --

Q. That's all I was trying to get to. Same way for DTREE, same question.

A. I -- I don't think they were made up or fabricated, they -- but they might not have come from Doctor Neuhaus' own clinical evaluation.

Q. But there's no -- these -- the DTREE and GAF were found within the -- the contents of Doctor Neuhaus' records, correct?

A. That is -- that is correct.

Q. And I think you said you presumed that because they were within Doctor Neuhaus' records, that they originated with Doctor Neuhaus, correct?

A. That's correct. In many of these cases, Doctor Neuhaus had access to these MI documents which could have formed the basis for the data, the yes -- the yes or no answers for the DTREE without her own clinical evaluation. So when you set-- so that's also possible. There's no evidence to indicate that a specific clinical evaluation of that specific patient was undertaken by Doctor Neuhaus in her file.

Q. Okay. You were also and -- and I -- I'm not sure I understood this altogether, but did you find that there was the fact that there wasn't a letter from Doctor Tiller to Doctor Neuhaus saying, I'm sending this patient to you for evaluation to be a documentation problem?

A. Not necessarily.

Q. You had patients referred to you over the phone and/or face-to-face consults from -- with another physician who refers a patient to you?

A. Yes.

Q. We were talking about Patient No. 2 and I think you were asked a question about her major

depressive disorder and whether that required a gatekeeper event.

A. Yeah. A gatekeeper criterion, yes.

Q. Would the rape and incest qualify as a gatekeeper event?

A. Well, there isn't a gatekeeper event. A gatekeeper criterion refers to the diagnostic criterion in the DSM. Now, for a post-traumatic stress disorder or acute stress disorder, which is the early stages of a post-traumatic stress disorder, typically, you have a traumatic event. But, for depression, a traumatic event is not required. The gatekeeper criterion refer to one or two symptoms that must be met in order for a diagnosis to be met.

Q. Could rape or in -- rape and incest be the cause of -- of a mental -- strike that -- of a psychiatric disorder?

A. It could.

Q. Which would include a major depressive disorder?

A. Possibly, yes.

Q. Doctor, to the extent that there -- there is DTREE and GAF information within Doctor Neuhaus' file, that would at least imply that

there had been an attempt by Doctor Neuhaus to generate information to enter into the GAF and DTREE, correct?

A. Not -- not --

MR. HAYS: Objection, speculation.

MR. EYE: No. I'm -- I just asked if she could infer that. It's --

PRESIDING OFFICER: You can answer it, if you can.

A. Yeah. Not, not necessarily.

BY MR. EYE:

Q. So the presence of the DTREE and -- and GAF within the chart doesn't have any significance as to the information that is -- that is used in the GAF and DTREE as far as it coming from a mental health exam? I mean --

A. Well, if -- if there was specific -- if there was information specific to that particular patient -- if there was clinical information specific to that particular patient included in the DTREE and GAF, then I would say, yes, clearly. But these documents do -- contain generic statements from the DSM, many of which are self-contradictory when answered with a yes answer that don't necessarily indicate the generation of

in -- of specific clinical information by Doctor Neuhaus.

Q. And is it the case that the GAF and DTREE are correlated to axes -- for example, GAF is related to Axis IV?

A. Correct.

Q. Okay. And DTREE could actually, I guess, theoretically apply to the other axes?

A. No, it really -- I would have to look at the program again to see if it includes Axis II, but it definitely doesn't in include Axis III, specifically only by exclusion. And it certainly doesn't include Axis IV. It does include Axis I, and I'd have to look at the program about Axis II.

Q. So you're not familiar with it enough to be able to know whether Axis II was covered by DTREE?

A. I -- I would have to look again, no, I don't remember.

MR. EYE: I think that's all my recross. Thank you, Your Honor.

PRESIDING OFFICER: Okay.

REDIRECT-EXAMINATION

BY MR. HAYS:

Q. Doctor Gold, is there any letter of

referral from Doctor Neuhaus to Doctor Tiller located in any of her patient records?

A. No.

Q. Let's take a look at Patient 11.

THE WITNESS: Can I --

MR. HAYS: Do you need a --

THE WITNESS: -- I need a break, yeah.

PRESIDING OFFICER: We'll take a 10-minute break.

(THEREUPON, a recess was taken.)

PRESIDING OFFICER: Back on the record. Mr. Hays.

MR. HAYS: Thank you, sir.

BY MR. HAYS:

Q. Could you turn to Exhibit 44, Bates page 46 and in Doctor Tiller's record.

MR. EYE: Which patient?

MR. HAYS: Patient 11.

A. Bates -- I'm sorry -- which Bates page?

BY MR. HAYS:

Q. 46, the last page.

A. The last page. Yes.

Q. And is -- that's the same type of a document you were talking about for Patient 1?

A. Correct.

Q. And if you look at the initials down at the MHC consult --

A. Yes.

Q. -- are those the same initials that were present on Patient 1's?

A. It doesn't look like it, but it's awfully hard to tell. But it -- it doesn't look like it.

Q. Do you need to compare them?

A. That would help.

Q. Patient 1's was located at Bates 85 in his record.

A. Can I take this out of here?

Q. Of course.

A. Easy to find since it's the last page. All right. Patient 1 is 80 -- Bates 85. It does not look like the same initials to me.

Q. So -- what's that?

A. To me. It's doesn't look like the same initials to me, but --

Q. So if those are not the same initials, does that indicate that someone else did the mental health consult for Patient 11?

A. I don't know what it indicates. There's nothing that says that the person who did -- did the item referred to has to check off. I mean,

this may just be a check off that it's in the chart, you know, like a utilization review person going through a chart and saying, is this there, is this there, is this there, and different people are responsible for checking off different things. I don't know what -- what that is. To me, it's doesn't imply -- to me, what it implies is that somebody was responsible for, at the very least, making sure that whatever documentation they felt constituted an MHC consult was in the chart. At the most, you could speculate that the person who was responsible for doing it checked -- had to initial this when they did it. But, there's really nothing to indicate either way what this means. At a minimum, it means it's a utilization review process.

Q. So you don't know whether the initials located on Bates 85 were Doctor Neuhaus' or not?

A. Well, I -- no, I don't know. They appear the same as some of the initials in her files, so I'm inferring and giving, you know, the benefit of the doubt that they are her's, but I don't know for a fact that those are her initials. I -- and -- and this one on Bates 46 from Patient 11 does not look the same to me.

Q. And is there any reference on Bates 46 out of Patient 11's record to a referral for psychiatric treatment?

A. No.

Q. Or -- let me rephrase. Is there any indication to aftercare for a psychiatric treatment?

A. No, there is not.

Q. And did Patient 11 have suicidality within -- notated within Doctor Neuhaus' record?

A. Which would be Exhibit 33?

Q. Correct.

A. Okay. Yes. To the extent that the DTREE documents it.

MR. HAYS: I have no further questions.

RECROSS-EXAMINATION

BY MR. EYE:

Q. Doctor Gold, I -- I have just one brief line here. I'm looking at Patient 2 and it's Bates page -- I think it's 30, although -- yeah, it's page -- Bates page 30.

A. In -- it would be in Doctor Tiller's then, right?

Q. Yeah, yeah, yes. Right.

A. I'm sorry. Bates -- I'm sorry.

Q. Well, actually it's 29 and 30. I -- I -- it looks like it's maybe copied twice in here.

A. I'm sorry. Which patient?

Q. 2?

A. 2. Yes, 29 and 30.

Q. Do these look like cover sheets on a chart, I mean, just kind of based on the -- what the -- how it looks like and the -- and -- or cover -- the cover on a chart, the stiffer --

A. Correct.

Q. And there's a -- a place where there's three foils basically. It says MHC, Doctor Neuhaus and Doctor Tiller. And it says, patients are ready for consent when all three are finished. Do you see that?

A. Yes, I do.

Q. And there's a checkmark for Doctor Neuhaus. Oh, and there's a -- there's a checkmark for MHC, Doctor Neuhaus and Doctor Tiller. Is that some sort of documentation that would indicate that there had been a -- a mental health consult completed by Doctor Neuhaus?

MR. HAYS: Objection, speculation.

MR. EYE: Just if she knows.

PRESIDING OFFICER: If she knows.

A. I mean -- to get -- there is -- to give the benefit of the doubt, I'd like to say yes. A -- a strict interpretation, there's one thing -- one line that says MHC and the Doctor Neuhaus and Doctor Tiller line could mean any task that Doctor Neuhaus and Doctor Tiller were assigned including just a review of the record. It -- it doesn't indicate that they've done mental health evaluations. A generous interpretation would be, yes.

BY MR. EYE:

Q. Okay. And you don't know of any other function that Doctor Neuhaus was carrying out related to Women's Health Care Services, other than the -- the mental health evaluations, correct?

A. That is correct.

MR. EYE: That's all I have. Thank you.

MR. HAYS: I have no further questions.

PRESIDING OFFICER: Thank you very much, Doctor Gold.

THE WITNESS: No, thank you.

MR. HAYS: And we have no further witnesses.

MR. EYE: Your Honor, I have a call in to

counsel that is -- that represents the three witnesses, the three fact witnesses, Erin Thompson. And I called her at the lunch break and told her I wasn't sure exactly when we would be getting to her clients, but asked her to call me and I haven't heard back from her. If I could have a few minutes, I'll call her again and see if I can find out anything about their availability.

PRESIDING OFFICER: Okay. I'll just make this suggestion and you take it any way that you want to. But we need to get out of here in about an hour anyway and we're going to be moving everything out of here tonight. Would it -- it -- it's up to you, your preference, would you rather just make arrangements to have those witnesses first thing in the morning or the first thing in the afternoon or whatever you want to do?

MR. EYE: That'd be great, Your Honor, because I -- again, we weren't sure exactly what their status was as far as -- because they'd subpoenaed by the petitioner. I wasn't sure just where they were at. So we're sort of changing this on the fly.

PRESIDING OFFICER: Is that acceptable?

MR. HAYS: Yes, sir, it is.

PRESIDING OFFICER: Okay. Then we'll adjourn and meet over at the Board of Healing Arts office. Let me give you the address for the record.

MS. BRYSON: 800 Southwest Jackson Street, Lower Level, Suite A, Topeka, Kansas 66612.

PRESIDING OFFICER: I know where it's at. At 8:30 in the morning. Okay.

(THEREUPON, the hearing concluded at 3:35 p.m.)

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CERTIFICATE

STATE OF KANSAS

ss:

COUNTY OF SHAWNEE

I, Cameron L. Gooden, a Certified Shorthand Reporter, commissioned as such by the Supreme Court of the State of Kansas, and authorized to take depositions and administer oaths within said State pursuant to K.S.A. 60-228, certify that the foregoing was reported by stenographic means, which matter was held on the date, and the time and place set out on the title page hereof and that the foregoing constitutes a true and accurate transcript of the same.

I further certify that I am not related to any of the parties, nor am I an employee of or related to any of the attorneys representing the parties, and I have no financial interest in the outcome of this matter.

Given under my hand and seal this day of , 2011.

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Cameron L. Gooden, C.S.R. No. 1335