BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In the Matter of	)	
	)	Docket No. 10-HA00129
ANN K. NEUHAUS, M.D.	)	
Kansas License No. 04-21596	)	OAH Docket No. 10-HA0014
	)	

PETITIONER'S DISCLOSURE OF EXPERT WITNESS:
Liza H. Gold, M.D.

COMES NOW, the Petitioner, Board of Healing Arts ("Board"), by and through Kelli J. Stevens, Litigation Counsel ("Petitioner"), and hereby discloses its expert witness in the above matter as follows:

1. Identity

Liza H. Gold, M.D.
Clinical Professor or Psychiatry
Georgetown University Medical Center
2501 North Glebe Road, Suite 204
Arlington, Virginia 22102
Phone: 703-875-0435

Dr. Gold practices in Arlington, Virginia, specializing in Psychiatry. A copy of Dr. Gold's curriculum vitae (Attachment A) summarizing her professional qualifications, education and experience is enclosed herewith.

2. Subject Matter

It is anticipated that Dr. Gold will testify and express opinions regarding Licensee's care and treatment of Patients 1 through 11, as set forth in the Petition, and whether Licensee met the applicable standard of care. The subject matter of Dr. Gold's opinions is further expressed in her reports (Attachment B), which are enclosed herewith. As further discovery is completed which may affect any opinions expressed herein or in Dr. Gold's reports, this disclosure will be supplemented. Additionally, Dr.

Gold may be asked to respond to any opinions expressed by Licensee and/or her experts.

3. Substance of Facts and Opinions

It is anticipated that Dr. Gold will testify regarding her background and qualifications to render an opinion with respect to Licensee's care and treatment of Patients 1 through 11. The substance of the facts and opinions expressed by Dr. Gold are generally set forth in her reports enclosed herewith. She will specifically testify about Licensee's consultative evaluations of Patients 1 through 11.

It is anticipated that Dr. Gold will provide opinion testimony that Licensee's evaluation of Patients 1 through 11 did not meet the applicable standard of care. As further discovery is completed which may affect any opinions expressed herein or in Dr. Gold's reports, this disclosure will be supplemented. Additionally, Dr. Gold may be asked to respond to any new facts disclosed or opinions expressed by Licensee and/or her experts.

4. Summary of Grounds for Opinions

Dr. Gold's opinions are based upon her education, training and experience as a psychiatrist, her review of patient records, the transcript of the proceedings in State of Kansas v. George Tiller, Sedgwick County Case No. 07CR 2112, relevant publications/literature and patient medical records for Patients 1 through 11 from Licensee and George Tiller, M.D. The grounds for Dr. Gold's opinions are generally set forth in her reports enclosed herewith. As further discovery is completed which may affect any opinions expressed in Dr. Gold's reports, this disclosure will be

supplemented. Additionally, Dr. Gold may be asked to respond to any new facts disclosed or opinions expressed by Licensee and/or her experts.

Respectfully submitted,

Kelli J. Stevens

Kelli J. Stevens, #16032
Litigation Counsel
Kansas State Board of Healing Arts
235 S. Topeka Boulevard
Topeka, Kansas 66603-3068
(785) 296-7413

CERTIFICATE OF SERVICE

I, Kelli J. Stevens, hereby certify that I served the above and foregoing **PETITIONER'S DISCLOSURE OF EXPERT WITNESSES** on the 27th day of August, 2010, via United States mail, first-class, postage pre-paid and addressed to:

Ann K. Neuhaus, M.D.
17127 Osage Road
Nortonville, Kansas 66060

Kelli J. Stevens
Signature

4/16/09

Liza H. Gold, MD
2501 North Glebe Road, Suite 204
Arlington, VA 22207

O: 703-875-0435
F: 703-875-0434

Website: www.lizahgoldmd.com

Curriculum Vitae

Board Certification

American Board of Psychiatry and Neurology (1991)
Forensic Psychiatry, Subspecialty Certification (1999)

Academic Appointments

Clinical Professor of Psychiatry, April 2006 - present
Georgetown University Medical Center
Department of Psychiatry

- Clinical Associate Professor of Psychiatry, 2003 - April 2006
- Clinical Assistant Professor of Psychiatry, 1998 - 2003

- Associate Director, Program in Psychiatry and Law, 2001 to present
- Course Director, Gender Issues in Psychiatry, 2003 - 2005
- Course Director, Writing in Forensic Psychiatry, 2009

Areas of Expertise

Clinical evaluation, diagnosis and treatment of psychiatric disorders in adults.

- Evaluation and psychopharmacologic and psychotherapeutic treatment of posttraumatic, affective (mood) disorders, anxiety disorders and personality disorders.
- Psychotherapeutic issues related to the psychological and medical consequences of childhood and adult trauma.
- Diagnostic and psychopharmacologic expertise in women's reproductive psychiatry, including postpartum disorders, management of medication during pregnancy and lactation, premenstrual dysphoric disorder and menopause.

Forensic and independent medical evaluations, including assessment of emotional injury, damages, and mental health assessments, including testimony if required.

- Psychiatric consequences of trauma and violence.
- Employment litigation, including ADA evaluations, sexual, gender, racial and other discrimination claims and litigation, fitness for duty and other employment related problems.

ATTACHMENT A

Postgraduate Medical Training

Boston University Psychiatry Residency Training Program, 1986 - 1990
Boston City Hospital, Boston, MA
University Hospital, Boston, MA
Chief Resident in Psychiatry, 1989
Edith Norse Rogers Veterans Administration Hospital, Bedford, MA
Brockton Hospital, Brockton, MA, Transitional Intern 1986 - 1987

Ginsberg Fellow, Group for the Advancement of Psychiatry, 1989 - 1990

Medical Education

New York University School of Medicine, M.D., 1986
- Alex Rosen Award for Excellence in Medicine and the Humanities, 1986

Graduate Education

University of Cambridge, Master of Philosophy in the History of Medicine, 1983

Undergraduate Education

Harvard/Radcliffe College, *magna cum laude*, B.A., 1981
- Elizabeth Cary Agassiz Scholar, in recognition of academic achievement of highest distinction, 1980-1981

Certification

Licenses (active): Commonwealth of Virginia (1991)
District of Columbia (renewed 2004)
National Board of Medical Examiners (1987)

Licenses (past): District of Columbia (1992 - 1997)
New Hampshire (1988 - 1992)
Massachusetts (1986 - 1992)

Awards

Washingtonian Magazine, Top Doctor, 2008

Manfred S. Guttmacher Award 2006, American Psychiatric Association and American Academy of Psychiatry and the Law , for outstanding contributions to the literature on forensic psychiatry, for Sexual Harassment: Psychiatric Assessment in Employment Litigation (American Psychiatric Publishing, Inc., 2004)

Washington Psychiatric Foundation Community Service Award, 1997

Experience Summary

2001 - present

Private Practice, Clinical and Forensic Psychiatry, Arlington, VA, since 1992
St. Elizabeths Hospital, Consultant, John Howard Pavilion, 2008
Virginia Hospital Center, Department of Psychiatry, Medical Staff, 2004
Court Consultant, Arlington County District and Circuit Courts, 2008 - present

1992 - 2000

Private Practice, Clinical and Forensic Psychiatry, McLean, VA
Columbia HCA Reston Hospital, Reston, VA, Attending Psychiatrist, 1997-2000
Psychiatric Institute of Washington, DC, Medical Director, Day Center Program, Center for Posttraumatic Disorders, 1996 - 1997
Psychiatric Institute of Washington, DC, Attending Psychiatrist, Center for Posttraumatic Disorders,1992 - 1997

1986 - 1992

Psychiatric Institute of Catholic Medical Center, Manchester, NH, Associate Medical Director, 1991 - 1992
Nashua Brookside Hospital, Nashua, NH, Attending Psychiatrist, 1991 - 1992
Nashua Memorial Hospital, Nashua, NH, Attending Psychiatrist, 1991 - 1992
Psychiatric Institute of Malden Hospital, Malden, MA, Assistant Clinical Director, 1990 - 1991
Clinical Instructor in Psychiatry, Boston University School of Medicine, Boston, MA, 1990 - 1991
Hampstead Hospital, Hampstead, NH, Attending Psychiatrist, 1989 - 1991
Charles River Hospital, Wellesley, MA, Attending Psychiatrist, 1988 - 1990

Professional Affiliations

American Academy of Psychiatry and the Law, 1997

Elected Offices

Board of Governance Councilor, 2006-2009

Chairmanships

Program Chair, 2006 Annual Meeting, Chicago, IL, 2005-2006
Chair, Task Force on the Development of Guidelines for Disability Evaluations, 2005-2007

Committees

- AAPL Newsletter Editor Search Committee, 2008
- Nominating Committee, 2006-2008
- Education Committee, 2006-2009
- Program Committee, 2005-2009
- Trauma and Stress Committee, 2003-2008
- Suicidology Committee, 1999-2008

- Gender Issues Committee, 1999-2009

Chesapeake Bay Chapter of the American Academy of Psychiatry and the Law, 1997
President, Chesapeake Bay Chapter, 2004-2008
Councilor for Virginia, Chesapeake Bay Chapter, 2001-2003

American Psychiatric Association, 1986 - present
Membership Status
- Distinguished Fellow, 2006
- Fellow, 2003

Chairmanships
Chair, Committee of Tellers, 2003-2006

Committees
- Council on Psychiatry and Law, 2007-2011
- Committee on Judicial Action, 2002-2006
- Committee of Tellers, 2002-2008
- Corresponding Committee on History and Library, 2002-2008

Washington Psychiatric Association, 1992 - present
American Medical Association, 2002 - present
American Society of Clinical Psychopharmacology, 1997 - present
Association of Women Psychiatrists, 1997 - present
Fairfax County Medical Society, 1992 - present

Committee Memberships
American Board of Psychiatry and Neurology
Forensic Psychiatry Certification Examination Committee, 2008 - 2011

Public Service Activities
Commonwealth of Virginia, Commission on Mental Health Law Reform
Working Group on Health Privacy and the Civil Commitment Process, 2007 - 2008

Academic Activities
CME LLC Psychiatric Congress Peer Reviewer, 2006-2008

American Academy of Psychiatry and the Law, Program Chair for the 2006 Annual Meeting, Chicago, IL, October 25-29, 2006

St. Elizabeths Hospital Sesquicentennial Celebration, 2004 -2005
Chair, Educational Symposium Committee

Program Director, Educational Symposium
"The Role of the Public Psychiatric Hospital in the 21st Century"
May 5 and May 6, 2005,
Washington Convention Center
Washington, DC

Psychiatric Times, Advisory Committee for CME, 2000

Journal Affiliations

Editorial Boards
Journal of the American Academy of Psychiatry and the Law, 2009-2011
Psychiatric Annals, Editorial Review Board, 1999 - present

Peer Reviewer
American Journal of Psychiatry
Journal of the American Academy of Psychiatry and the Law
Obstetrics and Gynecology
Primary Psychiatry
Behavioral Sciences and the Law

Publications

Books

Evaluating Mental Health Disability in the Workplace: Model, Process, and Analysis
Co-author Daniel W. Shuman, J.D., Springer, in press, publication scheduled for 2009

Sexual Harassment: Psychiatric Assessment in Employment Litigation.
American Psychiatric Publishing, Inc., 2004
- Guttmacher Award Winner, 2006, American Psychiatric Association

The American Psychiatric Publishing Textbook of Forensic Psychiatry
Coedited with Robert I. Simon, MD. American Psychiatric Publishing, Inc., 2004
- Guttmacher Award Nominee, 2005, American Psychiatric Association

The American Psychiatric Publishing Textbook of Forensic Psychiatry Study Guide
Co-written with Robert I. Simon, MD. American Psychiatric Publishing, Inc., 2004

Book Chapters

"Gender issues in suicide," in The American Psychiatric Publishing Textbook of Suicide Assessment and Management. Editors Robert I. Simon, MD and Robert E. Hales, MD, American Psychiatric Publishing, Inc., 2006

"Rediscovering forensic psychiatry", in The American Psychiatric Publishing Textbook of Forensic Psychiatry. Editors: Robert I. Simon, MD and Liza H. Gold, MD. American Psychiatric Publishing, Inc., 2004

"The Workplace," in The American Psychiatric Publishing Textbook of Forensic Psychiatry. Editors: Robert I. Simon, MD and Liza H. Gold, MD. American Psychiatric Publishing, Inc., 2004

"Ethical issues in Forensic Psychiatry," co-author with Robert Weinstock, MD, in The American Psychiatric Publishing Textbook of Forensic Psychiatry. Editors: Robert I. Simon MD and Liza H. Gold, MD. American Psychiatric Publishing, Inc., 2004

"Psychiatric diagnoses in Forensic Psychiatry," co-author Robert I. Simon, MD, in The American Psychiatric Publishing Textbook of Forensic Psychiatry. Editors: Robert I. Simon MD and Liza H. Gold, MD. American Psychiatric Publishing, Inc., 2004

"Sexual harassment," in Principles and Practice of Forensic Psychiatry, 2nd edition. Edited by Richard Rosner. Arnold Press, 2003

"Psychiatric diagnoses and the retrospective assessment of mental status," in Retrospective Assessment of Mental States in Litigation: Predicting the Past. Edited by Robert I. Simon and Daniel Shuman, American Psychiatric Publishing, Inc., 2002

• Guttmacher Award 2002, American Psychiatric Association, honorable mention

"PTSD in employment litigation," in the 2nd edition of Posttraumatic Stress Disorder in Litigation: Guidelines for Forensic Assessment. Edited by Robert I. Simon, MD. American Psychiatric Publishing, Inc., 2002

"Posttraumatic stress disorder in employment cases," co-author Robert I. Simon, M.D., in the 2nd edition of Mental and Emotional Injuries in Employment Litigation. Edited by James J. McDonald, Jr. and Francine Kulick, Washington DC: The Bureau of National Affairs, Inc., 2001

Articles

POWs v. Torturers: Forensic Evaluation of Military Personnel. Levin AP, Gold LH, Onorato AA. *Journal of the American Academy of Psychiatry and the Law*, accepted for publication, scheduled Sept 2009

Forensic Evaluation of Psychiatric Disability Practice Guideline. Gold LH, Anfang, SA, Drukteinis, MD, JD, et al. *Journal of the American Academy of Psychiatry and the Law*, 2008, Vol. 36, No. 4, Supplement 3, pp 1-50

Without thinking: Impulsive aggression and criminal responsibility. Shuman DW, Gold LH. *Behavioral Sciences and the Law*, 2008, Vol. 26, No. 6, pp. 723-34

Do you understand your risk? Liability and third party evaluations in civil litigation." Gold LH, Davidson J. *Journal of the American Academy of Psychiatry and the Law*, June 2007, Vol. 35, No. 2, pp. 200-210

"The Doctor-patient relationship and liability in third-party evaluations for civil litigation," *Psychiatric Times*, June 2006, Vol. 23, No. 7, pp 65-6.

"Psychiatric Employment Evaluations and the Health Insurance Portability and Accountability Act." Gold LH, Metzner JL. *The American Journal of Psychiatry,* Nov 2006, Vol. 163, No. 11, pp 1878-1882

"Robert I. Simon, MD: Of psychiatry, law and books." Gold LH, Gutheil TG. *The Journal of the American Academy of Psychiatry and the Law*, 2006, Vol. 34, No. 1: pp 9-13

"Formal training in women's issues in psychiatry: A survey of residency training directors." Gold LH, Epstein SJ. *Academic Psychiatry*, 2006, Vol. 30, No. 5, pp 403-409

"Posttraumatic Stress Disorder in Litigation," article for "Psychiatric Times Special Report on Forensic Psychiatry," *Psychiatric Times*, December 2005, Vol. XXII, No. 14, pp. 30-31

"Gender issues in suicide," *Psychiatric Times*, October 2005. Vol 22, No. 11, pp 64-72

"Psychopharmacological treatment of depression during pregnancy." *Current Women's Health Reports: Psychosocial Health* 2003, Vol. 3, No. 3

"Postpartum disorders and their pharmacological treatment." *Primary Care: Clinics in Office Practice, Special Issue on Women's Mental Health*, 2002, Vol. 29, No. 1, pp. 27-41

"Clinical and forensic aspects of postpartum depression." *Journal of the American Academy of Psychiatry and the Law*, 2001, Vol. 29, No. 3, pp. 344-347

"Use of psychotropic medication during pregnancy: Risk management guidelines." *Psychiatric Annals*, 2000, Vol. 30, No. 6, pp. 1-12

"Treatment of depression during pregnancy," *Journal of Women's Health*, 1999, Vol. 8, No. 5, pp. 1-7

"Addressing bias in the forensic assessment of sexual harassment claims," *Journal of the American Academy of Psychiatry and the Law*, 1998, Vol. 26, No. 4, pp. 563-578

"Why use a forensic psychiatrist? Role conflict between treating psychiatrist and forensic psychiatrist," *The Journal of the Virginia Trial Lawyers Association*, 1998, Vol. 10, No. 4, pp. 16-19.

Reprinted in *The Alaska Trial Lawyer*, published by the Alaska Academy of Trial Lawyers, Volume 1, 1999, pp. 18, 25

Editor

"Psychiatric Times Special Report on Forensic Psychiatry," *Psychiatric Times*, December 2005, Vol. XXII, No. 14, pp. 25-36

Editorials

"American Psychiatric Association honors Dorothea Dix with first posthumous fellowship." *Psychiatric Services* 56(4): 502, 2005

"AAPL and the death penalty: A historical perspective on the debate." *Journal of the American Academy of Psychiatry and the Law*, 33(1): 6-7, 2005

Book Reviews

American Journal of Psychiatry, Sarah C. Charles, Paul R. Frisch: A Physician's Guide: Adverse Events, Stress and Litigation (Oxford University Press, 2005). Vol. 163, No. 1, pp 166-167

American Journal of Psychiatry, Robert I. Simon, Daniel W. Shuman: *Clinical Manual of Psychiatry and the Law* (American Psychiatric Publishing, 2007). Vol. 164, No. 5, pp 837-838

Invited Presentations

Lecture: Delusional Disorder and Stalking: Clinical and Forensic Management
Sheppard Pratt Hospital Grand Rounds
December 17, 2008; Baltimore, MD

Panel Chair: Liability in Forensic Practice: Minimizing Increasing Risk
American Academy of Psychiatry and the Law, 2007 Annual Meeting

October 19, 2007: Miami, FL

Panel: Through the Eyes of the Expert: How Lawyers Can Improve Their Preparation of Experts
Virginia Bar Association Continuing Legal Education Seminar
The Survivor's Guide to Expert Witnesses: From Selection through Trial
June 7, 2007; Fairfax, VA

Panel: Advances in Assessment and Management of Suicide
Suicide and Gender
American Psychiatric Association 2007 Annual Meeting
May 22, 2007; San Diego, CA

Symposium: Bullying in the Workplace: Associated Health Problems
Co-Chair American Psychiatric Association 2007 Annual Meeting
May 22, 2007; San Diego, CA

Lecture: The History of Forensic Psychiatry in the US and UK
Anglo-American Conference on Forensic Psychiatry
Royal College of Psychiatry, Forensic Division
April 27, 2007; London, England

Lecture: Liability and Third-Party Evaluations in Civil Litigation
New York Chapter of the American Academy of Psychiatry and the Law
January 21, 2007; New York, NY

Lecture: Suicide and Gender
2006 U.S. Psychiatric and Mental Health Congress
November 16, 2006; New Orleans, LA

Lecture: Forensic Psychiatry: The Role of Medical Jurisprudence in the Development of Psychiatry
Association of Mental Health Librarians 2006 Annual Meeting
November 3, 2006; National Library of Medicine, Bethesda, MD

Mock Trial: Medical Malpractice: Postpartum Psychosis and Suicide
American Academy of Psychiatry and the Law 2006 Annual Meeting
October 26, 2006; Chicago, IL

Panel: POW's v. Torturers: A New Cause of Action?
American Academy of Psychiatry and the Law 2006 Annual Meeting
October 27, 2006; Chicago, IL

Panel: Proposed AAPL Guidelines: Trial Competence, Disability Assessments
American Academy of Psychiatry and the Law 2006 Annual Meeting

October 27, 2006; Chicago, IL

Panel: Sexual Harassment: Who is Believed?
American Academy of Psychiatry and the Law 2006 Annual Meeting
October 28, 2006; Chicago, IL

Guttmacher Award Lecture:
The Challenge of Employment-Related Psychiatric Evaluations
American Psychiatric Association 2006 Annual Meeting
May 21, 2006; Toronto, Canada

Symposium: Bullying in the Workplace
American Psychiatric Association 2006 Annual Meeting
May 23, 2006; Toronto, Canada

Workshop: Sexual Harassment in the Workplace: Reducing Risk and Liability
Chesapeake Human Resources Association
May 17, 2006; Towson, MD

Lecture: Psychiatric Expert Testimony in Employment Litigation
Montgomery County Bar Association
Employment Law Division
April 20, 2006; Rockville, MD

Lecture: Rediscovering forensic psychiatry
The American Academy of Psychiatry and the Law, 2005 Annual Meeting
October 2005; Montreal, Canada

Lecture: The Mental Health Expert in Employment Litigation
DC Bar Association, Labor and Employment Section
March 2005; Washington, DC

Lecture: The Mental Health Expert in Employment Litigation
Fairfax County Bar Association, Labor and Employment Section
February 2005; Fairfax, VA

Lecture: Sexual Harassment in the Workplace
The Annapolis Society for Human Resource Management
August 2004; Annapolis, MD

Panel: Does Gender Matter? Examining Gender's Role in Forensics
American Academy of Psychiatry and the Law, 2004 Annual Meeting
October 2004; Scottsdale, AZ

Panel Chair: Psychiatric Evaluation in Sexual Harassment Cases

American Academy of Psychiatry and the Law, 2004 Annual Meeting
October 2004; Scottsdale, AZ

Lecture: Sexual Harassment in the Workplace
Annapolis Chapter, Society for Human Resources Management
September 2004; Annapolis, MD

Seminar: Sexual Harassment in the Workplace
Human Resources Association of New York
June 2004; New York, NY

Workshop: Whither our own history: Rediscovering forensic psychiatry
American Psychiatric Association Annual Meeting
May 2004: New York, NY

Seminar: Posttraumatic Stress Disorder in Employment Litigation
The Forensic Network, Annual Mental and Emotional Injury Claims Conference and Seminar
November 2002; New Orleans, LA

Lecture: Women and depression
Sponsored by Glaxo-Welcome Pharmaceuticals
November 3, 2001; Washington, DC

Panel: Bending Gender: How Gender Makes a Difference
Panel Presentation Coordinator
American Academy of Psychiatry and the Law 2002 Annual Meeting
October 2002; Newport Beach, California

Panel: Retrospective Assessment: Daubert and the Insanity Defense
American Academy of Psychiatry and the Law 2002 Annual Meeting
October 2002; Newport Beach, California

Workshop: Writing and Publishing in Forensic Psychiatry
American Academy of Psychiatry and the Law 2001 Annual Meeting
October 27, 2001; Boston, MA

Seminar: Discharging Inpatients: Managed Care and Risk Assessment
American Academy of Psychiatry and the Law 2001 Annual Meeting
October 26, 2001; Boston, MA

Lecture: Use of Psychiatric Drugs and the Treatment of Depression During Pregnancy,
Sponsored by Forest Pharmaceuticals

January 24, 2002: Washington, DC
September 20, 2001; Chevy Chase, Maryland
June 20, 2001; McLean, Virginia

Panel: Inter-Profession Ethics: The Ethical Interplay between Psychologists, Psychiatrists and Attorneys
The Forensic Network, Annual Mental and Emotional Injury Claims Conference and Seminar
July 2001; Jackson Hole, WY

Seminar: Defending Emotional Injury Claims in Employment Litigation
The Forensic Network, Annual Mental and Emotional Injury Claims Conference and Seminar
July 2001; Jackson Hole, WY

Seminar: Sexual Harassment: Confidentiality, Rape Shield Laws, and Assessment in Litigation
American Psychiatric Association Annual Conference
May 9, 2001; New Orleans, Louisiana

Seminar: The Examination of Expert Witnesses
George Mason American Inn of Court
February 23, 2000; Roslyn, Virginia

Seminar: Espionage, psychological exploitation and entrapment,
American Academy of Psychiatry and Law 1999 Annual Meeting
October 14, 1999; Baltimore, Maryland

Lecture: Assessing emotional damages in sexual harassment litigation,
Virginia Trial Lawyers Association 1999 Annual Convention
March 27, 1999; The Greenbrier, White Sulphur Springs, WV

Lecture: Depression or just a bad day,
The New Moms Support Group, Columbia Reston Hospital Center
June 2, 1998; Reston, Virginia

Seminar: The use of psychiatric medication during pregnancy
Pfizer Inc. Physician Education Program
April 18, 1998; Alexandria, Virginia

Seminar: Posttraumatic Stress Disorder, Diagnosis and Treatment,
Vienna Women's Center
March 28, 1998; Vienna, Virginia

Lecture: Posttraumatic Stress Disorder and Trauma Related Disorders,
Springwood Hospital
February 12, 1998; Leesburg, Virginia

Lecture: Psychiatry and the Treatment of Women - A Biopsychosocial Model
Department of Family Practitioners, Reston Hospital
Reston, Virginia, 1997

Lecture: Secondary Rescuer Syndrome: Consultations in Working with Abuse
Survivors
International Society for the Study of Multiple Personality Disorders,
Chicago, Illinois, 1993

Lecture: Ignaz Semmelweis and Medical Mythology
Grand Rounds, Boston University Department of Psychiatry,
Boston, MA, 1988
Maine History of Medicine Society, Bangor, Maine, 1988
Benjamin Waterhouse History of Medicine Society, Boston, MA,
1987

Liza H. Gold, MD

Clinical Professor of Psychiatry
Georgetown University Medical Center

Certified, Board of Psychiatry and Neurology
Added Qualifications in Forensic Psychiatry

Kathleen Selzler-Lippert, Litigation Counsel
Kansas State Board of Healing Arts
235 SW Topeka Blvd.
Topeka, KS 66603

RE: Expert review of medical records for
Investigative Case Nos. 07-00158 & 07-00322

Report of Consultant Review

Physician: Licensee 2

Patient: #1

Dates of Treatment: 7/22/03

Date(s) of Consultant Review: 7/20/09 – 7/27/09

Records Reviewed

Records reviewed included, but were not limited to:

Kathleen Selzler-Lippert, Letter of referral, 6/19/09
Definition of Standard of Care
K.S.A. 65-6703, 65-6704, 65-6705, 65-6709, 65-6711, 65-6721
K.A.R. 100-24-1 Documentation Regulation
Sample Report

Medical Records

1. Investigative Case No. 07-00158
Patient #1's medical records from Licensee #2 (6 pages)

2. Investigative Case No. 07-00322
Patient #1's medical records from Licensee #1 (85 pages)

Statutes, Kansas Legislature: 65-6703

Abortion is prohibited when fetus is viable, except if the physician who performs the abortion has a documented referral from another physician not legally or financially affiliated with the physician performing or inducing the abortion and both physicians determine that

1. the abortion is necessary to preserve the life of the pregnant woman; or
2. a continuation of the pregnancy will cause a substantial and irreversible impairment of a major bodily function of the pregnant woman.

ATTACHMENT B

2501 North Glebe Road, Suite 204 • Arlington, VA 22207 • (703) 875-0435 • Fax: (703) 875-0434

Standard of Care: Within a reasonable degree of medical certainty did the practitioner meet the applicable standard of care?

- Ordinary negligence: Did the practitioner fail to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent practitioner as being acceptable under similar conditions and circumstances.

- Gross negligence: Did the practitioner fail to practice within the applicable standard of care and with reckless disregard or complete indifference to the probable consequences

A physician who holds himself out to be a specialist in a particular field of medicine has a duty to practice in a manner consistent with the special degree of skill and knowledge ordinarily possessed by other specialists in the same field of expertise at the time of the diagnosis/treatment.

Summary of Events

Licensee #1's records indicate Patient 1 is a 14 year old single white female from New York. She is pregnant by consensual intercourse. On the basis of a referral from Licensee #2 and Licensee #1's evaluation, Patient 1 underwent a late-term abortion at 26+ weeks on 7/24/03.

Review of Licensee 2's Records

1. Bates #00001: Intake Form - indicates an appointment date of 7/22/03 and time of 8:30 AM. A brief medical and psychiatric history checklist, present on the document, is not filled out.

2. Bates #00004: DTREE Positive Dx Report - Patient 1 is given a diagnosis of Anxiety Disorder NOS (300.00) in a document dated 7/21/03, one day before her appointment with Licensee #2. No diagnostic criteria are provided. No evidence supporting the diagnosis is provided. The document is unsigned. The document does not provide any specific examples or indicate any personal evaluation supporting this diagnosis.

A duplicate of this document is present in Licensee #1's records (Bates 00004), however Licensee #1's document has an apparent fax date of "Jul-28-03 7:19P" at the top. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document. This fax date is 4 days after the termination was completed.

3. Bates #00005-0006: GAF REPORT - Patient 1 is given a GAF (Global Assessment of Functioning) rating of 45: "The patient has presented with serious impairment in social, occupational or school functioning" in an unsigned document dated 7/21/03. No time period for which the GAF rating is assigned is indicated. This document is a computer generated rating list. The document is unsigned. No evidence supporting this rating is provided. The document does not provide any specific examples or indicate any personal evaluation supporting this diagnosis.

A duplicate of this document is present in Licensee #1's records (Bates #00005-00006), however Licensee #1's document has an apparent fax date of "Jul-28-03 7:19P" at the top. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document. This fax date is four days after the termination was completed.

4. Licensee #1's records include a letter (Bates #00003) from Licensee #2 to Licensee #1, dated July 22, 2003, which states, in its entirety,

> "RE: Patient #1
> DOB: 10/03/88
>
> Dear Dr. Licensee #1
>
> I am referring the above named patient to your organization for consultation regarding her unwanted pregnancy. The patient would suffer substantial and irreversible impairment of a major physical or mental function if she were forced to continue the pregnancy.
>
> Sincerely,
>
> Licensee 2, M.D."

This letter is not included in Licensee #2's records.

Opinions

These opinions are based upon a review of records only. These opinions are given within a reasonable degree of medical certainty. These opinions are subject to change pending the receipt and review of additional information.

1. **In your professional opinion, within a reasonable degree of medical certainty, did Licensee 2's care and treatment of this patient adhere to the applicable standard of care?** No.

2. **Explanation of opinion.**

Licensee 2, a general practitioner, undertook a psychiatric assessment of a 14 year old girl in a distressing psychosocial situation, specifically, an unwanted pregnancy. On the basis of this assessment, Licensee 2 referred Patient 1, not to a mental health professional for a second opinion for a presumptive psychiatric disorder, but rather to an Ob-Gyn. If a general practitioner felt the need to make a referral for evaluation and/or treatment for a patient with a presumptive psychiatric diagnosis, particularly an adolescent with a new onset psychiatric diagnosis, as there is no indication Patient 1 had any pre-existing psychiatric disorder, medical practice dictates that such a referral would be made to a mental health professional. Such professionals could be a child and adolescent psychiatrist, psychologist, or social worker, with expertise in the evaluation and treatment of the presumed disorder in adolescents.

There is no evidence of a standard child and adolescent psychiatric evaluation or review of any records in the assignment of the psychiatric diagnosis other than a review of a checklist. There are no specific examples or indications reflecting a personal interview or review of records that would support the presence of a new-onset diagnosis of Anxiety Disorder NOS in a 14 year old.

Licensee 2's referral to Licensee 1 was specifically for obtaining a termination for this 14 year old girl based presumably on this psychiatric diagnosis. Abortion is not a treatment for any psychiatric disorder. Many women suffer from exacerbations of pre-existing psychiatric disorders and new onset psychiatric disorders during pregnancy. Multiple effective treatments including psychotherapy and medication are available. There is no evaluation of any previous counseling or interventions, nor any consideration of whether counseling, medications or other interventions were appropriate at the time of the evaluation or in the future. Treatment options were not discussed. Termination is not a treatment for any psychiatric disorder. Moreover, the psychological ramifications of a late term termination in an adolescent were not discussed or considered, nor was she referred to a qualified specialist to discuss or evaluate this issue.

Licensee 2's referral to Licensee 1 for obtaining a termination for this 14 year old girl stated that Patient 1 would suffer "substantial and irreversible impairment of a physical or mental function if she were forced to continue the pregnancy." The specific nature of the substantial and irreversible impairment is not specified, but since the only diagnosis offered is a psychiatric diagnosis, presumably, the substantial and irreversible impairment

was psychiatric. Licensee 2's records give no indication either of the existence of a psychiatric symptom that might result in a substantial and irreversible impairment, nor do they speculate what such an impairment might be.

In making a diagnosis of Anxiety Disorder NOS and referring Patient 1 for an abortion as a treatment for this disorder, Licensee 2 has held him- or her-self out as a practitioner who can provide the same level of psychiatric assessment and treatment as a child and adolescent psychiatrist. The "Practice Parameters for the Psychiatric Assessment of Children and Adolescents" published by the American Academy of Child and Adolescent Psychiatry in 1997 clearly establishes a guide for clinicians evaluating psychiatric disorders in children and adolescents. The assessment process is intended to assist the clinician in arriving at accurate diagnoses and appropriate treatment for children and adolescents presenting with psychiatric disorders that impair emotional, cognitive, physical, or behavioral functioning.

These parameters are not rigid guidelines, nor do they of themselves establish a legal standard of care. Nevertheless, these guidelines represent an expert consensus of what constitutes appropriate psychiatric evaluation of children and adolescents and are officially endorsed by the American Academy of Child and Adolescent Psychiatry and the level of care required for the diagnosis of a psychiatric disorder in a child or adolescent. Any deviation from these guidelines should be justified by clinical or other circumstances.

The purpose of a diagnostic assessment of a child or adolescent is

A. to determine whether psychopathology is present, and, if so, to establish a differential diagnosis;
B. to determine whether treatment is indicated; and
C. if so, to develop treatment recommendations and plans

Licensee 2's evaluation and treatment recommendations of Patient 1 were deficient in the following ways:

i. The clinical assessment of a child or adolescent requires several hours, including time for parent interview and child interview. There is no indication of the amount of time Licensee 2 spent evaluating Patient 1. However, Licensee 2's documentation of Patient 1's assessment is so sparse that it is hard to imagine that it is the result of several hours of evaluation. In fact, there is no evidence of any personal evaluation of Patient 1 as Licensee 2's records consist basically of two apparently computer generated checklists based on DSM criteria, unsupported by any personal information.

ii. Licensee 2 does not document a review of Patient 1's psychiatric, medical or developmental history, prior psychiatric treatment symptoms, family history, family relationships, physical or sexual abuse, substance abuse or other possible causes of distress. A

psychiatric diagnosis cannot reasonably be arrived at without a review of this information.

iii. Licensee 2 does not document any discussion of behavioral or functional impact of the purported anxiety disorder. There is no documentation of any discussion of frequency, intensity, duration and circumstances of any specific symptoms or behaviors associated with Anxiety Disorder NOS. A computerized GAF score of 45, with no narrative, examples of impaired functioning, or other indication of the data upon which this score is based, is not an adequate assessment of the functional impact of psychiatric symptoms.

iv. Licensee 2 did not document conducting a mental status examination, which consists of observing and assessing

1. Physical appearance
2. Manner of relating to examiner and parent
3. Affect and mood
4. Motor behavior
5. Content and form of thought
6. Speech and language
7. Overall intelligence
8. Attention
9. Memory
10. Neurological functioning;
11. and most significantly, judgment and insight

v. Licensee 2 does not present evidence of performing a differential diagnosis. Licensee 2 could not perform an adequate differential diagnosis without obtaining the history, medical, social, and psychiatric information outlined in i, ii, iii, and iv above. A computer generated DTREE Positive Dx Report, unsupported by the necessary and relevant information, does not constitute a differential diagnosis.

vi. Licensee 2 implies the diagnosis of Anxiety Disorder NOS is solely due to the unwanted pregnancy with no evidence of consideration of any pre-existing or other possible source of anxiety. Undoubtedly, Patient 1 was distressed over her unwanted pregnancy. There is no evidence of consideration that the distress of an unwanted pregnancy is not actual psychiatric pathology, and there is no evidence supporting the conclusion that this distress actually represents psychiatric pathology warranting a DSM-IV diagnosis.

vii. Licensee 2 does not present evidence of considering treatment options other than referring Patient 1 to Licensee 1 for a termination. Other treatment options, including various forms of psychotherapy and medication, are available and have been demonstrated to be effective

for anxiety disorders. In contrast, an abortion is not considered a psychiatric treatment for Anxiety Disorder NOS or for any psychiatric diagnosis.

viii. Given Patient 1's age, Licensee 2's records contain no evidence that Licensee 2 considered obtaining a psychiatric consultation from a child and adolescent specialist, whether a social worker, psychologist, or psychiatrist. The circumstances involving the irreversible intervention of a late term termination in a 14 year old suggest that at the least, a consultation with a specialist should be obtained to ensure that no psychological harm would result from the late term termination.

ix. In referring Patient 1 to Licensee 1, Licensee 2 fails to specify what, if any, are the substantial and irreversible impairments Patient 1 would suffer, and which major mental function would be affected. The failure to communicate to a colleague the nature of the severe medical problem presents an obstacle to adequate ongoing medical care.

x. Licensee 2 makes no mention of discussion of, arrangements for, or provision of aftercare for Patient 1's diagnosis of Anxiety Disorder NOS. As a physician providing an assessment and referral for consultation and treatment, it is Licensee 2's professional obligation to make certain that Patient 1 obtains appropriate treatment subsequent to the termination, which, as stated above, is not a psychiatric treatment for any psychiatric disorder.

This is all the more essential, if, as Licensee 2 states, Patient 1's disorder presents substantial and irreversible risk of impairment. If Patient 1's Anxiety Disorder NOS was due in fact to another cause, then no treatment plan was in place to address this. If the treatment of a termination was not successful in alleviating Patient 1's Anxiety Disorder NOS, (and Licensee 2's records do not indicate whether this treatment was or was not successful), what other arrangements or plans did Licensee 2 have for Patient 1's severe psychiatric problem?

xi. Licensee 2 did not describe any circumstances that might justify the deviation from the accepted standard psychiatric evaluation of adolescents. Licensee 2 did not describe any circumstances that might justify the unorthodox treatment plan of treating Anxiety Disorder NOS with an abortion, but without any psychiatric intervention or psychiatric follow up care.

3. **If your opinion is that Licensee 2 did not adhere to the applicable standard of care, describe how, and to what degree (ordinary or gross negligence), the physicians' care deviated from the acceptable standards.**

The determination of whether Licensee 2's deviations from the standard of care amount to ordinary or gross negligence is not properly a medical opinion. I can only state

a. there is no evidence that Licensee 2 conducted anything even approximating an appropriate or adequate psychiatric evaluation or mental status examination that could reasonably lead to the conclusion that Patient 1 had a diagnosis of Anxiety Disorder NOS;
b. there is no evidence that Licensee 2 made a diagnosis based on a personal evaluation of Patient 1, and it is not clear whether the diagnosis was applied before or after an evaluation.
c. there is no evidence that Licensee 2 considered an appropriate treatment plan for a diagnosis of Anxiety Disorder NOS;
d. there is no evidence that Licensee 2 made any arrangements or assured that such arrangements were made for appropriate psychiatric follow up care of Patient 1's purported Anxiety Disorder NOS, given that termination of a pregnancy, even an unwanted pregnancy, is not a treatment or cure for this disorder.

4. **List any texts, medical literature or other resources relied upon (if applicable):**

a. Diagnostic and Statistical Manual IV-TR, American Psychiatric Association, 2000
b. Practice parameters for the Psychiatric Assessment of Children and Adolescents, Journal of the American Academy of Child and Adolescent Psychiatry 36(10 Supplement):4S-20S, 1997
c. Practice Parameter for the Assessment and Treatment of Children and Adolescents with Anxiety Disorders, Journal of the American Academy of Child and Adolescent Psychiatry, 46(2) 267-283, 2007
d. Cohen LS, Nonacs RM, eds: Mood and Anxiety Disorders during Pregnancy and Postpartum. American Psychiatric Publishing Inc., 2005
e. Yonkers K, Little B: Management of Psychiatric Disorders in Pregnancy. Arnold, 2001

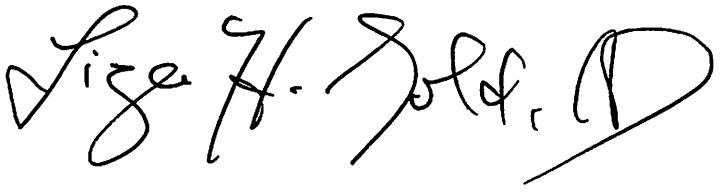
5. **Did Licensee 2 maintain an adequate medical record for this patient?**

No.

If not, please describe the basis for your opinion:

As per Article 24: Patient Records, Adequacy; minimal requirements, Licensee's 2's records are deficient in the following:

a. They do not contain pertinent and significant information concerning the patient's psychiatric condition;
b. They do not reflect what psychiatric or medical examinations, vital signs and tests were obtained, performed, or ordered and the findings and results of each;
c. They do not indicate the initial psychiatric diagnosis and the patient's psychiatric reasons for seeking the licensee's services, other than "unwanted pregnancy"
d. They do not reflect the recommended psychiatric treatment or discussion of psychiatric treatment options
e. They do not contain any record of discussion of appropriate aftercare of a psychiatric disorder or arrangements for such
f. They do not indicate if and when a personal evaluation was conducted and whether diagnoses were made before or after a personal evaluation if indeed one was conducted.



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Topeka, KS 66603

RE: Expert review of medical records for Investigative Case Nos. 07-00158 & 07-00322

Report of Consultant Review

Physician: Licensee 2

Patient: #2

Dates of Treatment: 7/8/03

Date(s) of Consultant Review: 7/20/09 – 7/27/09

Records Reviewed

Records reviewed included, but were not limited to:

Kathleen Selzler-Lippert, Letter of referral, 6/19/09
Definition of Standard of Care
K.S.A. 65-6703, 65-6704, 65-6705, 65-6709, 65-6711, 65-6721
K.A.R. 100-24-1 Documentation Regulation
Sample Report

Medical Records

1. Investigative Case No. 07-00158
Patient #2's medical records from Licensee #2 (7 pages)

2. Investigative Case No. 07-00322
Patient #2's medical records from Licensee #1 (78 pages)

Statutes, Kansas Legislature: 65-6703

Termination is prohibited when fetus is viable, except if the physician who performs the termination has a documented referral from another physician not legally or financially affiliated with the physician performing or inducing the termination and both physicians determine that

1. the termination is necessary to preserve the life of the pregnant woman; or
2. a continuation of the pregnancy will cause a substantial and irreversible impairment of a major bodily function of the pregnant woman.

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Standard of Care: Within a reasonable degree of medical certainty did the practitioner meet the applicable standard of care?

- Ordinary negligence: Did the practitioner fail to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent practitioner as being acceptable under similar conditions and circumstances.

- Gross negligence: Did the practitioner fail to practice within the applicable standard of care and with reckless disregard or complete indifference to the probable consequences

A physician who holds himself out to be a specialist in a particular field of medicine has a duty to practice in a manner consistent with the special degree of skill and knowledge ordinarily possessed by other specialists in the same field of expertise at the time of the diagnosis/treatment.

Summary of Events

Patient 2 is a 10 year old, incest/rape victim from California. At the time of her evaluation, Licensee 1 indicated that the gestational age of the fetus was 28 weeks and 6 days. Licensee 1 documents on 7/8/03 that "This 10 year old became pregnant as a result of rape, incest and sexual assault when she was 9 years old." The assailant was her step-father's brother. On the basis of a referral from Licensee #2 and Licensee #1's evaluation, Patient 2 underwent a termination beginning on 7/8/03 and completed on 7/11/03.

Review of Licensee 2's Records

1. Bates #00001: Intake Form - indicates an appointment date of 7/8/03 and time of 9:30 AM. A brief medical and psychiatric history checklist, on a yes/no answer basis, indicates no history of medical illness or depression, alcohol use, or other psychiatric illness. Typed comments indicate Patient 2 was an "incest/rape victim."

2. Bates #00004-00005: GAF REPORT - indicates that on 7/9/03, one day after Patient 2's scheduled appointment with Licensee 2, Patient 2 was assigned a GAF (Global Assessment of Functioning) score of 35: The patient has had major impairment in several such as judgment, thinking or mood [sic]" and "The patient has presented with major impairment in areas such as work or school, family relations, judgment, thinking or mood." The time period for which the GAF rating is assigned is the "past week." This document is a computer generated rating list. The document does not provide any specific examples or indicate any personal evaluation supporting the rating. The document is unsigned.

A duplicate of this document is present in Licensee #1's records (Bates #00003-00004), however Licensee #1's document has an apparent fax date of "Jul-09-03 08:10P" at the top. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document.

It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document.

3. Bates #00006: DTREE Positive Dx Report - indicates a diagnosis made on 7/9/03, one day after Patient 2's scheduled appointment with Licensee 2, of Major Depressive Disorder, Single Episode, Severe, Without Psychotic Features, 296.23. This unsigned document is a computer generated list of diagnostic criteria. No evidence supporting the diagnostic criteria is provided. The document does not provide any specific examples or indicate any personal evaluation supporting this diagnosis.

A duplicate of this document is present in Licensee #1's records (Bates #00005-00006), however Licensee #1's document has an apparent fax date of "Jul-09-03 08:09P" at the top. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document.

4. Licensee #1's records include a letter (Bates #00002) from Licensee #2 to Licensee #1, dated 7/8/03, which states, in its entirety,

> "RE: Patient #2
> DOB: 3/16/93
>
> Dear Dr. Licensee #1
>
> I am referring the above named patient to your organization for consultation regarding her unwanted pregnancy. The patient would suffer substantial and irreversible impairment of a major physical or mental function if she were forced to continue the pregnancy.
>
> Sincerely,
>
> Licensee 2, M.D."

This letter is not included in Licensee #2's records. The termination was begun on the same date, 7/8/03, although the documents indicating the psychiatric diagnosis and GAF score are dated on 7/9/03.

Licensee #1 (Bates #00045) notes that on 7/8/03, as the termination procedure was started, the patient was "very anxious." After the procedure and transfer to the recovery room, she was "much less anxious" (Bates 00046).

Opinions

These opinions are based upon a review of records only. These opinions are given within a reasonable degree of medical certainty. These opinions are subject to change pending the receipt and review of additional information.

1. **In your professional opinion, within a reasonable degree of medical certainty, did Licensee 2's care and treatment of this patient adhere to the applicable standard of care?** No.

2. **Explanation of opinion.**

Licensee 2, a general practitioner, undertook a psychiatric assessment of Patient 2, a 10 year old girl who had been the victim of child sexual abuse. On the basis of this assessment, Licensee 2 referred Patient 2, not to mental health professional for a second opinion for a presumptive psychiatric disorder, but rather to Licensee 1, an Ob-Gyn, for a termination. This termination was undertaken on the same day as the date of Licensee #2s referral letter, which was actually the day before the 7/9/03 documentation of a psychiatric disorder.

If a general practitioner felt the need to make a referral for evaluation and/or treatment for a patient with a presumptive psychiatric diagnosis, particularly a 10 year old victim of sexual abuse with a new onset psychiatric diagnosis, as there is no indication Patient 1 had any pre-existing psychiatric disorder, medical practice dictates that such a referral would be made to a mental health professional. Such professionals could be a child psychiatrist, psychologist, or social worker, with expertise in the evaluation and treatment of the presumed disorder in children. This is even more urgent in this case, where the child is the victim of sexual abuse, and a psychiatric diagnosis is made.

There is no evidence of a standard child psychiatric evaluation or an evaluation of the effects of sexual abuse in the assignment of the psychiatric diagnosis. There is no evidence of a standard psychiatric evaluation of any kind other than a review of a checklist. There are no specific examples or indications reflecting a personal interview or review of records that would support the presence of a new-onset diagnosis of depression in a 10 year old sexual abuse victim.

There is no evaluation of any previous counseling or interventions, nor any consideration of whether counseling, medications or other interventions were appropriate at the time of the evaluation or in the future. Treatment options were not discussed. Termination is not a treatment for any psychiatric disorder. Moreover, the psychological ramifications of a termination in a 10 year old sexual abuse victim were not discussed or considered, nor was she referred to a qualified specialist to discuss or evaluate this issue.

Licensee 2's referral to Licensee 1 was specifically for a termination, stating that Patient 2 would suffer "substantial and irreversible impairment of a physical or mental function if she were forced to continue the pregnancy." The specific nature of the substantial and irreversible impairment is not specified, but since the only diagnosis offered is a

psychiatric diagnosis, presumably, the substantial and irreversible impairment was psychiatric. Licensee 2's records give no indication either of the existence of psychiatric symptoms that might result in a substantial and irreversible impairment, nor do they speculate what such an impairment might be.

In making a diagnosis of Major Depressive Disorder and referring Patient 2 for a termination as a treatment for this disorder, Licensee 2 has held him- or her-self out as a practitioner who can provide the same level of psychiatric assessment and treatment as a child and adolescent psychiatrist. The "Practice Parameters for the Psychiatric Assessment of Children and Adolescents" published by the American Academy of Child and Adolescent Psychiatry in 1997 clearly establishes a guide for clinicians evaluating psychiatric disorders in children and adolescents. The assessment process is intended to assist the clinician in arriving at accurate diagnoses and appropriate treatment for children and adolescents presenting with psychiatric disorders that impair emotional, cognitive, physical or behavioral functioning.

Although these parameters are not rigid guidelines, nor do they of themselves establish a legal standard of care, they represent an expert consensus of what constitutes appropriate psychiatric evaluation of children and adolescents and are officially endorsed by the American Academy of Child and Adolescent Psychiatry and the level of care required for the diagnosis of a psychiatric disorder in a child or adolescent. Any deviation from these guidelines should be explicitly justified by clinical or other circumstances.

The purpose of a diagnostic assessment of a child or adolescent is

A. to determine whether psychopathology is present, and, if so, to establish a differential diagnosis;
B. to determine whether treatment is indicated; and
C. if so, to develop treatment recommendations and plans

Licensee 2's evaluation and treatment recommendations of Patient 2 were deficient in the following ways:

i. The clinical assessment of a child or adolescent requires several hours, including time for parent interview and child interview. There is no indication of the amount of time Licensee 2 spent evaluating Patient 2. However, Licensee 2's documentation of Patient 1's assessment is so sparse that it is hard to imagine that it is the result of several hours of evaluation. In fact, there is no evidence of any personal evaluation of Patient 2 as Licensee 2's records consist basically of two apparently computer generated checklists based on DSM criteria, unsupported by any personal information, dated on the date after the termination was undertaken.

ii. Licensee 2 does not document a review of Patient 2's psychiatric, medical or developmental history, prior psychiatric treatment symptoms, family history, family relationships, physical or sexual

abuse, or other possible causes of distress. A psychiatric diagnosis cannot reasonably be arrived at without a review of this information.

iii. Licensee 2 does not document any discussion of behavioral or functional impact of the purported anxiety disorder. There is no documentation of any discussion of frequency, intensity, duration and circumstances of any specific symptoms or behaviors associated with Major Depressive Disorder. A computerized GAF (Global Assessment of Functioning) score of 35, with no narrative or other indication of the data upon which this score is based, is not an adequate assessment of the functional impact of psychiatric symptoms.

iv. Licensee 2 did not document conducting a mental status examination, observing and assessing

1. Physical appearance
2. Manner of relating to examiner and parent
3. Affect and mood
4. Motor behavior
5. Content and form of thought
6. Speech and language
7. Overall intelligence
8. Attention
9. Memory
10. Neurological functioning;
11. and most significantly, judgment and insight

v. Licensee 2 does not present evidence of performing a differential diagnosis. Licensee 2 could not perform an adequate differential diagnosis without obtaining the history, medical, social, and psychiatric information outlined in i, ii, iii, and iv above. A computer generated DTREE Positive Dx Report, unsupported by the necessary and relevant information, does not constitute a differential diagnosis.

vi. Licensee 2 implies the diagnosis of Major Depressive Disorder is due solely to the pregnancy. There is no evidence of consideration of the effects of sexual abuse, and no consideration of whether the intervention of a late term termination will exacerbate or mitigate the effects of the sexual abuse.

vii. Licensee 2 does not present evidence of considering treatment options other than referring Patient 2 to Licensee 1 for a termination. Other treatment options, including various forms of psychotherapy and medication, are available and have been demonstrated to be effective for mood disorders, including depression. In contrast, a termination is not considered a psychiatric treatment for Major Depression or for any psychiatric diagnosis.

viii. Given Patient 2's age, Licensee 2's records contain no evidence that Licensee 2 considered obtaining a psychiatric consultation from a child mental health specialist, whether a social worker, psychologist, or psychiatrist, with experience in evaluating sexual abuse victims. The circumstances involving the sexual abuse of a 9 year old resulting in a termination of a pregnancy at age 10 suggest that at the least, a consultation with a specialist should be obtained to evaluate the patient's mental status, her level of understanding of the surgical procedure, and the risk of an adverse response to any treatment option including termination.

ix. In referring Patient 2 to Licensee 1, Licensee 2 fails to specify what, if any, are the substantial and irreversible impairments Patient 2 would suffer, and which major mental function would be affected. The failure to communicate to a colleague the nature of the severe medical problem presents an obstacle to adequate ongoing medical care.

x. Licensee 2 makes no mention of discussion of, arrangements for or provision of aftercare for Patient 2's diagnosis of Major Depressive Disorder As a physician providing an assessment and referral for consultation and treatment, it is Licensee 2's professional obligation to make certain that Patient 2 obtains appropriate treatment subsequent to the termination, which, as stated above, is not a psychiatric treatment for depression.

This is all the more essential, if, as Licensee 2 states, Patient 2's disorder presents substantial and irreversible risk of impairment. If the treatment of termination was not successful in alleviating Patient 2's Major Depressive Disorder, (and Licensee 2's records do not indicate whether this treatment was or was not successful), what other arrangements or plans did Licensee 2 have for Patient 2's severe psychiatric problem?

xi. Licensee 2 did not describe any circumstances that might justify the deviation from accepted standard psychiatric evaluation of children. Licensee 2 did not describe any circumstances that might justify the unorthodox treatment plan of treating Major Depressive Disorder with a termination, but without any psychiatric intervention or psychiatric follow up care.

3. If your opinion is that Licensee 2 did not adhere to the applicable standard of care, describe how, and to what degree (ordinary or gross negligence), the physicians' care deviated from the acceptable standards.

The determination of whether Licensee 2's deviations from the standard of care amount to ordinary or gross negligence is not properly a medical opinion. I can only state

a. there is no evidence that Licensee 2 conducted anything even approximating an appropriate or adequate psychiatric evaluation or mental status examination that could reasonably lead to the conclusion that Patient 1 had a diagnosis of Major Depressive Disorder;
b. there is no evidence that Licensee 2 made a diagnosis based on a personal evaluation of Patient 2;
c. there is no evidence that Licensee 2 considered an appropriate treatment plan for a diagnosis of Major Depressive Disorder;
d. there is no evidence that Licensee 2 made any arrangements or assured that such arrangements were made for follow up care of Patient 2's purported Major Depressive Disorder, given that pregnancy termination is not a treatment or cure for this a disorder.

4. List any texts, medical literature or other resources relied upon (if applicable):

a. Diagnostic and Statistical Manual IV-TR, American Psychiatric Association, 2000
b. Practice parameters for the Psychiatric Assessment of Children and Adolescents, Journal of the American Academy of Child and Adolescent Psychiatry 36(10 Supplement):4S-20S, 1997
c. Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorders, Journal of the American Academy of Child and Adolescent Psychiatry, 46(11) 1503-1526, 2007
d. Cohen LS, Nonacs RM, eds: Mood and Anxiety Disorders during Pregnancy and Postpartum. American Psychiatric Publishing Inc., 2005
e. Yonkers K, Little B: Management of Psychiatric Disorders in Pregnancy. Arnold, 2001

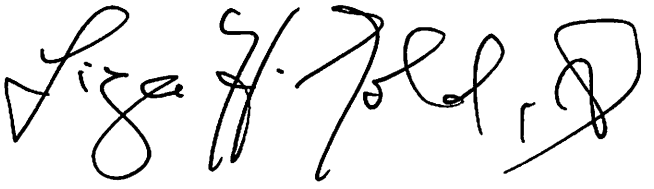
5. **Did Licensee 2 maintain an adequate medical record for this patient?**

No.

If not, please describe the basis for your opinion:

As per Article 24: Patient Records, Adequacy; minimal requirements, Licensee's 2's records are deficient in the following:

a. They do not contain pertinent and significant information concerning the patient's psychiatric condition;
b. They do not reflect what psychiatric or medical examinations, vital signs and tests were obtained, performed, or ordered and the findings and results of each;
c. They do not indicate the initial psychiatric diagnosis and the patient's psychiatric reasons for seeking the licensee's services;
d. They do not reflect the recommended psychiatric treatment or discussion of psychiatric treatment options;
e. They do not contain any record of discussion of appropriate aftercare of a psychiatric disorder or arrangements for such.
f. They do not indicate if and when a personal evaluation was conducted and whether diagnoses were made before or after a personal evaluation if indeed one was conducted.
g. They do not indicate whether the psychiatric diagnosis of Major Depressive Disorder, which was the basis for the termination, were made before or after the termination was undertaken by Licensee #1.



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Kathleen Selzler-Lippert, Litigation Counsel
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Topeka, KS 66603

RE: Expert review of medical records for Investigative Case Nos. 07-00158 & 07-00322

Report of Consultant Review

Physician: Licensee 2

Patient: #3

Dates of Treatment: 8/5/03

Date(s) of Consultant Review: 7/20/09 – 7/27/09

Records Reviewed

Records reviewed included, but were not limited to:

Kathleen Selzler-Lippert, Letter of referral, 6/19/09
Definition of Standard of Care
K.S.A. 65-6703, 65-6704, 65-6705, 65-6709, 65-6711, 65-6721
K.A.R. 100-24-1 Documentation Regulation
Sample Report

Medical Records

1. Investigative Case No. 07-00158
Patient #3's medical records from Licensee #2 (10 pages)

2. Investigative Case No. 07-00322
Patient #3's medical records from Licensee #1 (57 pages)

Statutes, Kansas Legislature: 65-6703

Abortion is prohibited when fetus is viable, except if the physician who performs the abortion has a documented referral from another physician not legally or financially affiliated with the physician performing or inducing the abortion and both physicians determine that

1. the abortion is necessary to preserve the life of the pregnant woman; or
2. a continuation of the pregnancy will cause a substantial and irreversible impairment of a major bodily function of the pregnant woman.

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Standard of Care: Within a reasonable degree of medical certainty did the practitioner meet the applicable standard of care?

- Ordinary negligence: Did the practitioner fail to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent practitioner as being acceptable under similar conditions and circumstances.

- Gross negligence: Did the practitioner fail to practice within the applicable standard of care and with reckless disregard or complete indifference to the probable consequences

A physician who holds himself out to be a specialist in a particular field of medicine has a duty to practice in a manner consistent with the special degree of skill and knowledge ordinarily possessed by other specialists in the same field of expertise at the time of the diagnosis/treatment.

Summary of Events

Licensee #1's records indicate Patient 3 is a 15 year old single white female from Kansas, who presents with a chief complaint of "unexpected/unwanted pregnancy." She became pregnant by consensual intercourse with a 17 year old boyfriend. On the basis of a referral from Licensee #2 and Licensee #1's evaluation, Patient 3 underwent a late-term abortion at 26+ weeks on 8/7/03.

Review of Licensee 2's Records

1. Bates #00001: Intake form - indicates an appointment date of 8/5/03 and time of 8:30 AM. A brief medical and psychiatric history checklist is unmarked except for a "y" [indicating yes] for drug allergy.

2. Bates 00002-00004: "MI STATEMENT Patient #3, 7/31" - This is apparently a typed interview with Patient #3, performed 5 days before the indicated date of her appointment with Licensee #2. This document does not indicate who performed the interview or prepared the document, and it is unsigned. The lower part of Bates #00004 has the notation, "OK per CM" [or possibly CRT or CAT]. The initials are difficult to decipher.

In this document, Patient 3 reports she does not want to continue her pregnancy because it would interfere with school, but more significantly, with riding in rodeos. She stated she would "lose her dreams" of riding in the rodeo if she had the child. Patient 3 reports her biggest issue is that she will not have a future in rodeo if she were known to be pregnant and to have a baby. She also does not want to disappoint her father by him finding out she is pregnant.

A "SIGECAPS" was performed. This is a checklist of significant symptoms of depression. Patient 3 reported problems with sleep, low energy, moodiness, guilt, concentration, and appetite. The specific examples given indicate that these symptoms

are related to the stress and distress associated with an unwanted pregnancy rather than a primary psychiatric diagnosis.

Patient 3 denied suicidal thinking. Other psychosocial factors are noted and with a Yes or No answer, such as drug and alcohol use, or a history of multiple partners, incest, or running away (all no).

The presumable original of this typed document is found in handwritten form in Licensee 1's records (Bates 00009-00010). This is a strong indication that this document was generated by someone in Licensee #1's office, typed and then provided to Licensee #2, rather than generated personally by Licensee #2.

3. Bates #00007-00008: DTREE Positive Dx Report - Patient 3 is given diagnosis of Major Depressive Disorder, Single Episode, Severe Without Psychotic Features (296.23) in an unsigned document dated 8/5/03, the date documented as the date of her appointment with Licensee #2. This document is a computer generated list of diagnostic criteria for this diagnosis. No evidence supporting the diagnostic criteria is provided. The document is unsigned.

A duplicate of this document is present in Licensee #1's records (Bates #00005-00006), however Licensee #1's document has an apparent fax date of "Aug 11-03 09:22P" at the top. This fax date is 6 days after Patient 3's appointment with Licensee #2, and approximately 5 days after the termination was completed. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document.

4. Bates #00009-00010: On 8/5/03, Patient 3 was assigned a GAF (Global Assessment of Functioning) score of 35: "The patient has presented with major impairment in areas such as work or school, family relations, judgment, thinking, or mood." The time period for which the GAF rating is assigned is the "past week." No time period for which the GAF rating is assigned is indicated. This document is a computer generated rating list. No evidence supporting this rating is provided. The document is unsigned. The document does not provide any specific examples or indicate any personal evaluation supporting the rating.

A duplicate of this document is present in Licensee #1's records (Bates #00007-00008), however Licensee #1's document has an apparent fax date of "Aug 11-03 09:22P" at the top. This fax date is 6 days after Patient 3's appointment with Licensee #2, and approximately 5 days after the termination was completed. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document.

5. Licensee #1's records include a letter (Bates #00004) from Licensee #2 to Licensee #1, dated Aug 5, 2003, which states, in its entirety,

> "RE: Patient #3
> DOB: 10/01/87
>
> Dear Dr. Licensee #1
>
> I am referring the above named patient to your organization for consultation regarding her unwanted pregnancy. The patient would suffer substantial and irreversible impairment of a major physical or mental function if she were forced to continue the pregnancy.
>
> Sincerely,
>
> Licensee 2, M.D."

This letter is not included in Licensee #2's records.

Opinions

These opinions are based upon a review of records only. These opinions are given within a reasonable degree of medical certainty. These opinions are subject to change pending the receipt and review of additional information.

1. **In your professional opinion, within a reasonable degree of medical certainty, did Licensee 2's care and treatment of this patient adhere to the applicable standard of care?** No.

2. **Explanation of opinion.**

Licensee 2, a general practitioner, undertook a psychiatric assessment of a 15 year old girl in a distressing psychosocial situation, specifically, an unwanted pregnancy. On the basis of this assessment, Licensee 2 referred Patient 3, not to a mental health professional for a second opinion for a presumptive psychiatric disorder, but rather to an Ob-Gyn. If a general practitioner felt the need to make a referral for evaluation and/or treatment for a patient with a presumptive psychiatric diagnosis, particularly an adolescent with a new onset psychiatric diagnosis, as there is no indication Patient 3 had any pre-existing psychiatric disorder, medical practice dictates that such a referral would be made to a mental health professional. Such professionals could be a child and adolescent psychiatrist, psychologist, or social worker, with expertise in the evaluation and treatment of the presumed disorder in adolescents.

There is no evidence of a standard child and adolescent psychiatric evaluation or review of any records in the assignment of the psychiatric diagnosis other than

1. a review of a checklist There are no specific examples or indications reflecting a personal interview or review of records that would support the presence of a new-onset diagnosis of Major Depressive Disorder in a 15 year old;
2. a typed "MI Statement" which included a "SIGECAPS" screening. A SIGECAPS screening is a tool to assess whether someone with more than a few positive indicators should be evaluated further for the presence of clinical depression. A SIGECAPS screening is not of itself a standard psychiatric evaluation method for making a diagnosis of a new onset Major Depressive Disorder.

Licensee 2's referral to Licensee 1 was specifically for obtaining a termination for this 15 year old girl based presumably on this psychiatric diagnosis. Abortion is not a treatment for any psychiatric disorder. Many women suffer from exacerbations of pre-existing psychiatric disorders and new onset psychiatric disorders during pregnancy. Multiple effective treatments including psychotherapy and medication are available. There is no evaluation of any previous counseling or interventions, nor any consideration of whether counseling, medications or other interventions were appropriate at the time of the evaluation or in the future. Treatment options were not discussed. Moreover, the psychological ramifications of a late term termination in an adolescent were not discussed or considered, nor was she referred to a qualified specialist to discuss or evaluate this issue.

Licensee 2's referral to Licensee 1 for obtaining a termination for this 15 year old girl stated that Patient 3 would suffer "substantial and irreversible impairment of a physical or mental function if she were forced to continue the pregnancy." The specific nature of the substantial and irreversible impairment is not specified, but since the only diagnosis offered is a psychiatric diagnosis, presumably, the substantial and irreversible impairment was psychiatric. Licensee 2's records give no indication either of the existence of a psychiatric symptom that might result in a substantial and irreversible impairment, nor do they speculate what such an impairment might be. In fact, the SIGECAPS review indicated that Patient 3 reported she was not suicidal, the only life threatening emergency that might meet the criteria of a "substantial and irreversible impairment" due to depression.

In making a diagnosis of Major Depressive Disorder and referring Patient 3 for an abortion as a treatment for this disorder, Licensee 2 has held him- or her-self out as a practitioner who can provide the same level of psychiatric assessment and treatment as a child and adolescent psychiatrist. The "Practice Parameters for the Psychiatric Assessment of Children and Adolescents" published by the American Academy of Child and Adolescent Psychiatry in 1997 clearly establishes a guide for clinicians evaluating psychiatric disorders in children and adolescents. The assessment process is intended to assist the clinician in arriving at accurate diagnoses and appropriate treatment for children and adolescents presenting with psychiatric disorders that impair emotional, cognitive, physical, or behavioral functioning.

These parameters are not rigid guidelines, nor do they of themselves establish a legal standard of care. Nevertheless, these guidelines represent an expert consensus of what constitutes appropriate psychiatric evaluation of children and adolescents and are officially endorsed by the American Academy of Child and Adolescent Psychiatry and the level of care required for the diagnosis of a psychiatric disorder in a child or adolescent. Any deviation from these guidelines should be justified by clinical or other circumstances.

The purpose of a diagnostic assessment of a child or adolescent is

A. to determine whether psychopathology is present, and, if so, to establish a differential diagnosis;
B. to determine whether treatment is indicated; and
C. if so, to develop treatment recommendations and plans

Licensee 2's evaluation and treatment recommendations of Patient 3 were deficient in the following ways:

i. The clinical assessment of a child or adolescent requires several hours, including time for parent interview and child interview. There is no indication of the amount of time Licensee 2 spent evaluating Patient 3. However, Licensee 2's documentation of Patient 3's assessment is so sparse that it is hard to imagine that it is the result of several hours of evaluation. In fact, there is no evidence of any personal evaluation of Patient 3 as Licensee 2's records consist basically of two apparently computer generated checklists based on DSM criteria, unsupported by any personal information, and typed notes of an MI Statement that do not indicate who performed the interview. Moreover, this interview took place on 7/31/03, five days before Patient 3's appointment with Licensee #2, making it unlikely that Licensee #2 conducted this evaluation.

ii. Licensee 2 does not document a review of Patient 3's psychiatric, medical or developmental history, prior psychiatric treatment symptoms, family history, family relationships, physical or sexual abuse, substance abuse or other possible causes of distress. A psychiatric diagnosis cannot reasonably be arrived at without a review of this information.

iii. Licensee 2 does not document any discussion of behavioral or functional impact of the purported mood disorder. There is no documentation of any discussion of frequency, intensity, duration and circumstances of any specific symptoms or behaviors associated with Major Depressive Disorder. A computerized GAF score of 35, with no narrative, examples of impaired functioning, or other indication of the data upon which this score is based, is not an adequate assessment of the functional impact of psychiatric symptoms.

iv. Licensee 2 did not document conducting a mental status examination, which consists of observing and assessing

1. Physical appearance
2. Manner of relating to examiner and parent
3. Affect and mood
4. Motor behavior
5. Content and form of thought
6. Speech and language
7. Overall intelligence
8. Attention
9. Memory
10. Neurological functioning;
11. and most significantly, judgment and insight

v. Licensee 2 does not present evidence of performing a differential diagnosis. Licensee 2 could not perform an adequate differential diagnosis without obtaining the history, medical, social, and psychiatric information outlined in i, ii, iii, and iv above. A computer generated DTREE Positive Dx Report, unsupported by the necessary and relevant information, does not constitute a differential diagnosis.

vi. Licensee 2 implies the diagnosis of Major Depressive Disorder is due solely to the unwanted pregnancy with no evidence of consideration of any pre-existing or other possible source of distress. Undoubtedly, Patient 3 was distressed over her unwanted pregnancy. There is no evidence of consideration that the distress of an unwanted pregnancy is not actual psychiatric pathology, and there is no evidence supporting the conclusion that this distress actually represents psychiatric pathology warranting a DSM-IV diagnosis.

vii. Licensee 2 does not present evidence of considering treatment options other than referring Patient 3 to Licensee 1 for a termination. Other treatment options, including various forms of psychotherapy and medication, are available and have been demonstrated to be effective for mood disorders. In contrast, an abortion is not considered a psychiatric treatment for Major Depressive Disorder or for any psychiatric diagnosis.

viii. Given Patient 3's age, Licensee 2's records contain no evidence that Licensee 2 considered obtaining a psychiatric consultation from a child and adolescent specialist, whether a social worker, psychologist, or psychiatrist. The circumstances involving the irreversible intervention of a late term termination in a 15 year old suggest that at the least, a consultation with a specialist should be obtained to ensure that no psychological harm would result from the late term

termination.

ix. In referring Patient 3 to Licensee 1, Licensee 2 fails to specify what, if any, are the substantial and irreversible impairments Patient 3 would suffer, and which major mental function would be affected. The failure to communicate to a colleague the nature of the severe medical problem presents an obstacle to adequate ongoing medical care.

x. Licensee 2 makes no mention of discussion of, arrangements for, or provision of aftercare for Patient 3's diagnosis of Major Depressive Disorder. As a physician providing an assessment and referral for consultation and treatment, it is Licensee 2's professional obligation to make certain that Patient 3 obtains appropriate treatment subsequent to the termination, which, as stated above, is not a psychiatric treatment for any psychiatric disorder.

This is all the more essential, if, as Licensee 2 states, Patient 3's disorder presents substantial and irreversible risk of impairment. If Patient 3's Major Depressive Disorder was due in fact to another cause, then no treatment plan was in place to address this. If the treatment of a termination was not successful in alleviating Patient 3's Major Depressive Disorder (and Licensee 2's records do not indicate whether this treatment was or was not successful), what other arrangements or plans did Licensee 2 have for Patient 3's severe psychiatric problem?

xi. Licensee 2 did not describe any circumstances that might justify the deviation from the accepted standard psychiatric evaluation of adolescents. Licensee 2 did not describe any circumstances that might justify the unorthodox treatment plan of treating Major Depressive Disorder with an abortion, but without any psychiatric intervention or psychiatric follow up care.

3. <u>If your opinion is that Licensee 2 did not adhere to the applicable standard of care, describe how, and to what degree (ordinary or gross negligence), the physicians' care deviated from the acceptable standards.</u>

The determination of whether Licensee 2's deviations from the standard of care amount to ordinary or gross negligence is not properly a medical opinion. I can only state

a. there is no evidence that Licensee 2 conducted anything even approximating an appropriate or adequate psychiatric evaluation or mental status examination that could reasonably lead to the conclusion that Patient 3 had a diagnosis of Major Depressive Disorder;
b. there is no evidence that Licensee 2 made a diagnosis based on a personal evaluation of Patient 3
c. there is no evidence that Licensee 2 considered an appropriate treatment

plan for a diagnosis of Major Depressive Disorder;

d. there is no evidence that Licensee 2 made any arrangements or assured that such arrangements were made for appropriate psychiatric follow up care of Patient 3's purported Major Depressive Disorder, given that termination of a pregnancy, even an unwanted pregnancy, is not a treatment or cure for this disorder.

4. List any texts, medical literature or other resources relied upon (if applicable):

a. Diagnostic and Statistical Manual IV-TR, American Psychiatric Association, 2000
b. Practice parameters for the Psychiatric Assessment of Children and Adolescents, Journal of the American Academy of Child and Adolescent Psychiatry 36(10 Supplement):4S-20S, 1997
c. Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorders, Journal of the American Academy of Child and Adolescent Psychiatry, 46(11) 1503-1526, 2007
d. Cohen LS, Nonacs RM, eds: Mood and Anxiety Disorders during Pregnancy and Postpartum. American Psychiatric Publishing Inc., 2005
e. Yonkers K, Little B: Management of Psychiatric Disorders in Pregnancy. Arnold, 2001

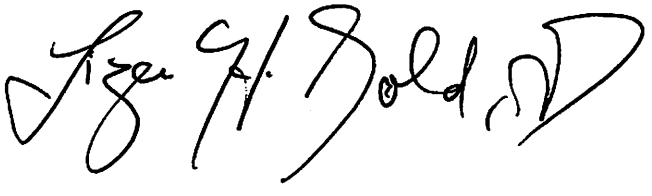
5. **Did Licensee 2 maintain an adequate medical record for this patient?**

No.

If not, please describe the basis for your opinion:

As per Article 24: Patient Records, Adequacy; minimal requirements, Licensee's 2's records are deficient in the following:

a. They do not contain pertinent and significant information concerning the patient's psychiatric condition;
b. They do not reflect what psychiatric or medical examinations, vital signs and tests were obtained, performed, or ordered and the findings and results of each;
c. They do not indicate the initial psychiatric diagnosis and the patient's psychiatric reasons for seeking the licensee's services
d. They do not reflect the recommended psychiatric treatment or discussion of psychiatric treatment options
e. They do not contain any record of discussion of appropriate aftercare of a psychiatric disorder or arrangements for such
f. They do not indicate if and when a personal evaluation was conducted and whether diagnoses were made before or after a personal evaluation if indeed one was conducted.



Liza H. Gold, MD

Clinical Professor of Psychiatry
Georgetown University Medical Center

Certified, Board of Psychiatry and Neurology
Added Qualifications in Forensic Psychiatry

Kathleen Selzler-Lippert, Litigation Counsel
Kansas State Board of Healing Arts
235 SW Topeka Blvd.
Topeka, KS 66603

RE: Expert review of medical records for Investigative Case Nos. 07-00158 & 07-00322

Report of Consultant Review

Physician: Licensee 2

Patient: #4

Dates of Treatment: 8/5/03

Date(s) of Consultant Review: 7/24/09

Records Reviewed

Records reviewed included, but were not limited to:

Kathleen Selzler-Lippert, Letter of referral, 6/19/09
Definition of Standard of Care
K.S.A. 65-6703, 65-6704, 65-6705, 65-6709, 65-6711, 65-6721
K.A.R. 100-24-1 Documentation Regulation
Sample Report

Medical Records

1. Investigative Case No. 07-00158
Patient #4's medical records from Licensee #2 (10 pages)

2. Investigative Case No. 07-00322
Patient #4's medical records from Licensee #1 (71 pages)

Statutes, Kansas Legislature: 65-6703

Abortion is prohibited when fetus is viable, except if the physician who performs the abortion has a documented referral from another physician not legally or financially affiliated with the physician performing or inducing the abortion and both physicians determine that

1. the abortion is necessary to preserve the life of the pregnant woman; or
2. a continuation of the pregnancy will cause a substantial and irreversible impairment of a major bodily function of the pregnant woman.

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Standard of Care: Within a reasonable degree of medical certainty did the practitioner meet the applicable standard of care?

- Ordinary negligence: Did the practitioner fail to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent practitioner as being acceptable under similar conditions and circumstances.

- Gross negligence: Did the practitioner fail to practice within the applicable standard of care and with reckless disregard or complete indifference to the probable consequences

A physician who holds himself out to be a specialist in a particular field of medicine has a duty to practice in a manner consistent with the special degree of skill and knowledge ordinarily possessed by other specialists in the same field of expertise at the time of the diagnosis/treatment.

Summary of Events

Licensee #1's records indicate Patient 4 is a 15 year old single African American female from New York. She became pregnant by consensual intercourse with her boyfriend. On the basis of a referral from Licensee #2 and Licensee #1's evaluation, Patient 4 underwent a late-term abortion at 28 weeks from 8/5/03 - 8/7/03.

Review of Licensee 2's Records

1. Bates #00001: Intake Form - Indicates an appointment date of 8/5/03 and appointment time of 8:30 AM. A brief review of history on a "yes/no" basis indicates no history of depression, alcohol use, or illnesses other than asthma.

2. Bates #00002: "MI Indicators, Patient #4, 15 yrs, 7/26/03" This handwritten document is a "SIGECAPS" screen. This is a checklist of significant symptoms of depression. Patient 4 reported problems with sleep, interest, crying, guilt, concentration and appetite "slightly." She acknowledged thoughts of suicide "so I wouldn't put my mom through this pain." There is no evidence that these symptoms are related to a primary psychiatric diagnosis rather than the stress and distress associated with an unwanted pregnancy.

   This document is unsigned. There is no way to determine from Licensee 1's or Licensee 2's records who performed this evaluation. The date of 7/26/03 however, indicates that this screening evaluation was performed 10 days before the scheduled appointment of 8/5/03.

3. Bates #00004-00005: "MI Statement: Patient 4, 8/5 MR." This document is marked as a copy. It is a typed interview that reviews the patient's pregnancy history, thoughts regarding adoption, and concerns about carrying the pregnancy to term. This document does not indicate who performed the interview or prepared the document, and it is unsigned. There appear to be initials towards the bottom of Bates #00005, but I cannot make out the letters.

   In this document, Patient 4 reports she does not want to continue her pregnancy because she will not be able to achieve goals in life such as finishing school, going to college, and that having a baby would "just kill my mom." She stated, "I would never get past it, I'll be stuck." It also includes a typed version of the SIGECAPS evaluation noted in Bates #00002, but with additional comments. Under suicide inquiry, the document indicates Patient 4 responded, "Yeah at first I did. It was just a thought going through my head."

   Licensee #1's records contain a duplicate of this document (Bates #00009-00010). This document is not marked as a copy and is presumably the original document. There is a similar but not identical set of initials towards the bottom of Bates #00010.

4. Bates #00007-00009: DTREE Positive Dx Report - indicates a diagnosis made on 8/5/03, the same date as the termination, of Acute Stress Disorder, Moderate (308.03). This unsigned document is a computer generated list of the diagnostic criteria for this diagnosis. No evidence supporting the diagnostic criteria is provided. The document does not provide any specific examples or indicate any personal evaluation supporting this diagnosis.

   A duplicate of this document is present in Licensee #1's records (Bates #00006-00008), however Licensee #1's document has an apparent fax date of "Aug 11-03 09:19P" at the top. This fax date is 6 days after Patient 4's appointment with Licensee #2, and approximately 4 days after the termination was completed. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document.

5. Bates #000010: GAF RATING - On 8/5/03, Patient 4 was assigned a GAF (Global Assessment of Functioning) score of 25: "The patient has been preoccupied with suicidal thoughts (but is not in danger of hurting herself) and The patient has been unable to function in almost all areas (e.g. she stays in bed all day, or has no job, home, or friends." The time period for which the GAF rating is assigned is the "past week." This document is a computer generated rating list. No evidence supporting this rating is provided. The document does not provide any specific examples or indicate any personal evaluation supporting the rating. This document is unsigned.

   A duplicate of this document is present in Licensee #1's records (Bates #00005), however Licensee #1's document has an apparent fax date of "Aug 11-03 09:18P"

at the top. This fax date is 6 days after Patient 4's appointment with Licensee #2, and approximately 4 days after the termination was completed. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document.

6. Licensee #1's records include a letter (Bates #00004) from Licensee #2 to Licensee #1, dated Aug 5, 2003, which states, in its entirety,

"RE: Patient #4
DOB: 04/05/88

Dear Licensee #1

I am referring the above named patient to your organization for consultation regarding her unwanted pregnancy. The patient would suffer substantial and irreversible impairment of a major physical or mental function if she were forced to continue the pregnancy.

Sincerely,

Licensee 2, M.D."

This letter is not included in Licensee #2's records.

Opinions

These opinions are based upon a review of records only. These opinions are given within a reasonable degree of medical certainty. These opinions are subject to change pending the receipt and review of additional information.

1. **In your professional opinion, within a reasonable degree of medical certainty, did Licensee 2's care and treatment of this patient adhere to the applicable standard of care?** No.

2. **Explanation of opinion**

Licensee 2, a general practitioner, undertook a psychiatric assessment of a 15 year old girl in a distressing psychosocial situation, specifically, an unwanted pregnancy. On the basis of this assessment, Licensee 2 referred Patient 4, not to a mental health professional for a second opinion for a presumptive psychiatric disorder, but rather to an Ob-Gyn. If a general practitioner felt the need to make a referral for evaluation and/or treatment for a patient with a presumptive psychiatric diagnosis, particularly an adolescent with a new onset psychiatric diagnosis, as there is no indication Patient 4 had any pre-existing psychiatric disorder, medical practice dictates that such a referral would be made to a

mental health professional. Such professionals could be a child and adolescent psychiatrist, psychologist, or social worker, with expertise in the evaluation and treatment of the presumed disorder in adolescents.

There is no evidence of a standard child and adolescent psychiatric evaluation or review of any records in the assignment of the psychiatric diagnosis other than

1. a review of a checklist of criteria associated with a diagnosis of Acute Stress Disorder. There are no specific examples or indications reflecting a personal interview or review of records that would support the presence of a new-onset diagnosis of Acute Stress Disorder in a 15 year old;
2. a SIGECAPS screening. This is a tool to assess whether someone with more than a few positive indicators should be evaluated further for the presence of clinical depression. A SIGECAPS screening is not of itself a standard psychiatric evaluation method for making a diagnosis of a new onset Acute Stress Disorder.

Moreover, the diagnosis of Acute Stress Disorder requires exposure to a traumatic stressor, as identified by the presence of both of the following

a. The person has experienced, witnessed, or been confronted with an event that involved actual or threatened death or serious injury, or a threat to physical integrity.
b. The persons' response to the extreme stressor involved intense fear, helplessness, or horror.

There is no doubt that Patient 4 was distressed and even distraught in finding herself pregnant. However, it is beyond any accepted psychiatric or psychological theory or evidence that an unwanted pregnancy, absent a sexual assault (which did not occur in this case), could be construed as a traumatic stressor that could result in Acute Stress Disorder.

Licensee 2's referral to Licensee 1 was specifically for obtaining a termination for this 15 year old girl based presumably on this psychiatric diagnosis. Abortion is not a treatment for any psychiatric disorder. Many women suffer from exacerbations of pre-existing psychiatric disorders and new onset psychiatric disorders during pregnancy. Multiple effective treatments including psychotherapy and medication are available. There is no evaluation of any previous counseling or interventions, nor any consideration of whether counseling, medications or other interventions were appropriate at the time of the evaluation or in the future. Treatment options were not discussed. Moreover, the psychological ramifications of a late term termination in an adolescent were not discussed or considered, nor was she referred to a qualified specialist to discuss or evaluate this issue.

Licensee 2's referral to Licensee 1 for obtaining a termination for this 15 year old girl stated that Patient 4 would suffer "substantial and irreversible impairment of a physical or mental function if she were forced to continue the pregnancy." The specific nature of the substantial and irreversible impairment is not specified, but since the only diagnosis offered is a psychiatric diagnosis, presumably, the substantial and irreversible impairment was psychiatric. Licensee 2's records give no indication either of the existence of a

psychiatric symptom that might result in a substantial and irreversible impairment, nor do they speculate what such an impairment might be.

Assuming the implication of this referral was in reference to suicidality, the SIGECAPS review indicated that Patient 4 reported she was initially suicidal, but the GAF assessment stated that she was not in danger of hurting herself. In fact, the incidence of suicide among women who have just given birth is one of the lowest for any demographic in the United States. The incidence of suicide in this population increases only in the presence of psychotic illness, when it approaches the incidence of suicide associated with psychotic illness generally. Thus there is not even any evidence that carrying a pregnancy to term, even an unwanted pregnancy, would result in suicide.

In making a diagnosis of Acute Stress Disorder and referring Patient 4 for an abortion as a treatment for this disorder, Licensee 2 has held him- or her-self out as a practitioner who can provide the same level of psychiatric assessment and treatment as a child and adolescent psychiatrist. The "Practice Parameters for the Psychiatric Assessment of Children and Adolescents" published by the American Academy of Child and Adolescent Psychiatry in 1997 clearly establishes a guide for clinicians evaluating psychiatric disorders in children and adolescents. The assessment process is intended to assist the clinician in arriving at accurate diagnoses and appropriate treatment for children and adolescents presenting with psychiatric disorders that impair emotional, cognitive, physical, or behavioral functioning.

These parameters are not rigid guidelines, nor do they of themselves establish a legal standard of care. Nevertheless, these guidelines represent an expert consensus of what constitutes appropriate psychiatric evaluation of children and adolescents and are officially endorsed by the American Academy of Child and Adolescent Psychiatry and the level of care required for the diagnosis of a psychiatric disorder in a child or adolescent. Any deviation from these guidelines should be justified by clinical or other circumstances.

The purpose of a diagnostic assessment of a child or adolescent is

A. to determine whether psychopathology is present, and, if so, to establish a differential diagnosis;
B. to determine whether treatment is indicated; and
C. if so, to develop treatment recommendations and plans

Licensee 2's evaluation and treatment recommendations of Patient 4 were deficient in the following ways:

i. The clinical assessment of a child or adolescent requires several hours, including time for parent interview and child interview. There is no indication of the amount of time Licensee 2 spent evaluating Patient 4. However, Licensee 2's documentation of Patient 4's assessment is so sparse that it is hard to imagine that it is the result of several hours of evaluation. In fact, there is no evidence of any personal evaluation of

Patient 4 as Licensee 2's records consist basically of two apparently computer generated checklists based on DSM criteria, unsupported by any personal information, and typed notes that do not indicate who performed the interview, and do not support the assigned diagnosis.

ii. Licensee 2 does not document a review of Patient 4's psychiatric, medical or developmental history, prior psychiatric treatment symptoms, family history, family relationships, physical or sexual abuse, substance abuse or other possible causes of distress. A psychiatric diagnosis cannot reasonably be arrived at without a review of this information.

iii. Licensee 2 does not document any discussion of behavioral or functional impact of the purported mood disorder. There is no documentation of any discussion of frequency, intensity, duration and circumstances of any specific symptoms or behaviors associated with Acute Stress Disorder. A computerized GAF score of 25, with no narrative, examples of impaired functioning, or other indication of the data upon which this score is based, is not an adequate assessment of the functional impact of psychiatric symptoms.

iv. Licensee 2 did not document conducting a mental status examination, which consists of observing and assessing

1. Physical appearance
2. Manner of relating to examiner and parent
3. Affect and mood
4. Motor behavior
5. Content and form of thought
6. Speech and language
7. Overall intelligence
8. Attention
9. Memory
10. Neurological functioning;
11. and most significantly, judgment and insight

v. Licensee 2 does not present evidence of performing a differential diagnosis. Licensee 2 could not perform an adequate differential diagnosis without obtaining the history, medical, social, and psychiatric information outlined in i, ii, iii, and iv above. A computer generated DTREE Positive Dx Report, unsupported by the necessary and relevant information, does not constitute a differential diagnosis.

vi. Licensee 2 implies that the diagnosis of Acute Stress Disorder is caused solely by unwanted pregnancy, which, in the absence of a sexual assault, is not psychiatrically supportable. There is no evidence of consideration that the distress of an unwanted pregnancy is not actual

psychiatric pathology, and there is no evidence supporting the conclusion that this distress actually represents psychiatric pathology warranting a DSM-IV diagnosis.

vii. Licensee 2 does not present evidence of considering treatment options other than referring Patient 4 to Licensee 1 for a termination. Other treatment options, including various forms of psychotherapy and medication, are available and have been demonstrated to be effective for anxiety disorders. In contrast, an abortion is not considered a psychiatric treatment for Acute Stress Disorder or for any psychiatric diagnosis.

viii. Given Patient 4's age, Licensee 2's records contain no evidence that Licensee 2 considered obtaining a psychiatric consultation from a child and adolescent specialist, whether a social worker, psychologist, or psychiatrist. The circumstances involving the irreversible intervention of a late term termination in a 15 year old suggest that at the least, a consultation with a specialist should be obtained to ensure that no psychological harm would result from the late term termination.

ix. In referring Patient 4 to Licensee 1, Licensee 2 fails to specify what, if any, are the substantial and irreversible impairments Patient 4 would suffer, and which major mental function would be affected. The failure to communicate to a colleague the nature of the severe medical problem presents an obstacle to adequate ongoing medical care.

x. Licensee 2 makes no mention of discussion of, arrangements for, or provision of aftercare for Patient 4's diagnosis of Acute Stress Disorder. As a physician providing an assessment and referral for consultation and treatment, it is Licensee 2's professional obligation to make certain that Patient 4 obtains appropriate treatment subsequent to the termination, which, as stated above, is not a psychiatric treatment for any psychiatric disorder.

This is all the more essential, if, as Licensee 2 states, Patient 4's disorder presents substantial and irreversible risk of impairment. If Patient 4 did meet criteria for Acute Stress Disorder, then it had to be due to some other traumatic stressor. This was not considered or investigated, and no treatment plan was in place to address this. If the treatment of a termination was not successful in alleviating Patient 4's Acute Stress Disorder (and Licensee 2's records do not indicate whether this treatment was or was not successful), what other arrangements or plans did Licensee 2 have for Patient 4's severe psychiatric problem?

xi. Licensee 2 did not describe any circumstances that might justify the deviation from the accepted standard psychiatric evaluation of adolescents. Licensee 2 did not describe any circumstances that might justify the unorthodox treatment plan of treating Acute Stress Disorder an abortion, but without any psychiatric intervention or psychiatric follow up care.

3. If your opinion is that Licensee 2 did not adhere to the applicable standard of care, describe how, and to what degree (ordinary or gross negligence), the physicians' care deviated from the acceptable standards.

The determination of whether Licensee 2's deviations from the standard of care amount to ordinary or gross negligence is not properly a medical opinion. I can only state

a. there is no evidence that Licensee 2 conducted anything even approximating an appropriate or adequate psychiatric evaluation or mental status examination that could reasonably lead to the conclusion that Patient 4 had a diagnosis of Acute Stress Disorder.
b. there is no evidence that Licensee 2 made a diagnosis based on a personal evaluation of Patient 4
c. there is no evidence that Licensee 2 considered an appropriate treatment plan for a diagnosis of Acute Stress Disorder;
d. there is no evidence that Licensee 2 made any arrangements or assured that such arrangements were made for appropriate psychiatric follow up care of Patient 4's purported Acute Stress Disorder, given that termination of a pregnancy, even an unwanted pregnancy, is not a treatment or cure for this disorder.

4. List any texts, medical literature or other resources relied upon (if applicable):

a. Diagnostic and Statistical Manual IV-TR, American Psychiatric Association, 2000
b. Practice parameters for the Psychiatric Assessment of Children and Adolescents, Journal of the American Academy of Child and Adolescent Psychiatry 36(10 Supplement):4S-20S, 1997
c. Practice Parameter for the Assessment and Treatment of Children and Adolescents with Anxiety Disorders, Journal of the American Academy of Child and Adolescent Psychiatry, 46(2) 267-283, 2007
d. Cohen LS, Nonacs RM, eds: Mood and Anxiety Disorders during Pregnancy and Postpartum. American Psychiatric Publishing Inc., 2005
e. Yonkers K, Little B: Management of Psychiatric Disorders in Pregnancy. Arnold, 2001

f. Yehuda R: Risk Factors for Posttraumatic Stress Disorder. American Psychiatric Publishing Inc., 1999
g. Wilson JP, Keane TM, eds.: Assessing Psychological Trauma and PTSD, 2nd edition. Guilford Press, 2004
h. Gold LH: "Gender issues in suicide," in The American Psychiatric Publishing Textbook of Suicide Assessment and Management. Editors Robert I. Simon, MD and Robert E. Hales, MD, American Psychiatric Publishing, Inc., 2006

5. **Did Licensee 2 maintain an adequate medical record for this patient?**

No.

If not, please describe the basis for your opinion:

As per Article 24: Patient Records, Adequacy; minimal requirements, Licensee's 2's records are deficient in the following:

a. They do not contain pertinent and significant information concerning the patient's psychiatric condition;
b. They do not reflect what psychiatric or medical examinations, vital signs and tests were obtained, performed, or ordered and the findings and results of each;
c. They do not indicate the initial psychiatric diagnosis and the patient's psychiatric reasons for seeking the licensee's services
d. They do not reflect the recommended psychiatric treatment or discussion of psychiatric treatment options
e. They do not contain any record of discussion of appropriate aftercare of a psychiatric disorder or arrangements for such
f. They do not indicate if and when a personal evaluation was conducted and whether diagnoses were made before or after a personal evaluation if indeed one was conducted.

Liza H. Gold, MD

Liza H. Gold, MD

Clinical Professor of Psychiatry
Georgetown University Medical Center

Certified, Board of Psychiatry and Neurology
Added Qualifications in Forensic Psychiatry

Kathleen Selzler-Lippert, Litigation Counsel
Kansas State Board of Healing Arts
235 SW Topeka Blvd.
Topeka, KS 66603

RE: Expert review of medical records for Investigative Case Nos. 07-00158 & 07-00322

Report of Consultant Review

Physician: Licensee 2

Patient: #5

Dates of Treatment: 8/12/03

Date(s) of Consultant Review: 7/20/09 – 7/27/09

Records Reviewed

Records reviewed included, but were not limited to:

Kathleen Selzler-Lippert, Letter of referral, 6/19/09
Definition of Standard of Care
K.S.A. 65-6703, 65-6704, 65-6705, 65-6709, 65-6711, 65-6721
K.A.R. 100-24-1 Documentation Regulation
Sample Report

Medical Records

1. Investigative Case No. 07-00158
Patient #5's medical records from Licensee #2 (8 pages)

2. Investigative Case No. 07-00322
Patient #5's medical records from Licensee #1 (57 pages)

Statutes, Kansas Legislature: 65-6703

Abortion is prohibited when fetus is viable, except if the physician who performs the abortion has a documented referral from another physician not legally or financially affiliated with the physician performing or inducing the abortion and both physicians determine that

1. the abortion is necessary to preserve the life of the pregnant woman; or
2. a continuation of the pregnancy will cause a substantial and irreversible impairment of a major bodily function of the pregnant woman.

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Standard of Care: Within a reasonable degree of medical certainty did the practitioner meet the applicable standard of care?

- Ordinary negligence: Did the practitioner fail to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent practitioner as being acceptable under similar conditions and circumstances.

- Gross negligence: Did the practitioner fail to practice within the applicable standard of care and with reckless disregard or complete indifference to the probable consequences

A physician who holds himself out to be a specialist in a particular field of medicine has a duty to practice in a manner consistent with the special degree of skill and knowledge ordinarily possessed by other specialists in the same field of expertise at the time of the diagnosis/treatment.

Summary of Events

Licensee #1's records indicate Patient 5 is a 15 year old single white female from Canada. She became pregnant by consensual intercourse with a 16 year old boyfriend. On the basis of a referral from Licensee #2 and Licensee #1's evaluation, Patient 5 underwent a late-term abortion at 25 weeks on 8/14/03.

Review of Licensee 2's Records

1. Bates #00001: Intake Form - indicates an appointment date of 8/12/03 and time of 8:30 AM. A brief medical and psychiatric history checklist indicates no history of depression, alcohol or other substance abuse, or any other medical or psychiatric illness, as marked by an "n" after each, indicating "no." A comment indicates that the "patient speaks only French."

2. Bates #00002-00003: "MI STATEMENT Patient #5." This is an undated and unsigned typed interview with Patient 5. This document does not indicate who performed the interview or prepared the document. There appear to be a set of initials at the lower left side of Bates #00003. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document.

In this document, Patient 5 reports she does not want to continue her pregnancy because "she would be obligated to keep the child and would not be able to continue her study [sic]."

A "SIGECAPS" was performed. This is a checklist of significant symptoms of depression. Patient 5 reported problems with sleep, interest, guilt, energy, concentration, and appetite. The specific examples given indicate that these symptoms are related to the stress and distress associated with an unwanted pregnancy rather than a primary psychiatric diagnosis. She denied problems with psychomotor activity or thoughts of suicide.

Other psychosocial factors, such as drug and alcohol use, or a history of multiple partners, incest, or running away, are listed on this document but not marked with an answer.

The presumable original of this typed document is found in handwritten form in Licensee 1's records (Bates # 00007-00009). The handwritten document is more extensive than the Licensee 2's typed document. This is a strong indication that Licensee's 2 document was generated by someone in Licensee #1's office, typed and then provided to Licensee #2, rather than generated personally by Licensee #2.

3. Bates #00006-00007: DTREE Positive Dx Report - Patient 5 is given a diagnosis of Major Depressive Disorder, Single Episode, Severe Without Psychotic Features (296.23) in an unsigned document indicating a "Rating" date of 8/12/03, the date of her appointment, and a "Report" date of 8/13/03.

The original typed date on this document for both rating and report is 8/7/03. Under "Rating," the typed date 8/7/03 has been crossed out and 8/12/03 has been handwritten. Under "Report," the typed date 8/7/03 is not crossed out, but next to it the date 8/13/03 has been handwritten in.

In Licensee #1's records (Bates #00006), this same document appears, dated 8/7/03 for both rating and report, and no handwritten alternative dates are entered. Licensee 1's document is apparently fax dated "Aug-13- 9:41A" at the top. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document.

This document is a computer generated list of the diagnostic criteria for this diagnosis. No evidence supporting the diagnostic criteria is provided. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document.

4. Bates #00008: GAF REPORT - On 8/7/03, five days before her scheduled appointment, Patient 5 was assigned a GAF (Global Assessment of Functioning) score of 25: "The patient has been unable to function in almost all areas (e.g., she stays in bed all day, or has no job, home, or friends." The time period for which the GAF rating is assigned is the past week. This document is a computer generated rating list. No evidence supporting this rating is provided. The document does not provide any specific examples or indicate any personal evaluation supporting the rating. The document is unsigned.

A duplicate of this document is present in Licensee #1's records (Bates #00004), however Licensee #1's document has an apparent fax date of "Aug 13-03 09:40A" at the top. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document.

5. Licensee #1's records include a letter (Bates #00003) from Licensee #2 to Licensee #1, dated August 12, 2003, which states, in its entirety,

> "RE: Patient #5
> DOB: 2/17/88
>
> Dear Licensee #1
>
> I am referring the above named patient to your organization for consultation regarding her unwanted pregnancy. The patient would suffer substantial and irreversible impairment of a major physical or mental function if she were forced to continue the pregnancy.
>
> Sincerely,
>
> Licensee 2"

This letter is not included in Licensee #2's records.

Opinions

These opinions are based upon a review of records only. These opinions are given within a reasonable degree of medical certainty. These opinions are subject to change pending the receipt and review of additional information.

1. **In your professional opinion, within a reasonable degree of medical certainty, did Licensee 2's care and treatment of this patient adhere to the applicable standard of care?** No.

2. **Explanation of opinion.**

Licensee 2, a general practitioner, undertook a psychiatric assessment of a 16 year old girl in a distressing psychosocial situation, specifically, an unwanted pregnancy. On the basis of this assessment, Licensee 2 referred Patient 5, not to a mental health professional for a second opinion for a presumptive psychiatric disorder, but rather to an Ob-Gyn. If a general practitioner felt the need to make a referral for evaluation and/or treatment for a patient with a presumptive psychiatric diagnosis, particularly an adolescent with a new onset psychiatric diagnosis, as there is no indication Patient 5 had any pre-existing psychiatric disorder, medical practice dictates that such a referral would be made to a mental health professional. Such professionals could be a child and adolescent psychiatrist, psychologist, or social worker, with expertise in the evaluation and treatment of the presumed disorder in adolescents.

There is no evidence of a standard child and adolescent psychiatric evaluation or review of any records in the assignment of the psychiatric diagnosis other than

1. a review of a checklist. There are no specific examples or indications reflecting a personal interview or review of records that would support the presence of a new-onset diagnosis of Major Depressive Disorder in a 16 year old;
2. a typed "MI Statement" which included a "SIGECAPS" screening. A SIGECAPS screening is a tool to assess whether someone with more than a few positive indicators should be evaluated further for the presence of clinical depression. A SIGECAPS screening is not of itself a standard psychiatric evaluation method for making a diagnosis of a new onset Major Depressive Disorder.

Licensee 2's referral to Licensee 1 was specifically for obtaining a termination for this 16 year old girl based presumably on this psychiatric diagnosis. Abortion is not a treatment for any psychiatric disorder. Many women suffer from exacerbations of pre-existing psychiatric disorders and new onset psychiatric disorders during pregnancy. Multiple effective treatments including psychotherapy and medication are available. There is no evaluation of any previous counseling or interventions, nor any consideration of whether counseling, medications or other interventions were appropriate at the time of the evaluation or in the future. Treatment options were not discussed. Moreover, the psychological ramifications of a late term termination in an adolescent were not discussed or considered, nor was she referred to a qualified specialist to discuss or evaluate this issue.

Licensee 2's referral to Licensee 1 for obtaining a termination for this 16 year old girl stated that Patient 5 would suffer "substantial and irreversible impairment of a physical or mental function if she were forced to continue the pregnancy." The specific nature of the substantial and irreversible impairment is not specified, but since the only diagnosis offered is a psychiatric diagnosis, presumably, the substantial and irreversible impairment was psychiatric. Licensee 2's records give no indication either of the existence of a psychiatric symptom that might result in a substantial and irreversible impairment, nor do they speculate what such an impairment might be. In fact, the SIGECAPS review indicated that Patient 5 reported she was not suicidal, the only life threatening emergency that might meet the criteria of a "substantial and irreversible impairment" due to depression.

In making a diagnosis of Major Depressive Disorder and referring Patient 5 for an abortion as a treatment for this disorder, Licensee 2 has held him- or her-self out as a practitioner who can provide the same level of psychiatric assessment and treatment as a child and adolescent psychiatrist. The "Practice Parameters for the Psychiatric Assessment of Children and Adolescents" published by the American Academy of Child and Adolescent Psychiatry in 1997 clearly establishes a guide for clinicians evaluating psychiatric disorders in children and adolescents. The assessment process is intended to assist the clinician in arriving at accurate diagnoses and appropriate treatment for children and adolescents presenting with psychiatric disorders that impair emotional, cognitive, physical, or behavioral functioning.

These parameters are not rigid guidelines, nor do they of themselves establish a legal standard of care. Nevertheless, these guidelines represent an expert consensus of what

constitutes appropriate psychiatric evaluation of children and adolescents and are officially endorsed by the American Academy of Child and Adolescent Psychiatry and the level of care required for the diagnosis of a psychiatric disorder in a child or adolescent. Any deviation from these guidelines should be justified by clinical or other circumstances.

The purpose of a diagnostic assessment of a child or adolescent is

A. to determine whether psychopathology is present, and, if so, to establish a differential diagnosis;
B. to determine whether treatment is indicated; and
C. if so, to develop treatment recommendations and plans

Licensee 2's evaluation and treatment recommendations of Patient 5 were deficient in the following ways:

i. The clinical assessment of a child or adolescent requires several hours, including time for parent interview and child interview. There is no indication of the amount of time Licensee 2 spent evaluating Patient 5. However, Licensee 2's documentation of Patient 5's assessment is so sparse that it is hard to imagine that it is the result of several hours of evaluation. In fact, there is no evidence of any personal evaluation of Patient 5 as Licensee 2's records consist basically of two apparently computer generated checklists based on DSM criteria, unsupported by any personal information, and typed notes of an MI Statement that do not indicate who performed the interview.

Moreover, it is unclear when these documents were generated, especially since the date on the GAF form is 8/7/03, the date on the diagnostic form is typed as 8/7/03, but handwritten in as 8/12/03, and the MI form is undated. Since Patient 5's appointment with Licensee #2 appears to have been scheduled for 8/23/03, the same date as the termination, and these documents bear earlier dates or no dates, it seems unlikely that Licensee #2 conducted this evaluation.

ii. Licensee 2 does not document a review of Patient 5's psychiatric, medical or developmental history, prior psychiatric treatment symptoms, family history, family relationships, physical or sexual abuse, substance abuse or other possible causes of distress. A psychiatric diagnosis cannot reasonably be arrived at without a review of this information.

iii. Licensee 2 does not document any discussion of behavioral or functional impact of the purported mood disorder. There is no documentation of any discussion of frequency, intensity, duration and circumstances of any specific symptoms or behaviors associated with Major Depressive Disorder. A computerized GAF score of 25, with no

narrative, examples of impaired functioning, or other indication of the data upon which this score is based, is not an adequate assessment of the functional impact of psychiatric symptoms.

iv. Licensee 2 did not document conducting a mental status examination, which consists of observing and assessing

1. Physical appearance
2. Manner of relating to examiner and parent
3. Affect and mood
4. Motor behavior
5. Content and form of thought
6. Speech and language
7. Overall intelligence
8. Attention
9. Memory
10. Neurological functioning;
11. and most significantly, judgment and insight

v. Licensee 2 does not present evidence of performing a differential diagnosis. Licensee 2 could not perform an adequate differential diagnosis without obtaining the history, medical, social, and psychiatric information outlined in i, ii, iii, and iv above. A computer generated DTREE Positive Dx Report, unsupported by the necessary and relevant information, does not constitute a differential diagnosis.

vi. Licensee 2 implies the diagnosis of Major Depressive Disorder is due solely to the unwanted pregnancy with no evidence of consideration of any pre-existing or other possible source of distress. Undoubtedly, Patient 5 was distressed over her unwanted pregnancy. There is no evidence of consideration that the distress of an unwanted pregnancy is not actual psychiatric pathology, and there is no evidence supporting the conclusion that this distress actually represents psychiatric pathology warranting a DSM-IV diagnosis.

vii. Licensee 2 does not present evidence of considering treatment options other than referring Patient 5 to Licensee 1 for a termination. Other treatment options, including various forms of psychotherapy and medication, are available and have been demonstrated to be effective for mood disorders. In contrast, an abortion is not considered a psychiatric treatment for Major Depressive Disorder or for any psychiatric diagnosis.

viii. Given Patient 5's age, Licensee 2's records contain no evidence that Licensee 2 considered obtaining a psychiatric consultation from a child and adolescent specialist, whether a social worker, psychologist, or psychiatrist. The circumstances involving the irreversible

intervention of a late term termination in a 16 year old suggest that at the least, a consultation with a specialist should be obtained to ensure that no psychological harm would result from the late term termination.

ix. In referring Patient 5 to Licensee 1, Licensee 2 fails to specify what, if any, are the substantial and irreversible impairments Patient 5 would suffer, and which major mental function would be affected. The failure to communicate to a colleague the nature of the severe medical problem presents an obstacle to adequate ongoing medical care.

x. Licensee 2 makes no mention of discussion of, arrangements for, or provision of aftercare for Patient 5's diagnosis of Major Depressive Disorder. As a physician providing an assessment and referral for consultation and treatment, it is Licensee 2's professional obligation to make certain that Patient 5 obtains appropriate treatment subsequent to the termination, which, as stated above, is not a psychiatric treatment for any psychiatric disorder.

This is all the more essential, if, as Licensee 2 states, Patient 5's disorder presents substantial and irreversible risk of impairment. If Patient 5's Major Depressive Disorder was due in fact to another cause, then no treatment plan was in place to address this. If the treatment of a termination was not successful in alleviating Patient 5's Major Depressive Disorder (and Licensee 2's records do not indicate whether this treatment was or was not successful), what other arrangements or plans did Licensee 2 have for Patient 5's severe psychiatric problem?

xi. Licensee 2 did not describe any circumstances that might justify the deviation from the accepted standard psychiatric evaluation of adolescents. Licensee 2 did not describe any circumstances that might justify the unorthodox treatment plan of treating Major Depressive Disorder with an abortion, but without any psychiatric intervention or psychiatric follow up care.

3. <u>If your opinion is that Licensee 2 did not adhere to the applicable standard of care, describe how, and to what degree (ordinary or gross negligence), the physicians' care deviated from the acceptable standards.</u>

The determination of whether Licensee 2's deviations from the standard of care amount to ordinary or gross negligence is not properly a medical opinion. I can only state

a. there is no evidence that Licensee 2 conducted anything even approximating an appropriate or adequate psychiatric evaluation or mental status examination that could reasonably lead to the conclusion that Patient 5 had a diagnosis of Major Depressive Disorder;

b. there is no evidence that Licensee 2 made a diagnosis based on a personal evaluation of Patient 5
c. there is no evidence that Licensee 2 considered an appropriate treatment plan for a diagnosis of Major Depressive Disorder;
d. there is no evidence that Licensee 2 made any arrangements or assured that such arrangements were made for appropriate psychiatric follow up care of Patient 5's purported Major Depressive Disorder, given that termination of a pregnancy, even an unwanted pregnancy, is not a treatment or cure for this disorder.

4. List any texts, medical literature or other resources relied upon (if applicable):

a. Diagnostic and Statistical Manual IV-TR, American Psychiatric Association, 2000
b. Practice parameters for the Psychiatric Assessment of Children and Adolescents, Journal of the American Academy of Child and Adolescent Psychiatry 36(10 Supplement):4S-20S, 1997
c. Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorders, Journal of the American Academy of Child and Adolescent Psychiatry, 46(11) 1503-1526, 2007
d. Cohen LS, Nonacs RM, eds: Mood and Anxiety Disorders during Pregnancy and Postpartum. American Psychiatric Publishing Inc., 2005
e. Yonkers K, Little B: Management of Psychiatric Disorders in Pregnancy. Arnold, 2001

5. **Did Licensee 2 maintain an adequate medical record for this patient?**
No.

If not, please describe the basis for your opinion:

As per Article 24: Patient Records, Adequacy; minimal requirements, Licensee's 2's records are deficient in the following:

a. They do not contain pertinent and significant information concerning the patient's psychiatric condition;
b. They do not reflect what psychiatric or medical examinations, vital signs and tests were obtained, performed, or ordered and the findings and results of each;
c. They do not indicate the initial psychiatric diagnosis and the patient's psychiatric reasons for seeking the licensee's services
d. They do not reflect the recommended psychiatric treatment or discussion of psychiatric treatment options
e. They do not contain any record of discussion of appropriate aftercare of a psychiatric disorder or arrangements for such
f. They do not indicate if and when a personal evaluation was conducted and whether diagnoses were made before or after a personal evaluation if indeed one was conducted.

Liza H. Gold, MD

Clinical Professor of Psychiatry
Georgetown University Medical Center

Certified, Board of Psychiatry and Neurology
Added Qualifications in Forensic Psychiatry

Kathleen Selzler-Lippert, Litigation Counsel
Kansas State Board of Healing Arts
235 SW Topeka Blvd.
Topeka, KS 66603

RE: Expert review of medical records for Investigative Case Nos. 07-00158 & 07-00322

Report of Consultant Review

Physician: Licensee 2

Patient: #6

Dates of Treatment: 8/26/03

Date(s) of Consultant Review: 7/20/09 – 7/27/09

Records Reviewed

Records reviewed included, but were not limited to:

Kathleen Selzler-Lippert, Letter of referral, 6/19/09
Definition of Standard of Care
K.S.A. 65-6703, 65-6704, 65-6705, 65-6709, 65-6711, 65-6721
K.A.R. 100-24-1 Documentation Regulation
Sample Report

Medical Records

1. Investigative Case No. 07-00158
Patient #6's medical records from Licensee #2 (20 pages)

2. Investigative Case No. 07-00322
Patient #6's medical records from Licensee #1 (53 pages)

Statutes, Kansas Legislature: 65-6703

Abortion is prohibited when fetus is viable, except if the physician who performs the abortion has a documented referral from another physician not legally or financially affiliated with the physician performing or inducing the abortion and both physicians determine that

1. the abortion is necessary to preserve the life of the pregnant woman; or
2. a continuation of the pregnancy will cause a substantial and irreversible impairment of a major bodily function of the pregnant woman.

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Standard of Care: Within a reasonable degree of medical certainty did the practitioner meet the applicable standard of care?

- Ordinary negligence: Did the practitioner fail to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent practitioner as being acceptable under similar conditions and circumstances.

- Gross negligence: Did the practitioner fail to practice within the applicable standard of care and with reckless disregard or complete indifference to the probable consequences

A physician who holds himself out to be a specialist in a particular field of medicine has a duty to practice in a manner consistent with the special degree of skill and knowledge ordinarily possessed by other specialists in the same field of expertise at the time of the diagnosis/treatment.

Summary of Events

Licensee #1's records indicate Patient 6 is a 14 year old single female from New York. She became pregnant by consensual intercourse with her boyfriend. On the basis of a referral from Licensee #2 and Licensee #1's evaluation, Patient 6 underwent a late-term abortion at 25 weeks and 3 days on 8/28/03 and 8/29/03.

Review of Licensee 2's Records

1. Bates #00002: Intake Form - Indicates an appointment date of 8/26/03 and appointment time of 8:30 AM. A brief review of psychiatric and medical history on a "yes/no" basis indicates no history of depression, alcohol use, or any medical illnesses by the letter "N" for "no."

2. Bates #00003: "MI Statement Patient 6 - This undated and unsigned typed document contains what appears to be a brief interview regarding the circumstances of becoming pregnant. Patient 6 stated that if she could not get an abortion, "I think I'd go into a depression. I'd be scared ... I can't get no job."

   Patient 6's mother is quoted as stating that if Patient 6 did not have an abortion, Patient 6 would "have depression. A lot, that's what I'm worried about. (Admits that she worried Pt. #6 would do something to harm herself or the infant.)"

   An identical copy of this document, also undated and usigned, appears in Licensee #1's records (Bates #00017).

3. Bates #00006: "MI Statement, Patient #6, 8/26" - This typed document is marked as a "COPY" and has a set of initials at the top left. I cannot read the initials. The document indicates that Patient 6 is living with her mother and multiple siblings in a chaotic and precarious financial situation, having to sleep on a couch at her aunt's house and worrying about there being enough food for everyone. She

states, "I have to have a baby, it would get in the way of me going to school. I think I would go into a depression."

This document contains a "SIGECAPS" screen. This is a checklist of significant symptoms of depression. Patient 6 reported problems with sleep, interest, guilt, energy, concentration, appetite, and restlessness. She denied thoughts of suicide. There is no evidence that these symptoms are related to a primary psychiatric diagnosis rather than the stress and distress associated with an unwanted pregnancy.

A checklist of relevant psychosocial and psychiatric factors indicates by the letter "N" for "no" that there is no history of use of drugs or alcohol, incest or abuse.

An identical document appears in Licensee #1's records (Bates #00009), with the notable exception that the handwritten initials, date and patient number at the top appear to be in a different handwriting. The initials also seem to differ. There is no way to determine from Licensee 1's or Licensee 2's records who performed this evaluation or prepared the document.

4. Bates #00009-00011: DTREE Positive Dx Report - indicates a diagnosis of Acute Stress Disorder (308.3). The rating date for this diagnosis is 8/26/03; the report date is 9/5/03, some ten days after the rating date and approximately one week after the termination was completed. This unsigned document is a computer generated list of diagnostic criteria for this diagnosis. No evidence supporting the diagnostic criteria is provided. The document does not provide any specific examples or indicate any personal evaluation supporting this diagnosis.

   A duplicate of this document is present in Licensee #1's records (Bates #00004-00006), however Licensee #1's document has an apparent fax date of "Sep-5-03 11:28A" at the top. This fax date is 10 days after Patient 6's appointment with Licensee #2, and approximately one week after the termination was completed. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document.

5. Bates #00012-00013: GAF REPORT - Patient 6 was assigned a GAF (Global Assessment of Functioning) score of 35: "The patient has presented with major impairment in such areas as work or school, family relations, judgment, thinking, or mood. The GAF Report indicates a rating date of 8/26/03, the same date as the termination, and states that the time frame covered by this rating is the "past week." However, the document indicates a report date of 9/5/03. The document is unsigned. This document is a computer generated rating list. No evidence supporting this rating is provided. The document does not provide any specific examples or indicate any personal evaluation supporting the rating.

6. A duplicate of this document is present in Licensee #1's records (Bates 00007-00008), however Licensee #1's document has an apparent fax date of "Sep-5-03

11:27A" at the top. This fax date is 10 days after Patient 6's appointment with Licensee #2, and approximately 5 days after the termination was completed. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document.

7. Licensee #1's records include a letter (Bates #00003) from Licensee #2 to Licensee #1, dated August 26, 2003, which states, in its entirety,

"RE: Patient #6
DOB: 11/20/88

Dear Dr. Licensee #1

I am referring the above named patient to your organization for consultation regarding her unwanted pregnancy. The patient would suffer substantial and irreversible impairment of a major physical or mental function if she were forced to continue the pregnancy.

Licensee 2"

This letter is not included in Licensee #2's records.

Opinions

These opinions are based upon a review of records only. These opinions are given within a reasonable degree of medical certainty. These opinions are subject to change pending the receipt and review of additional information.

1. **In your professional opinion, within a reasonable degree of medical certainty, did Licensee 2's care and treatment of this patient adhere to the applicable standard of care?** No.

2. **Explanation of opinion**

Licensee 2, a general practitioner, undertook a psychiatric assessment of a 14 year old girl in a distressing psychosocial situation, specifically, an unwanted pregnancy. On the basis of this assessment, Licensee 2 referred Patient 6, not to a mental health professional for a second opinion for a presumptive psychiatric disorder, but rather to an Ob-Gyn. If a general practitioner felt the need to make a referral for evaluation and/or treatment for a patient with a presumptive psychiatric diagnosis, particularly an adolescent with a new onset psychiatric diagnosis, as there is no indication Patient 6 had any pre-existing psychiatric disorder, medical practice dictates that such a referral would be made to a mental health professional. Such professionals could be a child and adolescent psychiatrist, psychologist, or social worker, with expertise in the evaluation and treatment of the presumed disorder in adolescents.

There is no evidence of a standard child and adolescent psychiatric evaluation or review of any records in the assignment of the psychiatric diagnosis other than

1. a review of a checklist of criteria associated with a diagnosis of Acute Stress Disorder. There are no specific examples or indications reflecting a personal interview or review of records that would support the presence of a new-onset diagnosis of Acute Stress Disorder in a 14 year old;
2. a SIGECAPS screening. This is a tool to assess whether someone with more than a few positive indicators should be evaluated further for the presence of clinical depression. A SIGECAPS screening is not of itself a standard psychiatric evaluation method for making a diagnosis of a new onset Acute Stress Disorder.

Moreover, the diagnosis of Acute Stress Disorder requires exposure to a traumatic stressor, as identified by the presence of both of the following

a. The person has experienced, witnessed, or been confronted with an event that involved actual or threatened death or serious injury, or a threat to physical integrity.
b. The persons' response to the extreme stressor involved intense fear, helplessness, or horror.

There is no doubt that Patient 6 was distressed in finding herself pregnant. However, it is beyond any accepted psychiatric or psychological theory or evidence that an unwanted pregnancy, absent a sexual assault (which did not occur in this case), could be construed as a traumatic stressor that could result in Acute Stress Disorder. Such a diagnosis in these circumstances cannot be construed as other than a misuse of psychiatry.

Licensee 2's referral to Licensee 1 was specifically for obtaining a termination for this 14 year old girl based presumably on this psychiatric diagnosis. Abortion is not a treatment for any psychiatric disorder. Many women suffer from exacerbations of pre-existing psychiatric disorders and new onset psychiatric disorders during pregnancy. Multiple effective treatments including psychotherapy and medication are available. There is no evaluation of any previous counseling or interventions, nor any consideration of whether counseling, medications or other interventions were appropriate at the time of the evaluation or in the future. Treatment options were not discussed. Moreover, the psychological ramifications of a late term termination in an adolescent were not discussed or considered, nor was she referred to a qualified specialist to discuss or evaluate this issue.

Licensee 2's referral to Licensee 1 for obtaining a termination for this 14 year old girl stated that Patient 6 would suffer "substantial and irreversible impairment of a physical or mental function if she were forced to continue the pregnancy." The specific nature of the substantial and irreversible impairment is not specified, but since the only diagnosis offered is a psychiatric diagnosis, presumably, the substantial and irreversible impairment was psychiatric. Licensee 2's records give no indication either of the existence of a psychiatric symptom that might result in a substantial and irreversible impairment, nor do they speculate what such an impairment might be. Patient 6's mother is quoted as stating that she was worried that her daughter might harm herself or the infant. However, no

indication of past or present self harming behavior or ideation is noted, and Patient 6 herself denied thoughts of suicide.

In fact, the incidence of suicide among women who have just given birth is one of the lowest for any demographic in the United States. The incidence of suicide in this population increases only in the presence of psychotic illness, when it approaches the incidence of suicide associated with psychotic illness generally. Thus there is not even any evidence that carrying a pregnancy to term, even an unwanted pregnancy, would result in suicide.

In making a diagnosis of Acute Stress Disorder and referring Patient 6 for an abortion as a treatment for this disorder, Licensee 2 has held him- or her-self out as a practitioner who can provide the same level of psychiatric assessment and treatment as a child and adolescent psychiatrist. The "Practice Parameters for the Psychiatric Assessment of Children and Adolescents" published by the American Academy of Child and Adolescent Psychiatry in 1997 clearly establishes a guide for clinicians evaluating psychiatric disorders in children and adolescents. The assessment process is intended to assist the clinician in arriving at accurate diagnoses and appropriate treatment for children and adolescents presenting with psychiatric disorders that impair emotional, cognitive, physical, or behavioral functioning.

These parameters are not rigid guidelines, nor do they of themselves establish a legal standard of care. Nevertheless, these guidelines represent an expert consensus of what constitutes appropriate psychiatric evaluation of children and adolescents and are officially endorsed by the American Academy of Child and Adolescent Psychiatry and the level of care required for the diagnosis of a psychiatric disorder in a child or adolescent. Any deviation from these guidelines should be justified by clinical or other circumstances.

The purpose of a diagnostic assessment of a child or adolescent is

A. to determine whether psychopathology is present, and, if so, to establish a differential diagnosis;
B. to determine whether treatment is indicated; and
C. if so, to develop treatment recommendations and plans

Licensee 2's evaluation and treatment recommendations of Patient 6 were deficient in the following ways:

i. The clinical assessment of a child or adolescent requires several hours, including time for parent interview and child interview. There is no indication of the amount of time Licensee 2 spent evaluating Patient 6. However, Licensee 2's documentation of Patient 6's assessment is so sparse that it is hard to imagine that it is the result of several hours of evaluation. In fact, there is no evidence of any personal evaluation of Patient 6 as Licensee 2's records consist basically of two apparently computer generated checklists based on DSM criteria, unsupported by

any personal information, and typed notes that do not indicate who performed the interview, and do not support the assigned diagnosis.

ii. Licensee 2 does not document a review of Patient 6's psychiatric, medical or developmental history, prior psychiatric treatment symptoms, family history, family relationships, physical or sexual abuse, substance abuse or other possible causes of distress. A psychiatric diagnosis cannot reasonably be arrived at without a review of this information.

iii. Licensee 2 does not document any discussion of behavioral or functional impact of the purported mood disorder. There is no documentation of any discussion of frequency, intensity, duration and circumstances of any specific symptoms or behaviors associated with Acute Stress Disorder. A computerized GAF score of 35, with no narrative, examples of impaired functioning, or other indication of the data upon which this score is based, is not an adequate assessment of the functional impact of psychiatric symptoms.

iv. Licensee 2 did not document conducting a mental status examination, which consists of observing and assessing

1. Physical appearance
2. Manner of relating to examiner and parent
3. Affect and mood
4. Motor behavior
5. Content and form of thought
6. Speech and language
7. Overall intelligence
8. Attention
9. Memory
10. Neurological functioning;
11. and most significantly, judgment and insight

v. Licensee 2 does not present evidence of performing a differential diagnosis. Licensee 2 could not perform an adequate differential diagnosis without obtaining the history, medical, social, and psychiatric information outlined in i, ii, iii, and iv above. A computer generated DTREE Positive Dx Report, unsupported by the necessary and relevant information, does not constitute a differential diagnosis.

vi. Licensee 2 implies that the diagnosis of Acute Stress Disorder is caused solely by unwanted pregnancy, which, in the absence of a sexual assault, is not psychiatrically supportable. There is no evidence of consideration that the distress of an unwanted pregnancy is not actual psychiatric pathology, and there is no evidence supporting the conclusion that this distress actually represents psychiatric pathology

warranting a DSM-IV diagnosis.

vii. Licensee 2 does not present evidence of considering treatment options other than referring Patient 6 to Licensee 1 for a termination. Other treatment options, including various forms of psychotherapy and medication, are available and have been demonstrated to be effective for anxiety disorders. In contrast, an abortion is not considered a psychiatric treatment for Acute Stress Disorder or for any psychiatric diagnosis.

viii. Given Patient 6's age, Licensee 2's records contain no evidence that Licensee 2 considered obtaining a psychiatric consultation from a child and adolescent specialist, whether a social worker, psychologist, or psychiatrist. The circumstances involving the irreversible intervention of a late term termination in a 14 year old suggest that at the least, a consultation with a specialist should be obtained to ensure that no psychological harm would result from the late term termination.

ix. In referring Patient 6 to Licensee 1, Licensee 2 fails to specify what, if any, are the substantial and irreversible impairments Patient 6 would suffer, and which major mental function would be affected. The failure to communicate to a colleague the nature of the severe medical problem presents an obstacle to adequate ongoing medical care.

x. Licensee 2 makes no mention of discussion of, arrangements for, or provision of aftercare for Patient 6's diagnosis of Acute Stress Disorder. As a physician providing an assessment and referral for consultation and treatment, it is Licensee 2's professional obligation to make certain that Patient 6 obtains appropriate treatment subsequent to the termination, which, as stated above, is not a psychiatric treatment for any psychiatric disorder.

This is all the more essential, if, as Licensee 2 states, Patient 6's disorder presents substantial and irreversible risk of impairment. If Patient 6 did meet criteria for Acute Stress Disorder, then it had to be due to some other traumatic stressor. This was not considered or investigated, and no treatment plan was in place to address this. If the treatment of a termination was not successful in alleviating Patient 6's Acute Stress Disorder (and Licensee 2's records do not indicate whether this treatment was or was not successful), what other arrangements or plans did Licensee 2 have for Patient 6's severe psychiatric problem?

xi. Licensee 2 did not describe any circumstances that might justify the deviation from the accepted standard psychiatric evaluation of adolescents. Licensee 2 did not describe any circumstances that might

justify the unorthodox treatment plan of treating Acute Stress Disorder an abortion, but without any psychiatric intervention or psychiatric follow up care.

3. **If your opinion is that Licensee 2 did not adhere to the applicable standard of care, describe how, and to what degree (ordinary or gross negligence), the physicians' care deviated from the acceptable standards.**

The determination of whether Licensee 2's deviations from the standard of care amount to ordinary or gross negligence is not properly a medical opinion. I can only state

a. there is no evidence that Licensee 2 conducted anything even approximating an appropriate or adequate psychiatric evaluation or mental status examination that could reasonably lead to the conclusion that Patient 6 had a diagnosis of Acute Stress Disorder, the diagnosis of which in this case represents a misuse of psychiatry
b. there is no evidence that Licensee 2 made a diagnosis based on a personal evaluation of Patient 6
c. there is no evidence that Licensee 2 considered an appropriate treatment plan for a diagnosis of Acute Stress Disorder;
d. there is no evidence that Licensee 2 made any arrangements or assured that such arrangements were made for appropriate psychiatric follow up care of Patient 6's purported Acute Stress Disorder, given that termination of a pregnancy, even an unwanted pregnancy, is not a treatment or cure for this disorder.

4. **List any texts, medical literature or other resources relied upon (if applicable):**

e. Diagnostic and Statistical Manual IV-TR, American Psychiatric Association, 2000
f. Practice parameters for the Psychiatric Assessment of Children and Adolescents, Journal of the American Academy of Child and Adolescent Psychiatry 36(10 Supplement):4S-20S, 1997
g. Practice Parameter for the Assessment and Treatment of Children and Adolescents with Anxiety Disorders, Journal of the American Academy of Child and Adolescent Psychiatry, 46(2) 267-283, 2007
h. Cohen LS, Nonacs RM, eds: Mood and Anxiety Disorders during Pregnancy and Postpartum. American Psychiatric Publishing Inc., 2005
i. Yonkers K, Little B: Management of Psychiatric Disorders in Pregnancy. Arnold, 2001
j. Yehuda R: Risk Factors for Posttraumatic Stress Disorder. American Psychiatric Publishing Inc., 1999
k. Wilson JP, Keane TM, eds.: Assessing Psychological Trauma and PTSD, 2nd edition. Guilford Press, 2004
l. Gold LH: "Gender issues in suicide," in The American Psychiatric Publishing Textbook of Suicide Assessment and Management. Editors Robert I. Simon, MD and Robert E. Hales, MD, American Psychiatric Publishing, Inc., 2006

5. **Did Licensee 2 maintain an adequate medical record for this patient?**

No.

If not, please describe the basis for your opinion:

As per Article 24: Patient Records, Adequacy; minimal requirements, Licensee's 2's records are deficient in the following:

i. They do not contain pertinent and significant information concerning the patient's psychiatric condition;
ii. They do not reflect what psychiatric or medical examinations, vital signs and tests were obtained, performed, or ordered and the findings and results of each;
iii. They do not indicate the initial psychiatric diagnosis and the patient's psychiatric reasons for seeking the licensee's services
iv. They do not reflect the recommended psychiatric treatment or discussion of psychiatric treatment options
v. They do not contain any record of discussion of appropriate aftercare of a psychiatric disorder or arrangements for such
vi. They do not indicate if and when a personal evaluation was conducted and whether diagnoses were made before or after a personal evaluation if indeed one was conducted.

Liza H. Gold, MD

Clinical Professor of Psychiatry
Georgetown University Medical Center

Certified, Board of Psychiatry and Neurology
Added Qualifications in Forensic Psychiatry

Kathleen Selzler-Lippert, Litigation Counsel
Kansas State Board of Healing Arts
235 SW Topeka Blvd.
Topeka, KS 66603

RE: Expert review of medical records for Investigative Case Nos. 07-00158 & 07-00322

Report of Consultant Review

Physician: Licensee 2

Patient: #7

Dates of Treatment: 9/9/03

Date(s) of Consultant Review: 7/20/09 – 7/27/09

Records Reviewed

Records reviewed included, but were not limited to:

Kathleen Selzler-Lippert, Letter of referral, 6/19/09
Definition of Standard of Care
K.S.A. 65-6703, 65-6704, 65-6705, 65-6709, 65-6711, 65-6721
K.A.R. 100-24-1 Documentation Regulation
Sample Report

Medical Records

1. Investigative Case No. 07-00158
Patient #7's medical records from Licensee #2 (7 pages)

2. Investigative Case No. 07-00322
Patient #7's medical records from Licensee #1 (68 pages)

Statutes, Kansas Legislature: 65-6703

Abortion is prohibited when fetus is viable, except if the physician who performs the abortion has a documented referral from another physician not legally or financially affiliated with the physician performing or inducing the abortion and both physicians determine that

1. the abortion is necessary to preserve the life of the pregnant woman; or
2. a continuation of the pregnancy will cause a substantial and irreversible impairment of a major bodily function of the pregnant woman.

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Standard of Care: Within a reasonable degree of medical certainty did the practitioner meet the applicable standard of care?

- Ordinary negligence: Did the practitioner fail to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent practitioner as being acceptable under similar conditions and circumstances.

- Gross negligence: Did the practitioner fail to practice within the applicable standard of care and with reckless disregard or complete indifference to the probable consequences

A physician who holds himself out to be a specialist in a particular field of medicine has a duty to practice in a manner consistent with the special degree of skill and knowledge ordinarily possessed by other specialists in the same field of expertise at the time of the diagnosis/treatment.

Summary of Events

Licensee #1's records indicate Patient 7 is a 15 year old single African-American female from Missouri. She became pregnant by consensual intercourse. On the basis of a referral from Licensee #2 and Licensee #1's evaluation, Patient 7 underwent a late-term abortion at 25 weeks from 9/9/03 – 9/11/03.

Review of Licensee 2's Records: (NB these documents are note Bates stamped)

1. Intake Form: indicates an appointment date of 9/9/03 and time of 8:30 AM. A brief medical and psychiatric history checklist indicates no history of depression, alcohol or other substance abuse, or any other medical or psychiatric illness, as marked by an "n" after each, indicating "no."

2. Document entitled "MI STATEMENT Patient #7" and marked as COPY - This is an undated and unsigned handwritten interview with Patient 7. This document does not indicate who performed the interview or prepared the document. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document.

The presumable original of this document is found in Licensee 1's records (Bates # 00008). This document is identical to the document in Licensee 2's records but is not marked "COPY." This is a strong indication that Licensee's 2 document was generated by someone in Licensee #1's office and provided to Licensee #2, rather than generated personally by Licensee #2.

In this document, Patient 7 reports she does not want to continue her pregnancy because "I need to finish school. I will get kicked out if I'm pregnant." She stated that if she did not get an abortion, "I don't think I would be the same mentally ... I'd have to go live with my sister in Ohio. .... My parents wouldn't be able to trust me. I owe them so much.

It would be like they did all this for nothing."

A "SIGECAPS" was performed. This is a checklist of significant symptoms of depression. Patient 7 reported problems with sleep, interest, guilt, energy, appetite, and increased fatigue. The specific examples given indicate that these symptoms are related to the stress and distress associated with an unwanted pregnancy rather than a primary psychiatric diagnosis. She denied problems with concentration or thoughts of suicide. She admitted to wanting to have a miscarriage, but did not apparently take any steps to cause herself to have one, other than go on a diet.

Other psychosocial factors, such as drug and alcohol use, or a history of multiple partners, incest, or running away, are marked "N" for no.

3. DTREE Positive Dx Report: Patient 7 is given diagnosis of Major Depressive Disorder, Single Episode, Severe Without Psychotic Features (296.23) in an unsigned document indicating a "Rating" and "Report" date of 9/9/03, the date of her appointment and the date of her termination. This document is a computer generated list of diagnostic criteria for this diagnosis. No evidence supporting the diagnostic criteria is provided.

A duplicate of this document is present in Licensee #1's records (Bates #00005-00006), however Licensee #1's document has an apparent fax date of "Sep-19-03 01:48P" at the top. This fax date is 10 days after Patient 7's appointment with Licensee #2, and approximately one week after the termination was completed. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document.

4. GAF REPORT: On 9/9/03, Patient 7 was assigned a GAF (Global Assessment of Functioning) score of 15: "The patient has been in some danger of hurting herself or others as a consequence of her impaired judgment." No time period for which the GAF rating is assigned is indicated. This document is a computer generated rating list. No evidence supporting this rating is provided. The document does not provide any specific examples or indicate any personal evaluation supporting the rating. It is unsigned.

A duplicate of this document is present in Licensee #1's records (Bates #00007), however Licensee #1's document has an apparent fax date of "Sep-19-03 01:48P" at the top. This fax date is 10 days after Patient 7's appointment with Licensee #2, and approximately one week after the termination was completed. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document.

5. Licensee #1's records include a letter (Bates #00004) from Licensee #2 to Licensee #1, dated September 9, 2003, which states, in its entirety,

> "RE: Patient #7
> DOB: 4/26/88
>
> Dear Licensee #1
>
> I am referring the above named patient to your organization for consultation regarding her unwanted pregnancy. The patient would suffer substantial and irreversible impairment of a major physical or mental function if she were forced to continue the pregnancy.
>
> Sincerely,
>
> Licensee 2"

This letter is not included in Licensee #2's records.

Opinions

These opinions are based upon a review of records only. These opinions are given within a reasonable degree of medical certainty. These opinions are subject to change pending the receipt and review of additional information.

1. **In your professional opinion, within a reasonable degree of medical certainty, did Licensee 2's care and treatment of this patient adhere to the applicable standard of care?** No.

2. **Explanation of opinion.**

Licensee 2, a general practitioner, undertook a psychiatric assessment of a 15 year old girl in a distressing psychosocial situation, specifically, an unwanted pregnancy. On the basis of this assessment, Licensee 2 referred Patient 7, not to a mental health professional for a second opinion for a presumptive psychiatric disorder, but rather to an Ob-Gyn. If a general practitioner felt the need to make a referral for evaluation and/or treatment for a patient with a presumptive psychiatric diagnosis, particularly an adolescent with a new onset psychiatric diagnosis, as there is no indication Patient 7 had any pre-existing psychiatric disorder, medical practice dictates that such a referral would be made to a mental health professional. Such professionals could be a child and adolescent psychiatrist, psychologist, or social worker, with expertise in the evaluation and treatment of the presumed disorder in adolescents.

There is no evidence of a standard child and adolescent psychiatric evaluation or review of any records in the assignment of the psychiatric diagnosis other than

1. a review of a checklist. There are no specific examples or indications reflecting a

personal interview or review of records that would support the presence of a new-onset diagnosis of Major Depressive Disorder in a 15 year old;

2. a handwritten "MI Statement" which included a "SIGECAPS" screening. A SIGECAPS screening is a tool to assess whether someone with more than a few positive indicators should be evaluated further for the presence of clinical depression. A SIGECAPS screening is not of itself a standard psychiatric evaluation method for making a diagnosis of a new onset Major Depressive Disorder.

Licensee 2's referral to Licensee 1 was specifically for obtaining a termination for this 15 year old girl based presumably on this psychiatric diagnosis. Abortion is not a treatment for any psychiatric disorder. Many women suffer from exacerbations of pre-existing psychiatric disorders and new onset psychiatric disorders during pregnancy. Multiple effective treatments including psychotherapy and medication are available. There is no evaluation of any previous counseling or interventions, nor any consideration of whether counseling, medications or other interventions were appropriate at the time of the evaluation or in the future. Treatment options were not discussed. Moreover, the psychological ramifications of a late term termination in an adolescent were not discussed or considered, nor was she referred to a qualified specialist to discuss or evaluate this issue.

Licensee 2's referral to Licensee 1 for obtaining a termination for this 15 year old girl stated that Patient 7 would suffer "substantial and irreversible impairment of a physical or mental function if she were forced to continue the pregnancy." The specific nature of the substantial and irreversible impairment is not specified, but since the only diagnosis offered is a psychiatric diagnosis, presumably, the substantial and irreversible impairment was psychiatric. Licensee 2's records give no indication either of the existence of a psychiatric symptom that might result in a substantial and irreversible impairment, nor do they speculate what such an impairment might be. In fact, the SIGECAPS review indicated that Patient 7 reported she was not suicidal, the only life threatening emergency that might meet the criteria of a "substantial and irreversible impairment" due to depression. The fact that Patient 7 considered inducing a miscarriage of an unwanted pregnancy is not an indication of dangerousness to self or others related to a psychiatric illness, but rather an expression of her distress at her situation. Patient 7 took no steps to induce a miscarriage other than go on a "diet."

In making a diagnosis of Major Depressive Disorder and referring Patient 7 for an abortion as a treatment for this disorder, Licensee 2 has held him- or her-self out as a practitioner who can provide the same level of psychiatric assessment and treatment as a child and adolescent psychiatrist. The "Practice Parameters for the Psychiatric Assessment of Children and Adolescents" published by the American Academy of Child and Adolescent Psychiatry in 1997 clearly establishes a guide for clinicians evaluating psychiatric disorders in children and adolescents. The assessment process is intended to assist the clinician in arriving at accurate diagnoses and appropriate treatment for children and adolescents presenting with psychiatric disorders that impair emotional, cognitive, physical, or behavioral functioning.

These parameters are not rigid guidelines, nor do they of themselves establish a legal standard of care. Nevertheless, these guidelines represent an expert consensus of what constitutes appropriate psychiatric evaluation of children and adolescents and are officially endorsed by the American Academy of Child and Adolescent Psychiatry and the level of care required for the diagnosis of a psychiatric disorder in a child or adolescent. Any deviation from these guidelines should be justified by clinical or other circumstances.

The purpose of a diagnostic assessment of a child or adolescent is

A. to determine whether psychopathology is present, and, if so, to establish a differential diagnosis;
B. to determine whether treatment is indicated; and
C. if so, to develop treatment recommendations and plans

Licensee 2's evaluation and treatment recommendations of Patient 7 were deficient in the following ways:

i. The clinical assessment of a child or adolescent requires several hours, including time for parent interview and child interview. There is no indication of the amount of time Licensee 2 spent evaluating Patient 7. However, Licensee 2's documentation of Patient 7's assessment is so sparse that it is hard to imagine that it is the result of several hours of evaluation. In fact, there is no evidence of any personal evaluation of Patient 7 as Licensee 2's records consist basically of two apparently computer generated checklists based on DSM criteria, unsupported by any personal information, and an MI Statement apparently generated by Licensee #1 at an unknown date that also does not indicate who performed the interview.

ii. Licensee 2 does not document a review of Patient 7's psychiatric, medical or developmental history, prior psychiatric treatment symptoms, family history, family relationships, physical or sexual abuse, substance abuse or other possible causes of distress. A psychiatric diagnosis cannot reasonably be arrived at without a review of this information.

iii. Licensee 2 does not document any discussion of behavioral or functional impact of the purported mood disorder. There is no documentation of any discussion of frequency, intensity, duration and circumstances of any specific symptoms or behaviors associated with Major Depressive Disorder. A computerized GAF score of 15, with no narrative, examples of impaired functioning, or other indication of the data upon which this score is based, is not an adequate assessment of the functional impact of psychiatric symptoms.

iv. Licensee 2 did not document conducting a mental status examination, which consists of observing and assessing

1. Physical appearance
2. Manner of relating to examiner and parent
3. Affect and mood
4. Motor behavior
5. Content and form of thought
6. Speech and language
7. Overall intelligence
8. Attention
9. Memory
10. Neurological functioning;
11. and most significantly, judgment and insight

v. Licensee 2 does not present evidence of performing a differential diagnosis. Licensee 2 could not perform an adequate differential diagnosis without obtaining the history, medical, social, and psychiatric information outlined in i, ii, iii, and iv above. A computer generated DTREE Positive Dx Report, unsupported by the necessary and relevant information, does not constitute a differential diagnosis.

vi. Licensee 2 implies the diagnosis of Major Depressive Disorder is due solely to the unwanted pregnancy with no evidence of consideration of any pre-existing or other possible source of distress. Undoubtedly, Patient 7 was distressed over her unwanted pregnancy. There is no evidence of consideration that the distress of an unwanted pregnancy is not actual psychiatric pathology, and there is no evidence supporting the conclusion that this distress actually represents psychiatric pathology warranting a DSM-IV diagnosis.

vii. Licensee 2 does not present evidence of considering treatment options other than referring Patient 7 to Licensee 1 for a termination. Other treatment options, including various forms of psychotherapy and medication, are available and have been demonstrated to be effective for mood disorders. In contrast, an abortion is not considered a psychiatric treatment for Major Depressive Disorder or for any psychiatric diagnosis.

viii. Given Patient 7's age, Licensee 2's records contain no evidence that Licensee 2 considered obtaining a psychiatric consultation from a child and adolescent specialist, whether a social worker, psychologist, or psychiatrist. The circumstances involving the irreversible intervention of a late term termination in a 15 year old suggest that at the least, a consultation with a specialist should be obtained to ensure that no psychological harm would result from the late term termination.

ix. In referring Patient 7 to Licensee 1, Licensee 2 fails to specify what, if any, are the substantial and irreversible impairments Patient 7 would suffer, and which major mental function would be affected. The failure to communicate to a colleague the nature of the severe medical problem presents an obstacle to adequate ongoing medical care.

x. Licensee 2 makes no mention of discussion of, arrangements for, or provision of aftercare for Patient 7's diagnosis of Major Depressive Disorder. As a physician providing an assessment and referral for consultation and treatment, it is Licensee 2's professional obligation to make certain that Patient 7 obtains appropriate treatment subsequent to the termination, which, as stated above, is not a psychiatric treatment for any psychiatric disorder.

This is all the more essential, if, as Licensee 2 states, Patient 7's disorder presents substantial and irreversible risk of impairment. If Patient 7's Major Depressive Disorder was due in fact to another cause, then no treatment plan was in place to address this. If the treatment of a termination was not successful in alleviating Patient 7's Major Depressive Disorder (and Licensee 2's records do not indicate whether this treatment was or was not successful), what other arrangements or plans did Licensee 2 have for Patient 7's severe psychiatric problem?

xi. Licensee 2 did not describe any circumstances that might justify the deviation from the accepted standard psychiatric evaluation of adolescents. Licensee 2 did not describe any circumstances that might justify the unorthodox treatment plan of treating Major Depressive Disorder with an abortion, but without any psychiatric intervention or psychiatric follow up care.

3. If your opinion is that Licensee 2 did not adhere to the applicable standard of care, describe how, and to what degree (ordinary or gross negligence), the physicians' care deviated from the acceptable standards.

The determination of whether Licensee 2's deviations from the standard of care amount to ordinary or gross negligence is not properly a medical opinion. I can only state

a. there is no evidence that Licensee 2 conducted anything even approximating an appropriate or adequate psychiatric evaluation or mental status examination that could reasonably lead to the conclusion that Patient 7 had a diagnosis of Major Depressive Disorder;
b. there is no evidence that Licensee 2 made a diagnosis based on a personal evaluation of Patient 7
c. there is no evidence that Licensee 2 considered an appropriate treatment plan for a diagnosis of Major Depressive Disorder;

d. there is no evidence that Licensee 2 made any arrangements or assured that such arrangements were made for appropriate psychiatric follow up care of Patient 7's purported Major Depressive Disorder, given that termination of a pregnancy, even an unwanted pregnancy, is not a treatment or cure for this disorder.

4. List any texts, medical literature or other resources relied upon (if applicable):

a. Diagnostic and Statistical Manual IV-TR, American Psychiatric Association, 2000
b. Practice parameters for the Psychiatric Assessment of Children and Adolescents, Journal of the American Academy of Child and Adolescent Psychiatry 36(10 Supplement):4S-20S, 1997
c. Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorders, Journal of the American Academy of Child and Adolescent Psychiatry, 46(11) 1503-1526, 2007
d. Cohen LS, Nonacs RM, eds: Mood and Anxiety Disorders during Pregnancy and Postpartum. American Psychiatric Publishing Inc., 2005
e. Yonkers K, Little B: Management of Psychiatric Disorders in Pregnancy. Arnold, 2001

5. **Did Licensee 2 maintain an adequate medical record for this patient?**

No.

If not, please describe the basis for your opinion:

As per Article 24: Patient Records, Adequacy; minimal requirements, Licensee's 2's records are deficient in the following:

a. They do not contain pertinent and significant information concerning the patient's psychiatric condition;
b. They do not reflect what psychiatric or medical examinations, vital signs and tests were obtained, performed, or ordered and the findings and results of each;
c. They do not indicate the initial psychiatric diagnosis and the patient's psychiatric reasons for seeking the licensee's services
d. They do not reflect the recommended psychiatric treatment or discussion of psychiatric treatment options
e. They do not contain any record of discussion of appropriate aftercare of a psychiatric disorder or arrangements for such
f. They do not indicate if and when a personal evaluation was conducted and whether diagnoses were made before or after a personal evaluation if indeed one was conducted.

Virginia Rold, MD

Liza H. Gold, MD

Clinical Professor of Psychiatry
Georgetown University Medical Center

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Added Qualifications in Forensic Psychiatry

Kathleen Selzler-Lippert, Litigation Counsel
Kansas State Board of Healing Arts
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RE: Expert review of medical records for Investigative Case Nos. 07-00158 & 07-00322

Report of Consultant Review

Physician: Licensee 2

Patient: #8

Dates of Treatment: 11/4/03

Date(s) of Consultant Review: 7/20/09 – 7/27/09

Records Reviewed

Records reviewed included, but were not limited to:

Kathleen Selzler-Lippert, Letter of referral, 6/19/09
Definition of Standard of Care
K.S.A. 65-6703, 65-6704, 65-6705, 65-6709, 65-6711, 65-6721
K.A.R. 100-24-1 Documentation Regulation
Sample Report

Medical Records

1. Investigative Case No. 07-00158
Patient #8's medical records from Licensee #2 (5 pages)

2. Investigative Case No. 07-00322
Patient #8's medical records from Licensee #1 (48 pages)

Statutes, Kansas Legislature: 65-6703

Termination is prohibited when fetus is viable, except if the physician who performs the termination has a documented referral from another physician not legally or financially affiliated with the physician performing or inducing the termination and both physicians determine that

1. the termination is necessary to preserve the life of the pregnant woman; or
2. a continuation of the pregnancy will cause a substantial and irreversible impairment of a major bodily function of the pregnant woman.

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Standard of Care: Within a reasonable degree of medical certainty did the practitioner meet the applicable standard of care?

- Ordinary negligence: Did the practitioner fail to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent practitioner as being acceptable under similar conditions and circumstances.

- Gross negligence: Did the practitioner fail to practice within the applicable standard of care and with reckless disregard or complete indifference to the probable consequences

A physician who holds himself out to be a specialist in a particular field of medicine has a duty to practice in a manner consistent with the special degree of skill and knowledge ordinarily possessed by other specialists in the same field of expertise at the time of the diagnosis/treatment.

Summary of Events

Patient 8 is a 13 year old girl from Englewood, NJ, who became pregnant at age 12 after consensual sex with a 15 year old. On the basis of a referral from Licensee #2 and Licensee #1's evaluation, Patient 8 underwent a late term abortion at 25 weeks from 11/4/03-11/5/03.

Review of Licensee 2's Records

1. Bates #00001: Intake form - indicates an appointment date of 11/4/03 and time of 8:30 AM. A brief medical and psychiatric history checklist, on a yes/no answer basis, indicates no history of medical illness or depression, alcohol use, or other psychiatric illness. The only positive response noted is "drug allergy." The document notes that the patient is "allergic to any artificial sweetener."

2. Bates #00004-00005: MI Indicators: This handwritten document is dated "11/4."It is unsigned and marked by hand as a copy. The presumable original of this document is found in Licensee 1's records (Bates # 00013-00014). Licensee #1's document is identical to the document in Licensee 2's records but is not marked "COPY." This is a strong indication that Licensee's 2 document was generated by someone in Licensee #1's office and provided to Licensee #2, rather than generated personally by Licensee #2. This document does not indicate who performed the interview or prepared the document. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document.

Patient 8 states "I don not think I will make it through. I don't I will live through it [sic]. I don't know why I think that but I think that either it or I will die. ... I think I would die or I would kill myself. If that did not happen, I would neglect the child or beat it senseless." Later she states, "I've been very depressed."

A "SIGECAPS" was performed. This is a checklist of significant symptoms of depression. Patient 7 reported problems with interest, guilt, energy, appetite, and decreased activity. The specific examples given indicate that these symptoms are related to the stress and distress associated with an unwanted pregnancy rather than a primary psychiatric diagnosis. She denied problems with sleep.

Patient 8, in responding to questions about suicide, stated, "I did think that. I thought at first slitting my wrists, then it went to falling downstairs." There is no indication that she took any action to harm herself.

Other psychosocial factors, such as drug and alcohol use, or a history of multiple partners, incest, or running away, are marked "N" for no.

3. Licensee #1's records include a letter (Bates #00002) from Licensee #2 to Licensee #1, dated 11/4/03, which states, in its entirety,

> "RE: Licensee 2 [sic]
> DOB: 2/3/90
>
> Dear Licensee #1
>
> I am referring the above named patient to your organization for consultation regarding her unwanted pregnancy. The patient would suffer substantial and irreversible impairment of a major physical or mental function if she were forced to continue the pregnancy.
>
> Sincerely,
>
> Licensee 2"

This letter is not included in Licensee #2's records. The termination was begun on the same date, 11/4/03.

Opinions

These opinions are based upon a review of records only. These opinions are given within a reasonable degree of medical certainty. These opinions are subject to change pending the receipt and review of additional information.

1. **In your professional opinion, within a reasonable degree of medical certainty, did Licensee 2's care and treatment of this patient adhere to the applicable standard of care?**

   No.

2. Explanation of opinion.

Licensee 2, a general practitioner, undertook a psychiatric assessment of Patient 8, a 13 year old girl in a distressing psychosocial situation, specifically, an unwanted pregnancy. Licensee 2 made no formal psychiatric diagnosis. However, the "MI Indicators document" implies that the basis of the "substantial and irreversible impairment" Patient 8 would suffer was a mental function, as there is no mention at all of any physical illnesses or complications. On the basis of this assessment (which is likely not based on a personal evaluation by Licensee 2), Licensee 2 referred Patient 8, not to a mental health professional for a second opinion or assessment, but rather to Licensee 1, an Ob-Gyn, for a termination. This termination was undertaken on the same day as the date of Licensee #2's referral letter and initial appointment with Patient 8.

If a general practitioner felt the need to make a referral for evaluation and/or treatment for a patient with a presumptive psychiatric disturbance, particularly a 13 year old pregnant girl with a possible new onset psychiatric problems, (there is no indication Patient 1 had any pre-existing psychiatric disorder), medical practice dictates that such a referral would be made to a mental health professional. Such professionals could be a child psychiatrist, psychologist, or social worker, with expertise in the evaluation and treatment of the presumed disorder in children.

There is no evidence of that Licensee #2 undertook a standard child psychiatric evaluation. There is no evidence of a standard psychiatric evaluation of any kind other than a brief evaluation of Patient 8's feelings regarding her pregnancy, the options of adoption and abortion, and a SIGECAPS review. A SIGECAPS screening is a tool to assess whether someone with more than a few positive indicators should be evaluated further for the presence of clinical depression. A SIGECAPS screening is not of itself a standard psychiatric evaluation method for making a formal assessment of the presence of depression. Although this formal diagnosis was not made, it seems implied as the basis for the referral to Licensee 1 for a termination. Again, it seems unlikely from a review of the records that Licensee #2 generated this document.

There is no evaluation of any previous counseling or interventions, nor any consideration of whether counseling, medications or other interventions were appropriate at the time of the evaluation or in the future. Treatment options were not discussed. Termination is not a treatment for any psychiatric disorder. Moreover, the psychological ramifications of a late term termination in a 13 year old were not discussed or considered, nor was she referred to a qualified specialist to discuss or evaluate this issue.

Licensee 2's referral to Licensee 1 was specifically for a termination, stating that Patient 8 would suffer "substantial and irreversible impairment of a physical or mental function if she were forced to continue the pregnancy." The specific nature of the substantial and irreversible impairment is not specified, but as noted above, presumably, the substantial and irreversible impairment was psychiatric, since no mention of any physical illness or medical complications are noted.

In undertaking what appears to be a psychiatric evaluation and referring Patient 8 for a termination as a treatment for psychiatric symptoms, Licensee 2 has held him- or her-self out as a practitioner who can provide the same level of psychiatric assessment and treatment as a child and adolescent psychiatrist. The "Practice Parameters for the Psychiatric Assessment of Children and Adolescents" published by the American Academy of Child and Adolescent Psychiatry in 1997 clearly establishes a guide for clinicians evaluating psychiatric disorders in children and adolescents. The assessment process is intended to assist the clinician in arriving at accurate diagnoses and appropriate treatment for children and adolescents presenting with psychiatric disorders that impair emotional, cognitive, physical or behavioral functioning.

Although these parameters are not rigid guidelines, nor do they of themselves establish a legal standard of care, they represent an expert consensus of what constitutes appropriate psychiatric evaluation of children and adolescents and are officially endorsed by the American Academy of Child and Adolescent Psychiatry and the level of care required for the diagnosis of a psychiatric disorder in a child or adolescent. Any deviation from these guidelines should be explicitly justified by clinical or other circumstances.

The purpose of a diagnostic assessment of a child or adolescent is

A. to determine whether psychopathology is present, and, if so, to establish a differential diagnosis;
B. to determine whether treatment is indicated; and
C. if so, to develop treatment recommendations and plans

Licensee 2's evaluation and treatment recommendations of Patient 8 were deficient in the following ways:

i. The clinical assessment of a child or adolescent requires several hours, including time for parent interview and child interview. There is no indication of the amount of time Licensee 2 spent evaluating Patient 8. However, Licensee 2's documentation of Patient 8's assessment is so sparse that it is hard to imagine that it is the result of several hours of evaluation. In fact, there is no evidence of any personal evaluation of Patient 8 as Licensee 2's records consist only of a copy of a document "MI Indicators" which appears to have been generated by Licensee 1's office on the date the termination was undertaken.

ii. Licensee 2 does not document a review of Patient 8's psychiatric, medical or developmental history, prior psychiatric treatment symptoms, family history, family relationships, physical or sexual abuse, or other possible causes of distress.

iii. Licensee 2 does not document any discussion of behavioral or functional impact of the supposed psychiatric symptoms. There is no documentation of any discussion of frequency, intensity, duration and circumstances of any specific symptoms or behaviors.

iv. Licensee 2 did not document conducting a mental status examination, observing and assessing

1. Physical appearance
2. Manner of relating to examiner and parent
3. Affect and mood
4. Motor behavior
5. Content and form of thought
6. Speech and language
7. Overall intelligence
8. Attention
9. Memory
10. Neurological functioning;
11. and most significantly, judgment and insight

v. Licensee 2 does not present evidence of arriving at a working diagnosis or performing a differential diagnosis. Licensee 2 could not perform an adequate differential diagnosis without obtaining the history, medical, social, and psychiatric information outlined in i, ii, iii, and iv above.

vi. Undoubtedly, Patient 9 was distressed over her unwanted pregnancy. There is no evidence that Licensee 2 considered the possible that this distress represented appropriate emotional reactions to a complicated and difficult set of circumstances rather than psychiatric symptoms.

vii. Licensee 2 does not present evidence of considering treatment options for Patient 8's undiagnosed psychiatric symptoms other than referring Patient 8 to Licensee 1 for a termination. Other treatment options, including various forms of psychotherapy and medication, are available and have been demonstrated to be effective for mood and anxiety disorders, including depression. In contrast, a termination is not considered a psychiatric treatment for any psychiatric diagnosis.

viii. Given Patient 8's age, Licensee 2's records contain no evidence that Licensee 2 considered obtaining a psychiatric consultation from a child mental health specialist, whether a social worker, psychologist, or psychiatrist. The circumstances involving late term termination in a 13 year old who exhibits limited understanding of her condition ("I don't think the baby is fully developed, so if I terminate it, there will be no problems for it and myself," Bates #00004) suggest that at the least, a consultation with a specialist should be obtained to evaluate the patient's mental status, her level of understanding of the surgical procedure, and the risk of an adverse response to any treatment option including termination.

ix. In referring Patient 8 to Licensee 1, Licensee 2 fails to specify what, if any, are the substantial and irreversible impairments Patient 8 would

suffer, and which major mental function would be affected. The failure to communicate to a colleague the nature of the severe medical problem presents an obstacle to adequate ongoing medical care.

x. Licensee 2 makes no mention of discussion of, arrangements for or provision of psychiatric aftercare for Patient 8. As a physician providing a mental health assessment and referral for consultation and treatment, it is Licensee 2's professional obligation to make certain that Patient 8 obtains appropriate treatment for her purported psychiatric symptoms subsequent to the termination, which, as stated above, is not a psychiatric treatment for any psychiatric disorder.

This is all the more essential, if, as Licensee 2 states, Patient 8's disorder presents substantial and irreversible risk of impairment. If the treatment of termination was not successful in alleviating Patient 8's psychiatric symptoms (and Licensee 2's records do not indicate whether this treatment was or was not successful), what other arrangements or plans did Licensee 2 have for Patient 8's psychiatric symptoms?

xi. Licensee 2 did not describe any circumstances that might justify the deviation from accepted standard psychiatric evaluation of children. Licensee 2 did not describe any circumstances that might justify the unorthodox treatment plan of treating undiagnosed psychiatric symptoms with a termination, but without any psychiatric intervention or psychiatric follow up care.

3. If your opinion is that Licensee 2 did not adhere to the applicable standard of care, describe how, and to what degree (ordinary or gross negligence), the physicians' care deviated from the acceptable standards.

The determination of whether Licensee 2's deviations from the standard of care amount to ordinary or gross negligence is not properly a medical opinion. I can only state

a. there is no evidence that Licensee 2 conducted anything even approximating an appropriate or adequate psychiatric evaluation or mental status examination
b. there is no evidence that Licensee 2 conducted a personal evaluation of Patient 2;
c. there is no evidence that Licensee 2 considered an appropriate treatment plan for Patient 8's undiagnosed psychiatric symptoms
d. there is no evidence that Licensee 2 made any arrangements or assured that such arrangements were made for follow up care of Patient 8's purported psychiatric symptoms, given that pregnancy termination is not a treatment or cure for this a disorder.

4. **List any texts, medical literature or other resources relied upon (if applicable):**

a. Diagnostic and Statistical Manual IV-TR, American Psychiatric Association, 2000
b. Practice parameters for the Psychiatric Assessment of Children and Adolescents, Journal of the American Academy of Child and Adolescent Psychiatry 36(10 Supplement):4S-20S, 1997
c. Practice Parameter for the Assessment and Treatment of Children and Adolescents with Anxiety Disorders, Journal of the American Academy of Child and Adolescent Psychiatry, 46(2) 267-283, 2007
d. Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorders, Journal of the American Academy of Child and Adolescent Psychiatry, 46(11) 1503-1526, 2007
e. Cohen LS, Nonacs RM, eds: Mood and Anxiety Disorders during Pregnancy and Postpartum. American Psychiatric Publishing Inc., 2005
f. Yonkers K, Little B: Management of Psychiatric Disorders in Pregnancy. Arnold, 2001

5. **Did Licensee 2 maintain an adequate medical record for this patient?**

No.

If not, please describe the basis for your opinion:

As per Article 24: Patient Records, Adequacy; minimal requirements, Licensee's 2's records are deficient in the following:

a. They do not contain pertinent and significant information concerning the patient's psychiatric condition;
b. They do not reflect what psychiatric or medical examinations, vital signs and tests were obtained, performed, or ordered and the findings and results of each;
c. They do not indicate the initial psychiatric diagnosis and the patient's psychiatric reasons for seeking the licensee's services;
d. They do not reflect the recommended psychiatric treatment or discussion of psychiatric treatment options;
e. They do not contain any record of discussion of appropriate aftercare of a psychiatric disorder or arrangements for such.
f. They do not indicate if and when a personal evaluation was conducted and whether diagnoses were made before or after a personal evaluation if indeed one was conducted.
g. They do not indicate whether the presence of psychiatric symptoms, which was the implied basis for the termination, were made before or after the termination was undertaken by Licensee #1.

Liza H. Gold, MD

Clinical Professor of Psychiatry
Georgetown University Medical Center

Certified, Board of Psychiatry and Neurology
Added Qualifications in Forensic Psychiatry

Kathleen Selzler-Lippert, Litigation Counsel
Kansas State Board of Healing Arts
235 SW Topeka Blvd.
Topeka, KS 66603

RE: Expert review of medical records for Investigative Case Nos. 07-00158 & 07-00322

Report of Consultant Review

Physician: Licensee 2

Patient: #9

Dates of Treatment: 11/4/03

Date(s) of Consultant Review: 7/20/09 – 7/27/09

Records Reviewed

Records reviewed included, but were not limited to:

Kathleen Selzler-Lippert, Letter of referral, 6/19/09
Definition of Standard of Care
K.S.A. 65-6703, 65-6704, 65-6705, 65-6709, 65-6711, 65-6721
K.A.R. 100-24-1 Documentation Regulation
Sample Report

Medical Records

1. Investigative Case No. 07-00158
Patient #9's medical records from Licensee #2 (10 pages)

2. Investigative Case No. 07-00322
Patient #9's medical records from Licensee #1 (52 pages)

Statutes, Kansas Legislature: 65-6703

Abortion is prohibited when fetus is viable, except if the physician who performs the abortion has a documented referral from another physician not legally or financially affiliated with the physician performing or inducing the abortion and both physicians determine that

1. the abortion is necessary to preserve the life of the pregnant woman; or
2. a continuation of the pregnancy will cause a substantial and irreversible impairment of a major bodily function of the pregnant woman.

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Standard of Care: Within a reasonable degree of medical certainty did the practitioner meet the applicable standard of care?

- Ordinary negligence: Did the practitioner fail to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent practitioner as being acceptable under similar conditions and circumstances.

- Gross negligence: Did the practitioner fail to practice within the applicable standard of care and with reckless disregard or complete indifference to the probable consequences

A physician who holds himself out to be a specialist in a particular field of medicine has a duty to practice in a manner consistent with the special degree of skill and knowledge ordinarily possessed by other specialists in the same field of expertise at the time of the diagnosis/treatment.

Summary of Events

Licensee #1's records indicate Patient 9 is a 15 year old single female from Illinois. She became pregnant by consensual intercourse. On the basis of a referral from Licensee #2 and Licensee #1's evaluation, Patient 9 underwent a late-term abortion at 25 weeks and 5 days from 11/5/03 – 11/7/03.

Review of Licensee 2's Records

1. Bates #00001 - Intake Form: indicates an appointment date of 11/4/03 and time of 8:30 AM. A brief medical and psychiatric history checklist indicates no history of depression, alcohol or other substance abuse, or any other medical or psychiatric illness, as marked by an "n" after each, indicating "no."

2. Bates #00002-00003: "MI INDICATORS Patient #9" - This is an undated and unsigned typed interview with Patient 9. Parts of this document are found in an original handwritten version in Licensee 1's records (Bates #00011). Presumably, the typed document in Licensee 2's records was prepared from these handwritten notes. This is a strong indication that Licensee's 2 document was generated by someone in Licensee #1's office, typed and then provided to Licensee #2, rather than generated personally by Licensee #2.

This document does not indicate who performed the interview or prepared the document. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document. What appears to be a handwritten notation "Ok Ch" is found on the lower right hand side of the document.

Patient 9 states that she could not carry the pregnancy to term because, I won't be able to support it. It won't have a father. Because the MIP [biological father] is denying everything. ... I don't have a choice but to have [an abortion]." Patient 9 states she does not want to have an abortion but "probably couldn't" go through with an adoption.

A "SIGECAPS" was performed. This is a checklist of significant symptoms of depression. Patient 9 reported problems with sleep, interest, guilt, energy, concentration, and appetite. The specific examples given indicate that these symptoms are related to the stress and distress associated with an unwanted pregnancy rather than a primary psychiatric diagnosis. She denied problems thoughts of suicide.

Other psychosocial factors, such as drug and alcohol use, or a history of multiple partners, incest, or running away, are listed on this document but not marked with an answer.

3. Bates #00006: MI INDICATORS, Patient 9 - This handwritten, unsigned form, dated 11/4/03, is marked "COPY." An identical document, not marked "COPY" is found in Licensee #1's records for Patient 9 (Bates 00010). Presumably, the document in Licensee 1's records is the original document.

Patient 9 indicates in this interview if she couldn't get an abortion, "I just wouldn't be the same – my dreams, school, college, wouldn't happen... That makes me mad and sad."

A "SIGECAPS" was performed. This is a checklist of significant symptoms of depression. Patient 9 reported problems with sleep, interest, guilt, energy, concentration, appetite, and decreased psychomotor activity. The specific examples given indicate that these symptoms are related to the stress and distress associated with an unwanted pregnancy rather than a primary psychiatric diagnosis.

Patient 9 denied thoughts of suicide. On inquiry regarding suicide, the documents reports that Patient 9 stated, "I just feel if I weren't here I wouldn't hurt my mom as much. I've thought about running away, but wherever I went, someone would find me."

4. Bates #00007-00008: DTREE Positive Dx Report: Patient 9 is given a diagnosis of Major Depressive Disorder, Single Episode, Severe Without Psychotic Features (296.23) in an unsigned document indicating a "Rating" and "Report" date of 11/5/03, the day after her appointment with Licensee #2 and the day before her termination was begun. This document is a computer generated list of the diagnostic criteria for this diagnosis.. No evidence supporting the diagnostic criteria is provided. The document is unsigned.

A duplicate of this document is present in Licensee #1's records (Bates #00027-00028), however Licensee #1's document has an apparent fax date of "Nov-10-03 11:33A" at the top. This fax date is 6 days after Patient 9's appointment with Licensee #2, and approximately 4 days after the termination was completed. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document.

5. Bates #00009-00010: GAF REPORT: Patient 9 was assigned a GAF (Global Assessment of Functioning) score of 35: "The patient has had major impairment in several such as judgment, thinking or mood [sic]. The patient has presented with major impairment in areas such as work or school, family relations, judgment, thinking, or mood. This document indicates a "Rating" and "Report" date of 11/5/09, one day after Patient 9's indicated appointment with Licensee #2 and one day before the termination was undertaken. The time period for which the GAF rating is assigned is the past week.

This document is a computer generated rating list. No evidence supporting this rating is provided. The document does not provide any specific examples or indicate any personal evaluation supporting the rating. The document is unsigned.

A duplicate of this document is present in Licensee #1's records (Bates #00025-00026), however Licensee #1's document has an apparent fax date of "Nov-10-03 11:33A" at the top. This fax date is 6 days after Patient 9's appointment with Licensee #2, and approximately 4 days after the termination was completed. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document.

6. Licensee #1's records include a letter (Bates #00017) from Licensee #2 to Licensee #1, dated November 4, 2003, which states, in its entirety,

> "RE: Patient #9
> DOB: 8/8/88
>
> Dear Licensee #1
>
> I am referring the above named patient to you [sic] organization for consultation regarding her unwanted pregnancy. The patient would suffer substantial and irreversible impairment of a major physical or mental function if she were forced to continue the pregnancy.
>
> Sincerely,
>
> Licensee 2"

This letter is not included in Licensee #2's records.

Opinions

These opinions are based upon a review of records only. These opinions are given within a reasonable degree of medical certainty. These opinions are subject to change pending the receipt and review of additional information.

1. **In your professional opinion, within a reasonable degree of medical certainty, did Licensee 2's care and treatment of this patient adhere to the applicable standard of care?** No.

2. **Explanation of opinion.**

Licensee 2, a general practitioner, undertook a psychiatric assessment of a 15 year old girl in a distressing psychosocial situation, specifically, an unwanted pregnancy. On the basis of this assessment, Licensee 2 referred Patient 9, not to a mental health professional for a second opinion for a presumptive psychiatric disorder, but rather to an Ob-Gyn. If a general practitioner felt the need to make a referral for evaluation and/or treatment for a patient with a presumptive psychiatric diagnosis, particularly an adolescent with a new onset psychiatric diagnosis, as there is no indication Patient 9 had any pre-existing psychiatric disorder, medical practice dictates that such a referral would be made to a mental health professional. Such professionals could be a child and adolescent psychiatrist, psychologist, or social worker, with expertise in the evaluation and treatment of the presumed disorder in adolescents.

There is no evidence of a standard child and adolescent psychiatric evaluation or review of any records in the assignment of the psychiatric diagnosis other than

1. a review of a checklist. There are no specific examples or indications reflecting a personal interview or review of records that would support the presence of a new-onset diagnosis of Major Depressive Disorder in a 15 year old;
2. two MI Indicator documents which included a "SIGECAPS" screening. A SIGECAPS screening is a tool to assess whether someone with more than a few positive indicators should be evaluated further for the presence of clinical depression. A SIGECAPS screening is not of itself a standard psychiatric evaluation method for making a diagnosis of a new onset Major Depressive Disorder.

Licensee 2's referral to Licensee 1 was specifically for obtaining a termination for this 15 year old girl based presumably on the psychiatric diagnosis of Major Depressive Disorder. Abortion is not a treatment for any psychiatric disorder. Many women suffer from exacerbations of pre-existing psychiatric disorders and new onset psychiatric disorders during pregnancy. Multiple effective treatments including psychotherapy and medication are available. There is no evaluation of any previous counseling or interventions, nor any consideration of whether counseling, medications or other interventions were appropriate at the time of the evaluation or in the future. Treatment options were not discussed. Moreover, the psychological ramifications of a late term termination in an adolescent were not discussed or considered, nor was she referred to a qualified specialist to discuss or evaluate this issue.

Licensee 2's referral to Licensee 1 for obtaining a termination for this 15 year old girl stated that Patient 9 would suffer "substantial and irreversible impairment of a physical or mental function if she were forced to continue the pregnancy." The specific nature of the substantial and irreversible impairment is not specified, but since the only diagnosis offered is a psychiatric diagnosis, presumably, the substantial and irreversible impairment was psychiatric. Licensee 2's records give no indication either of the existence of a psychiatric symptom that might result in a substantial and irreversible impairment, nor do they speculate what such an impairment might be. In fact, the SIGECAPS review indicated that Patient 9 reported she was not actively suicidal, the only life threatening emergency that might meet the criteria of a "substantial and irreversible impairment" due to depression.

In making a diagnosis of Major Depressive Disorder and referring Patient 9 for an abortion as a treatment for this disorder, Licensee 2 has held him- or her-self out as a practitioner who can provide the same level of psychiatric assessment and treatment as a child and adolescent psychiatrist. The "Practice Parameters for the Psychiatric Assessment of Children and Adolescents" published by the American Academy of Child and Adolescent Psychiatry in 1997 clearly establishes a guide for clinicians evaluating psychiatric disorders in children and adolescents. The assessment process is intended to assist the clinician in arriving at accurate diagnoses and appropriate treatment for children and adolescents presenting with psychiatric disorders that impair emotional, cognitive, physical, or behavioral functioning.

These parameters are not rigid guidelines, nor do they of themselves establish a legal standard of care. Nevertheless, these guidelines represent an expert consensus of what constitutes appropriate psychiatric evaluation of children and adolescents and are officially endorsed by the American Academy of Child and Adolescent Psychiatry and the level of care required for the diagnosis of a psychiatric disorder in a child or adolescent. Any deviation from these guidelines should be justified by clinical or other circumstances.

The purpose of a diagnostic assessment of a child or adolescent is

A. to determine whether psychopathology is present, and, if so, to establish a differential diagnosis;
B. to determine whether treatment is indicated; and
C. if so, to develop treatment recommendations and plans

Licensee 2's evaluation and treatment recommendations of Patient 9 were deficient in the following ways:

i. The clinical assessment of a child or adolescent requires several hours, including time for parent interview and child interview. There is no indication of the amount of time Licensee 2 spent evaluating Patient 9. However, Licensee 2's documentation of Patient 9's assessment is so sparse that it is hard to imagine that it is the result of several hours of

evaluation. In fact, there is no evidence of any personal evaluation of Patient 9 as Licensee 2's records consist basically of two apparently computer generated checklists based on DSM criteria dated the day after her appointment with Licensee 2 and unsupported by any personal information, and two MI Statements apparently generated by Licensee #1 that also do not indicate who performed the interview.

ii. Licensee 2 does not document a review of Patient 9's psychiatric, medical or developmental history, prior psychiatric treatment symptoms, family history, family relationships, physical or sexual abuse, substance abuse or other possible causes of distress. A psychiatric diagnosis cannot reasonably be arrived at without a review of this information.

iii. Licensee 2 does not document any discussion of behavioral or functional impact of the purported mood disorder. There is no documentation of any discussion of frequency, intensity, duration and circumstances of any specific symptoms or behaviors associated with Major Depressive Disorder. A computerized GAF score of 35, with no narrative, examples of impaired functioning, or other indication of the data upon which this score is based, is not an adequate assessment of the functional impact of psychiatric symptoms.

iv. Licensee 2 did not document conducting a mental status examination, which consists of observing and assessing

1. Physical appearance
2. Manner of relating to examiner and parent
3. Affect and mood
4. Motor behavior
5. Content and form of thought
6. Speech and language
7. Overall intelligence
8. Attention
9. Memory
10. Neurological functioning;
11. and most significantly, judgment and insight

v. Licensee 2 does not present evidence of performing a differential diagnosis. Licensee 2 could not perform an adequate differential diagnosis without obtaining the history, medical, social, and psychiatric information outlined in i, ii, iii, and iv above. A computer generated DTREE Positive Dx Report, unsupported by the necessary and relevant information, does not constitute a differential diagnosis.

vi. Licensee 2 implies the diagnosis of Major Depressive Disorder is due solely to the unwanted pregnancy with no evidence of consideration of

any pre-existing or other possible source of distress. Undoubtedly, Patient 9 was distressed over her unwanted pregnancy. There is no evidence of consideration that the distress of an unwanted pregnancy is not actual psychiatric pathology, and there is no evidence supporting the conclusion that this distress actually represents psychiatric pathology warranting a DSM-IV diagnosis.

vii. Licensee 2 does not present evidence of considering treatment options other than referring Patient 9 to Licensee 1 for a termination. Other treatment options, including various forms of psychotherapy and medication, are available and have been demonstrated to be effective for mood disorders. In contrast, an abortion is not considered a psychiatric treatment for Major Depressive Disorder or for any psychiatric diagnosis.

viii. Given Patient 9's age, Licensee 2's records contain no evidence that Licensee 2 considered obtaining a psychiatric consultation from a child and adolescent specialist, whether a social worker, psychologist, or psychiatrist. The circumstances involving the irreversible intervention of a late term termination in a 15 year old suggest that at the least, a consultation with a specialist should be obtained to ensure that no psychological harm would result from the late term termination.

ix. In referring Patient 9 to Licensee 1, Licensee 2 fails to specify what, if any, are the substantial and irreversible impairments Patient 9 would suffer, and which major mental function would be affected. The failure to communicate to a colleague the nature of the severe medical problem presents an obstacle to adequate ongoing medical care.

x. Licensee 2 makes no mention of discussion of, arrangements for, or provision of aftercare for Patient 9's diagnosis of Major Depressive Disorder. As a physician providing an assessment and referral for consultation and treatment, it is Licensee 2's professional obligation to make certain that Patient 9 obtains appropriate treatment subsequent to the termination, which, as stated above, is not a psychiatric treatment for any psychiatric disorder.

This is all the more essential, if, as Licensee 2 states, Patient 9's disorder presents substantial and irreversible risk of impairment. If Patient 9's Major Depressive Disorder was due in fact to another cause, then no treatment plan was in place to address this. If the treatment of a termination was not successful in alleviating Patient 9's Major Depressive Disorder (and Licensee 2's records do not indicate whether this treatment was or was not successful), what other arrangements or plans did Licensee 2 have for Patient 9's severe psychiatric problem?

xi. Licensee 2 did not describe any circumstances that might justify the deviation from the accepted standard psychiatric evaluation of adolescents. Licensee 2 did not describe any circumstances that might justify the unorthodox treatment plan of treating Major Depressive Disorder with an abortion, but without any psychiatric intervention or psychiatric follow up care.

3. If your opinion is that Licensee 2 did not adhere to the applicable standard of care, describe how, and to what degree (ordinary or gross negligence), the physicians' care deviated from the acceptable standards.

The determination of whether Licensee 2's deviations from the standard of care amount to ordinary or gross negligence is not properly a medical opinion. I can only state

a. there is no evidence that Licensee 2 conducted anything even approximating an appropriate or adequate psychiatric evaluation or mental status examination that could reasonably lead to the conclusion that Patient 9 had a diagnosis of Major Depressive Disorder;
b. there is no evidence that Licensee 2 made a diagnosis based on a personal evaluation of Patient 9
c. there is no evidence that Licensee 2 considered an appropriate treatment plan for a diagnosis of Major Depressive Disorder;
d. there is no evidence that Licensee 2 made any arrangements or assured that such arrangements were made for appropriate psychiatric follow up care of Patient 9's purported Major Depressive Disorder, given that termination of a pregnancy, even an unwanted pregnancy, is not a treatment or cure for this disorder.

4. List any texts, medical literature or other resources relied upon (if applicable):

a. Diagnostic and Statistical Manual IV-TR, American Psychiatric Association, 2000
b. Practice parameters for the Psychiatric Assessment of Children and Adolescents, Journal of the American Academy of Child and Adolescent Psychiatry 36(10 Supplement):4S-20S, 1997
c. Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorders, Journal of the American Academy of Child and Adolescent Psychiatry, 46(11) 1503-1526, 2007
d. Cohen LS, Nonacs RM, eds: Mood and Anxiety Disorders during Pregnancy and Postpartum. American Psychiatric Publishing Inc., 2005
e. Yonkers K, Little B: Management of Psychiatric Disorders in Pregnancy. Arnold, 2001

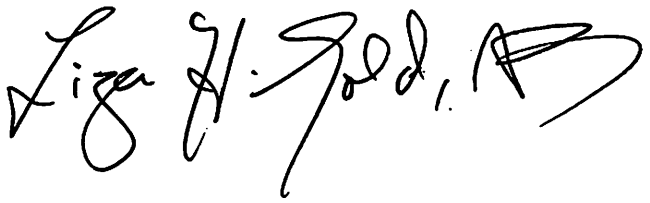
5. **Did Licensee 2 maintain an adequate medical record for this patient?**

No.

If not, please describe the basis for your opinion:

As per Article 24: Patient Records, Adequacy; minimal requirements, Licensee's 2's records are deficient in the following:

a. They do not contain pertinent and significant information concerning the patient's psychiatric condition;
b. They do not reflect what psychiatric or medical examinations, vital signs and tests were obtained, performed, or ordered and the findings and results of each;
c. They do not indicate the initial psychiatric diagnosis and the patient's psychiatric reasons for seeking the licensee's services
d. They do not reflect the recommended psychiatric treatment or discussion of psychiatric treatment options
e. They do not contain any record of discussion of appropriate aftercare of a psychiatric disorder or arrangements for such
f. They do not indicate if and when a personal evaluation was conducted and whether diagnoses were made before or after a personal evaluation if indeed one was conducted.



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Added Qualifications in Forensic Psychiatry

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RE: Expert review of medical records for Investigative Case Nos. 07-00158 & 07-00322

Report of Consultant Review

Physician: Licensee 2

Patient: #10

Dates of Treatment: 11/4/03

Date(s) of Consultant Review: 7/20/09 – 7/27/09

Records Reviewed

Records reviewed included, but were not limited to:

Kathleen Selzler-Lippert, Letter of referral, 6/19/09
Definition of Standard of Care
K.S.A. 65-6703, 65-6704, 65-6705, 65-6709, 65-6711, 65-6721
K.A.R. 100-24-1 Documentation Regulation
Sample Report

Medical Records

1. Investigative Case No. 07-00158
Patient #10's medical records from Licensee #2 (110 pages)

2. Investigative Case No. 07-00322
Patient #10's medical records from Licensee #1 (49 pages)

Statutes, Kansas Legislature: 65-6703

Abortion is prohibited when fetus is viable, except if the physician who performs the abortion has a documented referral from another physician not legally or financially affiliated with the physician performing or inducing the abortion and both physicians determine that

1. the abortion is necessary to preserve the life of the pregnant woman; or
2. a continuation of the pregnancy will cause a substantial and irreversible impairment of a major bodily function of the pregnant woman.

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Standard of Care: Within a reasonable degree of medical certainty did the practitioner meet the applicable standard of care?

- Ordinary negligence: Did the practitioner fail to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent practitioner as being acceptable under similar conditions and circumstances.

- Gross negligence: Did the practitioner fail to practice within the applicable standard of care and with reckless disregard or complete indifference to the probable consequences

A physician who holds himself out to be a specialist in a particular field of medicine has a duty to practice in a manner consistent with the special degree of skill and knowledge ordinarily possessed by other specialists in the same field of expertise at the time of the diagnosis/treatment.

Summary of Events

Licensee #1's records indicate Patient 10 is a 18 year old single female from Kansas who became pregnant as a result of consensual sex with her boyfriend. On the basis of a referral from Licensee #2 and Licensee #1's evaluation, Patient 10 underwent a late-term abortion at 25 weeks and 5 days on 11/5/03 – 11/7/03.

Review of Licensee's 2's Records

1. Bates #00001: Intake form - Indicates an appointment date of 11/4/03 and appointment time of 8:30 AM. A brief review of history on a "yes/no" basis indicates no history of depression, alcohol use, or illnesses other than asthma.

   This document reports, "Paxil: 40 mg 1 x a day: Anxiety attacks. Last anxiety attack was 6 months. Uses inhaler as needed."

2. Bates #00002-00003: "MI Indicators, Patient #10" - This typed document is unsigned and undated. It reviews the patient's pregnancy history, thoughts regarding adoption, and concerns about carrying the pregnancy to term. There is a notation at the lower right hand side of the document that appears to say, "Ok Ch".

   An exact duplicate of this document is found in Licensee #1's records (Bates #00022-00023). There is no way to tell from Licensee 1's or Licensee 2's records which copy is the original copy, who prepared this document, or when it was prepared.

   Patient 10 reports that she found out she was pregnant one week prior to the interview and she was "surprised and very upset.... I don't want to have a kid right now. I don't want to have it not at all. It is a choice between my boyfriend and I and we cannot take care of a kid right now. Because I am going to school

right now and don't have enough money. It is going to affect me emotionally. I am not ready to be a mom. Not at all." In regard to the option of abortion, Patient 10 states, "It is just something I really don't want to do. (teary)"

This document contains a "SIGECAPS" screen. This is a checklist of significant symptoms of depression. Patient 10 reported problems with sleep "since I found out," guilt "for having sex and ending up in this situation," energy, concentration, and appetite. There is no evidence that these symptoms are related to a primary psychiatric diagnosis rather than the stress and distress associated with an unwanted pregnancy. She denied thoughts of suicide.

A brief review of psychosocial and medical problems queried on a Yes/No basis indicates no history of drug or alcohol use, no history of incest or an eating disorder.

3. Bates #00004-00005: "MI Indicators Patient #10, 11/4/03" - This document is marked as a copy. It is a handwritten interview that reviews the patient's pregnancy history, thoughts regarding adoption, and concerns about carrying the pregnancy to term. This document does not indicate who performed the interview or prepared the document, and it is unsigned. An exact duplicate of this document appears in Licensee #1's records (Bates #00013-00014). It is not possible to determine from either Licensee #1's or Licensee #2's records which document is the original copy, who conducted this evaluation, or who prepared the document.

   Patient 10 reports that she has known she was pregnant "2 weeks yesterday. ... I was devastated, upset and scared. [The biological father] reacted the same way I did. ... I am not ready [to carry this pregnancy to term] ... I want to go to school, I have things I need to [?do]. I've never wanted this so young in life.

   When asked what the consequences of not having an abortion would be, Patient 10 states, "I don't know how stable I'd be. I'd be a very upset person all the time, I'd be wanting to hide at home. I wouldn't want to go to school. I have anxiety problems, I'm on Paxil. It'd make things worse."

   This document contains a "SIGECAPS" screen. This is a checklist of significant symptoms of depression. Patient 10 reported problems with sleep "It's no my mind so much it's hard to fall asleep," interest, guilt "I've felt that I've let my family down," energy, concentration "I'm always thinking about this," appetite, and decreased activity. There is no evidence that these symptoms are related to a primary psychiatric diagnosis rather than the stress and distress associated with an unwanted pregnancy. She denied thoughts of suicide or self induced abortion.

   A brief review of psychosocial and medical problems queried on a Yes/No basis indicates no history of drug or alcohol use, no history of incest or an eating disorder.

4. Bates #00008-00009: "DTREE Positive Dx Report: indicates a diagnosis made on 11/13/03, 9 days after the scheduled appointment with Licensee 2 and approximately one week after the termination, of Acute Stress Disorder, Severe (308.3). This unsigned document is a computer generated list of diagnostic criteria. No evidence supporting the diagnostic criteria is provided. The document does not provide any specific examples or indicate any personal evaluation supporting this diagnosis.

   The document includes in its last two lines the computer generated diagnosis of 300.00 Anxiety Disorder NOS (Not otherwise specified), In Partial Remission. No diagnostic criteria are listed, and no evidence supporting this diagnosis is provided.

   A duplicate of this document is found in Licensee #1's records (Bates #00025-00026), however Licensee #1's document has an apparent fax date of "Nov-10-03 11:31A at the top. This fax date is 3 days before the date on the document, 6 days after Patient 10's appointment with Licensee #2, and approximately 3 days after the termination was completed. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document.

5. Bates #00010: "GAF REPORT" - On 11/13/03, Patient 10 was assigned a GAF (Global Assessment of Functioning) score of 25: "The patient has been unable to function in almost all areas (e.gshe [sic] stays in bed all day, or has no job, home, or friends). The time period for which the GAF rating is assigned is the "past week." The date on this document is 9 days after Patient 10's appointment with Licensee 2, and approximately one week after her termination.

   This document is a computer generated rating list. No evidence supporting this rating is provided. The document does not provide any specific examples or indicate any personal evaluation supporting the rating. This document is unsigned.

   A duplicate appears in Licensee 1's records (Bates #00027), except that Licensee 1's copy has what appears to be fax date at the top of "Nov-10-03 11:30 A." This fax date is 3 days before the date on the document, 6 days after Patient 10's appointment with Licensee #2, and approximately 3 days after the termination was completed. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document.

6. Licensee #1's records include a letter (Bates #00019) from Licensee #2 to Licensee #1, dated November 4, 2003, which states, in its entirety,

> "RE: Patient #10
> DOB: 02/02/85
>
> Dear Licensee 1
>
> I am referring the above named patient to your organization for consultation regarding her unwanted pregnancy. The patient would suffer substantial and irreversible impairment of a major physical or mental function if she were forced to continue the pregnancy.
>
> Sincerely,
>
> Licensee 2"

This letter is not included in Licensee #2's records.

Opinions

These opinions are based upon a review of records only. These opinions are given within a reasonable degree of medical certainty. These opinions are subject to change pending the receipt and review of additional information.

1. **In your professional opinion, within a reasonable degree of medical certainty, did Licensee 2's care and treatment of this patient adhere to the applicable standard of care?** No.

2. **Explanation of opinion**

Licensee 2, a general practitioner, undertook a psychiatric assessment of an 18 year old girl in a distressing psychosocial situation, specifically, an unwanted pregnancy. Patient 10 was known on intake to have been receiving Paxil, 40 mg a day, for an anxiety disorder. On the basis of the assessment however, Licensee 2 referred Patient 10, not to a mental health professional for a second opinion for the presumptive new psychiatric disorder of Acute Stress Disorder, but rather to an Ob-Gyn. If a general practitioner felt the need to make a referral for evaluation and/or treatment for a patient with a presumptive psychiatric diagnosis, particularly an adolescent with a new onset psychiatric diagnosis, as well as a pre-existing anxiety disorder, medical practice dictates that such a referral would be made to a mental health professional. Such professionals could be a child and adolescent psychiatrist, psychologist, or social worker, with expertise in the evaluation and treatment of the presumed disorder in adolescents.

There is no evidence of a standard child and adolescent psychiatric evaluation or review

of any records in the assignment of the psychiatric diagnosis other than

1. a review of a checklist of criteria associated with a diagnosis of Acute Stress Disorder. There are no specific examples or indications reflecting a personal interview or review of records that would support the presence of a new-onset diagnosis of Acute Stress Disorder in a 18 year old;
2. a SIGECAPS screening. This is a tool to assess whether someone with more than a few positive indicators should be evaluated further for the presence of clinical depression. A SIGECAPS screening is not of itself a standard psychiatric evaluation method for making a diagnosis of a new onset Acute Stress Disorder.

Moreover, the diagnosis of Acute Stress Disorder requires exposure to a traumatic stressor, as identified by the presence of both of the following

a. The person has experienced, witnessed, or been confronted with an event that involved actual or threatened death or serious injury, or a threat to physical integrity.
b. The persons' response to the extreme stressor involved intense fear, helplessness, or horror.

There is no doubt that Patient 10 was distressed and even distraught in finding herself pregnant. However, it is beyond any accepted psychiatric or psychological theory or evidence that an unwanted pregnancy, absent a sexual assault (which did not occur in this case), could be construed as a traumatic stressor that could result in Acute Stress Disorder.

Licensee 2's referral to Licensee 1 was specifically for obtaining a termination for this patient based presumably on the psychiatric diagnosis of Acute Stress Disorder. The brief mention of a diagnosis of Anxiety Disorder NOS notes this diagnosis to be "in partial remission" and presumably therefore is not the basis for the referral. Regardless of which diagnosis formed the basis for the referral (or even if both did), abortion is not a treatment for any psychiatric disorder.

Many women suffer from exacerbations of pre-existing psychiatric disorders and new onset psychiatric disorders during pregnancy. Multiple effective treatments including psychotherapy and medication are available. There is no evaluation of any previous counseling or interventions, nor any consideration of whether counseling, medications or other interventions were appropriate at the time of the evaluation or in the future. Treatment options were not discussed. Moreover, the psychological ramifications of a late term termination in an adolescent were not discussed or considered, nor was she referred to a qualified specialist to discuss or evaluate this issue.

Licensee 2's referral to Licensee 1 for obtaining a termination for this patient stated that Patient 10 would suffer "substantial and irreversible impairment of a physical or mental function if she were forced to continue the pregnancy." The specific nature of the substantial and irreversible impairment is not specified, but since the only diagnosis offered is a psychiatric diagnosis, presumably, the substantial and irreversible impairment was psychiatric. Licensee 2's records give no indication either of the existence of a psychiatric symptom that might result in a substantial and irreversible impairment, nor do

they speculate what such an impairment might be. In fact, the SIGECAPS review indicated that Patient 10 reported she was not suicidal, the only life threatening emergency that might meet the criteria of a "substantial and irreversible impairment" due a psychiatric disorder.

In making a diagnosis of Acute Stress Disorder and referring Patient 10 for an abortion as a treatment for this disorder, Licensee 2 has held him- or her-self out as a practitioner who can provide the same level of psychiatric assessment and treatment as a child and adolescent psychiatrist. The "Practice Parameters for the Psychiatric Assessment of Children and Adolescents" published by the American Academy of Child and Adolescent Psychiatry in 1997 clearly establishes a guide for clinicians evaluating psychiatric disorders in children and adolescents. The assessment process is intended to assist the clinician in arriving at accurate diagnoses and appropriate treatment for children and adolescents presenting with psychiatric disorders that impair emotional, cognitive, physical, or behavioral functioning.

These parameters are not rigid guidelines, nor do they of themselves establish a legal standard of care. Nevertheless, these guidelines represent an expert consensus of what constitutes appropriate psychiatric evaluation of children and adolescents and are officially endorsed by the American Academy of Child and Adolescent Psychiatry and the level of care required for the diagnosis of a psychiatric disorder in a child or adolescent. Any deviation from these guidelines should be justified by clinical or other circumstances.

The purpose of a diagnostic assessment of a child or adolescent is

A. to determine whether psychopathology is present, and, if so, to establish a differential diagnosis;
B. to determine whether treatment is indicated; and
C. if so, to develop treatment recommendations and plans

Licensee 2's evaluation and treatment recommendations of Patient 10 were deficient in the following ways:

i. The clinical assessment of a child or adolescent requires several hours, including time for parent interview and child interview. There is no indication of the amount of time Licensee 2 spent evaluating Patient 10. However, Licensee 2's documentation of Patient 10's assessment is so sparse that it is hard to imagine that it is the result of several hours of evaluation. In fact, there is no evidence of any personal evaluation of Patient 10 as Licensee 2's records consist basically of two apparently computer generated checklists based on DSM criteria, unsupported by any personal information, dated 9 days after Patient 10's appointment with Licensee 2, and notes that do not indicate who performed the interview, and do not support the assigned diagnosis.

ii. Licensee 2 does not document a review of Patient 10's psychiatric, medical or developmental history, prior psychiatric treatment symptoms, family history, family relationships, physical or sexual abuse, substance abuse or other possible causes of distress. Only a brief mention of her treatment with Paxil for anxiety attacks is noted on the intake sheet. This does not constitute a review of psychiatric history. Standard practice indicates that at the least, an attempt should have been made to obtain information from her previous psychiatric treatment provider, and that this attempt should have been documented. A psychiatric diagnosis cannot reasonably be arrived at without a review of this information.

iii. Licensee 2 does not document any discussion of behavioral or functional impact of the purported anxiety disorder. There is no documentation of any discussion of frequency, intensity, duration and circumstances of any specific symptoms or behaviors associated with Acute Stress Disorder. A computerized GAF score of 25, with no narrative, examples of impaired functioning, or other indication of the data upon which this score is based, is not an adequate assessment of the functional impact of psychiatric symptoms.

iv. Licensee 2 did not document conducting a mental status examination, which consists of observing and assessing

1. Physical appearance
2. Manner of relating to examiner and parent
3. Affect and mood
4. Motor behavior
5. Content and form of thought
6. Speech and language
7. Overall intelligence
8. Attention
9. Memory
10. Neurological functioning;
11. and most significantly, judgment and insight

v. Licensee 2 does not present evidence of performing a differential diagnosis. Licensee 2 could not perform an adequate differential diagnosis without obtaining the history, medical, social, and psychiatric information outlined in i, ii, iii, and iv above. A computer generated DTREE Positive Dx Report, unsupported by the necessary and relevant information, does not constitute a differential diagnosis.

vi. Licensee 2 implies that the diagnosis of Acute Stress Disorder is caused solely by unwanted pregnancy, which, in the absence of a sexual assault, is not psychiatrically supportable. There is no evidence of consideration that the distress of an unwanted pregnancy is not actual

psychiatric pathology, and there is no evidence supporting the conclusion that this distress actually represents psychiatric pathology warranting a DSM-IV diagnosis.

vii. Licensee 2 does not present evidence of considering treatment options other than referring Patient 10 to Licensee 1 for a termination. Other treatment options, including various forms of psychotherapy and medication, are available and have been demonstrated to be effective for anxiety disorders. Indeed, Patient 10 was already receiving what appeared to be effective treatment for anxiety attacks in that taking Paxil and receiving counseling had resulted in no anxiety attacks for the previous six months. In contrast, an abortion is not considered a psychiatric treatment for Acute Stress Disorder or for any psychiatric diagnosis.

viii. Given Patient 10's age, Licensee 2's records contain no evidence that Licensee 2 considered obtaining a psychiatric consultation from a child and adolescent specialist, whether a social worker, psychologist, or psychiatrist. The circumstances involving the irreversible intervention of a late term termination in an 18 year old with a pre-existing psychiatric diagnosis suggest that at the least, a consultation with a specialist should be obtained to ensure that no psychological harm would result from the late term termination.

ix. In referring Patient 10 to Licensee 1, Licensee 2 fails to specify what, if any, are the substantial and irreversible impairments Patient 10 would suffer, and which major mental function would be affected. The failure to communicate to a colleague the nature of the severe medical problem presents an obstacle to adequate ongoing medical care.

x. Licensee 2 makes no mention of discussion of, arrangements for, or provision of aftercare for Patient 10's diagnosis of Acute Stress Disorder. As a physician providing an assessment and referral for consultation and treatment, it is Licensee 2's professional obligation to make certain that Patient 10 obtains appropriate treatment subsequent to the termination, which, as stated above, is not a psychiatric treatment for any psychiatric disorder.

This is all the more essential, if, as Licensee 2 states, Patient 10's disorder presents substantial and irreversible risk of impairment. If Patient 10 did meet criteria for Acute Stress Disorder, then it had to be due to some other traumatic stressor. This was not considered or investigated, and no treatment plan was in place to address this. If the treatment of a termination was not successful in alleviating Patient 10's Acute Stress Disorder (and Licensee 2's records do not indicate whether this treatment was or was not successful), what other

arrangements or plans did Licensee 2 have for Patient 10's severe psychiatric problem?

xi. Licensee 2 did not describe any circumstances that might justify the deviation from the accepted standard psychiatric evaluation of adolescents. Licensee 2 did not describe any circumstances that might justify the unorthodox treatment plan of treating Acute Stress Disorder an abortion, but without any psychiatric intervention or psychiatric follow up care.

3. If your opinion is that Licensee 2 did not adhere to the applicable standard of care, describe how, and to what degree (ordinary or gross negligence), the physicians' care deviated from the acceptable standards.

The determination of whether Licensee 2's deviations from the standard of care amount to ordinary or gross negligence is not properly a medical opinion. I can only state

a. there is no evidence that Licensee 2 conducted anything even approximating an appropriate or adequate psychiatric evaluation or mental status examination that could reasonably lead to the conclusion that Patient 10 had a diagnosis of Acute Stress Disorder
b. there is no evidence that Licensee 2 made a diagnosis based on a personal evaluation of Patient 10
c. there is no evidence that Licensee 2 considered an appropriate treatment plan for a diagnosis of Acute Stress Disorder;
d. there is no evidence that Licensee 2 made any arrangements or assured that such arrangements were made for appropriate psychiatric follow up care of Patient 10's purported Acute Stress Disorder, given that termination of a pregnancy, even an unwanted pregnancy, is not a treatment or cure for this disorder.

4. List any texts, medical literature or other resources relied upon (if applicable):

a. Diagnostic and Statistical Manual IV-TR, American Psychiatric Association, 2000
b. Practice parameters for the Psychiatric Assessment of Children and Adolescents, Journal of the American Academy of Child and Adolescent Psychiatry 36(10 Supplement):4S-20S, 1997
c. Practice Parameter for the Assessment and Treatment of Children and Adolescents with Anxiety Disorders, Journal of the American Academy of Child and Adolescent Psychiatry, 46(2) 267-283, 2007
d. Cohen LS, Nonacs RM, eds: Mood and Anxiety Disorders during Pregnancy and Postpartum. American Psychiatric Publishing Inc., 2005

e. Yonkers K, Little B: Management of Psychiatric Disorders in Pregnancy. Arnold, 2001
f. Yehuda R: Risk Factors for Posttraumatic Stress Disorder. American Psychiatric Publishing Inc., 1999
g. Wilson JP, Keane TM, eds.: Assessing Psychological Trauma and PTSD, 2nd edition. Guilford Press, 2004

5. **Did Licensee 2 maintain an adequate medical record for this patient?**

No.

If not, please describe the basis for your opinion:

As per Article 24: Patient Records, Adequacy; minimal requirements, Licensee 2's records are deficient in the following:

a. They do not contain pertinent and significant information concerning the patient's psychiatric condition;
b. They do not reflect what psychiatric or medical examinations, vital signs and tests were obtained, performed, or ordered and the findings and results of each;
c. They only minimally indicate the initial psychiatric diagnosis of an anxiety disorder and the patient's psychiatric reasons for seeking the licensee's services
d. They do not reflect the recommended psychiatric treatment or discussion of psychiatric treatment options
e. They do not contain any record of discussion of appropriate aftercare of a psychiatric disorder or arrangements for such
f. They do not indicate if and when a personal evaluation was conducted and whether diagnoses were made before or after a personal evaluation if indeed one was conducted.

Liza H. Gold, MD

Clinical Professor of Psychiatry
Georgetown University Medical Center

Certified, Board of Psychiatry and Neurology
Added Qualifications in Forensic Psychiatry

Kathleen Selzler-Lippert, Litigation Counsel
Kansas State Board of Healing Arts
235 SW Topeka Blvd.
Topeka, KS 66603

RE: Expert review of medical records for Investigative Case Nos. 07-00158 & 07-00322

Report of Consultant Review

Physician: Licensee 2

Patient: #11

Dates of Treatment: 11/18/03

Date(s) of Consultant Review: 7/20/09 – 7/27/09

Records Reviewed

Records reviewed included, but were not limited to:

Kathleen Selzler-Lippert, Letter of referral, 6/19/09
Definition of Standard of Care
K.S.A. 65-6703, 65-6704, 65-6705, 65-6709, 65-6711, 65-6721
K.A.R. 100-24-1 Documentation Regulation
Sample Report

Medical Records

1. Investigative Case No. 07-00158
Patient #11's medical records from Licensee #2 (5 pages)

2. Investigative Case No. 07-00322
Patient #11's medical records from Licensee #1 (46 pages)

Statutes, Kansas Legislature: 65-6703

Abortion is prohibited when fetus is viable, except if the physician who performs the abortion has a documented referral from another physician not legally or financially affiliated with the physician performing or inducing the abortion and both physicians determine that

1. the abortion is necessary to preserve the life of the pregnant woman; or
2. a continuation of the pregnancy will cause a substantial and irreversible impairment of a major bodily function of the pregnant woman.

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Standard of Care: Within a reasonable degree of medical certainty did the practitioner meet the applicable standard of care?

- Ordinary negligence: Did the practitioner fail to practice the healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent practitioner as being acceptable under similar conditions and circumstances.

- Gross negligence: Did the practitioner fail to practice within the applicable standard of care and with reckless disregard or complete indifference to the probable consequences

A physician who holds himself out to be a specialist in a particular field of medicine has a duty to practice in a manner consistent with the special degree of skill and knowledge ordinarily possessed by other specialists in the same field of expertise at the time of the diagnosis/treatment.

Summary of Events

Licensee #1's records indicate Patient 11 is a 16 year old single female from Kansas. She became pregnant by consensual intercourse. On the basis of a referral from Licensee #2 and Licensee #1's evaluation, Patient 11 underwent a late-term abortion at 29 weeks and 5 days from 11/19/03 – 11/20/03.

Review of Licensee's 2's Records

1. Bates #00001 - Intake Form: indicates an appointment date of 11/18/03 and time of 4:17 PM. A brief medical and psychiatric history checklist indicates no history of depression, alcohol or other substance abuse, or any other medical or psychiatric illness, is unmarked except for "y" indicating "yes" after "other ill." The comments indicate that Patient 11 is "on naproxen for injury related arthritis-has been taking meds for 3 wks." This comment is followed by the notation "sb," which presumably are someone's initials.

2. Bates #00003-00004, "DTREE Positive Dx Report" - Patient 11 is given a diagnosis of Major Depressive Disorder, Single Episode, Severe Without Psychotic Features (296.23) in an unsigned document indicating a "Rating" and "Report" date of 11/20/03, two days after her appointment with Licensee #2 and one day after her termination was begun. This document is a computer generated list of the diagnostic criteria for this diagnosis. No evidence supporting the diagnostic criteria is provided.

A duplicate of this document is present in Licensee #1's records (Bates #00013-00014). This document has what appears to be a fax date of "Nov-20-03 09:02P" at the top. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document.

3. Bates #00005: GAF REPORT - Patient 11 was assigned a GAF (Global Assessment of Functioning) score of 15: "The patient has been in some danger of hurting herself." This document indicates a "Rating" and "Report" date of 11/20/03, two days after Patient 11's

indicated appointment with Licensee #2 and one day ater the termination was undertaken. The time period for which the GAF rating is assigned is the past week. The document is unsigned.

This document is a computer generated rating list. No evidence supporting this rating is provided. The document does not provide any specific examples or indicate any personal evaluation supporting the rating. A duplicate of this document is found in Licensee #1's records (Bates #00015). This document has what appears to be a fax date of "Nov-20-03 09:01P" at the top. It is not possible to determine from either Licensee #1's or Licensee #2's records who conducted this evaluation or prepared the document.

4. Licensee #1's records include a letter (Bates #00016) from Licensee #2 to Licensee #1, dated November 18, 2003, which states, in its entirety,

> "RE: Patient #11
> DOB: 04/02/87
>
> Dear Licensee #1
>
> I am referring the above named patient to you [sic] organization for consultation regarding her unwanted pregnancy. The patient would suffer substantial and irreversible impairment of a major physical or mental function if she were forced to continue the pregnancy.
>
> Sincerely,
>
> Licensee 2"

This letter is not included in Licensee #2's records.

Opinions

These opinions are based upon a review of records only. These opinions are given within a reasonable degree of medical certainty. These opinions are subject to change pending the receipt and review of additional information.

1. **In your professional opinion, within a reasonable degree of medical certainty, did Licensee 2's care and treatment of this patient adhere to the applicable standard of care?** No.

2. **Explanation of opinion.**

Licensee 2, a general practitioner, undertook a psychiatric assessment of a 16 year old girl in a distressing psychosocial situation, specifically, an unwanted pregnancy. Based on Licensee 1's records, this girl and her family were apparently still experiencing the grief and bereavement associated with the death of the girl's father one year earlier.

On the basis of this assessment, Licensee 2 referred Patient 11, not to a mental health professional for a second opinion for a presumptive psychiatric disorder in a grieving adolescent with an unwanted preganancy, but rather to an Ob-Gyn. If a general practitioner felt the need to make a referral for evaluation and/or treatment for a patient with a presumptive psychiatric diagnosis, particularly an adolescent with complicated psychosocial circumstances and a new onset psychiatric diagnosis, as there is no indication Patient 11 had any pre-existing psychiatric disorder, medical practice dictates that such a referral would be made to a mental health professional. Such professionals could be a child and adolescent psychiatrist, psychologist, or social worker, with expertise in the evaluation and treatment of the presumed disorder in adolescents.

There is no evidence of a standard child and adolescent psychiatric evaluation or review of any records in the assignment of the psychiatric diagnosis other than a review of a diagnostic checklist. There are no specific examples or indications reflecting a personal interview or review of records that would support the presence of a new-onset diagnosis of Major Depressive Disorder in a 16 year old;

Licensee 2's referral to Licensee 1 was specifically for obtaining a termination for this 16 year old girl based presumably on the psychiatric diagnosis of Major Depressive Disorder. Abortion is not a treatment for any psychiatric disorder. Many women suffer from exacerbations of pre-existing psychiatric disorders and new onset psychiatric disorders during pregnancy. Multiple effective treatments including psychotherapy and medication are available. There is no evaluation of any previous counseling or interventions, nor any consideration of whether counseling, medications or other interventions were appropriate at the time of the evaluation or in the future. Treatment options were not discussed. Moreover, the psychological ramifications of a late term termination in an adolescent were not discussed or considered, nor was she referred to a qualified specialist to discuss or evaluate this issue.

Licensee 2's referral to Licensee 1 for obtaining a termination for this 16 year old girl stated that Patient 11 would suffer "substantial and irreversible impairment of a physical or mental function if she were forced to continue the pregnancy." The specific nature of the substantial and irreversible impairment is not specified, but since the only diagnosis offered is a psychiatric diagnosis, presumably, the substantial and irreversible impairment was psychiatric. Licensee 2's records give no indication either of the existence of a psychiatric symptom that might result in a substantial and irreversible impairment, nor do they speculate what such an impairment might be. Although the GAF Report indicates that "The patient has been in some danger of hurting herself," Licensee 2's records contain no information regarding or indication of suicidality.

In making a diagnosis of Major Depressive Disorder and referring Patient 11 for an abortion as a treatment for this disorder, Licensee 2 has held him- or her-self out as a practitioner who can provide the same level of psychiatric assessment and treatment as a child and adolescent psychiatrist. The "Practice Parameters for the Psychiatric Assessment of Children and Adolescents" published by the American Academy of Child and Adolescent Psychiatry in 1997 clearly establishes a guide for clinicians evaluating

psychiatric disorders in children and adolescents. The assessment process is intended to assist the clinician in arriving at accurate diagnoses and appropriate treatment for children and adolescents presenting with psychiatric disorders that impair emotional, cognitive, physical, or behavioral functioning.
These parameters are not rigid guidelines, nor do they of themselves establish a legal standard of care. Nevertheless, these guidelines represent an expert consensus of what constitutes appropriate psychiatric evaluation of children and adolescents and are officially endorsed by the American Academy of Child and Adolescent Psychiatry and the level of care required for the diagnosis of a psychiatric disorder in a child or adolescent. Any deviation from these guidelines should be justified by clinical or other circumstances.

The purpose of a diagnostic assessment of a child or adolescent is

A. to determine whether psychopathology is present, and, if so, to establish a differential diagnosis;
B. to determine whether treatment is indicated; and
C. if so, to develop treatment recommendations and plans

Licensee 2's evaluation and treatment recommendations of Patient 11 were deficient in the following ways:

i. The clinical assessment of a child or adolescent requires several hours, including time for parent interview and child interview. There is no indication of the amount of time Licensee 2 spent evaluating Patient 11. However, Licensee 2's documentation of Patient 11's assessment is so sparse that it is hard to imagine that it is the result of several hours of evaluation. In fact, there is no evidence of any personal evaluation of Patient 11 as Licensee 2's records consist basically of two apparently computer generated checklists based on DSM criteria dated two days after her appointment with Licensee 2 and unsupported by any personal information.

ii. Licensee 2 does not document a review of Patient 11's psychiatric, medical or developmental history, prior psychiatric treatment symptoms, family history, family relationships, physical or sexual abuse, substance abuse or other possible causes of distress. A psychiatric diagnosis cannot reasonably be arrived at without a review of this information. Licensee 1's records document that Patient 11 and her family are still grieving the loss of Patient 11's father one year previously. This alternate cause of distress and interventions undertaken in the previous year if any should have been evaluated.

iii. Licensee 2 does not document any discussion of behavioral or functional impact of the purported mood disorder. There is no documentation of any discussion of frequency, intensity, duration and circumstances of any specific symptoms or behaviors associated with

Major Depressive Disorder. A computerized GAF score of 15, with no narrative, examples of impaired functioning, or other indication of the data upon which this score is based, is not an adequate assessment of the functional impact of psychiatric symptoms.

iv. Licensee 2 did not document conducting a mental status examination, which consists of observing and assessing
    1. Physical appearance
    2. Manner of relating to examiner and parent
    3. Affect and mood
    4. Motor behavior
    5. Content and form of thought
    6. Speech and language
    7. Overall intelligence
    8. Attention
    9. Memory
    10. Neurological functioning;
    11. and most significantly, judgment and insight

v. Licensee 2 does not present evidence of performing a differential diagnosis. Licensee 2 could not perform an adequate differential diagnosis without obtaining the history, medical, social, and psychiatric information outlined in i, ii, iii, and iv above. A computer generated DTREE Positive Dx Report, unsupported by the necessary and relevant information, does not constitute a differential diagnosis.

vi. Licensee 2 implies the diagnosis of Major Depressive Disorder is solely due to the unwanted pregnancy with no evidence of consideration of any pre-existing or other possible source of distress, despite the loss of her father one year earlier (as per Licensee #1's records). Undoubtedly, Patient 11 was distressed over her unwanted pregnancy. However there is no evidence of consideration that the distress of an unwanted pregnancy is not actual psychiatric pathology, and there is no evidence supporting the conclusion that this distress actually represents psychiatric pathology warranting a DSM-IV diagnosis.

vii. Licensee 2 does not present evidence of considering treatment options other than referring Patient 11 to Licensee 1 for a termination. Other treatment options, including various forms of psychotherapy and medication, are available and have been demonstrated to be effective for mood disorders. In contrast, an abortion is not considered a psychiatric treatment for Major Depressive Disorder or for any psychiatric diagnosis.

viii. Given Patient 11's age, Licensee 2's records contain no evidence that Licensee 2 considered obtaining a psychiatric consultation from a

child and adolescent specialist, whether a social worker, psychologist, or psychiatrist. The circumstances involving the irreversible intervention of a late term termination in a 16 year old with complicated family circumstances suggest that at the least, a consultation with a specialist should be obtained to ensure that no psychological harm would result from the late term termination.

ix. In referring Patient 11 to Licensee 1, Licensee 2 fails to specify what, if any, are the substantial and irreversible impairments Patient 11 would suffer, and which major mental function would be affected. The failure to communicate to a colleague the nature of the severe medical problem presents an obstacle to adequate ongoing medical care.

x. Licensee 2 makes no mention of discussion of, arrangements for, or provision of aftercare for Patient 11's diagnosis of Major Depressive Disorder. As a physician providing an assessment and referral for consultation and treatment, it is Licensee 2's professional obligation to make certain that Patient 11 obtains appropriate treatment subsequent to the termination, which, as stated above, is not a psychiatric treatment for any psychiatric disorder.

This is all the more essential, if, as Licensee 2 states, Patient 11's disorder presents substantial and irreversible risk of impairment. If Patient 11's Major Depressive Disorder was due in fact to another cause, then no treatment plan was in place to address this. If the treatment of a termination was not successful in alleviating Patient 11's Major Depressive Disorder (and Licensee 2's records do not indicate whether this treatment was or was not successful), what other arrangements or plans did Licensee 2 have for Patient 11's severe psychiatric problem?

xi. Licensee 2 did not describe any circumstances that might justify the deviation from the accepted standard psychiatric evaluation of adolescents. Licensee 2 did not describe any circumstances that might justify the unorthodox treatment plan of treating Major Depressive Disorder with an abortion, but without any psychiatric intervention or psychiatric follow up care.

3. **If your opinion is that Licensee 2 did not adhere to the applicable standard of care, describe how, and to what degree (ordinary or gross negligence), the physicians' care deviated from the acceptable standards.**

The determination of whether Licensee 2's deviations from the standard of care amount to ordinary or gross negligence is not properly a medical opinion. I can only state

a. there is no evidence that Licensee 2 conducted anything even approximating an appropriate or adequate psychiatric evaluation or mental status examination that could reasonably lead to the conclusion that Patient 11 had a diagnosis of Major Depressive Disorder;
b. there is no evidence that Licensee 2 made a diagnosis based on a personal evaluation of Patient 11
c. there is no evidence that Licensee 2 considered an appropriate treatment plan for a diagnosis of Major Depressive Disorder;
d. there is no evidence that Licensee 2 made any arrangements or assured that such arrangements were made for appropriate psychiatric follow up care of Patient 11's purported Major Depressive Disorder, given that termination of a pregnancy, even an unwanted pregnancy, is not a treatment or cure for this disorder.

4. **List any texts, medical literature or other resources relied upon (if applicable):**

a. Diagnostic and Statistical Manual IV-TR, American Psychiatric Association, 2000
b. Practice parameters for the Psychiatric Assessment of Children and Adolescents, Journal of the American Academy of Child and Adolescent Psychiatry 36(10 Supplement):4S-20S, 1997
c. Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorders, Journal of the American Academy of Child and Adolescent Psychiatry, 46(11) 1503-1526, 2007
d. Cohen LS, Nonacs RM, eds: Mood and Anxiety Disorders during Pregnancy and Postpartum. American Psychiatric Publishing Inc., 2005
e. Yonkers K, Little B: Management of Psychiatric Disorders in Pregnancy. Arnold, 2001

5. **Did Licensee 2 maintain an adequate medical record for this patient?**

No.

If not, please describe the basis for your opinion:

As per Article 24: Patient Records, Adequacy; minimal requirements, Licensee's 2's records are deficient in the following:

a. They do not contain pertinent and significant information concerning the patient's psychiatric condition;
b. They do not reflect what psychiatric or medical examinations, vital signs and tests were obtained, performed, or ordered and the findings and results of each;
c. They do not indicate the initial psychiatric diagnosis and the patient's psychiatric reasons for seeking the licensee's services
d. They do not reflect the recommended psychiatric treatment or discussion of psychiatric treatment options
e. They do not contain any record of discussion of appropriate aftercare of a psychiatric disorder or arrangements for such
f. They do not indicate if and when a personal evaluation was conducted and whether diagnoses were made before or after a personal evaluation if indeed one was conducted.