

VIDEOCONFERENCE DEPOSITION OF LIZA H. GOLD, M.D.
CONDUCTED ON FRIDAY, JUNE 24, 2011

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	<p>BEFORE THE BOARD OF HEALING ARTS OF THE STATE OF KANSAS -----x In the Matter of) Docket No. 10-HA00129 ANN K. NEUHAUS, M.D.) OAH No. 10-HA0014 Kansas License No. 04-21596) -----x Videoconference Deposition of LIZA H. GOLD, M.D. Washington, DC Friday, June 24, 2011 9:33 a.m. Job No.: 11609 Pages: 1 - 291 Reported by: John L. Harmonson, RPR</p>		<p>APPEARANCES ON BEHALF OF THE KANSAS STATE BOARD OF THE HEALING ARTS: REESE HAYS, ESQUIRE LORI D. DOUGHERTY, ESQUIRE KANSAS STATE BOARD OF HEALING ARTS 800 SW Jackson Lower Level, Suite A Topeka, Kansas 66612 (785) 296-0961 ON BEHALF OF ANN K. NEUHAUS, M.D.: ROBERT V. EYE, ESQUIRE KELLY J. KAUFFMAN, ESQUIRE BRET JARMAR, ESQUIRE KAUFFMAN & EYE 123 SE 6th Avenue Suite 200 Topeka, Kansas 66603 (785) 234-4040 (Present via videoconference)</p>
	<p>Videoconference deposition of LIZA H. GOLD, M.D., held at the offices of: PILLSBURY, WINTHROP, SHAW, PITTMAN, LLP 2300 N Street, NW Washington, DC 20037 (202) 663-8000 Pursuant to K.S.A. 60-230, by Notice, before John L. Harmonson, Registered Professional Reporter, Notary Public in and for the District of Columbia, who officiated in administering the oath to the witness.</p>	2	4
			<p>APPEARANCES CONTINUED ALSO PRESENT: KEITH D. HUDOLIN, ESQUIRE PILLSBURY, WINTHROP, SHAW, PITTMAN, LLP 2300 N Street, NW Washington, DC 20037 (202) 663-8000</p>

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6

1 P R O C E E D I N G S

2 L I Z A H . G O L D , M . D . ,

3 after having been first duly sworn, was examined

4 and did testify under oath as follows:

5 E X A M I N A T I O N

6 BY MR. EYE:

7 Q. Good morning, Dr. Gold. My name is Robert

8 Eye, and I'm one of the lawyers that represents

9 Kristin Neuhaus in this case. We're here today to

10 take your deposition.

11 Just a couple of ground rules. And

12 probably we need to account for the fact that we're

13 doing this by a videoconference or a video hookup, if

14 you will. And because of that, if the audio is

15 interrupted during my questions, please ask me to

16 repeat it and we'll make sure that it's clear to you.

17 Likewise, if it's interrupted during one of your

18 responses, I may have to ask you to go back and repeat

19 it if that happens.

20 Additionally, just consistent with that, if

21 I ask you a question that you don't understand, will

22 you agree to ask me to rephrase it so that it is

7

1 understandable?

2 **A. Yes.**

3 Q. And also to make a good record, and I'm

4 sure you've been deposed many times, but just as much

5 to remind myself as anything, I'll do my best to wait

6 until you complete your response before I ask a

7 question, and if you would do the same in terms of

8 waiting to respond until I finish the question, I'm

9 sure our court reporter will appreciate that in terms

10 of making a good record.

11 Additionally, if at any time during the

12 course of this deposition you want to take a break,

13 please let us know and we can certainly do that. It's

14 not an endurance test, and I don't want it to turn

15 into one for anybody. So if a break is required, as I

16 say, please let us know.

17 Dr. Gold, again for the record, you are the

18 individual that provided a report to the Kansas State

19 Board of Healing Arts staff counsel concerning the

20 case that they have filed against Dr. Ann K. Neuhaus,

21 correct?

22 **A. I believe I have filed multiple reports,**

8

1 **but otherwise correct.**

2 Q. All right. And when you say multiple

3 reports, what do you mean by multiple reports?

4 **A. Well, they all involve Dr. Neuhaus, but**

5 **there was a separate report for each case file that I**

6 **reviewed.**

7 Q. Very well. Do you have your case file on

8 this matter with you today?

9 **A. Yes.**

10 Q. And I would like to -- If you're agreeable,

11 I would like to have that marked as an exhibit and

12 then go through it with you. Then I presume that we

13 can get a photocopy of that before you leave the

14 office there today, and then we can withdraw the

15 original as an exhibit and just use the photocopy, if

16 that's agreeable with you and counsel.

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

18 **okay.**

19 MR. HAYS: It is, Bob.

20 MR. EYE: Great. Thank you.

21 If you would give the case file to the

22 court reporter. And, sir, if you would mark that as

9

1 Exhibit No. 1.
2 THE WITNESS: It may be more than one
3 piece. These are copies of my reports. And then
4 there's some notes. And there -- Well, that's not
5 really the case file. So this is what I have.
6 BY MR. EYE:
7 Q. It consists of the various reports that you
8 prepared related to the charts you reviewed in this
9 matter and some notes; is that correct?
10 A. **Some notes and some office forms that I use**
11 **as comparative material. So...**
12 MR. EYE: Let's go ahead and have the
13 entire file marked as a single exhibit, and then if we
14 need to break it out into separate parts we can do
15 subparts of Exhibit 1. But let's go ahead and proceed
16 with the entire file at this point as a single unified
17 exhibit.
18 (Exhibit 1 marked for identification and retained
19 by the witness for copying and distribution.)
20 BY MR. EYE:
21 Q. Is your curriculum vitae part of your file?
22 A. **No.**

10

1 Q. Do you have it in front of you by any
2 chance?
3 A. **No.**
4 Q. Well, I have it in front of me, so if it's
5 all right, I'm going to ask you some questions about
6 your CV, at least to begin with.
7 According to your CV that is in front of
8 me, it's dated April 16, 2009. Do you have any
9 significant revisions to your CV since that time? It
10 would be about -- well, two years and a couple of
11 months ago.
12 A. **Yes, probably.**
13 Q. Well, as we go through your CV, if you
14 could let me know any updates that might apply. Let's
15 do it that way.
16 Are you still a clinical professor of
17 psychiatry at Georgetown University Medical Center?
18 A. **Yes.**
19 Q. And what courses do you teach?
20 A. **I teach a course in writing in forensic**
21 **psychiatry. I teach a course in assessment of**
22 **disability, and that's to the forensic fellows. I**

11

1 **supervise the fellows when they get disability**
2 **evaluations, and also certain types of civil**
3 **litigation evaluations.**
4 **And then I also teach the general**
5 **psychiatry residents in the courses -- they have to do**
6 **a certain number of hours of forensic psychiatry,**
7 **didactic lectures, and I give a number of those**
8 **lectures on various topics, boundary violations, role**
9 **of expert witness. I'm trying to think of the --**
10 **civil litigation issues.**
11 Q. And in the course of teaching those
12 classes, Dr. Gold, do you ever deal with anything
13 related to provision of abortion services?
14 A. **No.**
15 Q. Now, during the time that you were clinical
16 associate professor of psychiatry, which according to
17 your CV was 2003 to April 2006, were you teaching
18 classes as well in that designation?
19 A. **Yes.**
20 Q. And did any of those classes have anything
21 to do with providing abortion services?
22 A. **No.**

12

1 Q. Same question for when you were the
2 clinical assistant psychiatry -- or clinical assistant
3 professor of psychiatry from '98 to 2003. Same
4 question.
5 A. **No.**
6 Q. You were also the associate director of the
7 program in psychiatry in law. It says, according to
8 your CV, that that's been the case from 2001.
9 Are you still in that role as well?
10 A. **You know, that's kind of defunct at this**
11 **point because around 2009 Georgetown developed a**
12 **formal forensic fellowship, so a lot of that got**
13 **transferred there. So although technically I think I**
14 **still have the title, I don't think it means anything**
15 **anymore. I'm pretty sure it's not on my current CV.**
16 Q. Okay. Well, when it was active, or when it
17 was still something that you were engaged in, can you
18 tell us a bit about what your duties or your role was
19 in that capacity?
20 A. **That was more limited to providing forensic**
21 **didactic lectures to the general psychiatry residents.**
22 **I organized the lectures. I organized other**

13

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

5 Q. Over the course of an academic year?

6 A. Yes.

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

12 A. They did not.

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

16 A. Yes.

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

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

14

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

6 Q. Did you deliver any of these lectures?

7 A. Yes. I provided all of them.

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

11 A. No.

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

14 A. Yes.

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

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

15

1 hopefully can be published. That's the goal.

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

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

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

10 A. No.

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

15 A. Not academic, no.

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

21 A. Yes.

22 Q. And likewise for the forensic psychiatry

16

1 subspecialty certification, is that still an active
2 certification?

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

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

10 A. No.

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

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

16 Q. Sure.

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

22 A. No.

17

1 Q. Same question for the forensic psychiatry
2 board certification.
3 A. No.
4 Q. Now I want to go to the areas of expertise
5 that you set out in your CV. The first one that is in
6 the CV that I have in front of me is called areas of
7 expertise, and the first one -- I'm sorry, the first
8 area is "Clinical evaluation, diagnosis and treatment
9 of psychiatric disorders in adults."
10 Dr. Gold, just in terms of sort of giving
11 us a sense of how this breaks down, what age group do
12 you consider to be an adult? Is there an age
13 demographic that you would apply to, quote, adults,
14 end quote?
15 A. Well, technically, anyone over 18 is an
16 adult. So anyone over 18 I think I would characterize
17 as an adult, although some are more mature than others
18 and so sometimes there are still adolescent issues
19 even in people over 18.
20 Q. So it's fair to say that maybe there's not
21 a hard and fast rule in terms of when somebody is an
22 adult and when somebody is an adolescent based on

18

1 developmental or functioning parameters?
2 A. That's correct. You know, there is a
3 transition and for some people it's earlier, for some
4 people it's later. For legal purposes, 18 is an
5 adult.
6 Q. Fair enough.
7 Now, in terms of your areas of expertise,
8 the extent that you specify that it's for evaluation,
9 diagnosis and treatment of psychiatric disorders in
10 adults, do you have an area of expertise that relates
11 to individuals who are not adults; that is,
12 adolescents and children?
13 A. I see adolescents. I treat adolescents.
14 It is not a specialty area, which is why it's not
15 listed under areas of expertise. In the course of my
16 clinical practice, I have evaluated and treated
17 numerous adolescents for a variety of issues.
18 In terms of children, if I get a call
19 regarding a child, I typically will refer that to a
20 child specialist because the issues become that much
21 more complicated.
22 Q. In the -- In the first bullet point

19

1 underneath that area of expertise, it indicates that
2 you have an expertise in the evaluation and
3 psychopharmacologic and psychotherapeutic treatment of
4 post-traumatic affective mood disorders, anxiety
5 disorders and personality disorders.
6 Does that sound accurate? And I hope I
7 didn't mispronounce anything.
8 A. That's accurate. And again, the purpose is
9 to highlight the things that I consider I have special
10 expertise in, although in my clinical practice I have
11 treated people with other disorders and evaluated
12 other disorders.
13 Q. Now, is there anything in that particular
14 evaluation of psychopharmacologic and
15 psychotherapeutic treatment of these kinds of
16 disorders that would bear on providing abortion
17 services?
18 A. You would have to define what "bear on
19 providing abortion services" means.
20 Q. Does it -- Well, let me ask you this: Have
21 you ever treated a patient -- or strike that --
22 evaluated a patient for psychopharmacologic or

20

1 psychotherapeutic treatment, anything that has to do
2 with an abortion?
3 A. Well, I've had a number of patients with
4 whom I've discussed abortion. I evaluate and treat
5 many, many pregnant women. You know, when people are
6 pregnant, the issue of abortion does arise. Some of
7 them have abortions, some of them do not. Their
8 evaluation and treatment therefore has to include, if
9 that's an issue for them or an option for them,
10 whether or not they want or plan or need an abortion.
11 Q. And in that regard, do you have any
12 experience in those sorts of evaluations when it deals
13 with adolescents?
14 A. I've seen a couple of pregnant adolescents.
15 Q. For purposes of evaluating them for an
16 abortion?
17 A. Not specifically for purposes of evaluating
18 them for abortion. I evaluate for psychiatric
19 disorders.
20 Q. All right. The next bullet point is
21 "Psychotherapeutic issues related to the psychological
22 and medical consequences of childhood and adult

21

1 trauma."
2 Does that have anything to do with
3 abortions in your practice?
4 **A. That's a difficult question to answer**
5 **because if there is sexual abuse that leads to a**
6 **pregnancy, then that can be an issue where abortion**
7 **comes up. Women may have already had abortions before**
8 **they come to see me. Some women come in crisis**
9 **because they've become pregnant as the result of**
10 **trauma and are debating what to do, and one of the**
11 **options is, of course, an abortion.**
12 **So when you work with pregnant women,**
13 **evaluate pregnant women, inevitably the issue of**
14 **abortion arises regardless of whether there has been**
15 **trauma or not trauma.**
16 **So that's the best I can answer that**
17 **question.**
18 Q. Thank you.
19 The next bullet point indicates that you
20 have an area of expertise in the diagnostic and
21 psychopharmacologic expertise in women's reproductive
22 psychiatry including postpartum disorders, management

22

1 of medication during pregnancy and lactation,
2 premenstrual dysphoric disorder and menopause.
3 Does that sound accurate?
4 **A. Yes.**
5 Q. I want to look at the first subpart of
6 that, and that deals with women's reproductive
7 psychiatry. Have you evaluated any woman in the
8 course of your practice for purposes of determining
9 whether her mental health would be preserved by virtue
10 of having a late-term abortion?
11 **A. Not a late-term abortion, no.**
12 Q. How about an abortion that's not -- And
13 when we say late term, do you consider that to be the
14 last trimester?
15 **A. Yes.**
16 Q. How about for middle -- the middle
17 trimester? Same question.
18 **A. Possibly a handful. You know, three, four,**
19 **over the course of 20 years.**
20 Q. And how about a first term abortion?
21 **A. Oh, that's probably a much larger number.**
22 **Most women who have abortions typically have them in**

23

1 **the first trimester, so...**
2 Q. In that regard, have you ever generated a
3 report that indicates that an abortion would be
4 consistent with preserving the mental health of the
5 mother?
6 **A. No.**
7 Q. The next bullet point, Dr. Gold, indicates
8 that you have an area of expertise in forensic and
9 independent medical evaluation, including assessment
10 of emotional injury, damages and mental health
11 assessments, including testimony if required.
12 Have you ever testified in a case that
13 involved providing abortion services? Or strike that.
14 Have you ever testified in a case that had
15 an issue concerning abortion?
16 **A. No.**
17 Q. Have you ever served as a consultant in a
18 case that involved abortion other than this case?
19 **A. No.**
20 Q. In terms of your forensic and independent
21 medical evaluation work, is that -- does that
22 frequently relate to litigation?

24

1 **A. Not necessarily.**
2 Q. What else -- But it would include
3 litigation?
4 **A. It would include litigation, yes.**
5 Q. What else other than litigation would fall
6 under that category, Dr. Gold?
7 **A. I do independent evaluations for**
8 **disability, workers' comp. Not all of those involve**
9 **litigation.**
10 **I do some criminal evaluations; I guess**
11 **those by definition involve litigation.**
12 **And I do record reviews on occasion which**
13 **are referred to me by attorneys or insurance**
14 **companies, and those do not involve -- usually do not**
15 **involve litigation directly for me. They may involve**
16 **litigation for someone, but I'm not involved in that.**
17 Q. The next bullet point indicates an area of
18 expertise in psychiatric consequences of trauma and
19 violence.
20 Does that have anything to do with
21 abortions?
22 **A. Not directly, no.**

25

1 Q. How about indirectly?

2 **A. Well, again, a certain small percentage of**

3 **sexual assault and trauma results in pregnancy, and**

4 **for those people when you're evaluating or treating**

5 **the issue of what to do when a pregnancy arises.**

6 Q. In your work have you ever generated an

7 opinion that is consistent with preserving the mental

8 health of the mother if she has an abortion because of

9 a pregnancy that's been caused by a traumatic or

10 violent experience?

11 **A. Can you define generating an opinion?**

12 Q. Sure.

13 Providing an opinion to either a patient or

14 another physician or an attorney regarding whether

15 preserving a mother's health -- whether an abortion

16 would be consistent with preserving a mother's health.

17 **A. It's not my role to generate such opinions,**

18 **and I've never been asked to generate such opinions.**

19 **It's my role to help my patients come to decisions**

20 **about what's best for them, and that's an autonomous**

21 **function that I do not -- I actively do not usurp by**

22 **offering my own opinion unless there is a crisis or**

26

1 **emergency, and I have not been involved in a case that**

2 **is a crisis or emergency at that level.**

3 Q. So the answer would be no?

4 **A. I -- I can't explain it any better than I**

5 **did.**

6 Q. Is it safe to assume that none of your

7 employment litigation consults has anything to do with

8 abortion?

9 **A. That is correct.**

10 Q. I'm now looking at your -- Well, I should

11 ask --

12 **A. Although I would say that a couple of them**

13 **have had to do with pregnancy.**

14 Q. Sure.

15 **A. Pregnancy discrimination.**

16 Q. Right.

17 **A. But abortion didn't enter into those cases.**

18 Q. Fair enough.

19 Are there any other areas of expertise that

20 you would consider that should be added to your CV

21 from the April '09 version?

22 **A. I probably would add and probably have**

27

1 **added employment-related evaluations beyond**

2 **disability, such as fitness-for-duty, return to work,**

3 **ADA evaluations, Americans With Disabilities Act. So**

4 **those types of employment-related evaluations.**

5 Q. Very well.

6 I'm now looking at the second page of your

7 CV that's dated April 16, 2009. At the top of that

8 page it indicates postgraduate medical training. And

9 the first point is Boston University Psychiatry

10 Residency Training Program from 1986 to 1990.

11 Does that sound correct?

12 **A. Yes.**

13 Q. In that psychiatry residency training, did

14 any of that training have to do with providing

15 abortions?

16 **A. No.**

17 Q. Did it have anything to do with providing

18 anything that we would consider to be primary care?

19 **A. That's a difficult question to answer. I**

20 **would have to answer yes in that sometimes patients**

21 **came in for what they presume was a psychiatric**

22 **problem and needed really to be seen and treated like**

28

1 **a primary care patient.**

2 **And to the extent that I was able to do so,**

3 **I did so, but usually in conjunction with referring**

4 **them to a primary care doctor. But if they needed**

5 **services immediately that I could provide that were**

6 **primary care services, I would provide them.**

7 Q. Very well.

8 It indicates that this residency training

9 program, at least part of it, was conducted at Boston

10 City Hospital. Is that correct?

11 **A. That is correct.**

12 Q. Is that a facility that provides abortions?

13 **A. I don't know.**

14 Q. While you were at Boston City Hospital for

15 the residency training program, do you know whether

16 abortion services were provided at that time, that is

17 between '86 and '90?

18 **A. I don't know.**

19 Q. It indicates some of this training occurred

20 at the University Hospital in Boston, Massachusetts.

21 Is that correct?

22 **A. Yes.**

29

1 Q. And is that a hospital that provides
2 abortion services?
3 **A. I don't know.**
4 Q. While you were there, did it?
5 **A. I don't know.**
6 Q. It indicates that some of that training
7 took place at the Edith Nourse Rogers Veterans
8 Administration Hospital in Bedford, Massachusetts.
9 Was that a facility that provides abortion services?
10 **A. Well, it's a veterans hospital, and**
11 **98 percent of the population is male, so I doubt it.**
12 **But I don't know.**
13 Q. And that would be for when you were there
14 and currently?
15 **A. Well, I don't know about currently there.**
16 **But when I was there, it was 98 percent male, and I**
17 **can't imagine -- they didn't have an OB/GYN**
18 **department, so I can't imagine that they provided**
19 **abortions.**
20 Q. It indicates some of this training happened
21 at the Brockton Hospital in Brockton, Massachusetts.
22 Is that a facility that provides abortions?

30

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

31

1 Q. And is that what you did?
2 **A. Yes.**
3 Q. What kind of work did you do in relation to
4 this fellowship?
5 **A. I was assigned to the work group on managed**
6 **care, which at that time was a very, very big issue of**
7 **concern.**
8 Q. I have a vague recollection of when that
9 was going on.
10 **A. Yes.**
11 Q. Did any of that have to do with providing
12 abortion services?
13 **A. No.**
14 Q. Did any of the meetings that you attended
15 in relation to that fellowship have anything to do
16 with providing abortion services?
17 **A. Only tangentially.**
18 Q. In what way?
19 **A. Well, the project that we did, the fellows**
20 **have to present a project at the end of the two years,**
21 **and the project that we did was on postpartum**
22 **disorders. And in the course of that, we talked about**

32

1 **pregnancy, we talked about abortion, we talked about**
2 **birth control. We talked about a lot of things. So**
3 **it did not focus on abortion, but it was tangentially**
4 **involved in the discussion of postpartum disorders.**
5 Q. Did you in the course of that tangential
6 aspect of abortions deal with evaluating patients for
7 purposes of receiving late-term abortions?
8 **A. No.**
9 Q. The next point on your CV deals with your
10 medical education, which indicates that you graduated
11 from New York University School of Medicine with your
12 medical degree in 1986. Is that correct?
13 **A. Yes.**
14 Q. During the course of your medical education
15 at NYU, did you have any classroom work on abortion
16 services?
17 **A. No.**
18 Q. The next bullet point under medical
19 education indicates that you were the recipient of the
20 Alex Rosen Award for Excellence in Medicine and
21 Humanities in 1986. Is that correct?
22 **A. Yes.**

33

1 Q. Did that have anything to do with abortion
2 services?
3 A. No.
4 Q. During the course of your medical
5 education, did you have any clinical -- at NYU, did
6 you have clinical experience?
7 A. No.
8 Q. Your graduate education --
9 A. Well, I'm sorry. You asked if I had
10 clinical experience and I said no. That's not true.
11 I had lots of clinical experience.
12 Can you be more specific?
13 Q. I surely can. Thank you.
14 I'm talking about during your medical
15 education at NYU, did you have a clinical component to
16 that medical education?
17 A. Yes.
18 Q. And can you tell us whether any of that
19 clinical experience at NYU involved abortion services?
20 A. It did not.
21 Q. It indicates that you had graduate
22 education at the University of Cambridge. I assume

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

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1 given birth or had an abortion, which would be
2 unintentional -- well, I shouldn't say unintentional
3 but not legal at that time in Vienna -- well, yes, I
4 guess it was Vienna where he was, that they didn't get
5 infected and die. The death rate was higher than
6 50 percent in some of the wards from puerperal
7 infection.
8 So it revolved around theories of
9 pregnancy, infection, death and Semmelweis's role in
10 elucidating the connections between all of those
11 things. And abortion did come up in that in terms
12 of -- but it wasn't the focus, certainly, of the paper
13 at all.
14 Q. And it indicates that you received your
15 undergraduate degree from Harvard Radcliffe College in
16 1981. Correct?
17 A. Yes.
18 Q. In the course of your undergraduate
19 education did you have any course work that dealt with
20 abortions?
21 A. I took a course on medical ethics that
22 talked about abortion in terms of ethical issues.

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

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1 **A. I think it was late last year.**
2 Q. Okay. And how about New York?
3 **A. It would have been the year before, so it**
4 **would have been in 2009 but after April.**
5 Q. Do you do any practice in New Jersey?
6 **A. No, I do not.**
7 Q. How about New York?
8 **A. No.**
9 Q. What about District of Columbia?
10 **A. No. I did -- Well, I did consulting work**
11 **up until about a year or so ago at St. Elizabeth's**
12 **Hospital, which would probably be considered -- well,**
13 **it did -- actually I was writing orders, so yes, it**
14 **was clinical.**
15 Q. Do you still have privileges at
16 St. Elizabeth's Hospital?
17 **A. I'm not sure when the privileges expire. I**
18 **might.**
19 Q. Is St. Elizabeth's Hospital a facility that
20 provides abortion services?
21 **A. Not to my knowledge.**
22 Q. Do you have privileges at any other

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1 hospital within the District of Columbia?
2 **A. No.**
3 Q. What hospitals do you have privileges at in
4 the Commonwealth of Virginia?
5 **A. Virginia Hospital Center in Arlington.**
6 Q. Let me just stop with that one. Does it
7 provide abortion services?
8 **A. I don't know.**
9 Q. And then you were going to continue.
10 **A. No, that's the only one.**
11 Q. Do you have admission privileges or
12 practice privileges at any hospital in New York?
13 **A. No.**
14 Q. Or New Jersey?
15 **A. No.**
16 Q. Have we covered all of the hospitals at
17 which you have privileges?
18 **A. Yes.**
19 Q. It indicates that you had licenses -- Well,
20 strike that.
21 It indicates that you had licenses in New
22 Hampshire from '88 to '92. Is that correct?

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1 **A. Yes.**
2 Q. What were the circumstances for not
3 continuing your license in New Hampshire after '92?
4 **A. My husband and I move moved to the Northern**
5 **Virginia area, and I wasn't going to be working there**
6 **anymore.**
7 Q. When you were in New Hampshire did you have
8 admission privileges at any hospital?
9 **A. At a number of hospitals.**
10 Q. Did any of them provide abortion services?
11 **A. I don't know.**
12 Q. Did you ever admit a patient for abortion
13 services at any of the hospitals in New Hampshire at
14 which you had privileges?
15 **A. No.**
16 Q. It indicates that you had a Massachusetts
17 license from '86 to '92. Is that correct?
18 **A. Yes.**
19 Q. Did you have admission privileges at any
20 hospitals in Massachusetts during that time?
21 **A. Yes.**
22 Q. Did any of them provide abortion services?

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

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1 **medical school, the second one I think after your**
2 **fourth year of medical school, and then the third part**
3 **is after your internship.**
4 **I should know more about it, but at the**
5 **time they were the hoops you had to jump through and I**
6 **jumped through them. And you don't have to renew it,**
7 **so it's there. I have it.**
8 **I think it has to do with whether you went**
9 **to American medical schools or foreign medical**
10 **schools. I think you -- Yeah.**
11 Q. Well, do you do anything with that license
12 now? I mean, is it something that you actively use in
13 order to practice your craft?
14 A. **I presume that I couldn't practice unless I**
15 **had it. But I don't know for sure. I think you have**
16 **to have it in order to graduate from an accredited**
17 **residency, and if you don't graduate from an**
18 **accredited residency then you can't practice as a**
19 **specialist. So...**
20 Q. Now, granted you've had that license since
21 1987. You took a series of exams to get that license?
22 A. **Yes.**

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1 Q. Did any of that have to do with providing
2 abortion services?
3 A. **Oh, I certainly can't recall.**
4 Q. Do you renew that license periodically?
5 A. **No. It's not required.**
6 Q. Oh, once you have it, you have it?
7 A. **You have it, you have it. That may not be**
8 **the case anymore. Certain licenses that were lifetime**
9 **licenses now do require recertification. But if you**
10 **got them before that happened, then you were**
11 **grandfathered in. So I don't even know the status of**
12 **that one. I've never been notified that I need to**
13 **renew it.**
14 Q. Very well. Thank you.
15 The next point is awards, and it indicates
16 that you were the recipient of a top doctor award in
17 2008 in Washingtonian Magazine.
18 Do you recall that?
19 A. **Yes.**
20 Q. Did that have anything to do with abortion
21 services, that award?
22 A. **Only tangentially.**

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1 Q. And how was it tangentially related?
2 A. **Again, I believe it was related to**
3 **providing evaluation, consultation and treatment to**
4 **women who were pregnant, women who had psychiatric**
5 **disorders or potential psychiatric disorders who were**
6 **pregnant, and postpartum services and treatment as**
7 **well. And, of course, in the course of addressing**
8 **pregnancy, abortion arises on occasion.**
9 Q. Do you know how you were selected to
10 receive that award?
11 A. **I believe that the process is that the**
12 **magazine polls doctors randomly in the metro D.C. area**
13 **and asks them to list people they would refer their**
14 **friends and family to, and I think that that's how**
15 **they do that.**
16 Q. I see.
17 Did you -- Did you give a speech when you
18 got that award?
19 A. **No. They -- No, it's not that kind of**
20 **award. They give it to a number of -- They pick like**
21 **ten people from each specialty, and they list them in**
22 **the magazine. And, you know, if you want, you can buy**

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1 **a plaque to hang in your office.**
2 Q. I gotcha.
3 And did they do a little descriptive piece
4 about you when you got your award that appeared in the
5 Washingtonian Magazine?
6 A. **No. They just list your name.**
7 Q. I see. Okay.
8 A. **I think they also list your contact**
9 **information.**
10 Q. All right. The next award that's specified
11 here is Manfred S. Guttmacher award in 2006, and that
12 was awarded by the American Psychiatric Association --
13 the American Academy of Psychiatry and the Law.
14 And do you recall receiving that award?
15 A. **Yes. I just received it again, so I'm also**
16 **the 2011 recipient of that award as well.**
17 Q. Now, in 2006 you gave a speech when you
18 received that award, didn't you?
19 A. **Well, it's not a speech. It's an academic**
20 **lecture.**
21 Q. I see. Okay, an academic lecture.
22 And that was on sexual harassment and

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1 psychiatric assessment in employment litigation,
2 correct?
3 **A. Well, the book was. The speech wasn't.**
4 Q. What was the speech?
5 **A. It's not a speech. The lecture was on**
6 **sources of bias in employment evaluations.**
7 Q. That didn't have anything to do with
8 abortion services, did it?
9 **A. No.**
10 Q. And congratulations on being the 2011
11 recipient.
12 **A. Thank you.**
13 Q. Did you present a lecture in relation to
14 that award?
15 **A. Yes, I did.**
16 Q. And what was the topic of that lecture?
17 **A. It was a model for assessment of**
18 **disability, of psychiatric disability.**
19 Q. Did it have anything to do with abortion
20 services?
21 **A. No.**
22 Q. In 1997 you were the recipient of the

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1 Washington Psychiatric Foundation Community Service
2 Award.
3 Do you recall that?
4 **A. Yes.**
5 Q. And what did that award signify?
6 **A. At that time I was doing -- I was**
7 **volunteering hours for the local Washington**
8 **Psychiatric Society hotline for people who would call**
9 **up with psychiatric questions or needing a psychiatric**
10 **referral and I would try to help them out. I provided**
11 **a certain number of hours for I think it was a few**
12 **years.**
13 Q. So the award recognized that service?
14 **A. Right. It's a community service award.**
15 Q. Did you provide clinical consultations to
16 people who called in on that hotline or whatever it
17 was called?
18 **A. No.**
19 Q. Did you ever refer anybody to a physician
20 for an evaluation to get an abortion as a result of
21 working on that -- in that capacity?
22 **A. No. That would not be an appropriate**

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1 **suggestion.**
2 Q. Now, other than the 2011 Guttmacher award
3 that we just talked about a few moments ago, are there
4 any other awards that we should add to this part of
5 your CV?
6 **A. No.**
7 Q. The next page of your CV deals with the
8 summary of your professional experience, and it's
9 arranged in kind of reverse chronological so we'll
10 start with the most current and work our way back.
11 It indicates in this April 2009 version of
12 your CV that from 2001 to that time you were in
13 private practice in clinical and forensic psychiatry
14 in Arlington, Virginia, since 1992. Is that correct?
15 **A. No. My private practice was in the**
16 **District of Columbia where I treated inpatients at the**
17 **Psychiatric Institute of Washington, and I did that**
18 **from 1992 to 1997 I believe.**
19 **And until 2002 my office practice was**
20 **located in McLean, Virginia, and in 2002 I moved to**
21 **Arlington, Virginia.**
22 Q. Okay. So if it says since 1992, that was

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1 probably just a typo?
2 **A. Well, I would have to see it. I mean, if I**
3 **didn't delineate the locations, I would have to -- I**
4 **may have delineated them later. I would have to look**
5 **at the document to see whether it's a typo or just not**
6 **a clear statement.**
7 Q. All right.
8 MR. HAYS: Bob, we can show her a copy of
9 it. I have it up on my laptop.
10 MR. EYE: That would be great. Thank you,
11 Reese.
12 THE WITNESS: Yeah, I would say it looks
13 like for some reason I put -- well, the part that's
14 correct is private practice clinical and forensic
15 psychiatry since 1992. That part is correct. The
16 Arlington, Virginia, is not correct since I was also
17 in McLean, Virginia. And then I did list
18 St. Elizabeth's.
19 Yeah, it's a little confusing. I
20 apologize.
21 BY MR. EYE:
22 Q. That's all right.

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1 Doctor, in the course of the private
2 practice that you specify in that section of your CV,
3 I assume that you didn't provide any opinions to
4 either patients or other physicians concerning whether
5 a woman should receive a late-term abortion in order
6 to preserve her mental health?
7 **A. No.**
8 Q. No meaning you did not provide such an
9 opinion?
10 **A. Correct.**
11 Q. Thank you.
12 It indicates that you were a consultant at
13 St. Elizabeth's Hospital, the John Howard Pavilion,
14 in 2008. Is that correct?
15 **A. Yes.**
16 Q. What did you consult about?
17 **A. Those are -- That's the forensic wards, and**
18 **those are patients who are being treated and evaluated**
19 **for things like they've been found not competent to**
20 **stand trial and they've been committed in order to try**
21 **to restore competency. Some of them are there for**
22 **evaluations of whether -- for not guilty by reason of**

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1 **insanity evaluations. Some of the more significant or**
2 **other legal matters that may involve psychiatric**
3 **issues and evaluations.**
4 Q. I see.
5 I assume none of that had to do with
6 providing abortion services.
7 **A. Correct.**
8 Q. It indicates that you are on the medical
9 staff of the Virginia Hospital Center, Department of
10 Psychiatry in 2004. Is that correct?
11 **A. Yeah, starting in 2004 to the present. I'm**
12 **still on that.**
13 Q. Okay. And is the Virginia Hospital Center,
14 is that located in Arlington?
15 **A. Yes, it is.**
16 Q. And does it provide abortion services?
17 **A. I don't know.**
18 Q. And the next designation is that of a court
19 consultant for the Arlington County district and
20 circuit courts, and that's from 2008 to the present.
21 Are you still doing that consulting?
22 **A. Yes. And I've also -- I should probably**

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1 **put down Alexandria courts and Fairfax County courts.**
2 Q. And what sort of consultations do you
3 provide in that regard, Doctor?
4 **A. I do court ordered competency to stand**
5 **trial evaluations and some criminal responsibility**
6 **evaluations.**
7 Q. Nothing to do with abortions, correct?
8 **A. No.**
9 Q. Is there anything else that we should add
10 to that experience summary from 2001 to today other
11 than what we've already covered?
12 **A. No.**
13 Q. The next time designation is from 1992
14 to 2000, and recognizing that there may be some
15 overlap there with what you're doing currently, but
16 the first designation is private practice, clinical
17 and forensic psychiatry in McLean, Virginia.
18 **A. Okay.**
19 Q. And I think we covered the locale issue.
20 **A. Right.**
21 Q. Was that just a function of changing the
22 location of your office?

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1 **A. Yes. I moved.**
2 Q. All right. But did the scope of your
3 practice change as a result of moving? I presume it
4 stayed more or less the same.
5 **A. That is correct. There was no significant**
6 **change.**
7 Q. It indicates that you were attending
8 psychiatrist from 1997 through 2000 at the Columbia
9 HCA Reston Hospital in Reston, Virginia. Is that
10 correct?
11 **A. Yes.**
12 Q. Does the Columbia HCA Reston Hospital
13 provide abortion services?
14 **A. I don't know.**
15 Q. In your work as attending psychiatrist at
16 that facility from '97 through 2000, did you ever deal
17 with patients who were seeking abortion services?
18 **A. No.**
19 Q. Why did you end your affiliation with
20 Columbia HCA Reston in 2000?
21 **A. My role there was I would be called in,**
22 **often on an emergency basis for a medical or surgical**

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

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

13 Q. I understand.

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

21 A. No.

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

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

3 A. Yes.

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

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

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

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

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

15 A. Yes.

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

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

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

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1 A. That is correct.

2 Q. Is it an admitting hospital?

3 A. Yes, it is.

4 Q. And you had admission privileges there?

5 A. Yes.

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

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

12 Q. Dr. Gold, it indicates that from 1992 to
13 1997 you were an attending psychiatrist at the
14 Psychiatric Institute of Washington, D.C.

15 Did you see patients in that capacity?

16 A. Yes.

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

20 A. Yes.

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

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1 Institute. What did that deal with?

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

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

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

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

21 A. No.

22 Q. How about for abortions that weren't late

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1 term, that is first trimester or second trimester?
2 **A. Can you define what you mean by evaluate**
3 **patients for abortion?**
4 Q. Did you ever have an occasion to evaluate a
5 patient to determine whether an abortion in the first
6 or second trimester was consistent with preserving the
7 health of the mother?
8 **A. In the course of treating patients who were**
9 **pregnant and who may have wanted to consider the**
10 **option of an abortion, we would discuss the**
11 **implications of an abortion on their mental health as**
12 **well as on, you know, social issues, et cetera, that**
13 **they may have. That's the best I can answer that.**
14 Q. But specifically as to whether an abortion
15 would be consistent with preserving the mental health
16 of the mother, did you do that sort of evaluation?
17 **A. No.**
18 Q. The next time frame that's covered in your
19 CV is from --
20 **A. Let me back up and say that we would**
21 **discuss what the implications of getting an abortion**
22 **might be on her mental health. But a formal**

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1 **declaration, I'm doing an evaluation to determine**
2 **whether this is necessary to preserve the mental**
3 **health, no.**
4 Q. Thank you.
5 The next time frame is 1986 to 1992. And
6 the first thing that's specified there is an
7 affiliation with the Psychiatric Institute of Catholic
8 Medical Center of Manchester, New Hampshire.
9 **A. I'm pretty sure they didn't provide**
10 **abortions.**
11 Q. Okay. Thank you for anticipating that.
12 You were the associate medical director.
13 What were your duties in that capacity, Doctor?
14 **A. It was a smallish inpatient psychiatry**
15 **unit, and I evaluated and treated about half the**
16 **patients on the unit, so that would be anywhere**
17 **between nine and 12 patients, and also provided**
18 **psychiatric consultations in the rest of the hospital.**
19 Q. Did any of your practice at the Catholic
20 Medical Center have to do with abortions?
21 **A. Oh, unlikely. We weren't even allowed to**
22 **prescribe birth control pills, so, you know...**

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1 Q. Fair enough.
2 It indicates that in 1991 to 1992 you were
3 the attending psychiatrist at the Nashua Brookside
4 Hospital in Nashua, New Hampshire. What were your
5 duties in that regard?
6 **A. I believe that was a psychiatric facility**
7 **only, so I would evaluate and treat patients there.**
8 Q. Did any of your practice there have to do
9 with abortions?
10 **A. Not that I recall.**
11 Q. It indicates that in that same time frame,
12 '91 to '92, you were at the National Memorial Hospital
13 in Nashua, New Hampshire, as attending psychiatrist.
14 I assume that that's a different hospital than
15 Brookside?
16 **A. Yes.**
17 Q. So Nashua, New Hampshire, has two
18 hospitals?
19 **A. Well, I think the National Memorial**
20 **Hospital was a general hospital that had a small**
21 **psychiatric unit. Brookside was a separate**
22 **psychiatric hospital, freestanding psychiatric**

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1 **hospital.**
2 Q. I see. And did National Memorial Hospital
3 provide abortion services?
4 **A. I don't know.**
5 Q. Did any of your practice there in '91 to
6 '92 have to do with abortions?
7 **A. I don't recall. Certainly not directly.**
8 Q. It indicates that from 1990 to 1991 that
9 you were the assistant clinical director at the
10 Psychiatric Institute of Malden Hospital in Malden,
11 Massachusetts. Was that another freestanding
12 psychiatric facility?
13 **A. No. That was a general hospital.**
14 Q. I see.
15 And did it provide abortion services?
16 **A. I don't know.**
17 Q. Did any of your practice as the assistant
18 clinical director have to do with abortions?
19 **A. Again, not directly. It's possible that**
20 **indirectly -- I don't recall, but if any of the**
21 **patients were pregnant, it might have come up in the**
22 **course of treatment.**

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1 Q. In Massachusetts during the '90 to '91 time
2 frame could a woman get a late-term abortion?
3 **A. I don't know.**
4 Q. How about the same time frame in New
5 Hampshire, could a woman get a late-term abortion?
6 **A. I don't know.**
7 Q. It indicates that in '90 to '91 you were a
8 clinical instructor of psychiatry at Boston University
9 School of Medicine. Is that correct?
10 **A. Yes.**
11 Q. And is that affiliated with a hospital?
12 **A. That's affiliated with University Hospital
13 and Boston City Hospital and the VA Hospital in
14 Bedford, Massachusetts. It's affiliated with the
15 residency program.**
16 Q. I see. And do any of those hospitals, that
17 affiliation that you just mentioned, do any of those
18 hospitals provide abortion services?
19 **A. I don't know.**
20 Q. Did they during the 1990 to 1991 time
21 frame?
22 **A. I don't know.**

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1 Q. When you were the clinical instructor in
2 psychiatry from '90 to '91 at the Boston University
3 School of Medicine, what classes did you teach?
4 **A. Well, when it says clinical instructor, it
5 means you're not really doing classes, you're doing
6 clinical instruction. And basically that involved
7 teaching medical students and residents in training
8 who are less experienced than yourself.**
9 Q. I see.
10 **A. So if you're a third year, you teach first
11 year, second year and medical students.**
12 Q. I see. Okay.
13 And Doctor, did any of those duties involve
14 teaching students how to evaluate patients for
15 purposes of receiving an abortion?
16 **A. No. I don't think there is such a thing.**
17 Q. The next point in your CV is that you were
18 the attending psychiatrist at the Hampstead Hospital,
19 Hampstead, New Hampshire, in 1990 to 1991.
20 Do you recall that experience?
21 **A. Yes.**
22 Q. Did the Hampstead Hospital in 1990 to 1991

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1 provide abortion services?
2 **A. No. That was a freestanding psychiatric
3 hospital.**
4 Q. So the next point here is as an attending
5 psychiatrist at the Charles River Hospital in
6 Wellesley, Massachusetts, from '88 to 90.
7 Did Charles River Hospital provide abortion
8 services?
9 **A. No. That was a freestanding psychiatric
10 hospital.**
11 Q. In either Hampstead or Charles River
12 Hospital when you were attending psychiatrist, did any
13 of your practice deal with evaluating women for
14 abortion services?
15 **A. No.**
16 Q. The next section in your CV is
17 "Professional Affiliations," and the first thing that
18 is listed under that is the American Academy of
19 Psychiatry and the Law, 1997.
20 Is that correct, that you've been
21 affiliated with that since '97?
22 **A. Yes.**

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

65

1 abortions?
2 **A. I don't recall.**
3 Q. Did you have anything to do with presenting
4 a paper or a program or information during that annual
5 meeting?
6 **A. Yes.**
7 Q. And what was your presentation on?
8 **A. Let's see. I did one on sexual harassment,**
9 **one on the history of forensic psychiatry, and I**
10 **participated in a mock trial.**
11 Q. Cool.
12 **A. It was.**
13 Q. I bet.
14 Did any of your papers or presentations,
15 did it touch in any way on abortions?
16 **A. No.**
17 Q. Did the mock trial?
18 **A. No. The mock trial dealt with postpartum**
19 **psychosis, but not abortion.**
20 Q. It indicates that in your affiliation with
21 the American Academy of Psychiatry and the Law that
22 from 2005 to 2007 you chaired the task force on

66

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

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1 Q. You were active in some committees related
2 to that organization as well. One was the newsletter
3 editor search committee in 2008. I assume that didn't
4 have anything to do with abortions?
5 **A. Correct.**
6 Q. Let me just ask you: Did your work in any
7 of the committees have anything to do with abortions?
8 **A. No.**
9 Q. The next organization that's listed is the
10 Chesapeake Bay Chapter of the American Academy of
11 Psychiatry and the Law.
12 Are you still affiliated with that
13 organization?
14 **A. Well, I'm still a member.**
15 Q. You were president from 2004 to 2008,
16 correct?
17 **A. Correct.**
18 Q. Did the Chesapeake Bay Chapter of the
19 American Academy of Psychiatry and the Law ever deal
20 with abortion issues?
21 **A. I don't know about ever. Not in the time**
22 **that I was associated with it.**

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1 Q. So not while you've been associated with
2 it?
3 **A. Correct.**
4 Q. The next organization affiliation that's
5 listed is the American Psychiatric Association. It
6 indicates that you were a member of that from 1986.
7 Are you still a member?
8 **A. Yes.**
9 Q. And you were designated distinguished
10 fellow in 2006. How did you get to become a
11 distinguished fellow?
12 **A. Oh, you have to be nominated and letters of**
13 **support have to be written.**
14 Q. To your knowledge, does the American
15 Psychiatric Association, does it have an official
16 position related to abortion?
17 **A. Not that I'm aware of.**
18 Q. And you became as opposed to a
19 distinguished fellow, a fellow in 2003. Was the
20 selection process similar to becoming a distinguished
21 fellow?
22 **A. I don't think so. As you go up, fellow,**

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

7 Q. I see.
8 And did anything in terms of being either
9 distinguished fellow or fellow have any relationship
10 to abortion or abortion services?

11 A. No.

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

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

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

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

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

9 Q. Okay.

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

12 Q. Right.

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

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

19 Q. Okay. What did you do on --

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

22 Q. So are you not on that committee anymore?

71

1 A. That is correct.

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

5 A. No.

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

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

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

14 A. No.

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

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

21 A. No.

22 Q. The next organization that you list is the

72

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

3 Are you still a member of that?

4 A. Yes.

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

7 A. Yes, it is.

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

10 A. No.

11 Q. How about are you active in any committees?

12 A. No.

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

15 A. Not that I'm aware of.

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

18 A. I presume so, yes.

19 Q. You don't know?

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

22 Q. Why do you presume that?

73

1 **A. Because they're legal, and there is a**
2 **demand for them, and if something is legal and there**
3 **is a demand for it, someone provides a service.**
4 Q. So when you say available, you mean
5 someplace within the United States, if a woman wanted
6 an abortion she could find somebody to provide that?
7 **A. No. I presume there are doctors and**
8 **clinics who provide, among other services, abortions**
9 **under appropriate circumstances within the legal**
10 **parameters where that's allowed. And I presume**
11 **wherever it is legal to do so, there are services**
12 **available for people who desire to avail themselves of**
13 **those services.**
14 Q. You've already noted a couple of
15 affiliations that you've had with hospitals that did
16 not provide abortion services, correct?
17 **A. Yes.**
18 Q. Have you ever been affiliated with a
19 hospital that you know of that provides abortion
20 services?
21 **A. Again, I presume, but don't know for a**
22 **fact, that some of the general medical hospitals that**

74

1 **I've been affiliated with provide abortion services**
2 **because those are among standard services provided in**
3 **OB/GYN surgical departments.**
4 Q. Have you ever had any involvement with
5 those services, that is abortion services, at any of
6 those hospitals that you presume provide those
7 services?
8 **A. No.**
9 Q. You've been a member of the American
10 Medical Association since 2002. Are you still an
11 active member?
12 **A. Yes, I am.**
13 Q. Do you belong to any subgroups of the AMA?
14 **A. I might. I think by virtue of joining the**
15 **AMA they sign you up for your local chapter. I may be**
16 **a member of the Northern Virginia -- whatever the**
17 **local Northern Virginia chapter is, or it might be a**
18 **Metro D.C. chapter. I don't know.**
19 Q. In your affiliation with the AMA
20 since 2002, has any of that involved abortions?
21 **A. No.**
22 Q. The next thing you list is the American

75

1 Society of Clinical Psychopharmacology, and that's
2 from 1997.
3 Are you still a member of that?
4 **A. No.**
5 Q. And when did your membership cease?
6 **A. A few years ago, probably.**
7 Q. Any particular reason why you're no longer
8 a member of that particular organization?
9 **A. It was a relatively inactive organization**
10 **and I wasn't getting a lot out of it, but I had to pay**
11 **dues to belong to it, and it didn't seem like a useful**
12 **way to spend money.**
13 Q. When you were a part of that organization,
14 do you recall whether it ever dealt with, as an
15 organization, abortions?
16 **A. It didn't do much of anything, so no.**
17 Q. The next organization you list is
18 Association of Women Psychiatrists. It indicates you
19 joined it in '97.
20 Are you still a member?
21 **A. Yes.**
22 Q. And does that cover a particular geographic

76

1 area or is it a nationwide organization?
2 **A. That's a national organization. It's an**
3 **offshoot of the American Psychiatric Association,**
4 **affiliated.**
5 Q. Okay. And in that organization, does it
6 take a position on abortions?
7 **A. Not that I'm aware of.**
8 Q. Are you actively involved with that
9 organization in terms of serving on committees, for
10 example?
11 **A. No.**
12 Q. Have you ever presented any papers or
13 lectures with that organization?
14 **A. No.**
15 Q. Have you ever attended a meeting of that
16 organization?
17 **A. No.**
18 Q. So you wouldn't know whether at meetings
19 they talk about abortions?
20 **A. No, I would not know.**
21 Q. The last organization you list is the
22 Fairfax County Medical Society, and it indicates you

77

1 joined that in '92.
2 Are you still a member?
3 **A. No.**
4 Q. And when did your membership cease in that
5 organization?
6 **A. Probably before 2009, so it shouldn't be on**
7 **there.**
8 Q. And do you still practice in Fairfax
9 County?
10 **A. No. My office is Arlington County, so it**
11 **would be in Arlington County. I provide forensic**
12 **services, so I suppose I could rejoin on the basis of**
13 **my forensic services, but I have not done so.**
14 Q. Are you a member of the Arlington County
15 Medical Society or an equivalent organization?
16 **A. I am not. I don't know that there is an**
17 **Arlington County Medical Society.**
18 Q. During the time that you were affiliated
19 with the Fairfax County Medical Society, did you ever
20 deal with abortion issues as part of your membership?
21 **A. No.**
22 Q. Do you know whether that organization dealt

78

1 with abortion issues?
2 **A. I don't know.**
3 Q. The next designation deals with committee
4 memberships. The first one is the American Board of
5 Psychiatry and Neurology. It doesn't say when you
6 were -- what time frame that you had an affiliation
7 with that entity.
8 Can you recall when it was that you were a
9 part of that?
10 **A. I think it was 2008. And it's ongoing.**
11 Q. And what is that? What do you do in
12 relation to that?
13 **A. I'm on the subcommittee for forensic**
14 **psychiatry. We write the questions that are given as**
15 **part of the board certification test.**
16 Q. Does that have anything to do with
17 abortions?
18 **A. No.**
19 Q. The next thing that's designated is the
20 Forensic Psychiatry Certification Examination
21 Committee. It indicates on your CV that's from 2008
22 to 2011.

79

1 Are you affiliated with that committee?
2 **A. That sounds like the same thing to me. I'm**
3 **not sure where it's there twice.**
4 Q. And if I ask you a question about abortion
5 services, is your answer the same?
6 **A. Yes.**
7 Q. The next thing that is designated deals
8 with public service activities. And the first thing
9 that is noted there is the Commonwealth of Virginia
10 Commission on Mental Health Law Reform.
11 When was it that you were engaged in that
12 particular activity?
13 **A. Does it not say?**
14 Q. It doesn't.
15 **A. Ah, damn. It was in the year after the**
16 **Virginia Tech shootings. I think the Virginia Tech**
17 **shootings were 2008 or 2009. So...**
18 Q. Okay. So those shootings, did that
19 motivate you to get involved in the Commission on
20 Mental Health Reform?
21 **A. The Commission on Mental Health Reform was**
22 **organized in response to the Virginia Tech shootings.**

80

1 Q. Did you volunteer to be part of that
2 commission?
3 **A. Yes, I did.**
4 Q. Did it have anything to do with abortion
5 services?
6 **A. No.**
7 Q. The next designation is the working group
8 on health privacy and the civil commitment process.
9 That was from 2007 to 2008. Is that correct?
10 **A. Yes. That's what I did on the Virginia**
11 **mental health reform. That was the subcommittee I was**
12 **on.**
13 Q. Okay, I gotcha. Thank you.
14 The next designation on your CV deals with
15 academic activities, and the first thing that is
16 listed is CME, LLC, psychiatric congress peer
17 reviewer, 2006 to 2008. I'm going to assume that CME
18 deals with continuing medical education.
19 **A. That's correct.**
20 Q. And LLC, what does that stand for?
21 **A. I don't know. It's the name of their**
22 **company.**

81

1 Q. Okay.

2 A. **Yeah.**

3 Q. So it's a company?

4 A. **Yes.**

5 Q. And what's your activity with that company?

6 A. **Well, they put on programs where doctors**

7 **can earn continuing medical education. And the**

8 **programs that they put on, before they -- before**

9 **someone can present at one of those programs, their**

10 **presentation has to be evaluated by a peer reviewer,**

11 **or by a number of peer reviewers. So if the peer**

12 **reviewers say this is silly and it's not useful,**

13 **whatever, they won't put it on.**

14 Q. I see. Are you compensated for that --

15 A. **No.**

16 Q. -- peer review?

17 A. **Oh, I'm sorry. I think I am. I think I**

18 **get like \$25 an hour or something like that. It's**

19 **pretty minimal.**

20 Q. And you did that from 2006 to 2008. Do you

21 do it anymore?

22 A. **No.**

82

1 Q. So you actually reviewed programs that were

2 proposed to be offered for CME?

3 A. **Correct.**

4 Q. Did any of them have to do with abortions?

5 A. **Not that I recall.**

6 Q. The next thing that's designated is the

7 American Academy of Psychiatry and the Law program

8 chair for the 2006 annual meeting in Chicago.

9 Did we already talk about that?

10 A. **Yes.**

11 Q. Is there anything else that you need to add

12 as it relates to abortion services?

13 A. **No.**

14 Q. The next thing that's listed is the

15 St. Elizabeth's Hospital centennial celebration

16 from 2004 to 2005. I'm going to take a wild guess and

17 assume that that didn't have anything to do with

18 providing abortion services.

19 A. **That's correct.**

20 Q. The next thing that's listed, Dr. Gold, is

21 you served as a program director for the educational

22 symposium for something called the role of the public

83

1 psychiatric hospital in the 21st century.

2 Just to digress a moment, the public

3 psychiatric hospital entity is kind of an endangered

4 species these days, isn't it?

5 A. **Yes. Yes and no, but yes.**

6 Q. In your capacity as the program director of

7 that educational symposium, what did you do?

8 A. **Well, that was affiliated with the**

9 **St. Elizabeth's sesquicentennial. It was a day-long**

10 **educational program that I organized in which a number**

11 **of presenters presented academic lectures available**

12 **for CME credit for people who attended on that**

13 **particular topic, various aspects of that topic.**

14 Q. And when you were in that capacity, did you

15 review the presentations that were proposed, or the

16 topics?

17 A. **I didn't review them in detail. I reviewed**

18 **sort of abstracts or summaries.**

19 Q. Did you have the duty to approve or not

20 approve what was proposed to be presented?

21 A. **It wasn't quite that formal. These were**

22 **all people who were volunteering for no money to come**

84

1 **and talk. So...**

2 Q. I understand.

3 Did any of them present information about

4 abortions or abortion services?

5 A. **No.**

6 Q. The next thing that's listed is to be on

7 the advisory committee for continuing medical

8 education in Psychiatric Times. And that was in 2000.

9 What did that involve?

10 A. **I think that also involved some peer**

11 **review, but I don't recall specifically.**

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

13 or abortion services?

14 A. **No.**

15 Q. The next designation on your CV is journal

16 affiliations, and the first one that's specified is an

17 editorial board position with the Journal of the

18 American Academy of Psychiatry and the Law, and that

19 was from 2009 to it says 2011.

20 Are you still involved with that?

21 A. **I think my involvement ended last month.**

22 Q. Okay. And what did you do as a member of

85

1 the editorial board in that regard, or for that
2 organization?
3 **A. Well, there is a lot of stuff.**
4 Q. Did you review papers that were proposed
5 for publication?
6 **A. Yes, I'm a peer reviewer, but that's**
7 **separate from being on the board.**
8 Q. Okay. Did the board deal with abortions or
9 abortion services while you were on it?
10 **A. Not that I recall.**
11 Q. As part of the editorial function, did you
12 ever review papers that dealt with abortions or
13 abortion services?
14 **A. Not that I recall.**
15 Q. The next thing that's listed as an
16 editorial board affiliation is Psychiatric Analyst as
17 an editorial review board member from '99, it says to
18 present.
19 Are you still on that?
20 **A. Yes.**
21 Q. And what are your duties in that regard?
22 **A. Every once in a while they call me up and**

86

1 **ask me for opinions about various types of issues and**
2 **whether they might be of interest, et cetera. It's**
3 **pretty minimal.**
4 Q. Have you ever been asked to provide an
5 opinion about something related to abortions?
6 **A. For that journal?**
7 Q. Yes.
8 **A. No.**
9 Q. The next thing that's listed under your
10 journal affiliations is as a peer reviewer, and the
11 first one is the American Journal of Psychiatry.
12 Anything in that regard that you've done
13 related to abortions?
14 **A. No.**
15 Q. The next one is Journal of American Academy
16 of Psychiatry and the Law.
17 Anything that deals with abortions there?
18 **A. No.**
19 Q. You've been a peer reviewer for Obstetrics
20 and Gynecology. Anything that deals with abortions
21 there?
22 **A. No.**

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1 Q. The next one is for Primary Psychiatry.
2 Anything that deals with abortions there?
3 **A. No.**
4 Q. The last one listed is Behavioral Sciences
5 and the Law. The same question.
6 **A. No.**
7 Q. Are there any other peer reviewing
8 activities that you are engaged in that are not listed
9 there?
10 **A. There are. In the last couple of years**
11 **there have been some other ones. I can't remember**
12 **specifically what they are.**
13 Q. Did any of them have to do with abortions
14 or abortion services?
15 **A. No.**
16 Q. The next section of your CV is
17 publications. A lot of these I can sort of glean from
18 the title they don't have anything to do with
19 abortions.
20 MR. EYE: Reese, is it possible that you
21 could give Dr. Gold the CV that's on your laptop and
22 maybe it would expedite going through these.

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1 MR. HAYS: I can, and she has it.
2 MR. EYE: Thanks, Reese.
3 BY MR. EYE:
4 Q. Page 5, Doctor.
5 **A. Okay, got it.**
6 Q. Let's kind of do it this way. I'm going to
7 assume that the first two, Evaluating Mental Health
8 Discipline in the Workplace and Sexual Harassment,
9 Psychiatric Assessment and Employment Litigation don't
10 have anything to do with abortions.
11 **A. Correct.**
12 Q. The next one is the American Psychiatric
13 Publishing Textbook of Forensic Psychiatry. And you
14 were a co-editor of that, correct?
15 **A. Correct. And that's actually out now in a**
16 **second edition in 2009.**
17 Q. And were you the co-editor of the second
18 edition?
19 **A. Yes.**
20 Q. And does it deal with abortions or abortion
21 services? Is there anything in that text about
22 abortions?

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1 **A. No.**
2 Q. There is a study guide that I assume that
3 is part of that textbook that's listed right
4 underneath.
5 **A. Correct.**
6 Q. Does it cover abortions or abortion
7 services?
8 **A. No.**
9 Q. The next section is -- well, I should ask:
10 Are there any other books that you've had an
11 involvement with that ought to be listed there that we
12 haven't covered?
13 **A. No. Book chapters are listed in a separate**
14 **section, so...**
15 Q. Okay. And speaking of book chapters,
16 that's the next section. Gender Issues in Suicide.
17 Do you see that?
18 **A. Yes.**
19 Q. Did that deal with any aspect of abortions
20 or abortion services?
21 **A. No.**
22 Q. The next is -- and I'm looking at the top

90

1 of page 6. It says -- the title is "Rediscovering
2 Forensic Psychiatry." And you were an editor of that
3 publication?
4 **A. Well, I wrote that chapter and it's in the**
5 **edited publication.**
6 Q. I see. Okay. And did you cover anything
7 that deals with abortions in that chapter?
8 **A. No.**
9 Q. I'm going to assume that the next one, "The
10 Workplace," didn't have anything to do with abortions?
11 **A. Correct.**
12 Q. The next one is "Ethical Issues in Forensic
13 Psychiatry." Anything to do with abortions in that
14 chapter?
15 **A. No.**
16 Q. The next one is "Psychiatric Diagnoses in
17 Forensic Psychiatry." Anything to do with evaluations
18 for women who seek abortion services in that chapter?
19 **A. No.**
20 Q. I'm going to assume that there is nothing
21 in the sexual harassment chapter that deals with
22 abortion or abortion services. Correct?

91

1 **A. Correct.**
2 Q. The next one is "Psychiatric Diagnoses and
3 the Retrospective Assessment of Mental Status." Did
4 anything in that chapter cover abortions or abortion
5 services?
6 **A. No.**
7 Q. You were an honorable mention for the
8 Guttmacher Award for 2002.
9 **A. The book was.**
10 Q. Oh, I'm sorry, the book was.
11 **A. Yeah.**
12 Q. Thank you. Thank you.
13 I'm going to assume the PTFE employment
14 litigation doesn't have anything to do with abortions,
15 correct?
16 **A. Correct.**
17 Q. I assume nothing in the post-trauma stress
18 disorder employment cases have to do with abortions,
19 correct?
20 **A. Correct.**
21 Q. Any other book chapters that you've been
22 responsible for authoring other than that which is

92

1 covered in this section?
2 **A. No.**
3 Q. The next section is entitled "Articles."
4 **A. And I've had a few more things published**
5 **since 2009.**
6 Q. As articles?
7 **A. Yes.**
8 Q. Okay. Well, let's get to those -- Well,
9 what are they?
10 **A. I don't --**
11 Q. Has anything published since 2009 had any
12 discussion related to abortions or abortion services?
13 **A. No.**
14 Q. I'm going to assume the articles on "POWs
15 Against their Torturers" didn't have anything to do
16 with abortions.
17 **A. Correct.**
18 Q. Ditto with "Forensic Evaluation of
19 Psychiatric Disability Practice Guidelines"?
20 **A. Correct.**
21 Q. Maybe we could shorten this up. Is there
22 any article that's listed that covers abortions or

93

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

94

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

95

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

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1 this section?
2 **A. I don't think so, no.**
3 **Q.** The next section, you've written some book
4 reviews.
5 **A. Correct.**
6 **Q.** The first one is entitled -- well, it
7 reviewed a book that was entitled "A Physician's
8 Guide: Adverse Events, Stress, and Litigation."
9 Did any of that cover abortions or abortion
10 services?
11 **A. No.**
12 **Q.** The next one appeared in the American
13 Journal of Psychiatry, and it was a review of the
14 Clinical Manual of Psychiatry and the Law.
15 Do you remember that review?
16 **A. Yes.**
17 **Q.** Did anything in that review have to do with
18 abortions or abortion services?
19 **A. No.**
20 **Q.** Any other book reviews that you have
21 authored since April '09 that should be included in
22 this section?

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1 **A. No.**
2 Q. The next section is "Invited
3 Presentations," and that covers several pages. Can
4 you look at that list, Dr. Gold, and designate for us
5 or tell us which ones had anything to do with
6 abortions or abortion services.
7 **A. None of them.**
8 Q. One of the things that's listed there is
9 the Guttmacher Award lecture. We touched on that a
10 little bit earlier, the 2006 award.
11 Is it my understanding that as a recipient
12 of that award you can pick whatever topic you want,
13 basically, to provide a lecture about?
14 **A. Yeah, pretty much.**
15 Q. I looked at the other award recipients over
16 the years and it was a very wide ranging scope of
17 presentations.
18 **A. Yeah.**
19 Q. So were you limited in any way about the
20 topic that you could present on?
21 **A. No.**
22 Q. One of the -- it's at the bottom of page --

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1 I'm sorry, in the middle of page 11. You gave a
2 lecture on women and depression.
3 **A. Yes.**
4 Q. That was by Glaxo Wellcome Pharmaceuticals?
5 **A. Yes.**
6 Q. Is that a compensated presentation?
7 **A. That one was, yes.**
8 Q. And what about the one right at the bottom,
9 use of psychiatric drugs in treatment of depression
10 during pregnancy. That was sponsored by Forest
11 Pharmaceuticals. Was that compensated?
12 **A. Yes.**
13 Q. And there was -- at the top of page 12
14 there is one entitled "Interprofession Ethics." Did
15 you go to Jackson Hole, Wyoming, to present that?
16 **A. Yes, I did.**
17 Q. Great. Were you compensated?
18 **A. No.**
19 Q. Other than just getting to be in Jackson
20 Hole?
21 **A. Yeah.**
22 Q. Did you have to pay your own way there?

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1 **A. Yes. And there was another -- There were**
2 **two presentations in Jackson Hole. I'm trying to find**
3 **them. The other one was on employment discrimination**
4 **evaluations.**
5 Q. Okay.
6 **A. Defending emotional injury claims in**
7 **employment litigation.**
8 Q. Right. But it is the case that at least in
9 that which you have listed in this iteration of your
10 CV, none of these presentations dealt with abortions
11 or abortion services?
12 **A. Correct.**
13 Q. Are there presentations that you have given
14 since April of 2009 that deal with abortion or
15 abortion services?
16 **A. No.**
17 Q. That is the end of the CV as I have it in
18 front of me. Is there any addition to the CV that
19 should be made that we have not covered that you can
20 think of as you sit there today?
21 **A. No. Again, with the caveat that there have**
22 **been additions since 2009 and I can't recall**

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1 **specifically what presentations I've done since 2009**
2 **other than the Guttmacher one which was last month.**
3 **I have had some more articles published,**
4 **but I can't recall specifically. I'm certainly happy**
5 **to provide an updated CV, that's not a problem, I just**
6 **don't have one with me.**
7 Q. Thank you. I appreciate that. If you give
8 that to Mr. Hays, I'm sure he'll hand it off to me.
9 MR. EYE: We've been going about two hours.
10 Would it okay to take a ten-minute break at this
11 point?
12 THE WITNESS: Yes.
13 (Recess taken.)
14 MR. EYE: For the court reporter, my
15 colleague Kelly Kauffman, and that's K-a-u-f-f-m-a-n,
16 and Bret Jarmar, J-a-r-m-a-r, are also with me in the
17 room right now. So that should be on the record.
18 BY MR. EYE:
19 Q. Dr. Gold, currently in your professional
20 endeavors, about what percentage of time do you spend
21 in a clinical practice?
22 **A. About 50 percent.**

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1 Q. And does that time include time seeing
2 patients in your office and seeing patients in
3 hospitals?
4 **A. I don't see patients in hospitals anymore
5 right now. So it would be all seeing patients in my
6 office.**
7 Q. And approximately what percentage of time
8 do you spend in academic endeavors?
9 **A. Oh, well, okay, let me rephrase that, then.
10 Probably about 40 percent of time in clinical
11 activities, 20 percent of time in academic endeavors
12 including writing and research.**
13 Q. And the remaining 40 percent, how is that
14 spent?
15 **A. In litigation or related forensic
16 activities whether it's litigation or not, the other
17 types I also mentioned.**
18 Q. And is the work that you're doing for the
19 staff of the Board of Healing Arts, does that fall
20 under the category of litigation?
21 **A. Yes. Well, yes, it falls under the
22 category of forensic evaluations.**

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1 Q. For litigation purposes?
2 **A. Yes. I mean -- Yes, now. When it started
3 it wasn't so. I mean, things change and morph over
4 time.**
5 Q. What is your compensation arrangement for
6 this case?
7 **A. \$400 an hour.**
8 Q. And what have you billed and collected thus
9 far?
10 **A. You know, I really couldn't tell you. I
11 didn't bring that information with me, and I didn't
12 look at it.**
13 Q. And so your time, for example, today is
14 \$400 an hour?
15 **A. That's correct.**
16 Q. Now, I think we've already established that
17 you don't have any privileges at hospitals that
18 perform abortions that you know of?
19 **A. Well, the hospitals may or may not provide
20 abortions. I have privileges at the Virginia Hospital
21 Center. I don't know whether they do abortions or
22 not.**

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1 Q. Now, I think your testimony earlier was
2 that abortion services are available in Washington,
3 D.C., correct?
4 **A. That is my assumption. I assume they're
5 available in Washington, D.C., Maryland and Virginia,
6 New Jersey, New York.**
7 Q. Are you aware of any limitations on
8 expenditure of municipal funds in Washington, D.C. for
9 abortion services?
10 **A. I am not aware, no.**
11 Q. So you're not aware of limitations enacted
12 by Congress in the last year on Washington, D.C.'s
13 ability to use municipal funds for abortions?
14 **A. Not specifically, no.**
15 Q. Dr. Gold, have you ever practiced in the
16 state of Kansas?
17 **A. No.**
18 Q. Have you ever been in Kansas?
19 **A. Not that I'm aware of.**
20 Q. Dr. Gold, do you have any affiliations with
21 advocacy groups that are related to abortion or
22 abortion services?

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1 **A. No.**
2 Q. Do you know who Cheryl Sullinger is?
3 **A. No.**
4 Q. Kathy Ostrowski?
5 **A. No.**
6 Q. Randall Terry?
7 **A. The name sounds familiar, but I don't know
8 who he is.**
9 Q. How about an organization called Operation
10 Rescue?
11 **A. Well, I've heard of them. You know,
12 they're in the news and stuff. But other than that,
13 no.**
14 Q. How about an organization called Kansans
15 for Life?
16 **A. No, never heard of them.**
17 Q. Birthright?
18 **A. No.**
19 Q. Right to Life of Kansas?
20 **A. I'm sorry?**
21 Q. An organization called Right to Life of
22 Kansas.

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1 **A. No.**
2 Q. Have you ever heard of a man named Phill
3 Kline?
4 **A. No.**
5 Q. How about Scott Roeder?
6 **A. I think he's the guy that shot Dr. Tiller.**
7 Q. Have you ever heard of Eric Rucker?
8 **A. I think he's the guy that shot the doctor**
9 **in Buffalo.**
10 Q. How about Steve Maxwell?
11 **A. No.**
12 Q. Have you ever attended a public meeting of
13 an organization that professes to be opposed to
14 abortion rights?
15 **A. No. Not intentionally for sure.**
16 Q. Do you ever remember an unintentional
17 attendance at such a meeting?
18 **A. No.**
19 Q. Have you ever corresponded with government
20 officials, elected or otherwise, concerning any aspect
21 of abortion rights?
22 **A. No.**

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1 Q. Have you ever testified before any
2 legislative body, state, federal or local for that
3 matter, about abortion?
4 **A. No.**
5 Q. Have you ever provided consultations for
6 Planned Parenthood?
7 **A. No.**
8 Q. How about any other providers of abortion
9 services?
10 **A. You mean as a paid consultant?**
11 Q. Well, let's say paid or unpaid.
12 **A. No.**
13 Q. Do you have personal views or a personal
14 position concerning the propriety of abortions?
15 **A. Of course.**
16 * Q **And what is that?**
17 **A. I'm not going to answer that question.**
18 * Q **Do you -- Do you consider**
19 **yourself to be pro-choice?**
20 **A. Do I -- I mean, my personal opinions, I**
21 **don't see how they're relevant. I know you're allowed**
22 **to ask them, but I don't see how they're relevant, so**

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

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

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1 Q. Of those three that she sent you, did any
2 of those -- were any of those included in the 11 that
3 you discussed in your reports that have been provided
4 to me?
5 **A. I believe so, but I'm not 100 percent sure.**
6 **I didn't go back and match them page for page. But I**
7 **believe to the best of my recollection they were.**
8 Q. All together, Dr. Gold, how many patient
9 charts have you reviewed on behalf of the Board of
10 Healing Arts staff?
11 **A. I believe 16.**
12 Q. Of the 16, I take it, then, you selected 11
13 for inclusion in your reports?
14 **A. No. I was asked to provide reports on 11.**
15 **I did not select which 11.**
16 Q. Who selected them?
17 **A. Someone at the Kansas board. I don't**
18 **recall if it was Ms. Selzler Lippert. They've had a**
19 **few attorneys over the last few years involved in this**
20 **case, so I can't remember which one specifically**
21 **selected them.**
22 Q. What criteria were used, if you know, to

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1 select the charts for you to write about?
2 **A. I don't know.**
3 Q. Did you inquire about the criteria?
4 **A. No.**
5 Q. What opinions were you asked to formulate
6 in this matter?
7 **A. I would have to look at the complaint to**
8 **refresh my memory and make sure I got all of them, but**
9 **primarily, without looking at the complaint, opinions**
10 **regarding standard of care for psychiatric evaluation**
11 **and documentation. And those are the primary ones.**
12 **Initially there were some other questions,**
13 **I think regarding treatment, but ultimately those were**
14 **not included, I believe, in the complaint.**
15 Q. Did you -- in the report -- and I think of
16 it as one report with sort of 11 subparts for each
17 chart, so if I use the singular, that's why.
18 But at any rate, you had a section for
19 "Records Reviewed" for each one of the charts. Do you
20 recall that? Do you have your report in front of you?
21 **A. Yes.**
22 Q. Actually, Doctor, is that part of the file

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1 that we've marked as an exhibit?
2 **A. Yes.**
3 Q. Okay, fair enough.
4 Now, in the "Records Reviewed" section, and
5 I'm looking at page 1. Do you see that?
6 **A. Yes.**
7 Q. Now, under the "Records Reviewed" section
8 it says that you got a letter of referral dated
9 June 19, 2009, from Ms. Selzler Lippert.
10 Do you see that?
11 **A. Yes, I do.**
12 Q. Is that letter referral in your file?
13 **A. No.**
14 Q. Does that letter referral discuss the
15 substance of the opinions that you were asked to
16 render?
17 **A. No.**
18 Q. Can you provide a copy of that letter of
19 referral for me?
20 **A. I hope so. I think it may be in the**
21 **administrative file, not the case file.**
22 Q. Okay. The next thing that you specify that

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1 you reviewed was definition of standard of care.
2 Do you see that?
3 **A. Yes.**
4 Q. And is that a separate document?
5 **A. I don't recall. If I listed it, I believe**
6 **it would be a separate document, but I don't recall**
7 **off the top of my head.**
8 Q. Do you know what the document is where you
9 have a definition of standard of care?
10 **A. I presume it's in the administration file.**
11 Q. What is the administration file?
12 **A. Well, the administration file is**
13 **communication from attorneys and that kind of thing**
14 **that is separate -- I keep that separate from my**
15 **working case file because it's not psychiatric notes**
16 **or, you know, evaluations or interviews. So that's**
17 **just my standard practice.**
18 **Because often -- I don't know if it's the**
19 **case in this case, but often that communication is**
20 **purged and so I've just gotten in the habit of keeping**
21 **it in a separate file, and if it's not privileged I**
22 **can bring that file in. But if it is privileged, then**

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1 **I don't have to worry about accidentally providing**
2 **something I'm not supposed to provide.**
3 Q. What is the source of the definition of
4 standard of care that you specify in the records
5 reviewed?
6 **A. I don't recall. And it would have been**
7 **provided by Ms. Selzler Lippert, but I don't recall.**
8 Q. I see. So that definition of standard of
9 care was not something that you formulated but it was
10 provided to you by counsel for the Board?
11 **A. Yes.**
12 Q. The next thing that you specify in the
13 records reviewed is a series of Kansas statutes.
14 Do you see that?
15 **A. Yes.**
16 Q. And for what purpose did you review those
17 Kansas statutes, Dr. Gold?
18 **A. Well, there is a standard of care which is**
19 **based upon, you know, what the average practitioner**
20 **would do or should be required to do as a minimum to**
21 **provide adequate care. And then there are legal**
22 **requirements. And the two things may not be the same.**

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1 **So typically in a case that's involving any**
2 **kind of standard of care issue I want to review the**
3 **legal -- if there are statutes relating to that, I**
4 **want to review those. Because the legal statutes may**
5 **not be entirely congruent with the actual standard of**
6 **care in real life.**
7 Q. I'm sorry. I didn't mean to interrupt you.
8 Are you finished with your answer?
9 **A. I'm sorry. The legal standards may not be**
10 **100 percent congruent with the actual standards of**
11 **practice in real life.**
12 Q. The statutes that you specify that you
13 reviewed, which ones of those set forth standard of
14 care?
15 **A. Standard of care, I don't recall that any**
16 **of them set forth the standard of care per se. I**
17 **would have to review them again to see if they did,**
18 **but I don't recall that they set forth the standard of**
19 **care.**
20 **That's something that isn't established by**
21 **statute typically. Legal requirements are, but**
22 **standard of care typically is not.**

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1 Q. Did your review of the statutes that are
2 specified form a basis for your opinions in this
3 matter?
4 **A. I would have to say no in the sense that**
5 **it's useful to know what the legal requirements are**
6 **and how they might differ from the standard of care,**
7 **where they're the same and where they differ.**
8 **But if they differ from the legal standard**
9 **of care -- I'm sorry, I misspoke. If they differ from**
10 **the legal requirements, they still might not be**
11 **outside the standard of care. So they really don't**
12 **form a basis in the sense that deviation from the**
13 **legal requirements may or may not indicate deviation**
14 **from standard of care.**
15 Q. Now, the definition of standard of care
16 that you were provided by counsel, did you adopt that
17 definition for your purposes?
18 **A. Yes, I did.**
19 Q. What was the source of that standard of
20 care definition? I mean, I know you got it from
21 counsel, but was it -- was it shown on that where it
22 came from?

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1 **A. I don't recall. I would have to look at**
2 **the document. And I apologize, I don't have the**
3 **document with me.**
4 Q. Now, you also say that you looked at K.A.R.
5 100-24-1, documentation regulation, correct?
6 **A. Correct.**
7 Q. And your purpose in reviewing that was
8 what?
9 **A. Well, again, it's the same thing, to see**
10 **what the law requires for documentation, because that**
11 **varies from state to state. All of these statutes**
12 **vary from state to state. And really, a comparison of**
13 **what the standard of care would be for your average**
14 **psychiatric practitioner.**
15 Q. And Dr. Gold, have you in your litigation
16 consultation past, prior to this case, ever done a
17 standard of care analysis for somebody who is
18 providing abortion services or abortion-related
19 services?
20 **A. No.**
21 Q. And have you since this case where you
22 rendered a report, you know, last year basically, a

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1 year or so ago, have you done any further work related
2 to standard of care in abortion-related matters?
3 **A. No.**
4 Q. So this is your only one?
5 **A. That's correct.**
6 Q. Now, you were -- you were given -- Strike
7 that.
8 You reviewed a sample report. Do you see
9 that?
10 **A. Yes, I do.**
11 Q. What was that? Do you have it with you?
12 **A. No, I don't.**
13 **I don't recall. I'm sorry. The minimum**
14 **that I recall about it was it was opinions that I was**
15 **being asked to provide in terms of categories, not the**
16 **actual opinions. So, you know -- I'm not explaining**
17 **this very well because I don't recall it very well.**
18 **But more like an outline of what the report should**
19 **include.**
20 Q. I see. Sort of a template?
21 **A. Yes.**
22 Q. Okay. Fair enough.

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1 And did Ms. Selzler Lippert give you that
2 as well?
3 **A. Yes.**
4 Q. Do you have all of the charts that were
5 provided to you for review?
6 **A. Yes, I do.**
7 Q. And did you bring those with you today?
8 **A. Yes.**
9 Q. And is that the totality, all 16 charts?
10 **A. I would have to look. I know it's the**
11 **first 11.**
12 Q. Would you, please?
13 **A. Okay.**
14 MR. HAYS: And I would object to going into
15 any of the other patients who are not listed within
16 the petition on relevance and also confidentiality.
17 Confidentiality of the investigation pursuant to the
18 statutes.
19 THE WITNESS: The answer to your question
20 is yes, I do have them.
21 BY MR. EYE:
22 Q. Dr. Gold, did you review all 16 of those

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1 charts for purposes of standard of care evaluations at
2 some time or another?
3 **A. Yes.**
4 Q. Did you render opinions concerning the
5 other five that didn't make it into your report that
6 you've provided?
7 MR. HAYS: And I would also just reiterate
8 the same objection.
9 THE WITNESS: I believe I discussed them.
10 Nothing was written.
11 BY MR. EYE:
12 Q. Did you reach opinions about those other
13 five regarding standard of care?
14 MR. HAYS: And I'll renew my objection.
15 It's a continued objection so I don't have to keep on
16 doing it for each question.
17 MR. EYE: Right.
18 THE WITNESS: I'm trying to recall whether
19 they were specifically standard of care opinions. I
20 know I had opinions about the cases. I don't recall
21 if they were specifically standard of care.
22 BY MR. EYE:

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1 Q. Do you know where those charts came from,
2 that is how the Board of Healing Arts got access to
3 them?
4 **A. No.**
5 Q. Dr. Gold, have you ever had any formal
6 legal training? Let me back up and be a bit more
7 specific.
8 Did you ever attend a law school class as a
9 student?
10 **A. No.**
11 Q. Have you ever attended a legal education
12 seminar as an interested participant or observer?
13 **A. Yes.**
14 Q. Did any of those that you attended deal
15 with abortions or abortion services?
16 **A. No.**
17 Q. Do you have any other legal training other
18 than either attending a law school class or a
19 continuing legal ed that we just discussed?
20 **A. No. I mean, not formally. In the course**
21 **of becoming certified or studying forensic psychiatry,**
22 **one becomes familiar with certain aspects of the law**

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1 as they intersect with psychiatry. So in that sense,
2 yes. But I don't think that that's what you're asking
3 about. But if it is, then the answer is yes.
4 Q. Fair enough.
5 In that category, did any of that training
6 have any relationship to abortion or abortion
7 services?
8 A. No.
9 Q. Dr. Gold, would you agree with the
10 statement that a patient is entitled to an unimpeded
11 medical judgment from a physician with whom the
12 patient consults?
13 A. I'm sorry, could you say that again?
14 Q. Sure. Would you agree that a patient is
15 entitled to the unimpeded medical judgment of a
16 physician with whom the patient consults?
17 A. I'm not sure I understand what you mean by
18 unimpeded.
19 Q. No interference from extraneous sources.
20 That is, should the patient have the benefit of a free
21 flow of information and consultation from a physician
22 with whom a consultation is sought?

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1 A. Within certain restrictions.
2 Q. What would those restrictions be?
3 A. Well, if they're discussing child abuse,
4 sexual abuse, any kind of endangerment of a minor, the
5 primary obligation is to report that. If the patient
6 is discussing self-harm or harming others, there is
7 also usually a duty to report and/or intervene.
8 So there are certain areas where the real
9 world intrudes into what is an otherwise private and
10 confidential relationship. But outside of those, yes.
11 Q. Would you agree that a patient is entitled
12 to the best clinical judgment of a physician with whom
13 the patient consults?
14 A. I don't know if entitled is the right word.
15 One would hope that they get the best clinical
16 opinion. What they're entitled to -- I mean, to me,
17 entitled means they have a right to it. I don't know
18 if there is such a right to the best clinical opinion,
19 but certainly one would hope they get it.
20 Q. Would you agree that the exercise of good
21 faith clinical judgment is done routinely by
22 physicians who consult with patients?

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1 A. I'm sorry, what do you mean by good faith
2 clinical judgment?
3 Q. Clinical judgment that's based on the
4 physician's best efforts to understand the presenting
5 problems of a patient and the state of medicine as it
6 bears on those problems that are presented.
7 A. Again, I would hope that that is the
8 standard of care for everybody, yes.
9 Q. Would you agree that there can be examples
10 where best medical judgment is exercised in the
11 absence of documentation that you would consider
12 adequate?
13 A. It's certainly possible.
14 Q. Would you agree that in the evaluation of a
15 patient for purposes of rendering a medical opinion,
16 that there are both subjective and objective
17 parameters that should be considered?
18 A. I don't understand the question.
19 Q. In the evaluation of a patient, are there
20 objective measures by which a patient's condition can
21 be judged or evaluated?
22 A. It depends on the condition.

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1 Q. Let's think about vital signs. Are those
2 objective measures of a patient's condition?
3 A. Yes.
4 Q. What about subjective evaluations, do those
5 play a role in evaluating a patient's condition?
6 A. If I understand what you're saying -- Could
7 you define subjective?
8 Q. Let me give an example. How a patient
9 presents in appearance.
10 A. Yes.
11 Q. Is that a subjective evaluation?
12 A. Yes, it is. It may be a combination of
13 both subjective and objective.
14 Q. Can you think of any examples of a purely
15 subjective parameter that would be used to evaluate
16 the condition of a patient?
17 A. Sure. Someone comes in and says, you know,
18 I'm having a bad stomachache. There is no way to
19 really assess that in an objective way. But
20 subjectively, do they appear distressed? Are they
21 doubled over?
22 Q. I see.

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1 Now, Dr. Gold, have you ever had, as a
2 practitioner, any clinical primary care experience,
3 where you've taken care of patients as a primary care
4 physician?
5 **A. No.**
6 **Q. How about as an OB/GYN?**
7 **A. No. Not outside of training in medical**
8 **school.**
9 **Q. What about training outside of medical**
10 **school?**
11 **A. No. Well, that's not true. I guess my**
12 **first year of residency was -- again, although it was**
13 **in rotation, some of those rotations were basically**
14 **primary care medicines. Six months of that.**
15 **Q. And I think we established when we were**
16 **going over your CV that didn't involve any abortions**
17 **or abortion services?**
18 **A. That is correct.**
19 **Q. Dr. Gold, what all did you -- Other than**
20 **that -- Strike that.**
21 **Have you reviewed anything in addition to**
22 **the records that you've specified in the section under**

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1 "Records Reviewed" in your report? Have you reviewed
2 anything in addition to those to prepare for today's
3 deposition?
4 **A. Yes.**
5 **Q. And what would that be?**
6 **A. I have the inquisition testimony of**
7 **Dr. Neuhaus from 2006, and I have the testimony, the**
8 **trial transcript from I believe it was Dr. Tiller's**
9 **trial in 2009.**
10 **Q. What was your purpose in reviewing those**
11 **transcripts?**
12 **A. Well, they were provided for me to review,**
13 **and I was asked to review them. But they were helpful**
14 **to me in trying to figure out the process by which**
15 **patients were evaluated for the late-term abortions**
16 **that they received.**
17 **Q. Did you review those transcripts prior to**
18 **rendering your reports in this matter?**
19 **A. No.**
20 **Q. So it's fair to say that those transcripts**
21 **did not form one of the bases for your opinions?**
22 **A. That is correct.**

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1 **Q. What else did you review in anticipation of**
2 **today's deposition?**
3 **A. The American Academy of Child & Adolescent**
4 **Psychiatry guidelines for the evaluation of children**
5 **and adolescents.**
6 **Q. Is that the 1997 or the 2007 version?**
7 **A. I have the 1997 version.**
8 **Q. How does it differ from the 2000 version?**
9 **A. The 2007 version?**
10 **Q. Yeah. I misspoke.**
11 **A. I think the 2007 version was a specific**
12 **type of evaluation, if I recall correctly. It wasn't**
13 **general guidelines. So I didn't want to narrow -- I**
14 **forget which type of evaluation that one was, but it**
15 **wasn't -- I believe it was narrow enough so that I**
16 **don't think it would have been as helpful as the**
17 **general guidelines.**
18 **Q. Is that a document or a source that you**
19 **keep in your file?**
20 **A. Yes.**
21 **Q. Do you have it with you today?**
22 **A. Yes.**

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1 **Q. And so it's part of that which we've marked**
2 **as an exhibit?**
3 **A. No.**
4 **Q. Okay. Let's mark it as a separate exhibit.**
5 **I would like to get a copy of that as well.**
6 **(Exhibit 2 marked for identification and retained**
7 **by the witness for copying and distribution.)**
8 **BY MR. EYE:**
9 **Q. This is Exhibit No. 2, I presume. Correct?**
10 **A. Yes.**
11 **Q. In Exhibit No. 2, can you specify the part**
12 **of Exhibit No. 2 that relates to evaluation of**
13 **children or adolescents or adult women for purposes of**
14 **receiving a late-term abortion?**
15 **A. There is no section in there that specific.**
16 **Q. What about in the 2007 version?**
17 **A. I don't have that with me. I don't recall**
18 **what the specificity was for that one, but I don't**
19 **think it was about abortion.**
20 **Q. Is there other information that you have**
21 **reviewed in anticipation for today's deposition?**
22 **A. Not -- No, no other information.**

VIDEOCONFERENCE DEPOSITION OF LIZA H. GOLD, M.D.
CONDUCTED ON FRIDAY, JUNE 24, 2011

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1 Q. Do you know who Allen Greiner, M.D. is?
2 A. No.
3 Q. Did you speak with any professional
4 colleagues concerning your agreement with the staff of
5 the Board of Healing Arts to render opinions?
6 A. No.
7 Q. Did you review any of the investigation
8 file that was compiled by an investigator for the
9 Board named Clifford Packer?
10 A. No.
11 MR. EYE: Let's go off the record for just
12 a moment.
13 (Off the record.)
14 MR. EYE: Let's reconvene at the top of the
15 hour.
16 (Recess taken.)
17 BY MR. EYE:
18 Q. Dr. Gold, we'll go back on the record now
19 after our lunch break.
20 Up to now, have you understood my
21 questions?
22 A. Except the ones that I said I didn't

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

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

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

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1 **A. In my experience, in my practice, there is**
2 **no such thing as an abortion consult. If you have a**
3 **pregnant patient and the patient has issues or**
4 **problems, you refer them to the appropriate person to**
5 **help them address those problems.**
6 **So for example, if it's an issue with**
7 **pregnancy and they're not sure about a termination,**
8 **you might refer them to an OB/GYN. That's not an**
9 **abortion referral. That's an appropriate referral of**
10 **a patient with issues about pregnancy to a medical**
11 **specialist who may be able to assist them.**
12 Q. Have you ever referred a patient to an
13 OB/GYN, for instance, that you later spoke with the
14 OB/GYN about that patient receiving an abortion?
15 **A. No.**
16 Q. Dr. Gold, referencing the specific case
17 today, do you know who the complainant or complainants
18 are in this case?
19 **A. You mean who filed the complaint with the**
20 **Board of Medicine?**
21 Q. Yes.
22 **A. I believe it was a pro-life activist group.**

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1 **I'm not sure which one.**
2 Q. And do you know the basis of their
3 complaint, that is what it is that they complained
4 about?
5 **A. Well, I know what's in the complaint.**
6 Q. You've seen the complaint?
7 **A. Yes.**
8 Q. Is it in your file?
9 MR. HAYS: I would have her clarify what
10 the definition of a complaint is.
11 THE WITNESS: Oh, I'm sorry. It's not a
12 complaint. It's a petition. Sorry.
13 BY MR. EYE:
14 Q. So you don't have the complaint that was
15 actually submitted by whoever it was that made the
16 complaint?
17 **A. No. I have the Board's petition. Sorry**
18 **about that.**
19 MR. HAYS: And for the record, I guess if
20 she could clarify what she meant by complaint
21 specifically when she stated that.
22 THE WITNESS: Yeah. By complaint, I meant

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1 the Board's petition.
2 BY MR. EYE:
3 Q. Okay, fair enough. Thank you.
4 Dr. Gold, do you know the purpose or
5 purposes that Dr. Neuhaus was seeing the patients that
6 you evaluated the charge for? Do you know what her
7 purpose in seeing those patients was, or reasons were?
8 **A. I understand that the law in Kansas**
9 **requires that two physicians certify that an**
10 **individual needs -- In order to get a late-term**
11 **abortion, two physicians have to certify that there**
12 **would be substantial and irreversible consequences,**
13 **medical consequences, in order for that individual to**
14 **obtain a late-term abortion.**
15 **And so Dr. Neuhaus provided the second**
16 **opinion, so to speak. Patients would originally**
17 **contact Dr. Tiller, who I assume provided the first**
18 **opinion, and her role was to evaluate for the second**
19 **opinion.**
20 Q. How long did the evaluations in terms of
21 clock time, how long did the evaluations take that
22 Dr. Neuhaus performed?

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1 **A. Well, I know what she testified to and what**
2 **other people in the clinic testified to. But I have**
3 **no documentary evidence indicating how long they took.**
4 Q. What was her testimony, as you recall?
5 **A. I think she said they could take as much as**
6 **six hours but normally they were between 30 minutes**
7 **and 60 minutes, if I recall correctly.**
8 Q. Depending on the particular case, I
9 presume, or the particular patient?
10 **A. I'm only repeating what she said. That's**
11 **all the information I have.**
12 Q. Now, you didn't rely on that testimony to
13 write your opinions, though, right?
14 **A. That is correct.**
15 Q. Now, I'm looking at your report for Patient
16 No. 1, and I'm going to go to the top of page 2 of
17 that where it begins with "Standard of Care." It's at
18 the very top of the page in bold face, "Standard of
19 Care."
20 Do you see that?
21 **A. Yes.**
22 Q. Now, under that you have a designation for

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

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

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

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

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

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

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

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1 Q. No. Have you ever reviewed the literature
2 to determine whether there is empirical evidence to
3 support the statements that you just made?
4 **A. I have reviewed -- having an issue in**
5 **gender and psychiatry and reproductive and biological**
6 **psychiatry, reviewed -- one can't say all because that**
7 **would be unreasonable, but an extreme amount of the**
8 **literature regarding psychiatric interventions and**
9 **problems regarding pregnancy, psychiatric illness**
10 **during pregnancy, adoption issues, postpartum issues,**
11 **lactation in postpartum, the effects of maternal**
12 **illness on pregnancies, on children already born.**
13 **There is a huge amount of literature out**
14 **there and I have reviewed quite a bit of it. I have**
15 **written about some of it. The late-term abortion**
16 **issue is not a psychiatric issue.**
17 Q. You haven't written on late-term abortion,
18 have you?
19 **A. I'm sorry?**
20 Q. You've never written anything on late-term
21 abortion?
22 **A. No, I have not written anything on**

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1 **late-term abortion.**
2 Q. Or any abortion?
3 **A. Or on abortion as a subject, no.**
4 Q. Would you agree with the following: that
5 a therapeutic abortion is defined as any of various
6 procedures resulting in the termination of a pregnancy
7 in order to save a life or preserve the health of the
8 mother.
9 **A. You know, again, I know there is such a**
10 **thing as a therapeutic abortion. I know that there**
11 **are a variety of reasons that people have abortions.**
12 **I don't know specifically where and how those are**
13 **defined because that is not an area that comes up in**
14 **psychiatry under the kinds of circumstances that**
15 **you're talking about.**
16 Q. Thank you, Doctor.
17 Let's take a look at page 2 of the Patient
18 I report.
19 **A. Okay.**
20 Q. It indicates under "Summary of Events" that
21 Patient 1 is a 14-year-old single white female from
22 New York.

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1 Do you see that?
2 **A. Yes.**
3 Q. And she was pregnant, right?
4 **A. Correct.**
5 Q. Have you ever treated a 14-year-old
6 pregnant girl?
7 **A. No.**
8 Q. Can you think of any circumstance when it
9 would be advisable for the mental health of a
10 14-year-old to carry a pregnancy to term?
11 **A. When you're talking about mental health and**
12 **you're talking about psychiatric disorders, you are**
13 **talking about two overlapping spheres, but they are**
14 **not congruent. Okay?**
15 **There are all kinds of emotional stress and**
16 **distress that does not rise to the level of a**
17 **psychiatric disorder or a psychiatric emergency.**
18 **I am highly empathetic to a 14-year-old who**
19 **wants to get an abortion. I don't think that**
20 **14-year-olds having babies adds to the quality of**
21 **their lives or the babies' lives.**
22 **However, a 14-year-old having a pregnancy,**

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1 **an unwanted pregnancy, is not in and of itself an**
2 **indication that they are going to have a major**
3 **psychiatric disorder or that they have a major**
4 **psychiatric disorder. And there is no evidence that**
5 **having an unwanted baby creates an irreversible**
6 **impairment or substantial impairment that results in a**
7 **psychiatric disorder.**
8 Q. At least none that you know of?
9 **A. None that I've ever seen reviewed in the**
10 **literature. And postpartum disorders is something**
11 **that I have expertise in. Unwanted teenage pregnancy**
12 **carries a lot of risk to it. Most of them are social**
13 **risks and medical risks, but they are not acute**
14 **psychiatric emergencies.**
15 Q. In general terms, does it require an acute
16 psychiatric emergency to meet the standard for a
17 late-term abortion?
18 **A. I don't know in the sense that -- Are you**
19 **talking about the Kansas standard?**
20 Q. Let's deal with any standard you're
21 familiar with.
22 **A. Okay. Well, the only standard I am**

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1 **familiar with the specifics of is the Kansas standard.**
2 Q. Does it require an acute psychiatric
3 emergency under the Kansas standard to justify a
4 late-term abortion?
5 **A. It does not use the words acute psychiatric**
6 **emergency.**
7 Q. Those are your words?
8 **A. Those are my words.**
9 Q. Doctor, would it be reasonable -- would
10 there be a reasonable relationship between a
11 14-year-old being pregnant and the onset of an anxiety
12 disorder caused by that 14-year-old's pregnancy?
13 **A. There would be a reasonable relationship**
14 **between being pregnant and a 14-year-old having an**
15 **unwanted pregnancy and being anxious, distressed,**
16 **scared, and maybe even some other things. But of**
17 **themselves, having those appropriate emotional**
18 **reactions to an unwanted pregnancy does not mean that**
19 **those symptoms rise to the level of a psychiatric**
20 **diagnosis. They don't by themselves meet the criteria**
21 **needed to cross the line into an actual psychiatric**
22 **disorder.**

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1 Q. And does it require a psychiatric disorder
2 to justify a late-term abortion in Kansas?
3 A. **The words "psychiatric disorder" are not in**
4 **the statute. However, they were applied in almost all**
5 **the cases I reviewed by Dr. Neuhaus. So...**
6 Q. Does it require under the Kansas statute a
7 finding of a psychiatric disorder to justify a
8 late-term abortion?
9 A. **No. I don't know how you would make the**
10 **connection between a major organ being substantially**
11 **and irreversibly affected without there being --**
12 **without meeting a level for a diagnostic criteria.**
13 Q. Is the brain a major organ?
14 A. **It is. But for it to be substantially and**
15 **negatively and irreparably damaged, one, you have to**
16 **get from here to there, and you're not going to get**
17 **from the brain being a major organ to irreversible**
18 **damage without crossing that threshold somewhere of**
19 **meeting a psychiatric disorder.**
20 Q. And you can say that categorically for all
21 patients, correct?
22 A. **There is no evidence that that statement --**

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1 **There is no evidence showing it the other way around.**
2 **In other words, there is no evidence that shows that**
3 **having appropriate emotional reactions to pregnancy,**
4 **whether they're good reactions because you want it or**
5 **bad reactions because you didn't want it, anxious,**
6 **whatever, results in permanent, irreversible**
7 **substantial damage to the brain absent some kind of**
8 **intervening psychiatric disorder.**
9 Q. And you can say that categorically for all
10 patients, correct?
11 A. **In medicine you can't say anything**
12 **categorically 100 percent. But I can say that there**
13 **is not any literature that I've seen that would**
14 **support the position that having an unwanted**
15 **pregnancy, no matter how distressing it is, leads to**
16 **substantial and irreversible damage to the brain. It**
17 **just doesn't exist.**
18 Q. But you're not an abortion practitioner,
19 are you?
20 A. **No, I am not.**
21 Q. You're familiar with the global assessment
22 of functioning, correct?

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1 A. **Correct.**
2 Q. You use it in your practice?
3 A. **Correct.**
4 Q. You do use it in your practice?
5 A. **Yes.**
6 Q. And do you use it to assess the mental
7 functioning of pregnant teenagers?
8 A. **On a few occasions I have.**
9 Q. And what do you use when you don't use the
10 GAF?
11 A. **I meant that I only had a few patients who**
12 **qualified as pregnant teenagers.**
13 Q. I'm sorry. And did you use the GAF with
14 those patients?
15 A. **Yes, I did.**
16 Q. And do you use any other instrument or
17 battery?
18 A. **For assessing...**
19 Q. Their mental functioning.
20 A. **Well, sometimes I send people for**
21 **neuropsychological testing or psychological testing.**
22 Q. But not always?

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1 A. **No, not always. But you don't use the GAF**
2 **in isolation. The GAF is Axis V, meaning there are**
3 **five categories of assessment in the Diagnostic and**
4 **Statistical Manual. The GAF is the fifth one. You**
5 **have to go through the other four before you get to**
6 **that one.**
7 **So even though you use GAF, it's used in**
8 **conjunction with a significant amount of other data**
9 **when people use it.**
10 Q. And is that a standard of care?
11 A. **Well, I would say using the GAF -- using**
12 **the GAF is not always the standard of care. There are**
13 **plenty of doctors who only do Axis I, II or Axis I, II**
14 **and III and leave off Axis IV and V all together.**
15 **It is certainly not the standard of care to**
16 **use Axis V alone or alone with an unsupported**
17 **diagnosis, unsupported Axis I diagnosis. That's not**
18 **standard of care.**
19 Q. Is the standard -- Can the standard of care
20 for evaluating a patient for a late-term abortion be
21 met without using the GAF?
22 A. **Yes. I mean, I wouldn't do it, but I'm**





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1 **sure it can be done.**
2 Q. And meet the standard of care?
3 A. **Regardless of the circumstances, there are**
4 **many doctors who don't use the GAF to do evaluation --**
5 **in their evaluations. They use Axis I, II or Axis I,**
6 **II, III and stop there.**
7 Q. In fact, that would justify a diagnosis of
8 depression, for example, correct?
9 A. **I'm sorry, what would?**
10 Q. Using Axes I, II, III alone, one could
11 arrive at a diagnosis consistent with the standard of
12 care of, for instance, depression, correct?
13 A. **One could.**
14 Q. And could prescribe and treat accordingly,
15 correct?
16 A. **Assuming -- Yes, assuming that one had done**
17 **the evaluation to get to a reasonable conclusion on I,**
18 **II and III, or I and II.**
19 Q. Now, I'm looking at page 4 of your report
20 concerning Patient 1, Dr. Gold.
21 A. **Okay.**
22 Q. I'm looking under the section that says

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1 "Explanation of Opinion." And you describe Patient 1
2 as a girl in a, quote, distressing psychosocial
3 situation, specifically an unwanted pregnancy.
4 What do you consider to be a distressing --
5 or what are the attributes, rather, of a distressing
6 psychosocial situation?
7 A. **In this specific case or generally?**
8 Q. First of all, generally.
9 A. **Any situation that creates problems in a**
10 **person's life can be a distressing psychosocial**
11 **situation. If you have a child who becomes ill, if**
12 **you have a parent who has to be provided**
13 **round-the-clock care, if you go through a divorce.**
14 **There are plenty of life -- if you get fired from a**
15 **job.**
16 **I mean, there are plenty of circumstances**
17 **in life which create distress that are related to**
18 **someone's social circumstances and creates emotional**
19 **distress. That's what a psychosocial distressing**
20 **situation is.**
21 Q. And can a distressing psychosocial
22 situation, again speaking in general terms, be the

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1 genesis for a psychiatric diagnosis?
2 A. **Of itself, no.**
3 Q. In any circumstance?
4 A. **It is not -- Well, what do you mean by the**
5 **word "genesis"?**
6 Q. Origin.
7 A. **Life stressors can result in psychiatric**
8 **disorders. And certainly an unwanted pregnancy could**
9 **result in a psychiatric disorder.**
10 Q. Later on in that paragraph, Doctor, you
11 talk about how the medical practice dictates that a
12 referral be made to a mental health professional.
13 Do you see that?
14 A. **Yes.**
15 Q. What medical practice are you referring to?
16 A. **I guess that would be standard of care.**
17 Q. And what standard of care applies in that
18 situation? I mean, what's the origin of that standard
19 of care --
20 A. **I --**
21 Q. -- that you referred to that tells us what
22 the standard of care is that leads you to say that

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1 medical practice dictates that referral?
2 A. **That's standard practice, standard**
3 **training, what doctors are taught to do when they are**
4 **faced with a clinical situation that is outside their**
5 **expertise.**
6 **And when you have a new -- a presumptively**
7 **new onset psychiatric disorder in a 14-year-old**
8 **pregnant girl, that set of circumstances is typically**
9 **outside the mental health expertise of most**
10 **practitioners.**
11 **And the appropriate referral, especially**
12 **with a -- if you're diagnosing a new psychiatric**
13 **disorder in someone who didn't have one on the basis**
14 **of an unwanted pregnancy, the standard of care for any**
15 **psychiatrist would be to refer that person to an**
16 **appropriate child and adolescent psychiatrist for**
17 **evaluation and an OB/GYN if they didn't already have**
18 **one.**
19 Q. Is it your testimony that there is no
20 OB/GYN who would be able to make a diagnosis of a
21 mental health disorder arising from an unwanted
22 pregnancy?

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

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1 Q. So you don't know the answer to that, to my
2 question, do you?
3 **A. Could you repeat the question?**
4 Q. Objective or subjective criteria to make
5 differentiations between a stressor and a mental
6 health diagnosis, correct?
7 MR. HAYS: Bob, I don't believe she heard
8 the whole entire question. It cut out. I'm sorry
9 about that.
10 BY MR. EYE:
11 Q. Did you understand my question, Doctor?
12 **A. I'm not sure that I did.**
13 Q. You don't know what criteria Dr. Neuhaus
14 may have used, either objective or subjective, to
15 differentiate between a distressing psychosocial
16 situation and a mental health diagnosis?
17 **A. I don't know -- I don't know that she used**
18 **any criteria at all.**
19 Q. Well, you know that she used some objective
20 criteria because the GAF is an objective instrument,
21 is it not?
22 **A. No, it's not.**

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

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

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1 evaluations, correct?

2 **A. To a degree. Judgment, of course, is used**

3 **in every kind of assessment. You can't do an**

4 **assessment without judgment.**

5 Q. Now, the rest of that sentence says:

6 "...nor do they," referencing these parameters, "of

7 themselves establish a legal standard of care."

8 **A. That's my understanding.**

9 Q. Right. So if those don't, what do? What

10 does?

11 **A. Well, you know, that's a -- I don't know**

12 **how lawyers argue back and forth about how you**

13 **establish a legal standard of care. My understanding**

14 **of the standard of care is based on my understanding**

15 **that it is the average care provided by the average**

16 **skilled practitioner in a field, whether it's a**

17 **general field or a specialized field.**

18 Q. And that could also relate to a particular

19 geographic designation too?

20 **A. It could. Although it is fading to some**

21 **degree, historically there has been some flexibility**

22 **around the lines that even though 50 percent of states**

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1 do it one way -- I'm sorry, 49 states do it one way,

2 if it's done differently in the 50th state, then there

3 is a local standard of care.

4 However, in the modern times, so to speak,

5 when people have access to information and practices

6 on a much broader basis than they used to, that among

7 doctors is starting to be less of an issue.

8 How you do a mental status exam is how you

9 do a mental status exam, in my experience, anywhere in

10 the country. It's not taught differently anywhere. A

11 national board certification, if you have one, means

12 you know how to do it. The boards are national,

13 they're not local. Some of these are becoming less --

14 the local flexibility, some of it is becoming less and

15 less significant.

16 Now, could there be areas where it's still

17 significant? Sure, it could. But in psychiatry, my

18 experience has been that it's becoming less

19 significant. Certainly not in the judgment

20 necessarily applied but in the how you conduct an

21 appropriate evaluation. Okay? And these guidelines,

22 these parameters say how you conduct an appropriate

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1 **evaluation.**

2 **Now, people can deviate from them, but when**

3 **you deviate from guidelines, generally there has to be**

4 **a pretty good reason why you're deviating from them.**

5 Q. And is that -- is that deviation from these

6 guidelines --

7 **A. Or parameters in this case.**

8 Q. Thank you.

9 These parameters are essentially -- they're

10 not the exclusive means by which a physician can reach

11 a diagnosis of mental health disorder, correct?

12 **A. They represent an expert consensus of the**

13 **best practices in reaching a psychiatric assessment of**

14 **disorders in children and adolescents. If there is**

15 **another way to do it, I'm certainly not familiar with**

16 **it and it's not endorsed by the American Academy of**

17 **Child & Adolescent Psychiatrists or the APA or any**

18 **other professional organization I'm aware of.**

19 Q. But my question is those are not

20 necessarily the exclusive means by which to arrive at

21 a justifiable diagnosis that is consistent with the

22 standard of care, correct?

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1 **A. I don't know that that's correct. I would**

2 **have to look at it on a case-by-case basis and see if**

3 **it somehow could be justified to use something else.**

4 Practice parameters are not intended to be

5 exclusive, and I would not state that -- I can't

6 state -- I certainly don't believe that the authors of

7 these parameters would say that they're absolutely

8 exclusive. But you would really have to evaluate what

9 else there is that's being done besides this.

10 Q. Now, in addition to the GAF, were there

11 other instruments used for Patient 1 to determine her

12 mental health status?

13 **A. I'm sorry, could you repeat the question?**

14 Q. In addition to the GAF, were there other

15 instruments that were utilized to determine the mental

16 health status of Patient 1?

17 **A. No.**

18 Q. What is the DTREE? What is that?

19 **A. That's a good question.**

20 Q. You don't know?

21 **A. I know what it purports to be.**

22 Q. What does it purport to be?



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1 **A. It's a diagnostic algorithm, a**
2 **computer-generated diagnostic algorithm.**
3 **Q. Have you ever used it?**
4 **A. Nobody uses it.**
5 **Q. Nobody uses it?**
6 **A. As a standard of care, no, nobody uses it.**
7 **They were very popular in the 1980s because everyone**
8 **thought you would be able to turn over diagnostic**
9 **assessment to computerized algorithms. It turned out**
10 **not to be as a validity or reliability, and they were**
11 **for the most part abandoned.**
12 **It's not considered an instrument the way a**
13 **psychological test would be considered an instrument.**
14 **It's not a rating scale. It's -- I don't know what it**
15 **is other than to say it's a computerized algorithm for**
16 **establishing a diagnosis that has no validity or**
17 **reliability.**
18 **Q. It has no validity or reliability?**
19 **A. That's correct.**
20 **Q. And is it your testimony that use of the**
21 **DTREE is a deviation of the standard of care?**
22 **A. Not the use of it in conjunction -- If**

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1 **you're doing a complete psychiatric evaluation and you**
2 **want to use something like this in conjunction with**
3 **that, you can. But the use of it as an instrument**
4 **upon which to base a psychiatric diagnosis, that is**
5 **not standard of care.**
6 **Q. At least not by itself?**
7 **A. Certainly not by itself.**
8 **Q. In conjunction with other means and**
9 **methods, is it a deviation from the standard of care**
10 **to utilize the DTREE?**
11 **A. They're not used, so in the sense that**
12 **they're not used by psychiatrists, I would say it is a**
13 **deviation from the standard of care of psychiatrists.**
14 **But it's not of itself problematic except if it's used**
15 **as the basis of a diagnosis.**
16 **Q. Meaning not problematic meaning it's not**
17 **uncertain, or it's not invalid to use it in**
18 **conjunction with other means or methods to arrive at a**
19 **diagnosis concerning mental health?**
20 **A. It's not invalid to use it as a guide to**
21 **collecting information in a variety of ways. It's**
22 **sort of like a cheat sheet of things that you need to**

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

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



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1 **A. I wouldn't call it a methodology. I would**
2 **call it sort of a cheat sheet where it might have**
3 **things to remind someone, oh, I should ask about this,**
4 **I should ask about that, because basically it lists**
5 **DSM criteria that you should ask about. Okay?**
6 **But there is no evidence here of what the**
7 **data was put in. In other words, it's the data that**
8 **is important. It's not the algorithm that is**
9 **important. And the evaluation is what gets you the**
10 **data. Okay?**
11 **So the algorithm by itself, you know, there**
12 **is, like I said, no validity, no reliability, nothing**
13 **that says that if you put the data in in a certain**
14 **way, you're going to get a true positive a certain**
15 **amount of the time. There is just no data about that.**
16 **It's not there.**
17 **So it doesn't hurt to use cheat sheets,**
18 **okay, to remind yourself to ask about symptom A or**
19 **symptom B. But there is no evidence here that it was**
20 **used as a cheat sheet. It appears to have been used**
21 **as a diagnostic tool.**
22 **Q. But you don't know?**

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1 **A. I don't know why anyone would want to use**
2 **one for a reason other than to be a cheat sheet.**
3 **There is no -- There is no science behind it. So I**
4 **don't know why else you would use it.**
5 **Q. You mentioned a moment ago that the DTREE**
6 **includes DSM criteria; is that correct?**
7 **A. That's correct.**
8 **Q. Does the DTREE originate with the DSM or**
9 **was it the other way around?**
10 **A. Well, I presume that the DTREE originated**
11 **with the DSM, because the DSM has been around since**
12 **the turn of the century in one form or another. The**
13 **turn of the last century.**
14 **Q. And the DSM is a reliable source upon which**
15 **to -- that practitioners use to help arrive at**
16 **diagnoses and conclusions, correct?**
17 **A. Correct.**
18 **Q. And you restate in the third paragraph**
19 **under "Explanation of Opinion," you say twice that**
20 **termination is not a treatment for any psychiatric**
21 **disorder. You first say abortion is not a treatment**
22 **for a psychiatric disorder, then you later on say**

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1 termination is not a treatment for any psychiatric
2 disorder.
3 **A. I'm sorry, where are you?**
4 **Q. It's on page 4 under "Explanation of**
5 **Opinion," the third full paragraph.**
6 **A. Correct.**
7 **Q. Now, is there a literature cite that you**
8 **can point to that essentially states that abortion is**
9 **not a treatment for any psychiatric disorder?**
10 **A. Well, I can't cite something -- you know,**
11 **you're asking me to cite proof of a negative, which of**
12 **course you can't do. I mean, no one would ever do a**
13 **study. How could you possibly do an ethical study of**
14 **whether abortion is a treatment for a psychiatric**
15 **disorder?**
16 **Q. So that study has never been done?**
17 **A. No, of course that study has never been**
18 **done. I mean, it would constitute human**
19 **experimentation. Maybe the Nazis did it. But you**
20 **couldn't do that kind of study.**
21 **Q. What is it that you base your statement**
22 **that it's not a treatment for a psychiatric disorder?**

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1 **A. Because there are many, many, many**
2 **treatments for psychiatric disorders including all the**
3 **psychiatric disorders in the patients that I reviewed,**
4 **and it -- it's not done, it's never been done. No one**
5 **would refer someone with an adjustment disorder for an**
6 **abortion. It's just not a treatment. I don't know**
7 **how else to say it.**
8 **There are no signs to support that kind of**
9 **treatment. There is no experience, there's no**
10 **clinical judgment, there's no science. Whereas**
11 **someone with an adjustment disorder, there is tons of**
12 **evidence to support, assuming that you're going to**
13 **treat an adjustment disorder, counseling, medication,**
14 **psychosocial support. There is a variety of**
15 **interventions. So there are many interventions. But**
16 **an abortion is not one of them.**
17 **Q. Have you ever referred a patient for an**
18 **abortion?**
19 **A. It would not be my place to refer a patient**
20 **for an abortion.**
21 **MR. HAYS: Objection; asked and answered**
22 **earlier.**

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1 BY MR. EYE:
2 Q. Is it within the standard of care for a
3 psychiatrist in some instances to refer a patient for
4 an abortion?
5 **A. I wouldn't think so, no. I wouldn't think**
6 **so.**
7 Q. Have you ever spoken with any psychiatrist
8 about that question, or something akin to it?
9 **A. No. It doesn't come up because it doesn't**
10 **happen. You don't talk about stuff that doesn't**
11 **happen.**
12 Q. And you're not a member of any professional
13 organization that deals with abortions, are you?
14 **A. No.**
15 Q. You've never attended a conference that
16 deals with abortions, have you?
17 **A. No.**
18 Q. You don't subscribe to literature, medical
19 journals that is, that deal with abortions, do you?
20 **A. Not directly.**
21 Q. On page 8 of your report concerning Patient
22 1, under No. 3 you list four subpoints, A through D.

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1 Are those essentially summations or repetitions of
2 what you said earlier in your report?
3 **A. I believe so.**
4 Q. Okay. Now, that raises another question.
5 You've got your report laid out in a question and
6 answer colloquy kind of format, correct?
7 **A. Correct.**
8 Q. Who gave you the questions that you
9 answered?
10 **A. I believe that was -- when I testified**
11 **earlier about the sample report being categories, I**
12 **think that's what that was.**
13 Q. But you formulated these questions,
14 correct?
15 **A. No. That's what I'm saying. Those were**
16 **the questions that were in the sample report saying,**
17 **please respond to these questions.**
18 Q. And they were general enough that you could
19 have them apply to the question that you were dealing
20 with?
21 **A. Well, I think I made -- What I did was I**
22 **got very specific about them. So they opened the**

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1 **subject and then I specifically said what I could say.**
2 Q. All right. Let's take a look at No. 4 on
3 page 8 of your report concerning Patient 1. You
4 referenced the DSM-IV, correct?
5 **A. Correct.**
6 Q. What part of the DSM-IV did you rely on?
7 **A. Well, in a sense, you rely on all of it.**
8 **But there are sections of it that talk about the**
9 **appropriate use of the DSM in terms of coming to**
10 **diagnostic conclusions.**
11 Q. Did you actually open up the DSM and look
12 at those sections as you wrote the report concerning
13 Patient 1?
14 **A. No.**
15 Q. We've already talked about D&C, correct?
16 That's the '97 and 2007 versions of those practice
17 parameters?
18 **A. Correct. Oh, okay. So the 2007 is**
19 **specifically for anxiety disorders.**
20 Q. All right.
21 **A. Okay.**
22 Q. And it's your testimony that neither B nor

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1 C have any particular specific applicability to
2 pregnant teenagers?
3 **A. No, that's not my testimony.**
4 Q. Well, tell me how the practice parameters
5 set out in either the '97 or the 2007 versions relate
6 to the assessment of a pregnant teenager.
7 **A. They are the general guidelines for**
8 **assessing any teenager, and they do not**
9 **specifically -- well, the anxiety -- the 2007 one**
10 **talks about anxiety disorder specifically. But you**
11 **can have an anxiety disorder in a pregnant teenager,**
12 **an anxiety disorder in a nonpregnant teenager. The**
13 **evaluation is, generally speaking, the same. There**
14 **would be no difference in the psychiatric evaluation**
15 **other than explorations of the circumstances of the**
16 **pregnancy similarly to if the teenager was in the**
17 **process of parents divorcing versus parents not**
18 **divorcing.**
19 **Of course, it's a circumstance that you're**
20 **going to explore because it's unique to that teenager.**
21 **But the general guidelines remain the same. There are**
22 **no separate guidelines for evaluating children who**

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1 have diabetes and children who have a brain tumor and
2 children whose parents are divorcing and children who
3 are pregnant. The guidelines are the same.
4 Q. You reference under 4 at letter D a work by
5 Cohen and Novak were the editors. Can you tell me
6 exactly what it was in that reference that you relied
7 on?
8 A. Well, that's a book that documents the
9 variety of disorders and treatments available to women
10 who have psychiatric problems during pregnancy and
11 postpartum period.
12 Q. It talks about women?
13 A. Women -- I mean, they don't necessarily
14 differentiate between wanted and unwanted pregnancies.
15 Women have unwanted pregnancies, children have
16 unwanted pregnancies. But when I say women, I'm
17 referring to anybody who can get pregnant.
18 Q. Females?
19 A. Females, thank you.
20 Q. What about the Yonkers reference?
21 A. Same thing. And they're actually more
22 recent. I can update those also if you want more

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1 recent.
2 Q. Now, Yonkers deals with management of
3 psychiatric disorders in pregnancy?
4 A. Correct.
5 Q. Does it deal with the assessment of mental
6 health of a person who's pregnant?
7 A. No. I mean, in the sense that Yonkers, the
8 assessment of a female who is pregnant, now if you
9 want to use adult women, is the same assessment that
10 you would do for anybody following the general
11 practice guidelines of assessment of adults published
12 by the American Psychiatric Association.
13 So the guidelines remain the same
14 regardless of the individual circumstances. The
15 circumstances dictate things that you may need to
16 explore further, but it doesn't change the guidelines.
17 Q. Do you agree that children are frequently
18 more vulnerable than adolescents or adults when it
19 comes to issues like unwanted pregnancies?
20 A. Vulnerable to what?
21 Q. To being influenced about the decisions
22 they should make concerning that pregnancy.

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1 A. I'm not sure how to answer that question.
2 Q. Well, let me ask it in a different way,
3 then. Do you consider it to be valid that children
4 are more vulnerable to extraneous influences than
5 adolescents or adults?
6 A. Generally speaking, yes.
7 Q. Would you say that children generally
8 compared to adolescents and adults lack the same level
9 of maturity when it comes to decision-making?
10 A. Certainly.
11 Q. And would you agree that children usually
12 require a higher degree of parental involvement or
13 adult involvement, if you will, that's not a parent,
14 in terms of making decisions about something like
15 pregnancy?
16 A. I would say they require it around pretty
17 much anything.
18 Q. And so would you use the same diagnostic
19 methodology to evaluate a child as you would an adult?
20 A. No. That's why there are different
21 practice guidelines for children and adolescents than
22 there are for adults.

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1 Q. And so in Yonkers, did they differentiate
2 between adults and adolescents and children?
3 A. I would have to go back and look but I
4 doubt it.
5 Q. How about in Cohen?
6 A. They might have, but I would have to look.
7 And part of the purpose of those references, there's
8 two issues. Well, there's more than two issues. But
9 there's the evaluation issue, which I think is more or
10 less covered by the general parameters. Okay?
11 And then there's the treatment issues,
12 which are more what I relied on D and E for, those two
13 tests.
14 And these are the standard -- I shouldn't
15 say standard. These are some of the most respected
16 researchers in these two fields and clinicians in
17 these fields. And when you talk about treatment and
18 the question of whether abortion is a treatment,
19 nowhere in this respected literature is found the idea
20 that somehow abortion is a treatment for the common
21 and even the uncommon disorders associated with
22 pregnancy and the postpartum period.

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1 **So I don't know how much evaluation**
2 **material there is in Cohen and Yonkers, but the**
3 **evaluation is covered by the guidelines.**
4 Q. Doctor, were you asked to render an opinion
5 about treatment in this case?
6 **A. I think originally, although I understand**
7 **it did not become part of the petition. So...**
8 Q. That's a gratuitous opinion on your part,
9 isn't it?
10 **A. Well, at the time it wasn't, but it's not**
11 **useful now. So I wouldn't call it gratuitous. That's**
12 **kind of negative.**
13 Q. Were you asked to render an opinion in this
14 case concerning the propriety of abortion as a
15 treatment?
16 **A. Not specifically in those words, no.**
17 Q. Were you asked to give that opinion in any
18 words?
19 **A. I was asked about the standard of care**
20 **regarding treatment.**
21 Q. Really?
22 **A. Well, initially the question was about --**

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1 MR. HAYS: Objection; argumentative.
2 THE WITNESS: Standard of care and
3 documentation. And treatment was potentially an issue
4 at that time.
5 BY MR. EYE:
6 Q. So was it suggested to you by counsel for
7 the Board that they were going to contest the
8 abortions as treatment, or they were going to contest
9 the evaluation that led up to the recommendation for
10 abortion?
11 **A. Counsel did not suggest to me what they**
12 **were going to do with my reports. They wanted the**
13 **report, and they wanted me to be -- to address all of**
14 **these different aspects. I was never included in any**
15 **discussions about what they were going to do with the**
16 **reports.**
17 Q. In the letter of referral, does it ask you
18 to render opinions about propriety of treatment?
19 **A. The word propriety I know for a fact was**
20 **never used.**
21 Q. Does it ask you to render an opinion about
22 treatment?

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1 **A. I would have to look at the letter**
2 **specifically to recall.**
3 Q. Would you do so, and would you provide an
4 answer to that question under oath in a separate
5 writing to supplement this testimony?
6 **A. Sure.**
7 Q. And would you provide a copy of that
8 letter?
9 **A. Yeah. I think I already said I would do**
10 **that.**
11 Q. Very well.
12 MR. EYE: And counsel, I'm going to reserve
13 the right to reconvene this deposition depending upon
14 what is specified in that letter or anything else
15 that's produced subsequent to this deposition today.
16 MR. HAYS: If you want to go off the record
17 real quick, I can tell you. I can expound on this a
18 little bit.
19 MR. EYE: Can you do it on the record?
20 MR. HAYS: Sure.
21 I'm looking at what I believe is a final
22 draft of the letter, and I believe we provided it in

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1 discovery but I'm going to have to check on that.
2 MR. EYE: I don't remember seeing it.
3 MR. HAYS: Okay. And it states: "Once you
4 have reviewed the records, please prepare a separate
5 written report for each of the patients regarding
6 Licensee 2's care and treatment of the patients."
7 BY MR. EYE:
8 Q. So you weren't asked to render an opinion
9 about whether abortion was a proper referral, correct?
10 **A. Well, it appears -- That specific question**
11 **was not asked. But no specific question was asked, is**
12 **medication an appropriate referral, is therapy an**
13 **appropriate referral, is abortion. I was asked about**
14 **treatment and my opinions about the treatment.**
15 Q. And what treatment was Dr. Neuhaus
16 responsible for giving in the course of this
17 evaluation?
18 **A. Well, a referral for an abortion. Without**
19 **which -- Without her letter, I don't know if you would**
20 **call that letter a referral letter. I think it says I**
21 **am referring -- Let me see what it says.**
22 **The letter says: "I am referring the**

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1 above-named patient to your organization." It doesn't
2 say for abortion, but it says "for consultation
3 regarding her unwanted pregnancy. The patient would
4 suffer substantial and irreversible impairment of a
5 major physical or mental function if she were forced
6 to continue the pregnancy."
7 I saw that, rightly or wrongly, as a
8 referral under these circumstances for an abortion.
9 Q. Was there treatment that Dr. Neuhaus
10 provided Patient 1?
11 A. No. Other than the referral, no.
12 Q. Was there care that Dr. Neuhaus provided
13 Patient 1?
14 A. Again, other than the referral, no.
15 Q. Look at Patient 2. It's fair to say that
16 the records that you reviewed there other than the
17 specific chart of Patient 2 were the same, correct --
18 A. Correct.
19 Q. -- as Patient 1? All right.
20 Now, Patient No. 2 was a ten-year-old
21 incest and rape victim, correct?
22 A. Yes.

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1 Q. She was pregnant, correct?
2 A. Yes.
3 Q. Is it your opinion that the ten-year-old
4 should carry that pregnancy to term and not experience
5 any life impairing mental health problems?
6 MR. HAYS: Objection; compound question.
7 MR. EYE: All right, I'll break it down.
8 BY MR. EYE:
9 Q. Do you understand the question, Doctor?
10 A. I thought I did, but now I've forgotten it.
11 Q. I'll break it down.
12 Is it your opinion that a ten-year-old is
13 able to carry a pregnancy to term without having
14 adverse mental health consequences?
15 A. I don't have enough details -- Are you
16 asking me about this specific one or generally?
17 Q. I'll ask generally first.
18 A. Generally it's possible. Anything is
19 possible.
20 Q. How many pregnant girls have you counseled?
21 Any?
22 MR. HAYS: Objection; argumentative.

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1 THE WITNESS: There is no accepted axiom or
2 literature within the mental health profession that
3 says that any adverse circumstance is going to result
4 in permanent mental harm, injury or psychiatric
5 disorder. One cannot simply state that because
6 somebody is going through a horrible experience that
7 they will be psychologically brain -- irreversible
8 brain damaged for the rest of their life on the basis
9 of a psychiatric disorder.
10 It's hardly optimal for any child to be
11 pregnant, never mind have to carry a pregnancy to
12 term. Could a specific child develop severe emotional
13 problems from that or psychiatric problems? Sure, a
14 specific child could. Can you say generally that
15 every child will? No, you can't. The same way you
16 can't say that every concentration camp survivor had a
17 psychiatric disorder at the end of that horrible
18 experience, even though every one of them would have
19 told you it was an adverse horrible experience.
20 BY MR. EYE:
21 Q. How many ten-year-old pregnant girls have
22 you counseled, Doctor?

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1 A. None.
2 Q. How about 11-year-old pregnant girls?
3 A. None.
4 Q. What is the youngest pregnant girl you've
5 ever counseled?
6 A. 16.
7 Q. Now, in Patient 2 there was a GAF report.
8 Did you review that?
9 A. Yes, I did.
10 Q. Do you think that it was reasonable to
11 infer from the GAF score that the patient had an
12 impairment in several areas including thinking and
13 mood?
14 A. I don't -- I can't infer anything from the
15 GAF report other than the number because there is no
16 data to say how that number was arrived at.
17 Q. And in your clinical judgment, then, would
18 it have been in the case of a ten-year-old pregnant
19 girl, would the subjective assessment of that girl
20 play a more prominent role in her evaluation than,
21 let's say, the quantitative methods that GAF or other
22 quantitative instruments might yield?

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1 **A. I don't have any data about this particular**
2 **girl to allow me to come to a conclusion one way or**
3 **another. That's part of the difficulty or the**
4 **problem, which is that the data is not documented.**
5 **And so a conclusion -- an outside person who knows**
6 **nothing about the case specifically could not come to**
7 **an educated reasonable opinion on any of these**
8 **questions that you're asking.**
9 Q. Well, what are the data that you would look
10 to to assess the mental health functioning of a
11 pregnant ten-year-old?
12 **A. I would look at the data that one would use**
13 **for any child of that age and then explore further**
14 **whether the pregnancy is an additional impairment**
15 **factor. One would assume that it is, but one is not**
16 **supposed to make assumptions when you're doing the**
17 **evaluation. You're supposed to get the data.**
18 Data can be objective, data can be
19 subjective. There is no documentation of either
20 objective or subjective data in Dr. Neuhaus's GAF
21 report.
22 Q. And what are those data that you would look

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1 to and expect to find?
2 **A. Okay. I would refer back to the practice**
3 **parameters. You know, if you want me to, I can read**
4 **through all the different things that they tell you**
5 **you're supposed to collect.**
6 But there is a huge amount of data that
7 should be collected in order to reach not only a GAF,
8 which is only part of the diagnostic assessment, but
9 the whole diagnostic assessment. Some is objective,
10 some is subjective. They don't make a distinction
11 because you do use both. It's just not documented.
12 Was it collected? It may very well have
13 been collected, I just don't know. And so I can't
14 say.
15 Q. And those parameters that you just
16 referenced a moment ago, those are not standard of
17 care, are they?
18 **A. They do not represent a legal standard of**
19 **care.**
20 Q. Thank you.
21 **A. They represent best practices and expert**
22 **consensus of best practices of the American Academy of**

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1 **Child & Adolescent Psychiatry.**
2 Q. Which is still not a standard of care,
3 correct?
4 **A. No. They are -- It's the expert consensus**
5 **of best practices.**
6 Q. But you would agree that that's not a
7 standard of care?
8 MR. HAYS: Asked and answered.
9 MR. EYE: No. The record is confused.
10 BY MR. EYE:
11 Q. Do you agree that that is not a standard of
12 care?
13 **A. It is not a -- It does not establish a**
14 **legal standard of care.**
15 Q. Thank you.
16 Take a look at Patient No. 3. Patient
17 No. 3 is a 15-year-old pregnant girl, correct? Look
18 at page 2.
19 **A. Yes, correct.**
20 Q. And this is still younger than anybody
21 you've ever treated that was pregnant, correct?
22 **A. Correct.**

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1 Q. Now, in this instance there was an MI
2 statement. What's an MI statement?
3 **A. It's a document that was drawn up,**
4 **presumably by Dr. Tiller's clinic. My understanding**
5 **of it was that it was filled out by a member of**
6 **Dr. Tiller's staff, often by telephone interview.**
7 Q. But it was based upon an interview of the
8 patient?
9 **A. By a nonmental health professional, but**
10 **yes.**
11 Q. And what do you know about the
12 qualifications of the person who did that interview?
13 **A. Only the testimony that they were not**
14 **mental health professionals.**
15 Q. Did they have any training in using an MI
16 statement?
17 **A. Well, that MI statement is an idiosyncratic**
18 **document. They drew it up, so I don't know how you**
19 **could have training in it other than the clinic used**
20 **it as a standard document. It's not a -- at least**
21 **from a psychiatric perspective. Maybe it's a standard**
22 **document in other types of practices, but it's not a**

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1 **standard tool for psychiatrists or psychologists.**
2 Q. Do you have any objection to it, or do you
3 have any professional objection to the MI statement
4 being used to help evaluate the mental health status
5 of a patient that was seeking abortion services?
6 **A. Not as a -- Not as a screening instrument**
7 **for further evaluation by someone who was a mental**
8 **health professional.**
9 Q. Do you ever rely on assessments that are
10 made by somebody else to help you evaluate a patient?
11 In other words, a patient referred to you by a general
12 practitioner, do you sometimes look at that
13 practitioner's records?
14 **A. Well, if I get records sent to me, I look**
15 **at them regardless of who has generated them. But the**
16 **weight that I give the assessments vary depending on**
17 **the qualifications of the individual.**
18 Q. Did the MI statement that you looked at ask
19 relevant questions, in your judgment?
20 **A. Yes and no.**
21 Q. Go ahead.
22 **A. It was more geared towards determining why**

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1 **the individual wanted an abortion but there was some**
2 **mental health information -- there was some**
3 **information gleaned about the person's emotional**
4 **status. I wouldn't even call it mental health**
5 **information because it wasn't specific enough or**
6 **nuanced enough to be mental health. But it certainly**
7 **did ask them about their emotional state.**
8 Q. Is the motivation to seek an abortion a
9 relevant consideration in judging the mental health
10 status of the patient?
11 **A. It can be.**
12 Q. Are you familiar with the -- and I'm not
13 exactly sure how to pronounce it but it's the acronym
14 SIGECAPS?
15 **A. Yes.**
16 Q. I've heard it pronounced various ways.
17 SIGECAPS?
18 **A. SIGECAPS, yeah.**
19 Q. Are you familiar with that?
20 **A. Yes.**
21 Q. Do you ever use it?
22 **A. No.**

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1 Q. Is it beyond the standard of care to use
2 it, or outside the standard of care to use it?
3 **A. No, in the sense that it is the minimum**
4 **information you would want to know to screen for**
5 **depression.**
6 Q. And what about the SIGECAPS parameters that
7 it examined, why are those relevant parameters to
8 consider in evaluating the mental health status of a
9 patient?
10 **A. Because they are symptoms that can -- they**
11 **are potentially symptoms that could indicate -- could**
12 **indicate a diagnosis.**
13 Q. And what does SIGECAPS stand for?
14 **A. Oh, I knew you were going to ask that.**
15 **It's a pneumonic. And let's see. I think S is sleep.**
16 **I is -- no, that wouldn't be right. Okay. Suicide,**
17 **insomnia, guilt, energy, concentration, attention.**
18 **I'm not sure what the P is, and S is for I think**
19 **self-esteem. A might be for appetite, I'm sorry,**
20 **concentration and appetite.**
21 Q. Is SIGECAPS used by -- Strike that.
22 Was SIGECAPS something that got presented

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1 during your psychiatric training?
2 **A. No. Well, maybe. It's an acronym to help**
3 **teach medical students and really first-year trainees**
4 **how to remember to ask for the most significant**
5 **symptoms associated with depression. So it is the tip**
6 **of a -- it is the tip of a screening tool. And the**
7 **reason I don't -- the reason I don't use it or**
8 **remember specifically is because my evaluations go**
9 **into much more than just this, so that this pneumonic**
10 **is not particularly useful to me because I go past it.**
11 **And hopefully most psychiatrists would go past it.**
12 Q. And is SIGECAPS, the use of it to assess
13 the mental health of a patient, is that within or
14 outside the standard of care?
15 **A. It's within the standard of care if it's**
16 **used as a screening tool for further assessment.**
17 Q. And does SIGECAPS give any treatment by
18 practice parameter for assessment and treatment of
19 children that we've referenced, this '97 or the 2007
20 versions?
21 **A. I'm sorry, is the SIGECAPS mentioned in the**
22 **practice guidelines, is that the question?**

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1 Q. Right.

2 A. No, it's not mentioned in the practice

3 guidelines.

4 Q. And same question for the --

5 A. Well, let me go back. SIGECAPS is not a

6 formal diagnostic tool or screening assessment. It's

7 a mnemonic that is taught to people to get them to

8 ask specific questions. All of those questions are

9 referenced in the practice parameters in one way or

10 the other, they're just not referenced as SIGECAPS,

11 because SIGECAPS is sort of the minimum information

12 you would want to get.

13 And in the guidelines regarding best --

14 expert consensus of best practices, they're not

15 telling you to get the minimum that you can get.

16 Okay? So you're not going to find a specific

17 reference to SIGECAPS.

18 Q. So you wouldn't want to get anything less

19 than what SIGECAPS would yield?

20 A. If you are a mental health professional,

21 that would be sort of the lowest amount, the least

22 amount of information that you should ask to do a

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1 competent assessment.

2 Q. Now, Doctor, in your review of those Kansas

3 statutes, did it specify that the assessment to

4 determine whether a woman is going to have -- whether

5 a female is going to have impairment for mental health

6 from carrying an unwanted pregnancy, does that have to

7 be done by a mental health professional or like you, a

8 psychiatrist? Is that a requirement?

9 A. I don't think it specifies. I don't

10 recall. I would have to look at the statutes. I

11 don't recall.

12 Q. Now, with Patient 3, it was more than the

13 SIGECAPS that was used, correct?

14 A. Well, there was this narrative MI

15 statement.

16 Q. Okay. And what else? DTREE, right? Even

17 though you've sort of been critical of the DTREE, it

18 was one of the --

19 MR. HAYS: Objection; argumentative.

20 THE WITNESS: Yes, there was a DTREE.

21 BY MR. EYE:

22 Q. And there is a GAF?

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1 A. And a GAF.

2 Q. Now, with all of those together, do you

3 believe that that forms a basis of information in

4 addition to a face-to-face consultation that would

5 allow a practitioner to arrive at a diagnosis related

6 to a mental health impairment?

7 A. No.

8 Q. And what else would be required?

9 A. A mental health evaluation, which none of

10 this is.

11 Q. What else would be done in a mental health

12 evaluation that wasn't done here?

13 A. You would have to get a significant amount

14 of information regarding symptoms, length of symptoms,

15 intensity of symptoms. When I say length I mean how

16 long they have been present. Impairment, whether

17 they're causing any impairment. With someone who is

18 15 years old, again, with children and adolescents

19 they are often not the best source of information.

20 You want to get some collateral information from

21 somebody else if possible. Family history,

22 psychiatric history, social history, medication

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1 history. You know, there's a variety of information

2 including, but most importantly, specificity of

3 symptoms and specificity of impairment of functioning

4 to come up with a diagnosis of -- with a psychiatric

5 diagnosis.

6 And it's hard to imagine that all of that

7 information, since some of it is dated -- I mean, it's

8 hard to know -- The dating on this makes it even more

9 difficult to understand how this was an adequate

10 evaluation. The DTREE was documented on the date of

11 the appointment for the abortion. There is a

12 duplicate with a different date. There's -- Let's

13 see.

14 The MI statement was on 7/31. The

15 appointment, presumably for the abortion, was on 8/5.

16 The DTREE is dated 8/5. And the GAF is dated 8/5.

17 So presumably no information was collected

18 other than the MI, which was again presumably a

19 telephone conversation with a nonmental health

20 professional for which the SIGECAPS I guess is part of

21 that.

22 So there is one telephone conversation and



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1 then two documents, computer documents generated with
2 no specific information in them on the same date as
3 the procedure.
4 And how that would constitute a thorough
5 psychiatric evaluation or a minimally adequate
6 psychiatric evaluation is very difficult to
7 understand, because there is no evidence of other
8 information collected.
9 Q. What is the standard of care related to
10 Patient 3 and the evaluation that she underwent for
11 mental health purposes?
12 MR. HAYS: Objection; compound question.
13 BY MR. EYE:
14 Q. You may answer.
15 A. I'm sorry, can you repeat the question?
16 Q. What is the standard of care related to the
17 mental health evaluation for Patient No. 3?
18 A. It would be a -- It would be the standard
19 of care for the evaluation of an adolescent, which
20 includes obtaining not only face-to-face information
21 from the adolescent but collateral information from
22 other individuals including, for example, parents or

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1 involved adults, evidence or descriptive evidence of
2 functioning or changes in functioning, symptoms, plus
3 an extensive what's called a psychosocial history.
4 Perhaps -- perhaps -- I mean, I could come
5 up with any number of reasons of why this girl was
6 distressed about her pregnancy that have nothing to do
7 with having a major depressive disorder. I just don't
8 know.
9 And an evaluation that results in a
10 diagnosis should be able to provide the data that
11 says, oh, I understand how you got from the fact that
12 she's upset about her pregnancy to a psychiatric
13 diagnosis. And that's not present.
14 Assigning a GAF without specifying what
15 that GAF is based on is not standard of care. The
16 DTREE we have already discussed is not standard of
17 care in any way, shape or form.
18 And if the only information relied upon was
19 an MI statement which was a telephone screen for
20 initial eligibility by a nonmental health
21 professional, then that's certainly not standard of
22 care either.

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1 Q. The standard of care that you've just --
2 You said that those things aren't the standard of
3 care. Where do you get the standard of care that you
4 just applied?
5 A. From the practice of -- the average
6 practice of a prudent practitioner who, upon seeing a
7 patient that they have never met before, would do an
8 evaluation that would cover the information that I
9 suggested.
10 Q. And that's an average psychiatrist?
11 A. Yes. This would not be acceptable as a
12 mental health evaluation, I think, for the average
13 psychiatrist. If you handed the average psychiatrist
14 this information and said, okay, go ahead and treat
15 this patient, that doctor would not rely on this
16 information despite the fact that there is a diagnosis
17 listed in there to go ahead and treat that patient.
18 Q. Would you agree that practitioners make
19 diagnoses of depression, for example, and prescribe
20 treatment for it that don't necessarily do everything
21 that you just specified?
22 A. They may not on occasion.

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1 Q. Is that beneath the standard of care?
2 A. Well, the standard of care is what the
3 average doctor would want. Average means there are
4 people who do more and people who do less. So the
5 fact that there are people who would do less doesn't
6 defeat the standard of care.
7 Q. And is it the situation of people who do
8 less may be using their good faith judgment of what is
9 required in a particular set of circumstances? That
10 would be consistent with the standard of care?
11 A. I don't understand the question. I'm
12 sorry.
13 Q. Again, you agree that based upon your
14 review of the pertinent information, it doesn't
15 require a psychiatrist to do what Dr. Neuhaus is doing
16 here, correct?
17 A. I don't understand that question either.
18 Q. Does the law in Kansas require that a
19 psychiatrist do this mental health evaluation that's
20 part of the second opinion for a late-term abortion?
21 A. I'm not an expert on the law in Kansas.
22 I'm not aware of it, but I'm not qualified to talk

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1 about the law in Kansas.

2 Q. Well, what about practice in Kansas,

3 medical practice in Kansas, does it require a

4 psychiatrist to do this evaluation?

5 A. I think it would require someone with some

6 mental health expertise and training at the very

7 least. And again, that would be the very least. When

8 you're making a diagnosis of a new onset psychiatric

9 disorder in a young person which can have profound

10 implications for the rest of that person's life,

11 typically you're going to get a referral for a good

12 evaluation, especially if you are going to do an

13 extreme intervention.

14 If you're not going to do an extreme

15 intervention, you can certainly take your time and

16 gather information here and there and however you want

17 to do it, and that might meet the standard of care in

18 some places.

19 You know, my daughter doesn't like to do

20 her homework. Okay, you sort of collect information

21 over time and come up with an intervention on how to

22 get your daughter to do her homework.

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1 If you're talking about a major surgical

2 intervention in a new onset psychiatric diagnosis, by

3 definition someone with a new onset psychiatric

4 diagnosis that has never been treated is potentially

5 unstable, and a surgical intervention at that moment

6 in time is something that would be considered

7 potentially even more destabilizing for a person.

8 Okay?

9 So if you have a new onset psychiatric

10 diagnosis and you're going to perform a surgical

11 intervention, you are certainly going to want someone

12 with the experience and expertise to be able to talk

13 to you about that person's stability and the

14 appropriate treatment for the mental health problem.

15 Q. What do you know about Dr. Neuhaus's

16 experience and expertise?

17 A. Only what I read in her testimony.

18 Q. Do you know anything else? That's the

19 extent of it?

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

21 Q. And what did you read about? What did you

22 read in her testimony?

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1 A. That she -- Oh, gosh. She took every

2 psychology course that there was in Kansas State

3 University. That she thought about becoming a

4 psychiatrist. That she's read the DSM front to back

5 twice. That she has on occasion prescribed

6 antidepressants, although she doesn't like to

7 prescribe medication and uses that as a last resort,

8 which is perplexing.

9 Q. Is it beneath the standard of care to use

10 that as the last resort?

11 A. Certainly not. I'm sorry, could you repeat

12 the question?

13 Q. Is the decision to use medicine

14 necessarily -- not using it until it's a last resort,

15 is that a deviation of the standard of care in all

16 cases?

17 A. Nothing is a deviation in all cases every

18 single time. But she was speaking of a general

19 philosophy of not wanting to use medication except as

20 a last resort, which a mental health -- you know, a

21 mental health professional looks at all of the options

22 and decides which one is most appropriate without a

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1 priori assuming that one is less good than another in

2 any individual case.

3 So especially -- especially under the

4 present circumstances where there is tons and tons of

5 evidence for the use of medication as a treatment for

6 anxiety and depression during pregnancy and zero

7 evidence for the use of abortion as a treatment for

8 the use of depression during pregnancy. That's why

9 I'm very perplexed by that statement.

10 I think she said she considered becoming a

11 psychiatrist. She reads articles about psychiatry.

12 And she undertook her own research on pregnancy,

13 informally on pregnancy.

14 Q. Does that suggest to you that she didn't

15 appreciate the gravity of her task in evaluating these

16 patients?

17 A. I can't speak to Dr. Neuhaus's state of

18 mind. I don't know whether she appreciated it or

19 didn't appreciate it.

20 Q. Fair enough.

21 MR. EYE: I need to take about a

22 five-minute break. So reconvene here in about five

VIDEOCONFERENCE DEPOSITION OF LIZA H. GOLD, M.D.
CONDUCTED ON FRIDAY, JUNE 24, 2011

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

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

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1 Q. Do we agree that the purpose of Dr. Neuhaus
2 seeing these patients was for an evaluation concerning
3 whether there was a mental health impairment that
4 would justify a late-term abortion, correct?
5 A. **I'm sorry, could you repeat?**
6 Q. Sure.
7 The purpose of the evaluation -- I'm sorry.
8 The purpose of Dr. Neuhaus evaluating these
9 patients, really all 11 of them, was to determine
10 whether there was a mental health justification for a
11 late-term abortion?
12 A. **That's my understanding.**
13 Q. And that was the scope of her evaluation,
14 correct?
15 A. Yes.
16 Q. Now, in Roman X you talk about how a
17 physician providing an assessment and referral for
18 consultation and treatment -- that there should be
19 some provision for after care. I'm sorry, it's the
20 very first sentence of that Roman X.
21 A. Yes.
22 Q. Now, an evaluation that is done to meet the

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1 statutory requirements for late-term abortion, does
2 that require a provision for after care?
3 A. **Does the statute require it?**
4 Q. Right.
5 A. **I don't -- again, I would have to look at**
6 **the statutes, but I doubt it.**
7 Q. Does an evaluation require a treatment
8 plan?
9 A. **Yes and no. It depends on the nature of**
10 **the evaluation.**
11 Q. You do evaluations for disability and
12 workers' comp and so forth, don't you?
13 A. **Yes, I do.**
14 Q. And when you do those evaluations, do you
15 have a treatment plan that goes along with them?
16 A. **It's a recommendation for treatment. It's**
17 **not a personal treatment plan. But almost always I'm**
18 **asked for treatment recommendations.**
19 Q. Well, when you're not asked for treatment
20 recommendations, do you provide them anyway --
21 A. **If --**
22 Q. -- for a patient for a disability claim,

213

1 for example?
2 **A. If I think that there is a need for it, I**
3 **will do it. If I think that someone is receiving**
4 **inappropriate treatment or inadequate treatment or**
5 **potentially harmful treatment, I will absolutely make**
6 **a recommendation regarding treatment.**
7 Q. So if an insurer comes to you with a case
8 file of a person who is seeking a disability benefit
9 and you evaluate that file for that purpose, do you
10 make a recommendation for treatment?
11 **A. I will if I'm asked to. Or if not asked**
12 **to, I will if it seems important or indicated. In**
13 **other words, if I see something that really jumps out**
14 **at me and says, oh, this is not good, then I make the**
15 **recommendation.**
16 Q. And you do that without ever laying eyes on
17 the patient, correct?
18 **A. When it's a file review, sometimes. There**
19 **are some -- Yeah, there are some things that are so**
20 **obvious that you don't necessarily need to actually**
21 **see the person to know that they need a different kind**
22 **of treatment than they're getting.**

214

1 Q. So in those instances you don't rely at all
2 on subjective considerations, correct?
3 **A. Well, in the file there is going to be some**
4 **subjective information. It's inevitable that there**
5 **will be in any file. The question is how much weight**
6 **you put on it, and that depends on the source of the**
7 **information.**
8 Q. Does it depend on whether the subjective
9 considerations would be consistent with what you would
10 have drawn based upon the same, say, ability to assess
11 the patient in person?
12 **A. Well, the file review is limited by not**
13 **having access to the individual. So the treatment**
14 **recommendations that I would give for a file review**
15 **would be limited to something very general. For**
16 **example, the individual is being treated with**
17 **medication for depression by his primary care**
18 **physician and hasn't gotten better in two years. I**
19 **think it's probably time for this person to be**
20 **referred for an evaluation to a psychiatrist for**
21 **treatment.**
22 **So it's a very broad treatment**

215

1 **recommendation, and you're not really going to do much**
2 **more than that on a file review for someone that you**
3 **haven't seen.**
4 Q. And does it make a difference how the
5 person presents physically?
6 **A. Well, once you see the person, once you do**
7 **a face-to-face interview, of course then you have a**
8 **wealth of data that you observe and that the person**
9 **can report to you in addition to the collateral**
10 **sources, the other information that you get about**
11 **their status from other providers or from family**
12 **members or from employers or whatever.**
13 Q. I guess I just want to make sure about your
14 opinion here, Doctor. I take it that you consider the
15 failure to provide an after care treatment plan as a
16 deviation from standard of care that Dr. Neuhaus
17 should have met. Is that correct?
18 **A. Not necessarily that she would make**
19 **arrangements for after care but that she would be**
20 **discussing -- at least discussing after care with**
21 **Dr. Tiller, and that there would be some evidence that**
22 **somebody was thinking about after care, particularly**

216

1 **given the circumstances of this cases where almost**
2 **every one was a new onset psychiatric disorder who was**
3 **being again in a potentially inherently -- and I say**
4 **potentially unstable because none of them except one**
5 **was receiving treatment for their psychiatric**
6 **disorder, who is being referred for a surgical**
7 **intervention, which again this is my assumption, was**
8 **supposedly the treatment for the psychiatric disorder**
9 **because that's what they were doing.**
10 **And if that treatment didn't work a week or**
11 **two later and that patient still had depression or**
12 **acute distress disorder or whatever they had, who was**
13 **going to be looking at that?**
14 **So if Dr. Neuhaus is going to take the step**
15 **of referring for a therapeutic abortion for a**
16 **psychiatric disorder, a medical intervention for which**
17 **there is no evidentiary basis, then I think that there**
18 **has to be some discussion somewhere of, gee, if this**
19 **doesn't work, what is going to happen to her next in**
20 **terms of the psychiatric disorder that's been**
21 **discussed. The pregnancy has been taken care of, but**
22 **what about the psychiatric disorder.**

VIDEOCONFERENCE DEPOSITION OF LIZA H. GOLD, M.D.
CONDUCTED ON FRIDAY, JUNE 24, 2011

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1 MR. EYE: I'm going to move to strike based
2 on that it's not responsive.
3 BY MR. EYE:
4 Q. My question is: Is it a deviation from the
5 standard of care when a doctor is asked to evaluate a
6 patient that they do not provide -- for purposes of a
7 late-term abortion that they don't provide a plan for
8 after care?
9 A. It can be.
10 Q. And are you familiar with the after care
11 routine that Dr. Tiller's office engaged for each one
12 of these patients?
13 A. No, I am not.
14 Q. Let's move to Patient No. 5, Dr. Gold.
15 A. Okay.
16 Q. Again, some of these questions just because
17 they happen to relate to Patient 5, they actually are
18 common to others as well, but as appropriate they
19 would likely apply.
20 But at any rate, over on page 2 for Patient
21 No. 5, the middle of the page there is under "Review
22 of Licensee 2's Records," there is Paragraph No. 2 and

218

1 it says that -- in the middle of that paragraph there
2 appear to be a set of initials at the lower left side
3 of Bates No. 3.
4 Do you see that?
5 A. Yes.
6 Q. Now, if those initials were Dr. Neuhaus's,
7 is that enough to show that she's reviewed this?
8 A. It would certainly show that she had access
9 to it. You would have to ask her if she reviewed it.
10 Q. All right.
11 A. In other words, there is no note anywhere
12 that says reviewed MI statement. So I don't know but
13 she would have had access to it if she wrote her
14 initials on it.
15 Q. Now I would like you to go to the next
16 page, page 3. About the top fourth of the page under
17 Paragraph 3 it references Bates pages 6 and 7.
18 I want you to look at the paragraph just
19 underneath that. And there is some discussion there
20 about dates having been crossed out and dates being
21 handwritten.
22 A. Yes.

219

1 Q. What was the significance of that as to
2 whether the standard of care was met in the evaluation
3 of the patient for purposes of a late-term abortion?
4 A. Well, if you're going to do an evaluation
5 for referral, then the evaluation should take place
6 prior to the procedure for which the person is being
7 referred. And it's not clear when the dates have been
8 changed.
9 The procedure apparently was on 8/12. And
10 the report date -- and I could look at the document
11 itself, but based on my report, one date was crossed
12 out and 8/13 was written in. That's after the
13 procedure. 8/7 was crossed out and 8/12 was written
14 in. That's the date of the procedure.
15 So if there was an evaluation, when exactly
16 did it take place becomes unclear. And obviously if
17 it took place after the procedure, then that's a
18 deviation from the standard of care.
19 Q. Other than this, you know, typed date and
20 handwritten date and all that, do you have any
21 information to indicate that any evaluation that
22 Dr. Neuhaus did occur after an abortion procedure

220

1 had already been performed?
2 A. Other than the change in the date, no.
3 Q. Is it your opinion that an evaluation
4 occurred after an abortion procedure had already been
5 performed?
6 A. No.
7 Q. Again on page 3 there is a paragraph that's
8 numbered 4 and it references Bates page 8. There is a
9 recapitulation that you cite in here, and it's a quote
10 I believe from the GAF. "The patient has been unable
11 to function in almost all areas, e.g., she stays in
12 bed all day, has no job, home or friends."
13 Are those clinically significant findings
14 related to the mental health status of Patient No. 5?
15 A. I don't know. It's just a quote from the
16 GAF scale. It says nothing specific about Patient 5
17 at all. It doesn't say whether she's unable to
18 function or she has no harm -- I mean, it's a
19 statement with no specific reference to Patient 5 at
20 all.
21 Q. Does staying in bed all day tell you
22 anything clinically about the mental health of a

221

1 patient?

2 **A. It can. If that's true, then that can tell**

3 **you something about a patient's mental health. It can**

4 **tell you something about their physical health. It**

5 **can tell you a lot of things.**

6 Q. What about in conjunction with the fact

7 that she doesn't have a job or friends?

8 **A. I don't know that that -- I mean, are you**

9 **asking me to assume that that's true?**

10 Q. Well, do you assume -- Well, let me ask you

11 this. Do you think that the information that was

12 derived in the GAF was false?

13 **A. I don't know what information was derived**

14 **for the GAF. It's not documented.**

15 Q. The GAF information that you quoted here,

16 that was documented.

17 **A. That's not about Patient 5. That's just**

18 **what the rating scale says the score means.**

19 Q. Does that have clinical significance, that

20 score?

21 **A. Not as presented, no.**

22 Q. Would it be useful in conjunction with

222

1 other information?

2 **A. With other information it could be, yes.**

3 Q. Was other information utilized in that

4 regard?

5 **A. Well, there was no other information -- I'm**

6 **just looking before -- The only clinical information**

7 **was the SIGECAPS that was done by the nonmental health**

8 **screeener, telephone screeener and does not indicate**

9 **what the specific problems are except that they're**

10 **associated with an unwanted pregnancy rather than a**

11 **primary psychiatric diagnosis.**

12 **So, you know, you've got a bunch of --**

13 **you've got a lot of smoke but I can't find the fire.**

14 **I'm not sure what the problem is by looking at the GAF**

15 **score. There is no data supporting -- A GAF score of**

16 **25 means that that person is in acute crisis and needs**

17 **immediate psychiatric hospitalization if that score is**

18 **accurate. Okay? That is a person who is either**

19 **dangerous to themselves or so nonfunctional that they**

20 **can't take care of themselves.**

21 **I don't see anything here that would**

22 **correlate with that. Staying in bed all day by itself**

223

1 **does not give you a score of 25. So there is no**

2 **information to support that score. In fact, the**

3 **information that is there doesn't support the score.**

4 **I don't know how the score was derived at,**

5 **so I can't say that it's significant based on the**

6 **information that I have. If there's other**

7 **information, I'm happy to consider it.**

8 Q. That score of 25 wasn't just based on the

9 report that the patient stays in bed all day, correct?

10 **A. There is no report. I mean, I don't know**

11 **that there is a report that she stays in bed all day.**

12 **That is a quote from the GAF rating scale. It does**

13 **not say Patient 5 says that she stays in bed all day.**

14 Q. What about the MI, did you review that?

15 **A. Well, I'll be happy to look at it**

16 **specifically. The MI, as I summarized it, says that**

17 **there is a problem with sleep but it doesn't say what**

18 **that problem is. I'm happy to look at the original**

19 **document and tell you what it says.**

20 **Do you want me to look at the document?**

21 Q. No, let's move on.

22 **A. Okay.**

224

1 Q. Dr. Gold, is it permissible for Dr. Neuhaus

2 to rely on documentation that was gathered in

3 Dr. Tiller's office related to the mental health of

4 these patients?

5 **A. As a screening and a starting point, yes.**

6 Q. And it's your opinion that then she should

7 have done more?

8 **A. Yes.**

9 Q. And you're not sure what else she did do?

10 **A. Well, I'm not sure. Obviously, if she did**

11 **things and didn't document them, then I have no**

12 **evidence of what she did actually do. So she could**

13 **have done any number of things but I wouldn't know**

14 **because there is no documentation.**

15 Q. I beg your pardon, Doctor. I've lost my

16 place here.

17 **A. That's okay.**

18 Q. Just give me one moment here.

19 Doctor, let's review Patient No. 6.

20 **A. Okay.**

21 Q. Now, Patient 6 was a 14-year-old pregnant

22 girl, correct?

225

1 **A. Correct.**
2 Q. And what was the documentary basis that you
3 reviewed that was relied on to arrive at the
4 recommendation that Dr. Neuhaus made to -- or I should
5 say the referral that she made to Dr. Tiller?
6 **A. Well, again this is an assumption, and I'm**
7 **happy to be corrected if I'm wrong, but that the**
8 **information that's in Dr. Neuhaus's file is the**
9 **information she relied upon, and what was in**
10 **Dr. Neuhaus's file was an intake form, an MI**
11 **statement, a statement -- which included a statement**
12 **from the mother. A statement describing some chaotic**
13 **living situation circumstances, including SIGECAPS**
14 **screen.**
15 I note that there is no way to determine
16 who performed this evaluation or prepared that
17 document. And again I am presuming it was the
18 screening from Dr. Tiller's office.
19 There was the DTREE. There was the GAF
20 report. And that's it.
21 Q. Who gathered the information -- Strike
22 that.

226

1 Is information from the parent a useful
2 tool in making --
3 **A. I'm sorry, you got a little garbled at the**
4 **end. Could you repeat that?**
5 Q. Sorry about that.
6 Is getting information from the parent or
7 parents, depending on how many parents show up, is
8 that a useful tool to make assessments of the mental
9 health of these patients?
10 **A. It can be.**
11 Q. And is that something that you do, is get
12 information from parents?
13 **A. It depends on the circumstances.**
14 Q. It's appropriate to seek that -- at
15 least in these patients was it appropriate to use that
16 information?
17 **A. I think so.**
18 Q. Did you review the records to determine
19 which patients had parents' input and which ones
20 didn't?
21 **A. I didn't specifically review for that**
22 **information. What I did review was to see whether**

227

1 **there was any indication that Dr. Neuhaus had gotten**
2 **that information as opposed to relying on information**
3 **generated by a nonmental health professional doing an**
4 **initial screen.**
5 Q. Is it a deviation of standard of care to
6 rely on that nonmental health professional to do the
7 initial screening and rely on that information for
8 purposes of doing an evaluation?
9 **A. Yes, I would say so.**
10 Q. Okay. Why?
11 **A. Because first of all, you don't know -- you**
12 **don't know what information that person considered**
13 **significant and not significant when they wrote it**
14 **down. Because nontrained individuals may assign more**
15 **significance to something that is psychiatrically less**
16 **significant. For example, someone crying frequently**
17 **over an unwanted pregnancy could be easily construed**
18 **as a sign of depression when it's really just**
19 **appropriate sadness. You have to distinguish between**
20 **those two things. All right?**
21 And they may under -- they may not put
22 enough weight on other things that they hear. So for

228

1 **example, what jumps out at me just from this minimal**
2 **amount of information is it would be very hard to**
3 **figure out, and I would want to do a lot of**
4 **questioning if I was evaluating this patient based on**
5 **the information in the MI about who is more invested**
6 **in getting this abortion given that the patient lives**
7 **with the mother, has multiple siblings in the home,**
8 **it's a precarious financial situation, there may not**
9 **be enough food for everyone.**
10 Is the mom really the force behind this or
11 is the 14-year-old the force behind this? And I would
12 want to know. It doesn't have to be either/or, they
13 could both be doing it. But a parent's agenda is not
14 always in the child's best interest, unfortunately.
15 And that is something I would want to know
16 about this, and I would not want to rely on someone
17 else's evaluation or statement just to know that. I
18 would want to do my own evaluation.
19 Q. Okay. And you don't know whether that was
20 done or not?
21 **A. Well, I have no information that**
22 **Dr. Neuhaus did or did not do her own evaluation in**

229

1 **this case. There is no documentation to indicate that**
2 **she did.**
3 Q. Over on page 5 of your report for Patient
4 No. 6 -- I'm sorry, page 5 of Patient 5.
5 **A. I'm sorry? Page 5 of Patient No. 6?**
6 Q. Correct. I'm sorry.
7 **A. That's okay.**
8 Q. Page 5 of Patient No 6. About the middle
9 of the paragraph -- or the middle of the page there is
10 a paragraph that says: "There is no doubt that
11 Patient No. 6 was distressed in finding herself
12 pregnant."
13 Then you say: "However, it is beyond any
14 psychiatric or psychological theory or evidence that
15 an unwanted pregnancy after sexual assault," which
16 didn't occur in this case, "could be construed as a
17 traumatic stressor that could result in acute distress
18 disorder."
19 That's a categorical no exception kind of
20 statement as I read it. Is that how you intended it
21 to be read?
22 **A. You could add a couple more qualifiers to**

230

1 **it. But basically the way acute distress disorder is**
2 **defined is that there has to be a traumatic stressor.**
3 **That is the gatekeeper criterion for this diagnosis.**
4 **A traumatic stressor would be an assault, a**
5 **rape, an earthquake, a car accident, something not**
6 **just distressing but traumatic. So almost by**
7 **definition this is a diagnosis that excludes anything**
8 **that doesn't meet that gatekeeper criteria.**
9 Q. And there are no circumstances where an
10 unwanted pregnancy could cause trauma? Is that your
11 testimony? It could be a traumatic event?
12 **A. An unwanted pregnancy is not a traumatic**
13 **event, it's a distressing event. And there is a**
14 **psychiatric meaning. A traumatic stressor is a term**
15 **of art, and the fact that the word "trauma" is**
16 **frequently used to describe an upsetting experience**
17 **has created a lot of confusion, generally speaking.**
18 **But a traumatic stressor is defined in the**
19 **DSM, and the studies that support the diagnoses of**
20 **acute stress disorder, post-traumatic stress disorder,**
21 **which are traumatic stress-induced disorders, clearly**
22 **identify and define what a traumatic stressor is. And**

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1 **it's not an unwanted pregnancy. And they give**
2 **numerous examples of what such trauma could be.**
3 Q. Like an assault or living through an
4 earthquake?
5 **A. Right. Which is not to say that it's not**
6 **incredibly upsetting and distressing to find yourself**
7 **pregnant when you don't want to be pregnant under**
8 **these circumstances or other circumstances.**
9 **I have no doubt that, you know, these -- I**
10 **have no doubt that all of these young women and**
11 **children were in acute distress, but that's a very**
12 **different thing from saying accuse distress disorder.**
13 **So as close as you can get, there are a couple of**
14 **caveats, unless she had a previous psychiatric history**
15 **of trauma, previous traumatic assault, et cetera,**
16 **unless her mother was beating her because she got**
17 **pregnant, there could be other trauma that's not being**
18 **directly addressed, she could have acute stress**
19 **disorder because of those. But the unwanted pregnancy**
20 **by itself would not result in acute stress disorder.**
21 **By definition that could not happen.**
22 Q. Irrespective of the age of the patient?

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1 **A. Irrespective of the age of the patient.**
2 Q. Can the age of a patient be taken into
3 account in determining whether a mental health
4 impairment could result from an unwanted pregnancy?
5 **A. Well, there is no evidence that I'm aware**
6 **of that links those three things, age, unwanted**
7 **pregnancy, mental health impairment. There is just no**
8 **evidence to suggest. You know, females have**
9 **pregnancies, unfortunately, or fortunately, at all**
10 **ages, from, you know, I think eight might be the**
11 **youngest or seven to now 60. And there are mental**
12 **health consequences of pregnancy for everybody.**
13 **I mean, it's a big deal to get pregnant and**
14 **to either have a baby or to terminate a pregnancy.**
15 **It's a big deal. There is no linkage of which I'm**
16 **aware that would say a mental health impairment is**
17 **related to an unwanted pregnancy and it is more likely**
18 **if you're a child or a teenager or you're 60 years**
19 **old.**
20 Q. And in that regard, the vulnerability of a
21 child doesn't make any difference in terms of their
22 developmental -- at what developmental stage they are

233

1 in life?

2 **A. It, of course, makes a difference on an**

3 **individual case-by-case basis with an evaluation that**

4 **takes all of that into account. But if you're asking**

5 **generally does the age of a child make a difference,**

6 **there is no evidence to suggest that as a general rule**

7 **the age of a child having an unwanted pregnancy is**

8 **linked to a mental health impairment.**

9 **If you have a child that already has a**

10 **mental health impairment and that child becomes**

11 **pregnant and now you can build all kinds of**

12 **circumstances onto to that and say yes, that could be**

13 **a problem. Right?**

14 **But as a general statement, you can't make**

15 **that. There is no evidence to support that kind of**

16 **general statement. I think everybody can agree that**

17 **an unwanted pregnancy in a seven or eight-year-old**

18 **child not only is horrifying but is usually criminal.**

19 **So it's not a good thing, and I'm not trying to**

20 **suggest that it's a good thing. But not every bad**

21 **thing leads to a permanent or irreversible mental**

22 **health impairment. Some people have more resilience,**

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1 **some people have less.**

2 **Q. You mentioned a seven or eight-year-old. I**

3 **presume that you would say the same thing about the**

4 **typical 14-year-old, it's not exactly a great idea for**

5 **them to be pregnant?**

6 **A. Correct. Yes. Generally speaking, both**

7 **medically and psychosocially, it is not a good idea in**

8 **our society, in our culture, for 14-year-olds to be**

9 **pregnant.**

10 **Q. And that causes psychosocial distress,**

11 **correct, or it can?**

12 **A. Yeah, it often does, and can lead to some**

13 **very unfortunate things happening like babies being**

14 **abandoned and dying in garbage cans and other bad**

15 **things that I think we would all agree are bad.**

16 **Q. Do you remember reading in any of the MI**

17 **documentation here that some of these girls were**

18 **worried about that very thing, about the inability to**

19 **take care of a child or that they might harm a child**

20 **if they carried the pregnancy to term? Do you**

21 **remember seeing anything like that?**

22 **A. I don't recall specifically about harming**

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1 **the child intentionally; that I don't recall. And I'm**

2 **happy to look at the documents again if that's**

3 **present.**

4 **I do think some of them were appropriately**

5 **concerned about their ability to care for the child --**

6 **for a child.**

7 **Q. And the psychosocial distress that can**

8 **result from an unwanted pregnancy for a teenager, it's**

9 **your testimony that that cannot cause a psychiatric**

10 **disorder?**

11 **A. No. I said that that of itself does not**

12 **constitute a psychiatric disorder.**

13 **Q. Is it your testimony that it can cause a**

14 **psychiatric disorder? Be a contributing cause?**

15 **A. Any adverse or distressing event, whether**

16 **it's an unwanted pregnancy or a parent's divorce or**

17 **illness in a sibling can be a contributory cause to**

18 **the development of a psychiatric disorder such as**

19 **depression or anxiety or might even trigger an**

20 **underlying genetically coded more severe disorder.**

21 **But of itself it's not equivalent to a psychiatric**

22 **diagnosis.**

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1 **Q. Right. But as far as an underlying cause**

2 **of a psychiatric disorder, it could serve that**

3 **function?**

4 **A. I would not say underlying cause. I would**

5 **say it could be a contributory factor to the**

6 **development of a psychiatric disorder. There could**

7 **already be a psychiatric disorder present. I mean,**

8 **you have to do the evaluation to know.**

9 **Q. In some of these patients' evaluations**

10 **there was the mention of possible harm to the patient**

11 **in terms of them committing suicide or having suicidal**

12 **thoughts. Is that a significant finding?**

13 **A. Certainly it's a significant statement when**

14 **someone tells you that they're thinking of killing**

15 **themselves.**

16 **Q. What is the significance of it?**

17 **A. It's different -- It's different for each**

18 **individual. To go all the way from an extreme, it can**

19 **mean someone who is intent, has a plan, has a lethal**

20 **plan, has the means to carry out that plan and has it**

21 **ready to go. Okay? To someone -- One extreme.**

22 **To the other extreme is someone making a**

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1 **dramatic statement using those words to convey to**
2 **other people how upset they are but with no intent, no**
3 **plan, no lethality, et cetera. So you can run the**
4 **spectrum.**
5 Q. In the situation where a patient says that
6 they had suicidal thoughts but they don't express
7 necessarily a plan that implies lethality, can you
8 discount the statement that they were thinking about
9 it?
10 A. **Certainly not. Certainly not. You have to**
11 **explore it. You have to find out what it means, and**
12 **you have to find out what it means not only in the**
13 **context of the immediate circumstances but in the**
14 **context of the patient as a whole person, not just in**
15 **the context of an unwanted pregnancy but in their**
16 **whole life story.**
17 Q. Now, on page 6 of your report related to
18 patients, the top of that paragraph, the first full
19 paragraph, you talk about the incidence of suicide
20 among women who have just given birth is one of the
21 lowest rate demographics in the United States. That's
22 a statistical probability analysis, correct?

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1 A. **Yes.**
2 Q. And so is it permissible for an individual
3 practitioner to rely upon the statistical incidence of
4 a particular event to determine whether that is or
5 isn't going to happen with a patient that's sitting
6 across from them?
7 A. **No.**
8 Q. So why did you include that paragraph in
9 your report?
10 A. **Because it is a piece of data that would**
11 **inform an evaluation. When you do a risk assessment**
12 **of someone, a suicide risk assessment, there is a lot**
13 **of different data that you have to consider that**
14 **contributes to or mitigates the risk of suicide. And**
15 **although that's a general statistical piece of data,**
16 **it's certainly one that you want a person who is doing**
17 **a risk assessment to be aware of.**
18 Now, again, how much weight it would carry
19 in that specific evaluation, a different issue. But
20 you would want to be aware of it because it would be a
21 really uncommon thing for a woman who was pregnant or
22 who within the first year of giving birth to commit

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1 **suicide. It would be a very uncommon occurrence.**
2 **So does that mean it wouldn't happen here?**
3 **No. But it means that -- What it means is if you put**
4 **it together with other data that indicates, for**
5 **example, that it's just a statement of distress, then**
6 **you can be a little more comfortable with your**
7 **assessment that it's a statement of distress as**
8 **opposed to if it you take that and put it together**
9 **with someone who says, oh, no, I've been saving up**
10 **drugs and I've got them out in the car and the second**
11 **I walk out of here, you know, that's going to happen.**
12 I'd say okay, that statistical data goes
13 out the window because I have someone whose clinical
14 evaluation indicates that that statistic is not the
15 most weighty fact here.
16 Q. So a probabilistic risk analysis, which is
17 kind of what this paragraph infers --
18 A. **Uh-huh.**
19 Q. -- is not something that you would apply in
20 a case-specific situation?
21 A. **It is a piece of data that I would consider**
22 **and then based upon the clinical evaluation, I would**

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1 **give it the weight that it seems to merit based on the**
2 **clinical evaluation.**
3 Q. Now, have you ever sat across from a
4 patient and sensed that there may be suicide that's a
5 possibility even though more objective indicators
6 might tell you otherwise?
7 A. **You mean --**
8 Q. Sort of an intuitive sense, if you will, in
9 assessing a patient and determining whether they might
10 have the capacity or the intent to harm themselves.
11 A. **You know, really a risk assessment is not**
12 **an intuitive thing. It's based on the collection of,**
13 **again, a lot of data. So, you know, could someone**
14 **have all kinds of data that says they're at pretty**
15 **high risk and then sit across from me and tell me, oh,**
16 **I'm not planning on killing myself? I don't know that**
17 **I would call that intuition. I would say I have**
18 **enough data to suggest to me that you are planning on**
19 **killing yourself even though you're telling me that**
20 **you're not.**
21 Q. Let's not call it intuition. Let's call it
22 subjectivity.

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1 **A.** Well, there are plenty of people who will
2 say to your face but that they're not planning on
3 killing themselves when they are. But again I would
4 not say that it's an inference or it's a subjective
5 thing.
6 Usually there is enough information that
7 you've gathered from other things that they have said
8 or that you have gotten from the history or from a
9 collateral source that would lead you to believe that
10 they might not be telling you the truth and, in fact,
11 might be lying in order to get out so that they can
12 kill themselves. So...
13 **Q.** All right. Let's take a look at Patient
14 No. 7, Dr. Gold.
15 **A.** Okay.
16 **Q.** How old was this patient?
17 **A.** 15.
18 **Q.** And did she express concern that carrying
19 this pregnancy to term would cause her to be harmed
20 mentally?
21 **A.** Yes.
22 **Q.** Does that have clinical significance?

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1 **A.** Yes.
2 **Q.** How?
3 **A.** What I'm struggling with here is trying to
4 find a way to explain that there is no question that
5 having a baby when you're a teenager and going through
6 with the pregnancy and keeping the child is not a life
7 altering event and not necessarily a life altering
8 event for the better. Okay?
9 But mental harm is a much more nebulous
10 concept in the sense that if you call being upset and
11 having your life path diverted "mental harm," then
12 there are all kinds of things that you can call mental
13 harm. If you're in a car accident and you end up in
14 traction for 12 months, is that permanent mental harm?
15 **Q.** Is it?
16 **A.** Is it? I mean, it's a good question. It's
17 distressing. It's certainly going to cause problems.
18 It may create circumstances that alter the path of
19 your life that cannot be altered back. But I don't
20 know that that would qualify, you know, as a
21 psychiatric disorder. I don't know what -- mental
22 harm is sort of a laymen's term. Doctors talk about

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1 psychiatric disorders and -- You know, every adverse
2 event causes mental harm if you use the term
3 generically that way.
4 So yes, is this girl concerned about the
5 effect that this is going to have on her life, on her
6 relationship with her parents? Absolutely. Is that
7 appropriate? Absolutely. She's spot on. Her insight
8 is good, her judgment is good. Her understanding
9 that -- her feeling that her parents wouldn't trust
10 her anymore, her guilt, all of that is appropriate to
11 the circumstances. Okay? Because she knows her
12 parents would be upset and hurt and she feels guilty
13 that she would be the agent of upsetting and hurting
14 them.
15 All of that is absolutely legitimate and so
16 it's clinically significant. But it doesn't establish
17 the basis for assuming permanent mental harm or
18 irreversible harm.
19 **Q.** Not by itself?
20 **A.** No, it doesn't.
21 **Q.** Now, would it, in conjunction with reported
22 problems with sleep and interest and guilt and energy,

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1 appetite and increased fatigue?
2 **A.** Maybe.
3 **Q.** Okay.
4 **A.** Maybe.
5 **Q.** All right. And would it in conjunction
6 with, for example, the GAF score?
7 **A.** Well, you practically have to be dead to
8 have a GAF score of 15. I mean, you have to be, you
9 know, practically have to be holding a gun to your
10 head to get a GAF score of 15. That's a pretty --
11 That's almost as low as you get without being in a
12 coma from malnutrition from not eating.
13 So there is just no way that someone with
14 this kind of good insight and judgment has a GAF score
15 of 15. Those two things right there are
16 contradictory.
17 **Q.** And that's your conclusion based on the
18 Patient 7's own concern about mental health issues and
19 the SIGECAPS?
20 **A.** Without the benefit of being able to do
21 further evaluation or having other information, I
22 would say that -- I would say that this is a case of

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1 mistaking her profound distress with a psychiatric
2 diagnosis based on the information I have available to
3 me.
4 Now, if there is other information, I'm
5 happy to consider it. But there is no other
6 documented information. This unfortunate 15-year-old
7 is extremely upset about being pregnant and she
8 doesn't want to be pregnant anymore. And I empathize.
9 I do.
10 Q. Fine.
11 Doctor, let's take a look at Patient No. 8.
12 How old was this girl?
13 A. 13.
14 Q. And what's the significance that she
15 reported -- and I'm reading at the bottom of page 8 of
16 your report where Patient 8 said she didn't think she
17 was going to make it through, she didn't think she
18 would live through this, that she thought that either
19 it, I guess that refers to baby, or I will die. I
20 think I would die or I would kill myself. I would
21 neglect the child or beat it senseless. And she says,
22 I've been very depressed.

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1 Are those kind of self-reporting
2 information, does that have clinical significance?
3 A. Of course.
4 Q. Why?
5 A. Well, again, it's the patient's own report
6 of her own condition. You can't do an evaluation of
7 someone's emotional or mental or psychiatric status,
8 or it's much more difficult to do, if they can't
9 communicate it to you in some way.
10 So this girl is very clearly communicating
11 her distress and she's communicating it in words that
12 you have to take very seriously.
13 Q. And then on the following page, the second
14 paragraph from the top, you say, quote: "Patient 8 in
15 responding to questions about suicide stated, 'I did
16 think that. I thought at first slitting my wrists and
17 then falling down stairs.'"
18 And then you say: "There is no indication
19 she took any action to harm herself."
20 In that last sentence of that paragraph,
21 are you essentially dismissing her verbalizations of
22 harming herself or others?

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1 A. No.
2 Q. She didn't take any action to harm herself?
3 A. No. That's part of the risk assessment, is
4 that people can have thoughts, and then it's a higher
5 risk if they take actions. And then if they take
6 actions, the risk becomes higher if you consider that
7 those were high intent, high lethality. It's part of
8 a spectrum of risk assessment.
9 So you follow it up -- So in other words,
10 if she had taken an action, let's say she had taken an
11 aspirin and she thought she was taking an overdose, I
12 would say took -- actually did something. But then my
13 next sentence might be, if I was doing the risk
14 assessment or trying to figure out the risk assessment
15 based on someone else's documents, this was a
16 nonlethal attempt and -- with low intent, for example.
17 So you go through the risk assessment until
18 you start getting negatives, because that tells you
19 how significant the statements and the behaviors are.
20 It's not an invalidation of what went before it.
21 Q. Okay. Now, when she expresses these
22 thoughts about suicide, is that a fair way to

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1 characterize what she was doing, she was thinking
2 about suicide?
3 A. Sure. Yes.
4 Q. And would it be fair to say that she was
5 thinking about harming the baby?
6 A. Possibly, yes.
7 Q. If you couple those self-report -- that
8 self-report information with the SIGECAPS, can you
9 begin to form a clinical judgment about whether there
10 is a psychological impairment that might result from
11 carrying this pregnancy to term?
12 A. No.
13 Q. If you combine that with a face-to-face
14 evaluation that essentially validates those findings
15 in the MI and that validates the self-report about
16 harming herself or others, does that get you to a
17 point where you can arrive at a conclusion about the
18 mental health of this person and the likelihood that
19 carrying a pregnancy to term with that mental health
20 would be impaired?
21 A. No.
22 Q. And that's a standard of care question?

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1 **A. Well, you asked me if I could arrive at**
2 **that conclusion, and I said no.**
3 **Q. And why not?**
4 **A. Okay. Because you're talking about a**
5 **13-year-old child who presumably has adult care.**
6 **Someone has brought her to this clinic from New**
7 **Jersey, so there is someone involved in taking care of**
8 **her.**
9 **I don't see any assessment of her support**
10 **system. I don't see any assessment of her -- I don't**
11 **see any consideration of treatment interventions or**
12 **options.**
13 **Let's say this child does have an episode**
14 **of acute depression. Let's say she meets the criteria**
15 **for depression. There are treatments for depression.**
16 **People recover from depression even if that depression**
17 **has been triggered by adverse circumstances like an**
18 **unwanted pregnancy.**
19 **So to go from even a diagnosis, let's say**
20 **she meets the diagnostic criteria, to say irreversible**
21 **mental harm, you cannot conclude that. You cannot**
22 **reasonably conclude that, even with a complete**

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1 **evaluation. How could you conclude that in someone**
2 **who hasn't had any intervention?**
3 **Q. Even with a complete evaluation, one that**
4 **would satisfy Dr. Gold's standards, you still couldn't**
5 **get to that conclusion, correct?**
6 **A. To the irreversible mental harm?**
7 **Q. Yes. Is that your testimony?**
8 **A. No, you can't. Because that would be**
9 **saying that -- again, just for the sake of argument,**
10 **that there is no treatment for this child's**
11 **depression, that no intervention -- if she were to**
12 **have this baby, there is no intervention in the world**
13 **that could cause her depression to get better. And I**
14 **don't see how any physician could say that about**
15 **anything without attempting treatment.**
16 **Q. Dr. Gold, in the standard in Kansas that is**
17 **supposed to be determined whether the late-term**
18 **abortion is justified or not, is it required that the**
19 **physician who does the evaluation consider alternative**
20 **treatments to abortion? Is it specified that way?**
21 **A. I don't -- Again, I'm not an expert on the**
22 **Kansas statute. I assume it doesn't. But because**

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1 **that's a medical imperative that you consider**
2 **treatment options. There is never only one option.**
3 **It's below the standard of care to wed yourself to one**
4 **option and not consider anything else.**
5 **Q. What was the purpose of this evaluation,**
6 **again, towards this patient and the others? Was it to**
7 **determine treatment alternatives or was it whether**
8 **there was the possibility of a substantial mental**
9 **impairment that might result from carrying this**
10 **pregnancy to term?**
11 **MR. HAYS: Objection; compound question.**
12 **BY MR. EYE:**
13 **Q. You may answer.**
14 **A. My understanding is that these referrals to**
15 **Dr. Neuhaus were to determine -- was for her to**
16 **determine whether on the basis of a substantial and**
17 **irreversible mental harm these females qualified for a**
18 **late-term abortion.**
19 **Q. Right. So she was not obligated by that**
20 **standard to consider treatment alternatives, correct?**
21 **A. I guess not legally obligated.**
22 **Q. And under the standard of care for that**

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1 **evaluation's purpose she wouldn't have been required**
2 **to consider those alternatives, correct?**
3 **A. I would disagree with that. I would**
4 **disagree on the basis that one starts with the**
5 **least -- when one thinks about an intervention, which**
6 **is what she's being asked to consider, one thinks**
7 **about medical training, everybody's medical training.**
8 **You consider the least invasive -- again, risk**
9 **assessment, least invasive, most invasive, least risk,**
10 **most risk, least complication, most complication. If**
11 **you wed yourself to only one treatment intervention,**
12 **then you are not doing your duty, so to speak, to that**
13 **patient.**
14 **Now, just because that patient comes in**
15 **referred for that thing, if I think something else is**
16 **going to be better, in that patient's better interest,**
17 **then it's my obligation as a physician to say, you**
18 **know what, I know you came in for this but I think**
19 **it's in your best interest that you consider that.**
20 **Okay?**
21 **So to not do that, I just don't see how**
22 **that can be justified medically even if it's not**

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1 **written into the Kansas statutes.**
2 Q. And would you agree that to do these
3 additional evaluations that you would suggest are
4 appropriate would require additional time?
5 **A. Well, certainly additional -- well, I don't**
6 **know how long Dr. Neuhaus spent, but it certainly does**
7 **not appear that there was an effort to collect a lot**
8 **of other information that might have been available.**
9 **So that's time that it takes to collect and review**
10 **that information. So to that degree I would say yes.**
11 Q. And if you were to refer these patients to
12 other alternative mental health professionals, let's
13 say, it's a fair assumption that that would build time
14 into the process as well, right?
15 **A. One would assume, yes.**
16 Q. And would you agree that that then impinges
17 on the capacity of these girls to have a safe
18 procedure if too much time passes?
19 **A. That --**
20 Q. I think you're not really qualified to
21 answer that question.
22 **A. I'm sorry?**

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1 Q. Are you qualified to answer that question?
2 **A. Could you ask the question again? I'm**
3 **sorry.**
4 Q. If you allow enough time to pass while
5 additional evaluations are done and alternative mental
6 healthcare professionals evaluate these patients,
7 wouldn't that impinge on the capacity of these girls
8 to get a safe abortion? In other words, additional
9 time passing.
10 **A. I don't even know how to answer that**
11 **question because these are not emergency procedures.**
12 **And they're coming from various places, and there's**
13 **time involved in doing that. And I presume that there**
14 **are psychiatrists, child social workers, mental health**
15 **professionals in Kansas City -- I'm assuming, I could**
16 **be wrong -- that in Kansas there is not an inability**
17 **to access as there would like in a rural area. I**
18 **think there are three psychiatrists in the whole state**
19 **of Idaho or something like that. You know, there may**
20 **not be a child person there.**
21 **So if they have time to make appointments**
22 **and let's say they're urgent evaluations but not**

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1 **emergency evaluations, then there theoretically would**
2 **be time to collect their medical records and get them**
3 **sent on ahead. There would be time on the other end**
4 **in Kansas to get them to set up an appointment with**
5 **the child person the same way that Dr. Neuhaus was**
6 **recruited to be available to do evaluations. One**
7 **would presume that appointments could be made with**
8 **other people.**
9 **I don't understand -- I don't think that**
10 **lack of time is a factor in a non-emergent surgical**
11 **intervention. If it's life-threatening, then yes.**
12 **But I did not see any evidence that these were**
13 **life-threatening surgical -- interventions done for**
14 **physical life-threatening circumstances.**
15 Q. All right. Let's take a look at Patient
16 No. 9.
17 **A. Okay.**
18 Q. This girl was 15 years old, correct?
19 **A. Yes.**
20 Q. And if I remember your testimony, you've
21 actually treated 15-year-old pregnant girls?
22 **A. I think I said I had one 16-year-old.**

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1 Q. I'm sorry, I beg your pardon. I misspoke.
2 **A. That's okay.**
3 Q. Now, in this instance what was the
4 documentary evidence that you saw that was the
5 underpinning for the conclusion Dr. Neuhaus reached in
6 this case?
7 **A. The documentary evidence consisted again of**
8 **an intake form, an MI indicators form which included**
9 **some narrative as well as the SIGECAPS evaluation or**
10 **screening. I guess there was another MI indicators**
11 **form in this chart.**
12 **I would have to look at the records because**
13 **it's puzzling. I've got MI and SIGECAPS twice. I**
14 **don't know if two were done or if I've made an error**
15 **in this report.**
16 Q. Yeah, that was sort of the genesis of my
17 question.
18 **A. Okay. Well, I would have to take a look.**
19 **Do you want me to go ahead and do that?**
20 Q. I think that's probably a good idea.
21 **A. Can I take a quick break and -- I don't**
22 **know if anyone else needs to.**

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1 MR. HAYS: Can we go off the record?
2 MR. EYE: We're off the record then.
3 MR. HAYS: For about ten minutes?
4 MR. EYE: Yeah, that's fine.
5 (Recess taken.)
6 BY MR. EYE:
7 Q. Have you had a chance to look at the chart
8 for Patient No. 9?
9 A. Yes.
10 Q. And we have a better sense for what the
11 documentary evidence is in that chart?
12 A. Yes. There are actually two documents
13 labeled MI indicators. The first one is correct,
14 Bates 2 to 3. And the second one is also correct,
15 Bates 6 -- yeah, just Bates 6. So it is actually
16 correct as indicated in the report.
17 Q. All right. And as far as -- does the
18 information -- Is information on the two MI indicators
19 the same? Does it look like the same document to you?
20 A. Not exactly. No.
21 Q. All right. Did you compare the two to
22 determine whether together they form a more complete,

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1 more clinically complete picture as far as what this
2 person's condition was?
3 A. No. The first one, Bates 2 to 3, is really
4 minimal.
5 The second one, Bates 6, has a little more
6 information but still -- again, is a screening with a
7 little bit more information in it and more information
8 about the pregnancy issues.
9 Q. All right. And as far as the one that is
10 more complete, which I believe is probably Bates 6 --
11 A. Correct.
12 Q. Of the two that is more complete. Is there
13 information there that would -- Again, I'm not
14 assuming that it's standing alone, but it would be an
15 indicator of a mental health impairment?
16 A. Any of the information provided could be an
17 indicator of a mental health impairment. You know,
18 absent a complete evaluation, it's hard to know the
19 significance of any of it. Just sleep. It says:
20 "Some nights I can sleep, some I can't." You know,
21 first of all, pregnant women sleep less. So how much
22 of that is physiological, how much is psychological?

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1 Then she adds: "This is on my mind. I
2 feel I let everyone down." So is she staying awake at
3 night turning these thoughts over and over in her
4 head? That might be more of an indication of a
5 psychological issue, and you would need to go through
6 not only these symptoms but additional symptoms,
7 intensity, frequency, duration, et cetera.
8 If you look at the context around here, for
9 example, she doesn't play basketball as much.
10 "Everything I do is slower. I run slower, I'm not as
11 quick, my game is off." Well, you know, she's 25 and
12 a half weeks pregnant. So yeah, I'm sure that's true.
13 But I'm not sure that's an indicator of a psychiatric
14 problem.
15 And then the context around the bottom and
16 the outside of the page is all about, you know,
17 again -- it's about the pregnancy. So, you know, how
18 much of it is psychiatric, I don't know.
19 Q. How about her self-report that she's sad
20 all the time?
21 A. I'm sure she is. She's pregnant and she
22 doesn't want to be, and she doesn't want people to

260

1 know.
2 Q. Are pregnant women expected to be sad all
3 the time?
4 A. If it's an unwanted pregnancy and she's a
5 teenager and she knows that it's going to be a real
6 big problem, you bet they're all sad. They're not
7 happy. But that's appropriate to the circumstance.
8 It's not necessarily an indicator of a psychiatric
9 problem. It's appropriate to the circumstances in
10 which she finds herself.
11 And again, when you look at things like
12 insight, judgment, guilt, even -- you know, even the
13 suicide question in this patient, "I just feel if I
14 weren't here, I wouldn't hurt my mom as much," is the
15 kind of statement you would expect from someone who
16 finds themselves in a very bad situation, what they
17 perceive to be a bad situation, and they say, gee, I
18 wish I had never been born, then this problem wouldn't
19 have happened.
20 It's much more frequent in less mature
21 individuals to hear that kind of stuff but you see it
22 in adults too. I'm getting loose now because I've

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1 **been going.**
2 Q. I understand.
3 You mentioned earlier that pregnant women
4 sleep less. That's sort of a general condition of
5 pregnant women?
6 **A. Yes. Especially as they get towards the**
7 **end, physiologically they just sleep. They may be**
8 **more tired but they sleep less. They spend less hours**
9 **in sleep.**
10 Q. And not necessarily with this Patient
11 No. 9, but I'm sure that you saw other MIs where it
12 indicates that some of these girls were sleeping more?
13 **A. Well, and again, it's hard -- it's very**
14 **hard to know what they mean, what changes have there**
15 **been. What does more mean? Does more mean that**
16 **they're sleeping an hour a day more? Does it mean**
17 **they're sleeping five hours a day more?**
18 **In the early parts of pregnancy it is more**
19 **common to sleep more. They're all in third trimester.**
20 **It's more common to sleep less. But if they're not**
21 **going out, if they're not doing the stuff they**
22 **normally do, if they're teenagers who are used to**

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1 **being out and about and active, perhaps they are**
2 **staying home and napping more often because they're**
3 **not doing stuff.**
4 **Are they still going to school? I mean, I**
5 **don't know -- Some of these are in the summer but some**
6 **of these are not. Are they still going to school?**
7 **Are they still participating in extracurricular**
8 **activities? What is going on? How are their grades?**
9 **There is a lot more information you would want to get.**
10 **When someone says sleeping more, I don't know exactly**
11 **what that means.**
12 Q. All right. And the other documentary
13 evidence that you found related to Patient No. 9 in
14 addition to the two MI documents was what?
15 **A. Well, there was the DTREE report and the**
16 **GAF report.**
17 Q. All right. Now again, you don't know
18 whether in Kansas the standard of care would be met by
19 relying on MI, GAF and DTREE, correct?
20 **A. I would hope it would not be.**
21 Q. But you don't know?
22 **A. If it is, then Kansas deviates from**

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1 **practice that's accepted nationally. I don't know if**
2 **Kansas does or not, but I would hope not.**
3 Q. Let's take a look at Patient No. 10,
4 Doctor.
5 **A. Okay.**
6 Q. Patient 10 is an 18-year-old, right?
7 **A. Yes.**
8 Q. And she had a pre-existing diagnosis
9 apparently, correct?
10 **A. Correct.**
11 Q. And that was what?
12 **A. Apparently it was anxiety disorder.**
13 Q. Does that have any clinical significance?
14 **A. Of course.**
15 Q. What is it?
16 **A. She has an anxiety disorder.**
17 Q. Does that have any significance related to
18 the evaluation to determine whether she was a
19 candidate for a late-term abortion?
20 **A. Well, again, there is a connection that I**
21 **have the difficulty with, which is that any**
22 **psychiatric disorder makes you a candidate for a**

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1 **late-term abortion. No. So no, it has no relevance**
2 **as to whether she's a candidate for a late-term**
3 **abortion.**
4 Q. Is an anxiety disorder something that can
5 impair a person's mental functioning?
6 **A. At times it can. Not typically all the**
7 **time unless it's very, very severe or untreated.**
8 Q. And is prescribing Paxil indicative of an
9 anxiety disorder that is less than -- that is more
10 serious than just an irritant?
11 **A. Well, it means that somebody -- and again,**
12 **I have no other information besides the fact that she**
13 **has anxiety attacks and is on Paxil. But it means**
14 **that somebody somewhere made an assessment that her**
15 **symptoms met the criteria for an anxiety disorder and**
16 **that she might benefit from treatment with medication.**
17 **And apparently she does because she keeps taking it.**
18 **Usually when people take a medication that doesn't**
19 **help them, they stop taking it.**
20 Q. And does the diagnosis of an anxiety
21 disorder, which presumably triggered the prescription
22 for Paxil, in your judgment that diagnosis of an

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1 anxiety disorder doesn't have anything to do with
2 determining whether this person would be a candidate
3 for late-term abortion; is that correct?

4 **A. Yes. Because I don't think there is a way
5 to connect any psychiatric disorder with the
6 intervention of a late-term abortion, except under
7 extraordinary unusual circumstances.**

8 Q. Is that your interpretation? You said that
9 a number of times. That's your interpretation based
10 on what?

11 **A. On the fact that a late-term abortion is
12 not a treatment or intervention for any psychiatric
13 disorder under any circumstances. It's not -- It's
14 not how you treat these disorders. Even if you think
15 that someone is severely psychiatrically ill, you
16 don't perform abortions, you don't perform
17 sterilizations, you don't perform lobotomies.**

18 **There has been no surgical intervention
19 ever found, unless someone has a brain tumor. Again,
20 I'm talking about these extreme circumstances that can
21 cause psychiatric problems like a brain tumor that
22 will prevent or treat a psychiatric disorder.**

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1 Q. Now again, that's not necessarily -- Is
2 that consistent with what the standard is in Kansas?

3 **A. Well, I mean, again I can't speak to what
4 the statute says in Kansas. The evidence in Kansas is
5 the same as the evidence in Virginia and Washington,
6 that there is no psychiatric disorder that's treated
7 by a surgical intervention, I don't care what kind of
8 surgical -- Well, that's not true. See, you say stuff
9 and it's not true.**

10 **Every once in a while people are still
11 doing brain surgery on people with severe psychiatric
12 symptoms. But surgical interventions like abortions,
13 hysterectomies, sterilization, lobotomies, there's no
14 evidence for using any of those kinds of surgical
15 interventions to prevent harm from a psychiatric
16 disorder. It's not going to happen.**

17 Q. Okay. So in your judgment, the fact that
18 the law anticipates a mental health reason to get an
19 abortion is just what, superfluous?

20 **A. No. I can imagine some unique
21 circumstances where it might become an emergency on
22 the basis of psychiatric circumstances that someone**

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1 **might need a late-term abortion. Extreme
2 circumstances.**

3 **And extreme circumstances happen. I mean,
4 everything once in a while. But they only happen once
5 in a while. It's not routine.**

6 **This is routine. These are routine
7 psychiatric disorders, anxiety disorder, depression,
8 they're treatable with medication, if someone is
9 suicidal you put them in the hospital. You don't hear
10 someone suggesting abortion as an intervention for
11 this.**

12 **So when you ask the question is it
13 significant in terms of mental impairment justifying a
14 late-term abortion, there is an assumption of a
15 connection that I disagree with.**

16 Q. And is there anything in the Kansas statute
17 that requires an emergent situation to justify a
18 late-term abortion based on mental health reasons, the
19 condition that you have interjected?

20 **A. No. From what --**

21 MR. HAYS: Objection. Not qualified to
22 answer that question. It's a legal question.

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1 THE WITNESS: Yeah, from what I understand,
2 the Kansas statute isn't written to indicate
3 emergency. But that doesn't change the medical fact.
4 BY MR. EYE:

5 Q. Didn't you just say it should be an
6 emergent situation to justify a mental health, a
7 late-term abortion?

8 **A. I said I could imagine circumstances that
9 constituted an emergency that might justify mental
10 health basis for a late-term abortion. I didn't say
11 it would have to be an emergency, and I'm not trying
12 to reinterpret Kansas statutes.**

13 **I'm just trying to explain the basis for
14 why I think that having a pre-existing psychiatric
15 disorder like an anxiety disorder in this specific
16 patient does not make any difference in terms of
17 whether they would or would not qualify for a
18 late-term abortion.**

19 Q. Standing alone? Well, strike that.

20 So do you know of any legal or policy
21 that -- legal reason or policy reason that says you
22 have to have an emergency to justify a late-term

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1 abortion based on mental health considerations?
2 MR. HAYS: Objection; calls for a legal
3 conclusion.
4 THE WITNESS: Yeah, I mean, I'm not an
5 expert in all the state statutes and policies
6 regarding late-term abortions, so I don't know.
7 BY MR. EYE:
8 Q. Are you an expert on any of those?
9 A. No.
10 Q. And you don't consider yourself to be an
11 expert on standard of care in Kansas, correct?
12 A. Only in the sense that Kansas is part of
13 the United States of America and I believe that there
14 is a national standard about doing evaluations
15 regardless of whether someone is pregnant or not. So
16 if things are done differently in Kansas, then no, I'm
17 not an expert in Kansas.
18 Q. And you've never undertaken an inquiry to
19 determine what the standard of care is in Kansas,
20 correct?
21 A. No. I have operated on the assumption
22 Kansas does what everybody else does in regard to

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1 psychiatric evaluations.
2 Q. That's an assumption?
3 A. It is an assumption.
4 Q. Take a look at the Patient No. 11 report.
5 A. Okay.
6 Q. This is a 16-year-old pregnant girl, right?
7 A. Yes.
8 Q. And just to kind of clear up my own use of
9 nomenclature here, is a 16-year-old a girl or an
10 adolescent?
11 A. Both.
12 Q. Okay. All right. But not an adult, at
13 least in terms of legal age of consent kind of things,
14 correct?
15 A. Correct. Well, it depends on what you're
16 talking about. Consent is not blanket for everything.
17 Q. Well, consent to get an abortion, for
18 example?
19 A. I don't know what the legal age is for
20 that.
21 Q. All right, fair enough.
22 A. I think in some places -- I think in some

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1 places you can get an abortion if you're 16 without
2 parental consent.
3 Q. But you've not undertaken a determination
4 of that either?
5 A. No, no.
6 Q. In the GAF report it indicates that the
7 patient has been in some danger of hurting herself?
8 Do you see that down at the bottom of
9 page 2 of that?
10 A. I see that that was written there. But
11 there is no information that that was true in the case
12 of this patient.
13 Q. And the GAF score there is 15. I think
14 earlier that 15 is just barely above comatose?
15 A. Well, that might be a little bit of
16 hyperbole but only a little.
17 Q. In terms of clinical description, what
18 would it reflect?
19 A. When you see a GAF score of 15 you're
20 thinking immediate psychiatric hospitalization.
21 Q. Okay.
22 A. Either because the person is completely

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1 unable to care for themselves up to and including not
2 being able to eat or drink or come in out of the
3 freezing cold and might die of exposure, or they're
4 imminently dangerous to themselves and others.
5 Q. And what role did this girl's family
6 history play in her assessment of her mental state to
7 justify getting a late-term abortion?
8 A. I don't know from looking at the report. I
9 would have to look at the records.
10 Q. Did her family situation, based on the
11 report, was it a contributor to the finding that she
12 was suffering a major depressive disorder?
13 A. I can't tell from the report.
14 Q. All right. Down at the bottom of page 3 --
15 A. I'm sorry. Okay. All right, okay.
16 Q. Would this be an example of a pre-existing
17 condition aggravated by an unwanted pregnancy?
18 A. Well, bereavement is not considered to be a
19 psychiatric disorder. Bereavement is a normal
20 reaction to loss and death. There is such a thing as
21 complicated bereavement where the bereavement sort of
22 morphs into depression. And it's not clear whether

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1 **that was the case with this girl or not.**
2 **It's certainly clear that this family's**
3 **emotional resources were already taxed to the limit**
4 **and that another adverse life circumstance was more**
5 **than they could handle. That's clear.**
6 Q. Would you consider that this unwanted
7 pregnancy was an exacerbation of the bereavement or
8 grief that she was feeling?
9 **A. How do you mean?**
10 Q. Did it aggravate the pre-existing -- Before
11 she was pregnant, evidently she was experiencing grief
12 because of the loss of her father. Is then the
13 unwanted pregnancy, is that something that can
14 aggravate that feeling of grief or the dealing with
15 grief?
16 **A. Well, the loss of the father is an adverse**
17 **event. Right? The unwanted pregnancy is another**
18 **adverse event. There is no -- There is no evidence**
19 **presented that the cumulative -- even the cumulative**
20 **effects of these adverse events rose to the level of**
21 **diagnostic criteria for major depressive disorder.**
22 **So I mean, just common sense wise,**

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1 **obviously if someone -- you know, if the family has**
2 **suffered one major blow and now they have another**
3 **major blow, it's going to be very, very upsetting, and**
4 **more upsetting perhaps in the context that they've**
5 **already had one major blow. But even so, it doesn't**
6 **mean that there is a psychiatric disorder.**
7 Q. Did you in the process of reviewing the
8 information for Patient No. 11 rule out a major
9 depressive disorder?
10 **A. How could I possibly have done that? I**
11 **didn't evaluate the patient.**
12 Q. I'm just asking if that's something you
13 did.
14 **A. It's not possible. So no.**
15 Q. And it's not possible partly because you
16 didn't evaluate the patient?
17 **A. A, I didn't evaluate the patient; B, if I**
18 **was going to do a record review to see whether that**
19 **diagnosis was justified based on the information**
20 **collected, I wouldn't be able to do that because there**
21 **is no documentation available.**
22 Q. And that would be your answer if you were

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1 asked that question for the other ten charts as well,
2 correct?
3 **A. Yeah. I would have to say yes.**
4 MR. EYE: I am close to being wrapped up, I
5 think. It would probably be useful if I could have
6 like just ten minutes to go back over things. If
7 there is anything more that I want to cover, I'll do
8 it. I could probably do it in a more expeditious way
9 if I can have a few minutes to review what I've
10 already got.
11 MR. HAYS: Okay.
12 MR. EYE: So in about ten minutes we'll
13 reconvene.
14 (Recess taken.)
15 BY MR. EYE:
16 Q. Doctor, we've just had an off-the-record
17 conversation about how we're going to handle getting a
18 copy of your file to us. And what we've agreed is
19 that one of the counsel for the Board will do a count
20 of the number of pages, we'll enter that into the
21 record, we'll withdraw the exhibit, hand it back to
22 you, and then you'll make a copy for us, us meaning

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1 the lawyers for Dr. Neuhaus.
2 **A. What I'll do is I'll make a copy and send**
3 **them to the Board and then I'll trust you guys to**
4 **distribute them to whoever. Is that okay?**
5 MR. HAYS: We can do that.
6 BY MR. EYE:
7 Q. That's great. Thank you.
8 **A. Okay.**
9 *** Q The only other thing I want to**
10 **do, Doctor, is give you one more opportunity**
11 **to answer the questions to which you've**
12 **objected earlier, and that is about your**
13 **personal views concerning abortion.**
14 MR. HAYS: Asked and answered. Objection.
15 THE WITNESS: I still don't want to answer
16 them if that's the question. Is that the question?
17 BY MR. EYE:
18 *** Q If that's your answer.**
19 **And the other question is: Do you consider**
20 **yourself pro-choice?**
21 **A. I'm not going to answer any questions about**
22 **my opinions regarding abortion.**



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1 *** Q Do you consider yourself**
2 **anti-choice?**
3 **A. I decline to answer.**
4 MR. EYE: Okay. Then I think that would
5 conclude the questions I have. I thank you, Doctor,
6 for your cooperation today.
7 MR. HAYS: And I just have a couple of
8 follow-up questions.
9 EXAMINATION
10 BY MR. HAYS:
11 Q. Dr. Gold, you spoke about transcripts that
12 you reviewed after making your report.
13 A. Yes.
14 Q. Have those transcripts changed your
15 opinion?
16 A. **The transcripts made me -- my degree of**
17 **certainty regarding my opinion stronger in the sense**
18 **that they validated what appeared to be the inferences**
19 **that I made. When I wrote the report, for example, I**
20 **had to infer that certain documents were generated by**
21 **Dr. Tiller's office. When I read the transcripts, it**
22 **became clear that they were generated by Dr. Tiller's**

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1 **office. So...**
2 Q. Do you recall what documents those were?
3 A. **The initial phone screening, the MI, the**
4 **SIGECAPS, all of those were not done by Dr. Neuhaus**
5 **herself but by someone screening in Dr. Tiller's**
6 **office, and usually by phone. And a nontrained mental**
7 **health professional.**
8 **So not only was it not done by Dr. Neuhaus,**
9 **but it was often done by phone and always done by a**
10 **nontrained mental health professional.**
11 Q. And how -- Strike that.
12 And you spoke about the dates of
13 evaluations that you gleaned from dates on the
14 documents.
15 A. **Correct.**
16 Q. Do you know, was that evidence of when
17 those evaluations actually occurred?
18 A. **It's hard to say what it's evidence of.**
19 **People can do evaluations and then document it days**
20 **later. So it's hard to know whether the evaluations**
21 **were done later or whether there was an error in the**
22 **date and someone just corrected it to reflect the**

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1 **correct date or whether the evaluation was done at the**
2 **appropriate time but the document was generated later.**
3 Q. And to direct your attention to the
4 standard of care, there were several questions on
5 standard of care in Kansas. Let's talk about the
6 standard of care itself.
7 There are certain guidelines that you
8 referenced in your report from the American Academy of
9 Child & Adolescent Psychiatry. And what does that
10 form the basis of?
11 A. **Those guidelines are a consensus of experts**
12 **about the best practices for the evaluation of**
13 **children and adolescents.**
14 Q. Would that form the basis of someone
15 determining what the standard of care would be?
16 A. **It would be contributory information. It's**
17 **not the basis. The standard of care is based on what**
18 **the average practitioner, skilled practitioner, based**
19 **on knowledge and clinical experience and usual and**
20 **customary practice would actually do.**
21 **So you can have guidelines that describe**
22 **best practices but not everybody is going to do all of**

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1 **that -- all of the things that are in the practice**
2 **guidelines. And they may not all be indicated in**
3 **every case.**
4 Q. Are there practice guidelines for other
5 specialties also?
6 A. **Absolutely.**
7 Q. And are there certain guidelines that are
8 standard across the entire United States?
9 A. **Well, the American Academy of Child &**
10 **Adolescent Psychiatry is a national organization. The**
11 **APA is a national organization, the American Academy**
12 **of Psychiatry in Law. These are all national**
13 **organizations.**
14 **They are the ones who generate -- Usually**
15 **when guidelines are generated, they are generated**
16 **using people from all parts of the country so that**
17 **they form a consensus of national practice.**
18 Q. Are there basic standards of care that
19 apply throughout the United States?
20 A. **It depends on what you're talking about.**
21 **That's very broad.**
22 Q. To give an example, treating a strep throat

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1 with antibiotics, that would be basic standard of care
2 throughout?
3 **A. Well, I would have to say that I assume so,**
4 **but since I don't do that, I don't know. Let me give**
5 **you a different one. It is always below the standard**
6 **of care to have sexual relations with your patients**
7 **when you're a psychiatrist. I don't know about other**
8 **doctors, but for psychiatrists that's a national**
9 **standard, the breach of which is always wrong, and it**
10 **doesn't matter if all the psychiatrists in your**
11 **community do it, it's still wrong. Even if it's usual**
12 **and customary practice, it's still wrong.**
13 Q. And are these types of standards of care
14 taught in medical school?
15 **A. They're taught -- I mean they are gleaned.**
16 **Standard of care is not directly taught. It is a**
17 **legal term. Medical schools and psychiatry**
18 **residencies teach medical and psychiatric, and other**
19 **specialties teach their specialty. Standard of care**
20 **is gleaned from best practices, experience, usual and**
21 **customary practices and review of literature and**
22 **knowledge gained academically.**

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1 **So one hopes that people learn what the**
2 **minimum standard of care is just because you want**
3 **people to be trained to be good doctors.**
4 **To answer that a little bit differently,**
5 **when doctors learn it, it's ethics and obligations as**
6 **opposed to being called standard of care.**
7 Q. Okay. And just to go back to when we first
8 started and talked about your CV, did you also get
9 awarded the top mental health doctor in 2009 also?
10 **A. I think it was only one year.**
11 Q. Only one year?
12 **A. I thought it was 2009, but I don't have my**
13 **CV in front of me. It could have been 2008, it could**
14 **have been 2009. I don't remember. But it was only**
15 **once.**
16 MR. HAYS: That's all I have.
17 MR. EYE: I'm sorry. Were you done, Reese?
18 MR. HAYS: Yes, that's all I have.
19 MR. EYE: I've just got a couple of
20 follow-ups on that.
21 EXAMINATION
22 BY MR. EYE:

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1 Q. I just want to make sure that I understand
2 a couple of things that you just testified about,
3 Doctor.
4 Guidelines are not standard of care,
5 correct?
6 **A. Correct.**
7 Q. And is it the case that the standard of
8 care that relates to a child might not be the same
9 standard of care that relates to an adolescent?
10 **A. Yes.**
11 Q. And it would be true that the same standard
12 of care that relates to a child would not necessarily
13 relate to an adult?
14 **A. In certain aspects, yes.**
15 Q. Okay. So it's not a one size fits all?
16 **A. No. That's why there are subspecialties,**
17 **because one size doesn't fit all.**
18 Q. And you have acknowledged that the standard
19 of care may actually have some potential regional or
20 community variations. So you may disagree with what
21 it is, but you acknowledge that that may be the case
22 depending upon, as I say, regional or community

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1 variations?
2 **A. Yes. Historically that's always been the**
3 **case.**
4 Q. When you got top mental health doctor
5 in 2009, I am assuming it didn't have anything to do
6 with providing abortion services or abortion
7 consultations?
8 **A. No, it did not.**
9 Q. You were asked about reviewing the
10 transcripts and whether it changed your opinion, and
11 you said it made your conclusions stronger, I believe
12 was how you characterized it.
13 Was that the totality of the effect on your
14 opinions having read the transcripts?
15 **A. Pretty much, yes. I mean, there wasn't new**
16 **information about the patients in there. It was**
17 **really about the process and procedures. So...**
18 Q. And as far as the process and procedures
19 are concerned, you've never been affiliated in a
20 professional way with any institution or facility that
21 has included you in the process of evaluating patients
22 for purposes of late-term abortions, correct?

VIDEOCONFERENCE DEPOSITION OF LIZA H. GOLD, M.D.
CONDUCTED ON FRIDAY, JUNE 24, 2011

285	1 A. Correct. 2 MR. EYE: That's all I have. 3 MR. HAYS: My co-counsel has a count for 4 the documents. 5 MR. EYE: Great. And what is that, Lori? 6 MS. DOUGHERTY: This is Lori Dougherty for 7 the board. 8 Exhibit 1, 16 pages, eight double-sided, 9 titled "New Patient Evaluation." 10 There is a second one called "Mental Status 11 Exam." It's two pages, one double-sided. 12 The final part of Exhibit 1 is Gold's 13 notes. There are six pages, and those are 14 single-sided. 15 Exhibit 2 contains 11 attachments -- excuse 16 me, 12. The first is "Practice Parameters for 17 Psychological Assessment of Children and Adolescents." 18 That's 17 pages single-sided. 19 There is the report for Patient 1, which is 20 nine pages single-sided; the report for Patient 2, 21 which is nine pages single-sided; Patient 3, nine 22 pages single-sided; Patient 4, ten pages single-sided;	287	1 today, Doctor. 2 THE WITNESS: Thank you. 3 MR. EYE: We're off the record now. Thank 4 you. 5 (Signature having not been waived, the 6 videoconference deposition of LIZA H. GOLD, M.D. was 7 concluded at 5:15 p.m.) 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22
286	1 Patient 5, nine pages single-sided; Patient 6, ten 2 pages single-sided; Patient 7, nine pages 3 single-sided; Patient 8, eight pages single-sided; 4 Patient 9, ten pages single-sided; Patient 10, 11 5 pages single-sided; and Patient 11, nine pages 6 single-sided. 7 MR. EYE: Very well. Thank you for doing 8 that. 9 MS. DOUGHERTY: You're welcome. 10 MR. EYE: You probably know that you can 11 read your transcript or you can waive reading it. We 12 should probably determine which you're going to do 13 here. 14 THE WITNESS: I'll read. 15 MR. EYE: I'll let you make arrangements 16 with the court reporter or counsel as to how you get 17 that transcript in hand. 18 Is there anything else that needs to be put 19 on the record, counsel? 20 MR. HAYS: I'm good if you are. 21 MR. EYE: I think we're good on this end. 22 Again, thank you for your cooperation	288	1 ACKNOWLEDGMENT OF DEPONENT 2 I, LIZA H. GOLD, M.D., do hereby 3 acknowledge that I have read and examined the 4 foregoing testimony, and the same is a true, correct 5 and complete transcription of the testimony given by 6 me and any corrections appear on the attached Errata 7 sheet signed by me. 8 9 10 _____ 11 (DATE) (SIGNATURE) 12 13 14 15 16 17 18 19 20 21 22

VIDEOCONFERENCE DEPOSITION OF LIZA H. GOLD, M.D.
 CONDUCTED ON FRIDAY, JUNE 24, 2011

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1 **REPORTER'S CERTIFICATE**

2 I, the undersigned Registered Professional

3 Reporter and Notary Public, do hereby certify that

4 LIZA H. GOLD, M.D., after having been first duly

5 sworn by me to testify to the truth, did testify as

6 set forth in the foregoing pages, that the testimony

7 was reported by me in stenotype and transcribed

8 under my personal direction and supervision, and is

9 a true and correct transcript.

10 I further certify that I am not of

11 counsel, not related to counsel or the parties

12 hereto, and not in any way interested in the outcome

13 of this matter.

14 **SUBSCRIBED AND SWORN TO** under my hand and

15 seal this 7th day of July, 2011.

16

17 My commission expires November 14, 2015.

18

19 _____

20

21 **NOTARY PUBLIC IN AND FOR**

22 **THE DISTRICT OF COLUMBIA**

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1 **ERRATA SHEET CONTINUED**

2 IN RE: Ann K. Neuhaus, M.D.

3 RETURN BY: _____

4 **PAGE LINE CORRECTION AND REASON**

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1 **ERRATA SHEET**

2 IN RE: Ann K. Neuhaus, M.D.

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4 **PAGE LINE CORRECTION AND REASON**

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