IN THE DISTRICT COURT OF SHAWNEE COUNTY, KANSAS
DIVISION SEVEN

ANN K. NEUHAUS,	)	
	)	
Petitioner,	)	Case No. 12C873
	)	
vs.	)	
	)	
KANSAS STATE BOARD OF HEALING ARTS,	)	
	)	
Respondent.	)	
	)	
	)	

MEMORANDUM OPINION AND ENTRY OF JUDGMENT

NATURE OF THE CASE

This matter is before the Court on an appeal pursuant to the Kansas Judicial Review Act, as amended, K.S.A. 77-601 *et seq.*, from a decision of the Kansas State Board of Healing Arts, which affirmed as its *Final Order* the *Initial Order* of a hearing officer assigned, which had revoked the license of the Petitioner here, Dr. Ann K. Neuhaus, M.D., and assessed

against her the costs of the proceedings against her.

The background of the case arises from Dr. Neuhaus's engagement by George K. Tiller, M.D., of Wichita, Kansas, now deceased, to provide a statutorily required referral in the form of a second opinion by another physician of a patient's qualification for a late term abortion before a requested late term abortion could be performed by him. Dr. Neuhaus's services at issue were performed in 2003 and investigation of the complaint began in 2007, culminating in the filing of a complaint by the Kansas State Board of Healing Arts on April 16, 2010. After the pre-hearing processes were finalized, the formal evidentiary hearing conducted by an appointed hearing officer from the Office of Administrative Hearings was held in September, 2011, which culminated in the *Initial Order* entered February 20, 2012, which was adopted in full by the Board by a *Final Order* entered July 6, 2012. This appeal then ensued.

The Court greatly empathizes with the hearing officer who was required to hear and filter the

evidence in this case initially. The resolution of this appeal, quite frankly, has been an arduous task given the record in this case encompasses over 3,500 pages and that the principal focus of the appeal rests in the quantity and quality of the evidence provided and whether the hearing officer and ultimately the Board, by adoption of the hearing officer's findings and conclusions, properly evaluated the evidence against the allegations set forth in the Board's complaint. Additionally, since the decisions made by this state agency arise in relation to questions concerning the lawful provision of abortion services by the medical community, the ultimate result to be had here needs to be articulated such as to be stripped of the polarization that attends the delivery of such abortion procedures.

Because the record in this case is voluminous, this Court has elected to set forth what it believes to be the relevant and material evidence in the record as an appendix hereto and first discuss the legal and factual issues in an analysis and conclusions of law section.

A reader may therefore elect his or her own beginning.

The Court is well aware of the legal parameters for the Court's review of the quasi-judicial decisions of administrative agencies, both historically, as well articulated in *Kansas State Bd. of Healing Arts v. Foote*, 200 Kan. 447 (1968), and, as well, under the Kansas Judicial Review Act as amended, effective July 1, 2009, K.S.A. 77-601 *et seq.*, whereby, now, on contested issues of fact, deference to the initial decision maker who viewed the witnesses and their demeanor, must, nevertheless, be viewed against the "record as a whole" (K.S.A. 77-621 (c)(7) and (d); *Herrera-Gallegos v. H & H Delivery Service, Inc.*, 42 Kan. App. 2d 360 (2009). It is in the facts advanced against the background of the Board's complaint against Dr. Neuhaus that the proper resolution of this case rests. How the 2009 amendment affected the evaluation of the evidence adduced at an administrative hearing in relation to that review permitted prior is succinctly explained in *Friedman v. Kansas State Bd. of Healing Arts,* 296 Kan. 636 (2013). No longer is a reviewing

Court bound to review just the positive evidence in support of such a decision, but it may now review the entirety of the record to judge the quality of the conclusions reached. By example, an administrative hearing officer or an administrative board acting either initially as a hearing panel or in a review capacity is not privileged to simply ignore, without evaluation or explanation why, any material, substantive evidence that is contrary to its conclusions reached. Even a factfinder entering a negative finding that a burden of proof has not been met is not entirely privileged to do so. *Nance v. Harvey County*, 263 Kan. 542, 551 (1997). Further, too, any deference to an agency decision must yield to fundamental errors in analysis that would render a decision as arbitrary or capricious because it was unreasonable in result due to its lack of determining principles, an absence of sufficient foundation in fact, or because it effectively ignored the law to accommodate a particular result. The range of inquiry, as appropriate, is set forth in *Dillon Stores v. Board*

of County Comm'rs of Sedgwick County, 259 Kan. 295, 299-300 (1996). Of course, questions of law are for the courts. *Fort Hays State University v. University Ch., Am. Ass'n of Univ. Profs.*, 290 Kan. 446, 457 (2010). Whether sufficient facts, *i.e.*, "substantial evidence", exists to support any finding is a question of law. *Williams. v. Cities Service Gas Co.*, 151 Kan. 497, 503 (1940).

The burden of proof at the administrative level, as with every party in the position of a plaintiff, was on the Kansas State Board of Healing Arts. (*State v. Carter*, 214 Kan. 533, 536 (1974)). However, on appeal the burden of proof was upon the Petitioner, Dr. Neuhaus, to demonstrate that the agency's burden of proof obligation at the hearing was not met (K.S.A. 77-621(a)).

While the Board's counsel on appeal has suggested that the Court should defer to the Board's expertise when it evaluated and approved in full its hearing officer's opinion, citing *Hart v. Kansas State Bd. of Healing Arts*, 27 Kan. App. 2d 213, 216 (2000), the

Court is of the view that the question here is, principally, the sufficiency of the evidence, which, as noted, is a question of law for the Court, hence, the deference sought is, at least on the record here, inapplicable as to a matter of the facts presented of record. Further, no policy aspects within the Board's purview have been directly implicated by this appeal, such as would a decision by it as to the sanctions to be applied on the facts found in a particular case, which extend to its purely enforcement authority (*See Zafer v. Kansas State Board of Healing Arts,* (*Memorandum Opinion*, p. 17, 12C415 Sn. Co. District Ct. (2/17/13)). However, if counsel is suggesting the Board members might supplement the record, *sub silentio*, with their own internal testimony or personal beliefs on a review, the Board should keep in mind the long time restraint, still applying, on judicial or quasi-judicial factfinders as follows:

> "'That general knowledge that any man may bring to the subject a juror may use; but if he has any particular knowledge on the trade he must be sworn.'"

Missouri River R. Co. v. Richards, 8 Kan. 76 (*101), 82 (*111) (1871).

Further, the Board of Healing Arts is comprised of a mix of healing arts professional disciplines and includes, as well, three lay members. K.S.A. 65-2813. Embedding an evidentiary presence in the Board's considerations could, apart from the more obvious due process concerns, yield an undue superiority of opinion to some members over that of other members on some issues before them. However, there is neither allegation nor evidence in this case that the Board adopted its counsel's suggestion of its authority.

ANALYSIS AND CONCLUSIONS OF LAW

The prosecutorial complaint, denominated as a "Petition", that was lodged against Dr. Neuhaus involved eleven patients referred to her by Dr. Tiller in 2003. All of these patients, but one, were younger than eighteen, one, an incest victim, was only ten years old. All, at the time of such abortions, were carrying a viable fetus as that term was statutorily defined by K.S.A. (2003) 65-6701(k), now (m). In each

instance, Dr. Neuhaus, in her capacity as the provider of a referral and second opinion that a patient of Dr. Tiller's qualified for an abortion, provided an opinion that the patient did, in fact, qualify for a late term abortion as that procedure is regulated by K.S.A. 65-6703(a).

The complaint against Dr. Neuhaus is exampled below through its allegations in reference to patient #1. The allegations in the complaint founded on the additional ten patients bear the same or substantially similar wording in regard to the allegations, the only apparent differences existing being in a particular diagnosis given by Dr. Neuhaus to a patient that she deemed qualified for an abortion and, of course, the age of the patient.

The complaint in its beginning general allegations pertaining to each of its Counts I - XI and continuing through its allegations pertaining to "Patient 1" is as follows:

"*PETITION* and first paragraph

Facts Common To All Counts

1. The Board is the sole and exclusive administrative agency in the State of Kansas authorized to regulate the practice of the healing arts, specifically the practice of medicine and surgery. K.S.A. 65-2801 *et* seq.

2. Licensee's last known mailing address as she provided to the Board is: 17127 Osage Road, Nortonville, Kansas 66060.

3. Licensee is or has been entitled to engage in the practice of medicine and surgery in the State of Kansas, having been issued license no. 04-21596 on approximately December 5, 1986 and having renewed her license on approximately June 30, 2009.

4. On or about October 18, 1999, a Stipulation and Agreement and Enforcement Order was filed with the Board in Docket Number OO-HA00020 imposing disciplinary action in the form of limitations on Licensee's license to practice medicine and surgery in Kansas. The allegations underlying the Stipulation and Agreement and Enforcement Order were that Licensee had violated federal regulations concerning controlled substances and had her U.S. Drug Enforcement Agency registration limited.

5. On or about August 24, 2001, a Consent Order was filed with the Board in Docket Number 01-HA00014 imposing disciplinary action in the form of further limitations on Licensee's license to practice medicine and surgery in Kansas. The allegations underlying the Consent Order were that Licensee repeatedly deviated from the standard of care in treating patients.

6. Licensee is a general practitioner who is not board-certified in any specialty. However, Licensee's practice for the at least the past ten (10) years has primarily involved providing abortion services and/or providing consultation regarding abortion services.

7. Since issuance of [her] license, and while engaged in a regulated profession as a doctor of medicine and surgery in the State of Kansas, pursuant to K.S.A. 65-2801 *et seq.*, Licensee did commit the following act(s):

COUNT I

8. Petitioner incorporates herein by reference paragraphs 1 through 7 inclusive.

9. On or about July 22, 2003, Licensee performed an evaluation of Patient #1, a fourteen (14) year-old female who was more than twenty-six (26) weeks pregnant with a viable fetus.

10. The purpose of Licensee's evaluation of Patient #1 was to assess whether Patient #1 qualified for a referral for an abortion of a viable fetus pursuant to the provisions of K.S.A. 65-6703(a).

11. Licensee's evaluation of Patient #1 involved making a determination whether an abortion was necessary to preserve the life of Patient #1, or if a continuation of Patient #1's pregnancy would cause a substantial and irreversible impairment of a major bodily function of Patient #1.

12. The documentation in Licensee's patient chart for Patient #1 indicates a psychiatric diagnosis of Anxiety Disorder, Not Otherwise Specified.

13. On or about July 22, 2003, Licensee determined that Patient #1 would suffer a substantial and irreversible impairment of a major physical or mental function if she were forced to continue the pregnancy.

14. On or about July 22, 2003, Licensee made a referral of Patient #1 to George Tiller, M.D. for an abortion of a viable fetus.

15. Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence in evaluating Patient #1 and determining whether an abortion was necessary to preserve the life of Patient #1, or if a continuation of Patient #1's pregnancy would cause a substantial and irreversible impairment of a major bodily function, including but not limited to, each of the following acts or omissions:

a. Licensee failed to perform an adequate patient interview;

b. Licensee failed to perform an adequate review of the patient's history;

c. Licensee failed to perform an adequate evaluation of the behavioral or functional impact of the patient's condition and symptoms;

d. Licensee failed to perform an adequate mental status examination of the patient; and

e. Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence which is believed and alleged and will be disclosed upon proper discovery in the course of these proceedings.

16. Licensee's acts and conduct during the course of treating Patient #1 constitute violations of the Kansas Healing Arts Act as follows:

a. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(a)(2), in that Licensee has committed repeated instances of failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the Board;

b. K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(24), in that Licensee has repeated failure to practice healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances; and

c. K.S.A. 65-2836(k), in that Licensee has violated a lawful regulation promulgated by the Board, specifically, K.A.R. 100-24-1, by failing to meet the minimum requirements for an adequate patient record.

17. Pursuant to K.S.A. 65-2836, the Board has grounds to revoke, suspend, censure, place on probation, fine or otherwise limit Licensee's license for violations of the Kansas Healing Arts Act."

ROA: 000005 - 000009.

This complaint or *Petition* against Dr. Neuhaus was never amended either formally or as a result of any prehearing order (ROA: 000093) nor was it amended or attempted to be amended to flesh out the catchall, wait and see, allegation made in ¶ 15(e), hence, the foundation for the Board's allegations that Dr. Neuhaus, in her provision of services in the second opinion capacity allotted to her by K.S.A. 65-6703(a)'s requirement, violated the Kansas Healing Arts Act remained as stated originally in the *Petition* as set

out above.

Further, as noted from the portion of the complaint set out in ¶ 16c, Dr. Neuhaus was alleged to have violated K.S.A. 65-2836(k) by failing to comply with the record keeping requirements of K.A.R. 100-24-1. While that record keeping requirement and Dr. Neuhaus's fidelity to its terms undergirds and permeates this entire case, the Court would defer its specific conclusion regarding that allegation until after the analysis of the evidence relating to what is, essentially, the negligence claim invoked as to each of patients #1-#11 in ¶ 15 a-e of the *Petition*. The Board's citation to K.S.A. 65-2837(a)(2) and K.S.A. 65-2837(b)(24) in reference to "repeated" failures to adhere to a requisite standard of care and avoid negligence in her practice of medicine (K.S.A. 65-2837(a)(2)) or to consistently live up to the standards of care in her practice of medicine (K.S.A. 65-2837(b)(24)) both appear to be grounded in the allegations in ¶ 15 then coupled with the two prior sanctions of her by the Board as set out in ¶s 4 and 5

of the *Petition*. The allegation of "negligence" as used in K.S.A. 65-2837(a)(2) would imply the existence of a bad result (*McMillen v. Foncannon*, 127 Kan. 573, 575 (1929)) whereas repeated failures to adhere to standards of care in the practice of medicine seemingly could encompass mere inconsistent attention to proper protocols or procedures generally but not necessarily encompassing an identifiable bad result, hence, merely unorthodox, taking short cuts, or sloppy and otherwise loose in approach.

The statutory sections above noted governing the conduct of Board licensed practitioners of the Healing Arts state, in relevant part, as follows:

> "K.S.A. 65-2836. A licensee's license may be revoked, suspended or limited, or the licensee may be publicly or privately censured or placed under probationary conditions, or an application for a license or for reinstatement of a license may be denied upon a finding of the existence of any of the following grounds:
>
> . . .
>
> (b) The licensee has committed an act of unprofessional . . . conduct [K.S.A. 65-2837(b)] or professional incompetency [K.S.A. 65-2837(a)] except that the board may take appropriate disciplinary action or enter into a non-disciplinary resolution when a licensee

has engaged in any conduct or professional practice on a single occasion that, if continued, would reasonably be expected to constitute an inability to practice the healing arts with reasonable skill and safety to patients or unprofessional conduct as defined in K.S.A. 65-2837, and amendments thereto.

. . .

(k) The licensee has violated any lawful rule and regulation promulgated by the board . . .

. . ."

[added by the Court]

"K.S.A. 65-2837. As used in K.S.A. 65-2836, and amendments thereto, and in this section:

(a) 'Professional incompetency' means:

. .

(2) Repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the board.

. . .

(b) 'Unprofessional conduct' means:

(24) Repeated failure to practice healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances.

. . .

Kansas Administrative Regulation (K.A.R.) 100-24-1 provides as follows:

Adequacy; minimal requirements.

(a) Each licensee of the board shall maintain an adequate record for each patient for whom the licensee performs a professional service.

(b) Each patient record shall meet these requirements:

(1) Be legible;

(2) contain only those terms and abbreviations that are or should be comprehensible to similar licensees;

(3) contain adequate identification of the patient;

(4) indicate the dates any professional service was provided;

(5) contain pertinent and significant information concerning the patient's condition;

(6) reflect what examinations, vital signs, and tests were obtained, performed, or ordered and the findings and results of each;

(7) indicate the initial diagnosis and the patient's initial reason for seeking the licensee's services;

(8) indicate the medications prescribed, dispensed, or administered and the quantity and strength of each;

(9) reflect the treatment performed or recommended;

(10) document the patient's progress during the course of treatment provided by the licensee; and

(11) include all patient records received from other health care providers, if those records formed the basis for a treatment decision by the licensee.

(c) Each entry shall be authenticated by the person making the entry unless the entire patient record is maintained in the licensee's own hand-writing.

(d) Each patient record shall include any writing intended to be a final record, but shall not require the maintenance of rough drafts, notes, other writings, or recordings once this information is converted to final form. The final form shall accurately reflect the care and services rendered to the patient.

(e) For purposes of implementing the healing arts act and this regulation, an electronic patient record shall be deemed a written patient record if the electronic record cannot be altered and if each entry in the electronic record is authenticated by the licensee."

The hearing officer set out his basis for sustaining the Board's allegations under the *Petition's* terminology set forth earlier in ¶s 15 and 16 of the *Petition* as to each of these eleven individuals scheduled by Dr. Tiller for an opinion from Dr. Neuhaus as to each's qualification for a late term abortion. Thus, it is best here to set forth the hearing officer's perception of the fundamental evidence

presented and its quality or persuasiveness, which, to him, and by the Board's adoption of his findings and conclusions *en masse,* underpinned the findings of violation by Dr. Neuhaus and the revocation of her license. Since, as relevant here, his findings in regard to each of patients #1-#11 are, in substance and in his analysis and conclusions, all similarly grounded, only his findings in reference to patient #1 and his general conclusions, as relevant, in relation to all these patients are displayed following as an example. Any additional material distinction will be noted within the context of the Court's discussion subsequent.

"Findings of Fact
Applicable to All Counts

1. The Licensee has been licensed by the Board since approximately December 5, 1986 to practice medicine and surgery in the state of Kansas.

2. The Licensee is a general practitioner and is not board-certified in any specialty. The Board has previously disciplined the Licensee and imposed limitations on the Licensee's practice of medicine and surgery.

3. The Board, through its investigators, subpoenaed records for Patients #1 through #11

that were in the Licensee's possession. The Licensee had provided reports on all these patients to George R. Tiller, M.D. The purpose of obtaining the Licensee's reports was to allow Dr. Tiller to perform abortions on Patients #I through #11.

4. Eliza [sic] H. Gold, M.D. has been licensed to practice medicine and surgery in Virginia, the District of Columbia, New Jersey, and New York. Dr. Gold has been licensed to practice medicine since 1986, is board-certified in psychiatric medicine, and has a subspecialty certification for forensic psychiatry.

5. Dr. Gold has written for a variety of publications dealing with psychiatric medicine.

6. Dr. Gold testified regarding the Licensee's practice of medicine as it relates to the Licensee's treatment of Patients #1 through #11.

7. In evaluating the Licensee's care of Patients #1 through #11, Dr. Gold reviewed the records maintained by the Licensee, the medical records of Dr. Tiller, inquisition testimony and court testimony of the Licensee, applicable Kansas statutes, and the Licensee's expert report provided by K. Allen Greiner, Jr., M.D. Additionally, Dr. Gold reviewed the American Academy of Child and Adolescent Psychiatric Practice Parameters and other written materials as well as the Diagnostic and Statistical Manual 4th Edition with Text Revisions (hereafter DSM-IV-TR).

8. Dr. Gold is a highly qualified expert in the field of psychiatric medicine.

9. The Licensee presented expert testimony from Dr. Greiner, a medical doctor who practices at the University of Kansas Medical

Center.

10. It is somewhat unclear but there appears to be some type of relationship between Dr. Greiner and the Licensee. For example, prior to the Licensee submitting an application to be a fellow with the University of Kansas Medical Center Primary Care Research Development Program, Dr. Greiner had notified the Licensee that she had been selected as a fellow. Similarly, the Licensee submitted an incomplete application for the Fellowship Program and Primary Care Research Development Program at the University of Kansas and even though the application was incomplete in that it lacked character references and a letter of recommendation from a department chairperson, the application was accepted. Why Dr. Greiner accepted an incomplete application from the Licensee is unknown.

11. After the Licensee's acceptance into the program, Dr. Greiner became the Licensee's mentor.

12. Prior to viewing the records of the Licensee, Dr. Greiner agreed to provide expert testimony for the Licensee without charging the Licensee for his expert opinion.

13. Dr. Greiner, before reaching an opinion as to the Licensee's practice, had to verbally discuss what occurred with regard to these patients because he could not determine this from the medical records he reviewed. The testimony of Dr. Greiner is not persuasive and is not credible.

14. In each count of the Board's petition, the Board alleges that the Licensee committed an act of unprofessional or dishonorable conduct or professional incompetency in violation of K.S.A. 65-2836(b). The Board further alleges that the practice of the

Licensee was professionally incompetent and was unprofessional conduct as set forth in K.S.A. 65-2837(a)(2) and K.S.A. 65-2837(b). Additionally, the Board alleges that the Licensee's practice was in violation of K.S.A. 65-2836(k) in that the Licensee violated K.A.R. 100-24-1 in failing to meet the minimum requirements for maintaining adequate patient records.

15. The DSM-IV-TR is the 'current taxonomy of psychiatric disorders' in the words of Dr. Gold. The DSM-IV-TR recommends that you collect all the information needed for a standard psychiatric examination. This information is listed below at paragraph 22. The DSM-IV-TR is used nationally and internationally.

16. In her treatment of Patients #1 through #11, the Licensee utilized computer based programs that are based upon the DSM-IV-TR.

17. The Licensee, in her care of Patients #1 through #11, utilized computer programs from Psychmanager Lite computer software. These programs utilized by the Licensee were the DTREE Positive DX and the GAF reports. DTREE and the GAF reports are the only documents in the files for Patients # 1 through #11 for which the Licensee claims ownership. None of these documents are authenticated by the Licensee.

18. The DSM-IV-TR and the Psychmanager Lite DTREE modules provide cautionary statements for practitioners. These cautionary statements require a practitioner to have and use the proper clinical training and skills in using either the DSM-IV-TR or the Psychmanager Lite programs.

19. In the patients' records containing computer printout material from the Licensee, there is

nothing specific about the patients listed that was generated by the Licensee. The computer printouts do not contain any specific information about the functioning of any of the patients. The computer printouts merely reflect answers to specific 'Yes' or 'No' questions.

20. It was Dr. Gold's professional opinion that utilizing the Psychmanager Lite DTREE Positive DX and GAF modules standing alone does not meet the applicable standard of care because there is not sufficient information regarding specific behavioral information regarding the patients as presented at the time of the examination.

21. Nothing in the computerized programs as utilized by the Licensee establishes that the Licensee performed a mental health evaluation within the applicable standard of care for these patients.

22. In conducting mental health evaluations or examinations, it is necessary for the physician to review the patient's presenting problems, the duration and frequency of the problems, the intensity of symptoms, the patient's past history, including treatment and any response to the treatment, family history, social history, occupational history, as well as past medical history, and an examination of past medical records. Additionally, based upon the condition of the patient, if a medical problem is suspected, a medical evaluation may be needed.

23. The applicable standard of care for mental health evaluations is basically a nationwide standard of care. While there might be slight regional or geographical variations, the standard of care is substantially the same nationwide.

24. The Licensee testified that her appointment date for the patients would be the date listed on Dr. Tiller's face sheet.

Count I

25. Patient #1 was a 14-year-old single white female who was 26 weeks plus pregnant.

26. The Licensee's patient records for Patient #1 are set forth in Exhibit 23. There is nothing in Patient #1's file bearing the name or leading to the identity of the Licensee with the exception of an Authorization to Disclose Protected Health Information form.

27. In Patient #1's file, there is no evidence that the Licensee conducted any type of personal evaluation of Patient #1 and the only evidence consists of the computer reports generated by the Licensee. There is no review of Patient #1's psychiatric, medical or developmental history, no review of prior medical treatment or symptoms, and no review of family history or review of any medical documentation by the Licensee.

28. The Licensee did not provide a review of the patient's psychiatric, medical, or developmental history, prior psychiatric treatment or symptoms, family history, family relationships, physical or sexual abuse, substance abuse, or any other possible cause of distress. The Licensee did not document the patient's physical appearance, affect, mood, or anything personal to Patient #1. There is no evidence of any type of mental status examination.

29. The computer forms generated by the Licensee conflict with the Licensee's testimony in that the Licensee reports that the face sheet of Dr. Tiller's containing the examination date of July 22, 2003 would be the

appropriate appointment date when the DTREE and GAF reports generated by the Licensee bear a date of June 21, 2003.

30. In the care and treatment of Patient #1, the Licensee departed from the applicable standard of care in that the Licensee failed to conduct a mental health evaluation. There is nothing to establish that any specific evaluation was performed by the Licensee. Further, there is nothing in the record to establish that the Licensee did anything other than subjecting the patient to the computerized programs the Licensee utilized. This is in violation of K.S.A. 65-2836(b) and K.S.A. 65-2837(a).

31. In Patient #1's records, except for the computer printouts, there is absolutely no evidence of any examination by the Licensee of Patient #1 nor is there any evidence whatsoever of what transpired between Patient #1 and the Licensee. Notwithstanding the claims of the Licensee, the date of the contact between the Licensee and Patient #1 is not clear and there is certainly no 'pertinent and significant information concerning the patient's condition.' There are merely computer generated documents that in no way provide for a meaningful record of Patient #1. This is in violation of K.S.A. 65-2836(k) and K.A.R. 1 00-24-1.

. . ."

ROA: 001036-40.

"Conclusions

1. Based upon the above findings and conclusions, it is clear that the Licensee has held herself out as a specialist in the field of psychiatric medicine in making mental health evaluations. It is equally

clear that the Licensee has failed in the cases cited above to make competent mental health evaluations that meet the applicable standard of care for the 11 patients listed above.

2. In each of the cases listed above, the only thing that is clear that the Licensee did was have patients answer "Yes" or "No" questions and plug these answers into a computer. There is no indication that the Licensee on any occasion actually conversed with a patient concerning the items necessary for a competent mental health examination to be completed.

3. The testimony of Dr. Greiner is largely discounted. This is based upon his relationship with the Licensee as well as the inability to find him credible. This is because despite the fact that even in the Licensee's treatment of Patient #8, where there was absolutely nothing done by the Licensee to reach a diagnosis, Dr. Greiner testified he believed the Licensee met the standard of care. There is no documentation whatsoever of the Licensee ever seeing Patient #8, or treating Patient #8, or performing any examination, or having any contact with Patient #8 at all. Yet, Dr. Greiner was of the opinion that the Licensee's care and treatment of Patient #8 met the applicable standard of care and that the documentation of the care for Patient #8 was adequate and met the applicable standard of care. The question then becomes, if there is absolutely nothing in the file from the Licensee, how could it possibly meet the applicable standard of care? Clearly it could not.

4. It must be noted that in each of the 11 cases above the Licensee diagnosed each patient as having a major mental illness. In some cases,

the patients were, according to the Licensee's diagnosis, suicidal. Yet, in not one single case did the Licensee make any recommendations that the patient be seen by a psychiatrist, a psychologist, or any other type of mental health worker. The Licensee simply referred each patient for a pregnancy termination. If the Licensee sincerely believed that the patients were seriously mentally ill, it would seem likely that a treating physician would recommend treatment for these rather serious mental illnesses. Yet, the Licensee ignored these alleged mental illnesses.

5. Based upon the evidence, the Licensee simply completed yes/no questions and answers and whatever diagnosis the computer gave, she assigned that diagnosis. This method of practicing medicine does not meet the applicable standard of care.

. . ."

ROA: 001051-52.

As a premise to the further analysis following, it probably is best, in the interest of clarity, to state what this case, by its evidence, did not reach.

K.S.A. 65-6703(a) establishes the legal qualifications necessary for a permissive abortion when the unborn child is viable. This in common parlance is referred to as a late term or third trimester abortion. K.S.A. 65-6703(a) provides:

"(a) No person shall perform or induce, or attempt

> to perform or induce an abortion when the unborn child is viable unless such person is a physician and has a documented referral from another physician not legally or financially affiliated with the physician performing or inducing, or attempting to perform or induce the abortion and both physicians provide a written determination, based upon a medical judgment arrived at using and exercising that degree of care, skill and proficiency commonly exercised by the ordinary skillful, careful and prudent physician in the same or similar circumstances and that would be made by a reasonably prudent physician, knowledgeable in the field, and knowledgeable about the case and the treatment possibilities with respect to the conditions involved, 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 physical impairment of a major bodily function of the pregnant woman. No condition shall be deemed to exist if it is based on a claim or diagnosis that the woman will engage in conduct that would result in her death or in substantial and irreversible physical impairment of a major bodily function."

The determination governing viability is fixed at a gestational age of an unborn child at 22 or above weeks. As relevant here, the statute further provides the following protocols.

K.S.A. 65-6703(b) states, as relevant here:

> "(b) Except in the case of a medical emergency, a copy of the written documented referral and of the abortion-performing physician's written determination shall be provided to the pregnant woman no less than 30 minutes prior to the initiation of the abortion. The written

determination shall be time-stamped at the time it is delivered to the pregnant woman. The medical basis for the determination shall also be reported by the physician as part of the written report made by the physician to the secretary of health and environment under K.S.A. 65-445, and amendments thereto. Such determination shall specify:

. . .

(3) if a continuation of the pregnancy will cause a substantial and irreversible physical impairment of a major bodily function of the pregnant woman and the medical basis of such determination, including the specific medical condition the physician believes would constitute a substantial and irreversible physical impairment of a major bodily function of the pregnant woman."

K.S.A. 65-6703(c) states, as relevant here:

". . .

(4) If the physician who is to perform the abortion determines the gestational age of an unborn child is 22 or more weeks, and determines that the unborn child is viable, both physicians under subsection (a) determine in accordance with the provisions of subsection (a) that an abortion is necessary to preserve the life of the pregnant woman or that a continuation of the pregnancy will cause a substantial and irreversible physical impairment of a major bodily function of the pregnant woman and the physician performs an abortion on the woman, [then] . . . if the abortion is not performed in a medical care facility, the physician who performs the abortion shall report such determinations, the medical basis and the reasons for such determinations, including the specific medical diagnosis for the determination that an abortion is necessary to preserve the life of the pregnant woman or that a

> continuation of the pregnancy will cause a substantial and irreversible physical impairment of a major bodily function of the pregnant woman and the name of the referring physician required by subsection (a) in writing to the secretary of health and environment as part of the written report made by the physician to the secretary of health and environment under K.S.A. 65-445, and amendments thereto.
>
> (5) The physician shall retain the medical records required to be kept under paragraphs (1) and (2) of this subsection (c) for not less than 10 years and shall retain a copy of the written reports required under paragraphs (3) and (4) of this subsection (c) for not less than 10 years."

As can be noted, for the referring physician, other than being required to make a written referral, further reporting and the maintenance of the required records is cast upon the physician actually performing the abortion by the statute.

There is no allegation in the Board's *Petition* against Dr. Neuhaus that she violated K.S.A. 65-6703 in any respect. The Kansas Healing Arts Act, since July 1, 2000, specifically empowers the Board to charge a violation of K.S.A. 65-6703 under the definition in K.S.A. 65-2837(b) of "unprofessional conduct" (K.S.A. 65-2837(b)(31)) or by an allegation that a licensee aided or abetted the performance or procurement of an

illegal abortion (K.S.A. 65-2837(b)(5)). *See* L. 2000, ch. 141, § 6. Following suit, the hearing officer, early in the proceeding, specifically advised the parties "we are not here to determine whether Doctor Neuhaus violated a criminal law. We're not here for that. We're here to determine whether she adhered to the standard of care . . . we're not here for this statute." (ROA: 002273). Hence, there is no finding by the hearing officer that K.S.A. 65-6703 was violated in any of its requirements, including its specific record keeping requirements.

Additionally, there is no allegation in the *Petition* nor did the hearing officer find that any of the diagnoses given patients #1-#11 would not qualify any one of them for an abortion under K.S.A. 65-6703(a). Further, there is no evidence that any diagnosis given *for any one of these particular eleven patients* was fully abatable, *i.e.*, reversible, by alternative treatment had the abortion not occurred or that, with or without a given diagnosis, *any one of this particular eleven patients'* general mental health would,

nevertheless, not have been permanently diminished to some greater degree, had the abortion not occurred. Rather in this regard, there was only a general, in the abstract, statement by the Board's expert, Dr. Gold, as follows:

> "A. Well, that's what I'm saying. I mean, I'm I -- I can't imagine that there could be circumstances where irreversible harm could occur, but it's not possible to say that there is irreversible harm absent treatment. So if you're talking about a psychiatric disorder or mental disorder, the standard treatments for those which have been found to be *in many, many people* effective, would imply that it's not a permanent or irreversible harm to develop depression or anxiety, or even a posttraumatic distress disorder, people recover from those." (Emphasis added)

ROA: 002853, l. 11-22.

Further, as Dr. Gold stated, "the late term abortion issue" was "not a focus of psychiatric practice or research" (ROA: 002761-62). Further, that while she believed an abortion for a psychiatric condition would be "extremely rare and unusual" (ROA: 002749), a psychiatrist would not recommend it as a treatment because a psychiatrist does not recommend "life choices" for patients (ROA: 002796-97).

Importantly, Dr. Gold, on behalf of the Board, undertook no independent diagnosis of any of these patients nor did she attempt to test any diagnosis given by forensic means from the records of Dr. Tiller, whose records she did not criticize and, in fact, acknowledged, when asked, fell within the standard of care for making such determinations, *e.g.*, ROA: 002529-30.

Thus, not only was there a lack of a charge by the Board or finding by the hearing officer that any diagnosis given failed to meet the "irreversible" test of the statute for qualification for an abortion, but any evidence that was proffered, as well, was stated in the abstract only and was never tied to any of patients #1-#11 and, hence, would fail to sustain any finding that K.S.A. 65-6703(a) was violated. This latter omission in the evidence fully carries forward in the further analysis of the administrative record in regard to the actual allegations made by the Board against Dr. Neuhaus.

What the Board has seemingly embarked upon, or at

least what its disciplinary arm thrust it into, is an indirect, in the abstract, attempt to establish or identify a standard or standards of care for making the necessary K.S.A. 65-6703(a) determination for qualification for a late term abortion on mental health grounds and, then, a violation of such standard or standards using Dr. Neuhaus's lack of records as its fulcrum, but without, at the same time, establishing noncompliance with K.S.A. 65-6703(a), without establishing a mis-diagnosis in the instances at hand, and without establishing a basis for a finding that for any diagnosis rendered or that, even regardless of the diagnosis, the failure to approve the abortion would *not* have left, to some degree, a substantial, lingering, permanent consequence to the patient's mental health.

As will be discussed following, the Court finds the Board's evidence stands as insufficient to establish that only a "mental health professional" such as a psychiatrist or child and adolescent psychiatrist, a psychologist, or a properly trained social worker is

required for such determinations or that Dr. Neuhaus lacked the ability to make, or was negligent in making, without referral, such determinations in regard to the eleven patients identified here (K.S.A. 65-2837(a)(2)) or that she consistently deviated from any applicable, identified standards of care in relation to the eleven patients identified here (K.S.A. 65-2837(b)(24)), other than in her record keeping as dictated by K.A.R. 100-24-1.

Beginning here, it cannot be emphasized enough that Dr. Gold did in her *written* expert reports, only give her opinions of Dr. Neuhaus performance as a physician in the K.S.A. 65-6703 late term abortion qualification procedure *based on the records evidenced in Dr. Neuhaus's medical files.* While Dr. Gold did have the medical record files of Dr. Tiller for each of those patients, nevertheless, those records maintained by Dr. Tiller, unless duplicated in Dr. Neuhaus's medical records, were clearly not considered by her in rendering her *written* opinions. However, in fact, beyond her written opinions, Dr. Gold's opinions

rendered at the hearing, nevertheless, remained focused only on Dr. Neuhaus's records. This conclusion can be derived by close reference to what Dr. Gold said she reviewed *subsequent* to submitting her written reports to the Board in regard to prior testimony given in other proceedings by Dr. Neuhaus. Dr. Gold recalled that Dr. Neuhaus had said that if she, Dr. Neuhaus, reviewed a record from another physician she put it in her records (ROA: 002457, l. 9 - l. 14). Further, it is clear that Dr. Gold was never directly asked a question, nor did she ever consider Dr. Neuhaus's conduct nor give an opinion, premised on an assumption that Dr. Neuhaus had, in fact, interviewed each of patients #1-#11, interviewed an accompanying parent as may have been required, or had reviewed the records for each of the patients as reflected in Dr. Tiller's files, rather her focus was only on the lack of documentation of these procedures (e.*g.*, ROA: 002660). What, at first, facially appeared to be an exception to this focus were a series of questions by the Board's prosecuting attorney with answers as follows:

"Q. After you submitted your reports to the Board of Healing Arts, did you review supplemental material that was sent to you by the board staff?

A. Yes, I did.

Q. And what did you review?

A. I reviewed the inqui -- Doctor Neuhaus' inquisition testimony from 2006, and Doctor Neuhaus' testimony in Doctor Tiller's trial in 2009.

Q. And did those items change your opinions in any way?

A. They strengthened my opinions, served to strengthen my opinions.

Q. Have you reviewed the respondent's expert's reports?

A. Yeah. I'm sorry. Yes, I have also reviewed the respondent's expert's report, I've reviewed the respondent's expert's deposition, and I have reviewed the computer programs that generate the documents entitled DTREE Positive Report --

THE REPORTER: I'm sorry. Restate that. Entitled?

A. DTREE Positive Report Diagnosis and GAF.

BY MR. HAYS:

Q. And did Doctor Greiner's opinion letter change your opinion in any way?

A. No.

Q. What about his deposition?

A. No, it did not."

ROA: 002438, l. 3 - 002439, l. 7.

However, closer review reveals these questions to Dr. Gold, and her answers, were clearly posed against the line of questions proceeding, all of which dealt with her opinions in her reports. The context of this latter testimony, particularly, when coupled with her earlier noted testimony of what she restricted her consideration of Dr. Neuhaus's prior testimony to, *i.e.*, what Dr. Neuhaus said her records contained, were, again, *all premised on the records in Dr. Neuhaus's files* (ROA: 002430, l. 14, *et seq.*)

Thus, while it is true, as a matter of grammar, that Dr. Gold expressed certain opinions that facially and literally could be said to be criticisms rendered toward Dr. Neuhaus, each of Dr. Gold's criticisms must be seen in their proper context and tempered, hence limited, by her exclusive focus on the underlying records of Dr. Neuhaus for her opinions in reference to Dr. Neuhaus's conduct and performance.

This exclusivity to her opinions about Dr. Neuhaus's performance first originates in the

"*Opinions*" section that prefaces her written reports (Board Exhibit 68, p. 4) where she states:

> "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." (Emphasis added)

ROA: 002053.

Going further, Dr. Gold in response to one of the opinions that was solicited of her by the Board, *i.e.* "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.", she expressed that Dr. Neuhaus, a family practitioner, should have referred Patient #1 to a "mental health professional" because there was "*no indication* Patient 1 had any pre-existing psychiatric disorder". Such a "mental health professional", she noted, would include a child and adolescent psychiatrist, psychologist, or social worker, with expertise in the evaluation and treatment of the presumed disorder in adolescents. (Exhibit 68, p. 4, at "Explanation of Opinion", ¶ 1 (emphasis added)).

In ¶ 2 of her "Explanation", she refers to "*no evidence*" to support the diagnosis given.

In ¶ 3, she expresses the blanket view that abortion is not a treatment for any psychiatric disorder, however, she expresses that there was "*no evaluation*" of other treatment options or they were "*not discussed*".

In ¶ 4, she expresses that "*no records*" support symptoms to support substantial or irreversible impairment.

In ¶s 5 and 6, at page 5, of her report on patient #1, she referred to the "Practice Parameters for the Psychiatric Assessment of Children and Adolescents" and states that "[a]ny deviation from these guidelines should be justified by clinical or other circumstances". Then in apparent reference to these guidelines, states:

> "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"

ROA: 002054.

She thus concludes that Dr. Neuhaus's "evaluation and treatment recommendations concerning patient #1 were deficient in the following ways", however, each and every one of the next eleven paragraphs (*Id.*, pps. 5-8) references *only* a shortfall in Dr. Neuhaus records, *e.g.* "so sparse", "does not document", "did not document", "does not present evidence", "no evidence of consideration", "no evidence" "fails to specify what", "makes no mention", "records do not indicate", or "did not describe".

Further, her answer to the second opinion solicited from her by the Board, *i.e.*, "3. If your opinion is that licensee did not adhere to the applicable standard of care, describe how, and to what degree (ordinary or gross negligence), the physician's care deviated from acceptable standards.", followed the first noted in that after first properly noting the request to cite

the different quality of the negligence, she said she could not as it was not a medical opinion, she said "I can only state", then again in each of "a - "d" of ¶ 9, she premised each answer with "there is *no evidence*". She admitted that in preparing her reports as to each patient at issue, she did not consider any statements from Dr. Neuhaus. (ROA: 002757-58; 002774-79).

However, when other questions beyond Dr. Neuhaus's records were posed to Dr. Gold, such as whether Dr. Neuhaus was qualified generally to render mental health evaluations and diagnoses in reference to patients 1-11, she was not allowed to do so, correctly the Court believes, since she had never disclosed such opinion prior. (ROA: 002443-44). She further later agreed that an internal medicine specialist (ROA: 002722) or an obstetrician and gynecologist (ROA: 002776) with training and experience could perform a mental health evaluation competently. Also see ROA: 002795-96. Although Dr. Gold was not familiar with the DTREE, she agreed the DTREE, would be useful to focus the necessary questions, but accuracy of the input

information was necessary to its effectiveness (ROA: 002792-94). She admitted that psycho-social stressors such as an unwanted pregnancy can cause a mental disorder (ROA: 002798-99). It was her opinion that she did not believe an abortion would be recommended by a psychiatrist as a treatment since psychiatrists do not recommend "life choices" for patients. (ROA: 002796-97). Dr. Gold was taken through the patients' records as subpoenaed from both Dr. Tiller (Board Exhibits 34-44) and Dr. Neuhaus (Board Exhibits 23-33) by the Board's prosecutor. In comparing the two sets of files, as reviewed by Dr. Gold, she noted that Dr. Tiller's records were within the standard of care (ROA: 002878) and his mental health evaluations, when in the record, revealed he had met the standard of care, even though one might disagree with the conclusion he reached, in that his records reflected personal contact with the patient and the exercise of judgment (ROA: 002529-30), thus distinguishing what she believed was absent *from the records of Dr. Neuhaus*.

The consequence of this testimony on Dr. Gold's

opinions, given as noted earlier that even her opinions that might at first blush be seen to extend beyond Dr. Neuahus's records actually did not, is that it shows that her opinions in reference to Dr. Neuhaus's perceived deficiencies reflect no consideration at all to what Dr. Neuhaus said she did in reference to each patient beyond what Dr. Neuhaus's records would reflect. A fair extension of this limitation could also go to her review of Dr. Greiner's report and his deposition since his opinion, in part, also encompassed what Dr. Neuhaus told him she had done.

Importantly, however, what the testimony of Dr. Gold does reflect, based on her description of what a proper mental health evaluation consists of, is that if, in fact, Dr. Neuhaus had the training and experience to exercise "clinical judgment", had interviewed each patient, and a parent, if necessary, and did review the records in Dr. Tiller's file prior to a patients' interview, which the records of Dr. Tiller support (showing the "MHC" file folder sticker fully checked on all but one file and, as well, showing

the other smaller sticker with "MHC Consult" initialed), then Dr. Gold could not but opine, had the question been posed, that Dr. Neuhaus performed within the standard of care as well.

In reviewing the hearing officer's *Initial Order* no credence whatsoever was given to this latter evidence by the hearing officer nor was it even discussed. It is as if Dr. Neuhaus had been tried *in abstentia* and her witnesses had not been called. That Dr. Neuhaus interviewed each of the noted patients and her parent, as necessary, was testified to by Dr. Neuhaus, which the testimony of Joan Armentrout and Dr. Tiller's records support. If other followup mental health treatment was needed she counseled on that (ROA: 003097, 003305), notwithstanding that her general assumption, however, was that Dr. Tiller would do the followup (ROA: 003167).

Hence, the Board's *Final Order*, by its adoption of the hearing officer's *Initial Order*, can not stand as sufficient proof to support the Board's findings of "professional incompetency", premised as it is on

failing, "to adhere to an applicable standard of care to a degree constituting ordinary negligence" or "unprofessional conduct", premised as a failure "to practice healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner", unless substantially the whole of Dr. Neuhaus's hearing presentation is disregarded since it was Dr. Neuahus's failure to maintain adequate records to support the diagnosis made that is the upper limit inherent in the opinions given by Dr. Gold and Dr. Gold admitted, otherwise, that a physician with proper training and experience could, as well, perform a mental health evaluation and establish a differential diagnosis that would be consistent with the standard of care and Dr. Gold was not allowed to express an opinion, *beyond Dr. Neuhaus's records*, about the specific or overall ability of Dr. Neuhaus to perform to any standard of care.

Further, this insufficiency in the evidence is compounded by the fact that the hearing officer, as did the Board *de facto*, wholly set aside certain material

testimony of Dr. Greiner. Other than the hearing officer's notation of those facts revealed in Dr. Greiner's testimony which indicated Dr. Greiner knew Dr. Neuhaus, had sheparded her into a fellowship program, perhaps, on a looser standard than other applicants, had obtained practice privileges for her at the clinic where he worked, and testified for her without charge, nevertheless, the hearing officer never did acknowledge the substance of Dr. Greiner's testimony in regard to the fact of the regular performance of mental health evaluations and differential diagnoses by family practice physicians or credit Dr. Geiner's professional teaching and experience in regard to such. In fact, Dr. Greiner, as an expert, directly and specifically went beyond Dr. Neuhaus's records and opined that she did conduct mental health evaluations and differential diagnoses that would meet the standard of care with respect to each of the eleven patients at issue. In fact, Dr. Greiner was the only expert that was asked, all the evidence considered, whether Dr. Neuhaus had met the

standard of care in these areas of medical practice. (ROA: 003340-41)

Even Dr. Gold recognized that this ability resided in physicians trained to do so, which she admits was part of the regular curricula of a medical school. Dr. Gold candidly recognized that this ability was not limited to psychiatrists or other denominated mental health professionals alone. Dr. Gold also found no fault with Dr. Tiller's mental health evaluations or his records and, as Dr. Tiller's records reflect, he was, like Dr. Neuhaus, a family practitioner. As noted, Dr. Gold would have had to admit, considering her testimony as a whole, that if Dr. Neuahus did what she said she did in terms of interviews and record reviews and then inputted this information though the DTREE and GAF software programs, Dr. Neuhaus would have performed to the standards of care.

Further, the hearing officer completely ignored, and never even mentioned, Dr. Neuhaus's explanation of what she did, except only very limitedly and then only in a negative context. For the most part, his opinion

rested on what he deemed was her lack of records to support his findings under those two questions posed by the Board to Dr. Gold and charged under ¶ 16 (a) and (b) of the Petition, which charged Dr. Neuhaus with failure to perform competently without negligence or consistently to the standards of care he apparently thought applicable, respectively, but, nevertheless, his findings or conclusions, either implicitly or expressly, can be seen to be more expansive that merely framed from the lack of records in relation to some patients, which is exampled here by ¶ 30 of his findings in regard to patient #1:

> "30. *In the care and treatment of Patient #1, the Licensee departed from the applicable standard of care in that the Licensee failed to conduct a mental health evaluation.* There is nothing to establish that any specific evaluation was performed by the Licensee. Further, there is nothing in the record to establish that the Licensee did anything other than subjecting the patient to the computerized programs the Licensee utilized. This is in violation of K.S.A. 65-2836(b) and K.S.A. 65-2837(a)." (Emphasis added)

ROA: *Initial Order* at 001040. *See also Initial Order* at *Findings* ¶¶ *43, 51, 61, 62, 70, 78, 89, 97, 105,*

116, and *128.*

Further, the hearing officer seemed to speak more broadly than from the mere absence of records when, in his "Conclusions", he announced as follows:

> 1. Based upon the above findings and conclusions, it is clear that the Licensee has held herself out as a specialist in the field of psychiatric medicine in making mental health evaluations. It is equally clear that the Licensee *has failed in the cases cited above to make competent mental health evaluations* that meet the applicable standard of care for the 11 patients listed above.
>
> 2. In each of the cases listed above, *the only thing that is clear that the Licensee did* was have patients answer "Yes" or "No" questions and plug these answers into a computer. *There is no indication that the Licensee on any occasion actually conversed with a patient* concerning the items necessary for a competent mental health examination to be completed.
>
> . . .
>
> 4. It must be noted that in each of the 11 cases above the Licensee diagnosed each patient as having a major mental illness. In some cases, the patients were, according to the Licensee's diagnosis, suicidal. Yet, *in not one single case did the Licensee make any recommendations* that the patient be seen by a psychiatrist, a psychologist, or any other type of mental health worker. The Licensee simply referred each patient for a pregnancy termination. If the Licensee sincerely believed that the patients were seriously mentally ill, it would seem likely that a treating physician would recommend treatment for these rather serious

mental illnesses. *Yet, the Licensee ignored these alleged mental illnesses.*

5. *Based upon the evidence*, the Licensee simply completed yes/no questions and answers and whatever diagnosis the computer gave, she assigned that diagnosis. This method of practicing medicine does not meet the applicable standard of care." (Emphasis added)

Initial Order at 1051-52.

The hearing officer made findings in regard to patients #2 and #11 that Dr. Neuhaus should have referred them for further examination by a specialist (patient #2, Findings No. 40, 41 at ROA: 1041; patient #11, Finding No. 129 at ROA: 1051), notwithstanding that it had never been established that Dr. Neuahus, herself, was unqualified to render such an opinion, other than a conclusion framed from her lack of records. As noted, in his overall "Conclusions" he found that Dr. Neuahus should have recommended further mental health treatment for all these patients. *Supra, Conclusion* No. 4.

Additionally, though struck from the record for no apparent reason by the hearing officer, Dr. Neuhaus had further explained that her records, uninventoried, had

been seized by Attorney General Kline (ROA: 003264) so she could not vouch for or recall their earlier original status. Further, Dr. Neuhaus was testifying in September, 2011, about specific events and patients encountered in 2003. He discounted the DTREE, though it was a software program specifically structured for use of the DSM-IV along with the GAF (ROA: 003033-50). He did this notwithstanding that simply no substantive authoritative evidence in the record, other than the insufficiencies claimed existing in Dr. Neuhaus's records reflecting a lack of documentation to support the proper inputs necessary to the DTREE questions, that would impeach either Dr. Neuhaus's particular use of such a program nor its particular use in the specific instances here. One specie of negative reference in his opinion to Dr. Neuhaus's testimony came in reference to conflicts between what the records reflected was her appointment date with a patient (*Initial Order* at ¶ "24") and the dates shown on her DTREE reports (*Id.* at ¶ "29"), notwithstanding her explanation about her use of the programs after the

fact and the intended use as documentation, which the DTREE manual would support (Exhibit 54, p. 92). Hence, it could only be in the proof of the complete absence of an interview with the patient and a total disregard of Dr. Tiller's records by Dr. Neuhaus that a conclusion could be reached that use of the DTREE application in the instances cited by Dr. Neuhaus was either amiss of its intended purposes or an improper application of it, particularly, such as to violate any standard of care that would be unrelated to simply record keeping.

Notwithstanding a lack of charge by the Board of a violation of K.S.A. 65-6703(a) and the hearing officer's exclusion of compliance with it as an issue, the terms of the statute was brought into the case at the initiative of the Board's prosecutor in relation to his attempt to establish, or arrive at the parameters of, a standard of care. Dr. Gold was allowed to testify that she, as a psychiatrist, could envision no circumstance where an abortion would constitute a "treatment" for a mental illness. However, the record

is completely devoid of either an explanation of what would constitute, or a succinct prognosis for, the successful treatment of any of the mental illnesses diagnosed by Dr. Neuhaus or, for that matter, any of the mental diagnoses for the patients here given by Dr. Tiller. Further, what treatments, given the brief timeline in which mental health treatments could be effected before the presenting condition - an unwanted pregnancy, hence, an unwanted chid, could not be altered, if, in fact, that condition and the circumstance sought to be avoided was causative of the mental condition found, in whole or in part, was not addressed. Hence, in the absence of evidence to the degree of a reasonable medical probability that the mental condition cited would eventually permanently abate, *i.e.*, be reversible, if treated alternatively for each of the particular patients here at issue, or that the future mental health of each of these individuals generally would *not* be substantially and permanently affected adversely if an abortion was not allowed, lacks sufficient foundation in the record to

support that the abortion was not the appropriate medical course of action or violated any standard of care.

While a psychiatrist, as Dr. Gold opined, would not recommend abortion as a course of action for a patient, or otherwise seek to impose such "life choices" on a patient, she never opined that such a course of medical proceeding would or could not be reasonable, but rather only "extremely rare and unusual" (ROA: 002747-48) and outside of a psychiatrist's recommended treatment modalities (ROA: 002796-97). She believed an abortion would be "a situational intervention for a situational problem, but not *necessarily* a psychiatric disorder" (ROA: 002788) (Emphasis added). In this case, the eleven patients here were drawn from twenty-three patients of Dr. Neuhaus, fifteen of which were the focus of Dr. Tiller's criminal trial. (ROA: 002298-99; 002337; 002342-43). Beyond that, what the parameters were for selecting the eleven patients chosen here are unknown, hence, whether these selected patients, among all the patients that could be selected, were not

within that "extremely rare and unusual" group can not be tested. Dr. Neuhaus testified that among those she saw for Dr. Tiller she did not approve all she saw (ROA: 003136-37). Ms. Armentrout affirmed this (ROA: 002928). Further, all patients were screened and tentatively approved by Dr. Tiller before an appointment could even be scheduled with his clinic (ROA: 002918, 002922).

More salent here, however, is Dr. Gold's acknowledged lack of experience with the impact of an unwanted pregnancy on the mental health of individuals, particularly, children and adolescents, such as those under scrutiny here and, hence, the absence of an opinion by her of the affect that a therapeutic abortion might provide each in regard to their mental health, particularly a mental condition diagnosed. She further acknowledged that this was neither a subject of psychiatric practice or research (ROA: 002762). Nevertheless, her opinions were that a "mental health professional" was the appropriate one to make these determinations, that in complex cases involving

children and adolescents a further referral to one specifically versed in childhood and adolescent psychiatry be made, and that only such identified professionals could make the required "differential diagnosis". The latter term was defined in *Kuhn v. Sandoz Pharmaceuticals Corp.*, 270 Kan. 443, 452, (2000) as "'[t]he determination of which of two or more diseases with similar symptoms is the one from which the patient is suffering, by a systematic comparison and contrasting of the clinical findings.'" Presumptively, here, since the diagnoses themselves were not materially challenged, the differential diagnosis referenced seems to be in relation to the pregnancy itself, such as to exclude the mere physical state of pregnancy alone as but temporarily causative of the mental condition. Dr. Gold's declaration was that she could never envision where an abortion could be considered an appropriate "treatment" for the mental conditions identified for the cases reviewed by Dr. Neuhaus.

Dr. Gold's opinion testimony in this area seems

highly declaratory in nature, greatly in the abstract, not coupled with explanation nor reflective of demonstrated experience. It may be that it is was declaratory because Dr. Gold had little practical experience in the area of children and adolescents and no experience with the particular circumstances here involving these patients, *i.e.*, pregnancy and the prospect of facing unwanted motherhood in the absence of an abortion or giving up the child for adoption and the perceived prospect, as at least one of the patients noted, of a lingering unknown of the child's future fate. Further, as she noted, this area of medicine was not an area of psychiatrist study or research. Dr. Gold could not cite to, and did not cite to, any other identifiable authority, *but her own opinion*, of what the appropriate standard of care in such a circumstance would encompass in this regard, unless it would rest in her recitation of the "Practice Parameters for the Psychiatric Assessment of Children and Adolescents", *supra*, pps. 40-41, which she characterized as "guidelines" only and which was her only proffered

quotation from any third party source. Nothing in that noted reference declares the restrictions nor mandates the additional referral she opines. Thus, at best, Dr. Gold's opinions can only rest either in the limitations of psychiatric practice, *i.e.*, psychiatrists do not make recommendations on "life choices", or her own professional limitations or her own personal practice preferences. Of course, personal practice preferences as a comparison with other physicians' methods are not properly within the realm of sound evidence to establish a standard of care. *Schlaikjer v. Kaplan*, 296 Kan. 456, 469-470 (2013); *Karrigan v. Nazareth Convent & Academy, Inc.*, 212 Kan. 44, 50 (1973).

On the other hand, family practitioners, such as Drs. Tiller, Neuhaus, and Greiner do recommend life choices, *e.g.*, stop smoking, move to a more hospitable climate, start exercising, hence, if with the training and experience to perform mental health evaluations and weigh the source of the illness, *i.e.*, make a differential diagnosis, including the impact of an unwanted pregnancy on a patient's mental health, it

would seem a family practitioner would not be constrained from recommending "life choices", if the mental health of his patient so dictated. Dr. Greiner opined as much. (ROA: 003325-26). The United States Supreme Court has not been blind to the variations:

> "I agree with the Court that a physician—within the limits of his own expertise—would be able to say that an abortion at a particular time performed on a designated patient would or would not be necessary for the 'preservation' of her 'life or health.' That judgment, however, is highly subjective, dependent on the training and insight of the particular physician and his standard as to what is 'necessary' for the 'preservation' of the mother's 'life or health.'
>
> The answers may well differ, physician to physician. Those trained in conventional obstetrics may have one answer; those with deeper psychiatric insight may have another. Each answer is clear to the particular physician. If we could read the Act as making that determination conclusive, not subject to review by judge and by jury, the case would be simple, as Mr. Justice STEWART points out. But that does such violence to the statutory scheme that I believe it is beyond the range of judicial interpretation so to read the Act. If it is to be revised in that manner, Congress should do it."

U.S. v. Vuitch, 402 U.S. 62, 74-75 (1971) (Justice Douglas dissenting, in part). See *also Doe v. Bolton,* 410 U.S. 179, 192 (1973). Kansas follows the federal law regarding abortion. *Alpha Med. Clinic v. Anderson,*

280 Kan. 903, 923-924 (2006). Thus, any restraint here, if applicable, would only come from the statute - K.S.A. 65-6703(a)) - and compliance with that statute was expressly not made part of this case nor would the evidence that crept into the record in regard to it demonstrate its violation here either.

Here, *as Dr. Neuhaus's records did not demonstrate* that expertise and experience, Dr. Gold concluded Dr. Neuhaus violated a standard of care in reference to the performance of mental health evaluations and arriving at differential diagnoses, including not making a patient referral to a specialist. No other evidence impeached Dr. Neuhaus's qualifications to perform these medical services. Accordingly, other than for the ability required to make mental health evaluations and the inherent need for one to be able to make a differential diagnosis therefrom, no further standard of care was authoritatively identified by Dr. Gold nor, even if so, was a breach by Dr. Neuhaus shown, except from her lack of records. Further, any opinion derived from Dr. Gold's opinions, based as they were on Dr.

Neuhaus's records *alone*, could only assume Dr. Neuhaus could do, or did, neither.

The flaw made in the evaluation of the evidence here, if the Board conclusions reached, or intended to be reached, went beyond the violation of a standard of care relating to the maintenance of adequate diagnostic records, is that the Board completely, as did Dr. Gold, and, as well, the hearing officer, ignore or disregard without sound reason the testimony of the witnesses presented by Dr. Neuhaus, not to mention Dr. Neuhaus herself. The principal evidence provided by her, including the records of Dr. Tiller, was that she personally individually interviewed all the patients at issue. This evidence, testimonial and documentary, was never rebutted except from any inference that could be drawn from her failure to record any patient specifics derived from her interviews or document what records of Dr. Tiller she reviewed, other than ones obtained from Dr. Tiller's office that still appeared in her file. Dr. Neuhaus testified she performed interviews and Joan Armentrout of Dr. Tiller's office, where the interviews

were conducted, testified to their regular occurrence. The records of Dr. Tiller, which reflected methods to assure the performance of mental health consultations occurred with a patient prior to sanctioning an abortion, both by himself and Dr. Neuhaus, also reflect as a whole that the personal mental health consultations occurred. (Testimony of J. Amentrout (ROA: 002953); Board Exhibits 34-44 at "MHC" file folder face sheet stickers and "MHC consult" sticker *e.g.* Patient #1 at ROA: 001328 and ROA: 001390, respectively). Only in one instance was the larger MHC sticker not checked, but yet it was still initialed as done by staff (ROA: 001543; Board Exhibit 37, patient #4) and, as well, the smaller "MHC Consult" sticker was also initialed as done. (ROA: 001597). In only one instance was the smaller "MHC Consult" sticker not initialed (ROA: 001927) but the larger MHC sticker reflected all protocols done. (Exhibit 43, patient #10). Further, that Dr. Tiller's records were provided to Dr. Neuhaus was both testified to by Dr. Neuhaus and Ms. Armentrout and was never rebutted except by the

defect in record keeping identified to Dr. Neuhaus and by Dr. Gold's recollection of what Dr. Neuhaus had said her record would contain. However, Dr. Neuhaus had explained she could not vouch for her records now by the passage of time and also because they had been seized by the Attorney General's Office. While the latter statement was stricken, however, she later noted that she had been examined on her records by an assistant attorney general at a subsequent inquisition (ROA: 003297). She further had explained that the records in her file would only have been ones she had copied for her which she wanted during her interviews and were not all the records reviewed and made available to her. (ROA: 003294 - 003300).

In terms of ability to perform mental health evaluations and exercise clinical judgment, Dr. Neuhaus held an undergraduate degree in psychology, she had, as part of her medical school training, a rotation in child and adolescent psychiatry, she was trained to do, and did, mental health evaluations and her professional career had intersected with 10,000 patients seeking

pregnancy terminations under three separate physicians who performed abortions. Certainly Dr. Gold did not consider, nor did the hearing officer materially consider, any of these facts.

Of course, undoubtedly, inherent liars do exist, but in a court of law the purpose of an oath is to deter and bring consequence, whether moral or legal, to falsehoods. *See Oaths, Their Origin, Nature and History,* James Endell Tyler (1834). As such, testimony under oath bears a facial presumption of truth. Only if within the context of a case, whether from other evidentiary circumstances, whether these circumstances emanate from a witness's testimony, from the logic of the case, or from other witnesses or evidentiary circumstances that may be present in the case, may the presumption of truth that an oath imparts to testimony given be undermined such as to not be accepted. Whether that presumption is fleeting, lingering, or lasting is one of the particular case at hand. Most certainly, relevant and material testimony can not be rejected without a rational explanation in a proceeding

such as this. General verdicts are permitted only to the security provided by a jury of peers and then only on specific instructions by the Court. Were not such the case, then no person with an interest in the result of a proceeding, even tangential, need ever testify if merely to have their testimony summarily disregarded because of such a perceived interest. Often, where witnesses detail opposite recollections such that from other circumstances existing both renditions could not be true or accurate, those subtle influences that might arise in evaluating one or the other's testimony might be brought into play. However, in the absence of controversy, that is, competing versions or other competing circumstances in the case, either specifically or overall, or other rational defects in either the witness or the testimony, that raise substantial and overriding impediments such that the proffered testimony or evidence cannot reasonably and believably stand as true or as a rational articulation of what occurred may mere expressions by a factfinder of non-belief for diminishing such testimony, or even

the total disregard of it, stand as other than arbitrary or capricious. Particularly, unless the evidence specifically or overall provides an avenue for the complete disregard of testimony, a fact finder is not wholly privileged to disregard undisputed evidence or, within the privilege of written opinion, fail to explain the basis for that diminishment or its disregard. *In re Estate of Johnson,* 155 Kan. 437, 439 (1942). While the burden of proof may invoke a mindset of skepticism, it is not a warrant for unjustified disregard. Hence, even on a negative finding that a burden of proof had not been met, a factfinder can not wholly escape scrutiny from its unexplained rejection. *Nance v. Harvey County,* 263 Kan. 542 (1997). Except by the perceived lack of supporting documentation in Dr. Neuhaus's records, none of the evidence advanced by Dr. Neuhaus stood as either materially disputed or contested. Dr. Neuhaus had no burden of proof in this proceeding on any fact or issue before the Board.

Here, as to witness, Ms. Armentrout, no basis is stated for the disregard of her testimony, whatsoever,

such that from the decision made it would be as if she had never testified that yes, interviews were arranged by her office, and, yes, Dr. Neuhaus met with each patient and, yes, Dr. Tiller's records were all provided to Dr. Neuhaus in advance. The hearing officer limited and foreclosed the testimony of other former personnel in Dr. Tiller's office for a technical violation of a sequester order, inappropriately this Court believes (*Barber v. Emery,* 101 Kan. 314, 317 (1917); *Davenport v. Ogg,* 15 Kan. 278 (*363) (1875)), which witnesses, being known to Dr. Neuhaus, would most likely have been favorable, *e.g.*, ROA: 001641. Nevertheless, Ms. Armentrout was not substantively impeached overall, which testimony independently confirmed the fact of Dr. Neuahus's interviews and the provision of Dr. Tiller's records to her. Further, as previously noted, Dr. Tiller's office protocols recorded the fact of interviews and personal contact by each physician, hence, further reflecting the happening of these occurrences. None of these undisputed evidentiary supports to Dr. Neuhaus's testimony were

discussed by the hearing officer. As noted earlier, Dr. Gold's written opinions never encompassed this information and, had it been, Dr. Gold would certainly not have been privileged to or justified in wholly ignoring it when providing her expert opinions. As noted earlier, even when considering some testimony of Dr. Neuhaus that was provided to her subsequently, Dr. Gold only employed it in her hearing testimony to establish what records Dr. Neuhaus had reviewed (ROA: 002457). As noted, Dr. Neuhaus more fully explained in the hearing in this case that prior testimony referenced, explaining that it was only in reference to records she took into her interviews, not all records she reviewed. (ROA: 003294-003300).

Here, Dr. Neuhaus testified she reviewed the records of Dr. Tiller, conducted interviews, and later inputed the DTREE program based on her notes and recollections since her earlier experience indicated that attempting to work the DTREE program while interviewing a patient was disruptive of the interview process and made it less effective. Yet, the hearing

officer wholly ignored Dr. Neuhaus's testimony, with the sole basis for doing so as either her lack of adequate record keeping, a perceived misplaced justification for that lack, or an occasional date discrepancy between the patient appointment date and the date printed on Dr. Neuhaus's DTREE and GAF reports, notwithstanding Dr. Neuhaus attributed any error in the dates was occasioned principally by the fact these reports were printed later. As noted from the respective user manuals for the DTREE and GAF programs, the computer would reflect the day the data was entered on the computer unless manually altered to reflect the actual date of the rating or report. (Exhibit 54, p. 92; Exhibit 57, p. 86).

By not crediting Ms. Armentrout's testimony, Dr. Tiller's records, or that of Dr. Neuhaus, it would have to be concluded that the hearing officer, though unexpressed by him, believed that no interviews whatsoever, in fact, were ever conducted by Dr. Neuhaus, that the appropriate records were never reviewed, and that Dr. Neuhaus, by training and

experience, was incompetent to perform a mental health examination or make a differential diagnosis. As to the latter, Dr. Greiner's testimony relating to mental health evaluations and by whom and what training is needed to perform them and a resulting differential diagnosis would have to be wholly set aside. These omissions are enhanced because even Dr. Gold's opinions on the standard of care for performing mental health evaluations and making a differential diagnosis, including her testimony concerning use of the DTREE program, acknowledge implicitly that if the records existing in Dr. Tiller's files were reviewed, interviews were had, and "clinical judgment" was applied, including to the DTREE, her opinion on the standard of care would be satisfied. Thus, if Dr. Neuhaus conducted interviews with these denominated patients, reviewed Dr. Tiller's records, and applied clinical judgment, which she then posted to the DSM-IV criteria through the DTREE, Dr. Gold's opinion on the standard of care for mental health evaluations and making a differential diagnosis would have to have been

found to have been met on all bases unrelated to record keeping.

Here, accordingly, if the hearing officer's opinion is to be construed to conclude that Dr. Neuhaus violated a standard of care, whether in performing mental health evaluations, arriving at a differential diagnosis, not making a referral, or on some other perceived standard of care, beyond a breach of the standard of care relating to record keeping, it must rest solely on an inference founded on his view of the quality, or, rather, the lack of quality of, or quantity to, Dr. Neuhaus's records. In this Court's view, such an inference is too slim, too frail, and too conjectual to support any of his conclusions reached beyond a breach of adequate record keeping. His disregard of Dr. Neuhaus's testimony, that of Ms. Armentrout, the whole of Dr. Greiner's testimony concerning the "how to" and "who can" conduct mental health evaluations and make differential diagnoses, and the fact of Dr. Tiller's confirming records that all interviews and record protocols were followed is both

unexplained and unexplainable. Hence, permitting an inference, arising from the paucity or patchiness of Dr. Neuhaus's records, to stand as the sole proof of any of the propositions advanced that go beyond the proper standard for the maintenance of medical records, grossly affronts the burden of proof, which burden rested fully on the Kansas State Board of Healing Arts. Clearly, the "record as a whole" lacks "substantial evidence" to support such an inference.

The hearing officer treated this case, beyond any issue purely of the requirements of record maintenance, as one consisting of circumstantial evidence only, where he believed he could choose to follow the absence of documentation to a conclusion of no, or non, performance by Dr. Neuhaus. While certainly a factfinder may pick from competing conclusions to be drawn from circumstantial evidence (*Arterburn v. St. Joseph Hosp. & Rehab. Ctr.*, 220 Kan. 57, 62-63 (1976); *Friedman,* 296 Kan. at 668), the conclusion ultimately selected must have "substantial evidence" to support it:

"In Duncan v. Railway Co., 82 Kan. 230, 108 Pac. 101, syl. 2, it was held that-

'Where there is no substantial evidence, direct or circumstantial, tending to prove a material fact in issue, a finding that it exists cannot be sustained.'

In the opinion, Justice Benson said:

'Presumptions, as understood in the law of evidence, must have substantial probative force as distinguished from surmise. If a fact may be established by inference from the presumption of another fact, it should at least be a logical deduction and reasonably certain in the light of all other proper presumptions and of all collateral facts. The chain of presumptions ought not to be extended into the region of conjecture. Diel v. Mo. Pac. Ry. Co., 37 Mo. App. 454. A fact is not proved by circumstances which are merely consistent with its existence. Carruthers v. C., R. I. & P. Ry. Co., 55 Kan. 600 [40 Pac. 915].

. . ."

Cash v. Kansas Oil Refining Co., 103 Kan. 880, 889-890 (1918).

Admittedly, the testimonial evidence proffered by Dr. Neuhaus herself competed with the dismal state of her records. However, the testimony from Ms. Armentrout was not circumstantial, but direct, as were the records of Dr. Tiller, which physically supported the testimony of both Ms. Armentrout and Dr. Neuhaus. It can also be noted here there was no direct evidence

offered from any former patient or one of these eleven patients here, or a parent or a guardian of one of them, that no interviews occurred nor was there explanation why this evidence was not available even from at least one former patient of Dr. Neuhaus, or a care giver, or some other of the scores of abortion seeking patients seen by her. As Dr. Neuhaus testified, and as Ms. Armentrout confirmed, she did not approve all patients she saw for an abortion and some were upset. Certainly, it would seem, given, as Ms. Armentrout testified, the records for all scheduled patients at Dr. Tiller's clinic were maintained, that one of such unapproved patients, or a sponsoring individual with knowledge, could have been identified.

Further, here there is no evidence that any diagnosis given by Dr. Neuahus was incorrect except by the absence of supporting documentation in Dr. Neuhaus's records. However, even when error was cited based on the lack of documentation in Dr. Neuhaus's file, Dr. Gold gave no opinion nor proffered any explanation for whether the error was the result of a

failure to follow a standard of care unrelated to omissions in Dr. Neuhaus's records or whether another diagnosis, in fact, existed. Without an actual interview of the particular patient, Dr. Gold, herself, by her own stated standards of record, could not provide any authoritative diagnosis. However, even at that, she made no attempt to forensically use what she described as records meeting the standard of care maintained in Dr. Tiller's files for each patient to test any diagnosis given by either Dr. Neuhaus or Dr. Tiller.

From the Court's review of this record, the Court perceives Dr. Gold as a straight forward witness who, unlike many hired experts, commendably did not shy from recognizing either factual limitations on the opinions she could render, her own professional or personal limitations, or her own field of medicine's limitations in regard to the issues before her. Given that her expert reports were limited to Dr. Neuhaus's records and given further the limitation she placed on her use of the testimony of Dr. Neuhaus that she reviewed

subsequent to providing her reports, this Court's impression is that she was, most likely, drawn beyond the bounds of her preparation and her experience and did the best she then could in responding to the Board prosecutor's attempt to flesh out its unspecified allegations as embodied in ¶ *15.e.* of the Board's *Petition*. Additionally, it should neither be inferred nor concluded from this Court's overall opinion in this case that the Court has concluded that only physicians who provide abortions have the exclusive experience to make the character of medical judgments called for in this case, notwithstanding that such medical providers do have significant experience that, in the absence of other equally quantifiable medical experience or study, can not be discounted when assessing the intersection of the physical and mental effects that may have come to fore, or may have been exacerbated, due to an unwanted pregnancy.

Accordingly, based on the evidentiary references and discussions above and the evidence of record greatly summarized by the Court in its appendix hereto,

which is incorporated herein in full, the Court would find that the Board's allegations in its Petition, for which the Board's findings thereon are reflected in its *Final Order*, incorporating the *Initial Order* of its hearing officer, can be sustained as a matter of the burden of proof at the agency level as to each of its Counts I - XI *only* as stated and alleged at ¶ 16c, which, again, provides:

> "16. Licensee's acts and conduct during the course of treating Patient #1 constitute violations of the Kansas Healing Arts Act as follows:
>
> . . .
>
> c. K.S.A. 65-2836(k), in that Licensee has violated a lawful regulation promulgated by the Board, specifically, K.A.R. 100-24-1, by failing to meet the minimum requirements for an adequate patient record."

ROA: 000008.

This allegation states a violation of K.S.A. 65-2837(k) based on a violation of K.A.R. 100-24-1 in relation to the maintenance of adequate medical records by Dr. Neuhaus. That regulation of the Board, the Court finds, is not only for the protection of the public, but also for the protection of an individual

licensee of the Board of Healing Arts from misdirected claims. It is also for the protection of the integrity of the applicable healing arts profession itself. It further operates to facilitate proper peer review, where appropriate, and, of course, supports effective regulatory oversight of a licensee's profession by the Kansas State Board of Healing Arts.

Fundamentally, K.A.R. 100-24-1 requires the maintenance of records in regard to patient encounters such that a like provider, trained and knowledgeable in the particular field of the healing arts, could, upon review, say that, based on the record maintained or, in the least, by reference to other readily reliable and readily available sources clearly identified in the record, the particular diagnosis or actions taken or omitted by that particular healing arts provider facially indicate a compliance with relevant standards of care or other accepted professional practices in the licensee's field of practice.

It is clear here that Dr. Neuhaus's maintenance of records as to each of patients #1-#11 fell below the

requirements of K.A.R. 100-24-1 and below any reasonably required standard of care for their maintenance because she failed to document and maintain the reference material she used for her inputs into the DTREE and GAF programs, such that, without such documentation, her own professional conduct, the integrity of her profession in the field of medicine in which she was then engaged, which was, and is, highly controversial, and the proper functioning of regulatory oversight was placed in jeopardy and made subject to allegations of inept, unprofessional, even illegal, conduct which could not be, at least, *prima facie* resolved by reference to her own records. However, from the record as a whole, her omissions have not been proven to have been for nefarious reasons, but, rather, just quite inadequate and short-sighted. While it is correct that from a DTREE or GAF report one can deduce the patient's circumstances from the response to the questions asked, it is equally clear that without a record of the inputs there is a lack of means for verification of the resulting diagnosis. It was in

this omission of record retention that Dr. Neuhaus principally erred. Nevertheless, this omission has brought great attention, belabored many, and its resolution has, and will upset some, regardless, all of which K.S.A. 65-2836(k) and K.A.R. 100-24-1 seeks to forestall or mitigate, if not ever wholly prevent.

As discussed, the Board's findings concerning its charges stated in ¶ 16.a. and ¶ 16.b. of its *Petition* under each of its Counts I - XI in support of a violation of K.S.A. 65-2837(a)(2) and K.S.A. 65-2837(b)(24) lack "substantial evidence" to support them within the meaning of K.S.A. 77-621(c)(7) and (d). This lack of substantial evidence renders the Board's *Final Order* as to those charges "arbitrary" and "capricious" as those terms are used in K.S.A. 77-621(c)(8). Because the pleading structure of the Board's *Petition*, charging separately in ¶ 16.c. the violation of K.S.A. 65-2836(k) by violation of K.A.R. 100-24-1, the Court must construe the charge of unprofessional conduct in ¶ 16.b., citing only subparagraph "(24)" of K.S.A. 65-2837(b), not subparagraph "(25)", as intending to be

applicable only to conduct other than that charged in ¶ *16.c.*, notwithstanding that a violation of K.S.A. 65-2837(b)(25), which relates to inadequate medical record keeping, would constitute "unprofessional conduct" as well. Further, since the Court found that the Board failed to prove by substantial evidence that Dr. Neuhaus could not perform mental health evaluations or make differential diagnoses generally, or as to any cited patient, or prove that the doing of the same were within the exclusive province of psychiatrists or other like specialties, any claim Dr. Neuhaus held herself out as able to perform medical services beyond her training and licensure must fail.

Here, because the license to practice the healing arts of Dr. Neuhaus was revoked and the hearing's costs assessed to her were both based on the *Final Order* of the Board, which encompassed erroneous findings, both the order of revocation and the order of cost assessment are vacated.

Nevertheless, except as to the allegation set forth in ¶ *16.c.* of its *Petition*, which Board finding is

sustained, all other findings in support of its *Petition* under ¶ *16.a.* and ¶ *16.b.* are reversed as a matter of the Board's pleadings, the facts of the case, and the law applying. Further, because the revocation of licensure and the costs assessment sanctions were premised on the findings in the Board's *Final Order* as a whole, this matter must be remanded back to the Kansas State Board of Healing Arts for rehearing as to the appropriate sanction or sanctions, if any, to be imposed upon Dr. Neuhaus's for her violation of K.S.A. 65-2836(k) by her violation of K.A.R. 100-24-1.

ENTRY OF JUDGMENT

Judgment is hereby entered sustaining in part, and reversing in part, the *Final Order* of the Kansas State Board of Healing Arts for the reasons stated in the foregoing *Memorandum Opinion*. The Board's order of revocation of licensure and its order assessing costs are each vacated. This case is remanded to the Kansas State Board of Healing Arts for further hearing concerning the sanction or sanctions, if any, to be imposed upon Ann K. Neuhaus, M.D., for her violation of

K.S.A. 65-2836(k) by her violation of K.A.R. 100-24-1. The Court's filing fee is taxed as paid.

This entry of judgment shall be effective when filed with the Clerk of this Court and no further journal entry is required.

IT IS SO ORDERED, this 7th day of March, 2014.

Franklin R. Theis
Judge of the District Court
Division Seven

cc: Robert Eye
Kelly Kauffman
Kelli Stevens

APPENDIX

The following is a synopsis by the Court of what it believed the record revealed was the substantive, relevant, and material testimony given by witnesses at the hearing, excluding the testimony of Board witness, Mr. Hacker, the Board's investigator, who testified as to the origin of the complaint and his record gathering. (ROA: 002251-002358). Testimony that the Court believed was materially repetitive has been omitted.

Further, the Court has exampled various provisions of the separate user manuals for the DTREE and GAF computer programs used by Dr. Neuhaus.

Finally, the Court reviewed and inventoried the records of Dr. Tiller and Dr. Neuhaus in relation to the eleven patients setting the contents of the record out as to each patient, first with Dr. Tiller's, then followed by Dr. Neuhaus's.

The pages listing for the appendix are as follows:

THE TESTIMONY OF BOARD EXPERT WITNESS LIZA H. GOLD, M.D. (ROA: 002374-002907) AND AN EXAMPLE OF ONE OF HER REPORTS

The Board of Healing Arts proffered in support of its case Dr. Liza H. Gold, M.D., who held the designation as a Board Certified psychiatrist. She also held a designation in a sub-specialty as a forensic psychiatrist. Her use of that latter specialty has rested exclusively in consulting in civil litigation involving workmen's compensation and disability claims. She is also a professor in psychiatry at Georgetown in Washington, D.C. She presently is an assistant editor of the *Journal of the American Academy of Psychiatry and Law* where she reviews submitted articles for statistical problems,

research techniques and the like. She initially learned how to screen for mental health problems as part of her general medical school training by using a variety of tools to do so. Her internship and residency of 3 1/2 years was, she stated, primarily consumed with mental health evaluations. In regard to this latter training, she testified as follows:

> "Q. Now, you also stated that you had a psychiatry residency?
>
> A. Yes.
>
> Q. What's involved in that?
>
> A. You have to do -- well, for most specialties, you have to do a year of internship. So you have to do a year of internship to go on to the residency. Internship is - there are different kinds, medical, surgical. There's also rotational or transitional internship. But you have to complete a year of internship and then you go on to a specialty training. It's three years of specialty training in all areas of psychiatry or psychiatric practice.
>
> Q. And what did yours involve?
>
> A. Extensive inpatient and outpatient clinical practice, training, treating patients, diagnosing patients, outpatient follow-up. Mine also involved some training in electroshock therapy, issues involving commitment, treating children, adolescents. They - they are also required rotational required rotations within a residency. So, for a general psychiatry residency, you have to do or have exposure to

most or all of the subspecialties. So, for example, there's a rotation child and adolescent psychiatry, there's a rotation in geriatric psychiatry. If your school has the -- or if your training program has access to forensic, there's a rotation in forensic. If there aren't rotations, there are also didactics or lectures, courses on those. And, so, you're also expected to do quite a bit of course work while you're a resident, as well.

Q. Now, within all of your formal medical school training, have you been trained on how to perform a mental health evaluation?

A. Yes.

Q. And what kind of training have you received?

A. In med -- in medical school?

Q. (Nods head.)

A. In medical school, it's relatively basic, obviously, and it gets more complex as you go on. But you basically learn how to screen someone for mental health problems through a variety of screening tools, the clinical interview, use of rating scales or inventories, that type of thing.

Q. And what additional training have you had on mental health evaluations?

A. Well, after - after that, I did three years -- three-and-a half, because I did some of it during my internship as well, of almost exclusive training on doing mental health evaluations, diagnosing, admitting, treating, et cetera. So you go from the relatively basic training you get in medical school that all medical students have to have to highly specialized training.

Q. And what's some of that highly specialized training?

A. I'm sorry?

Q. What's some of that highly specialized training ?

A. Working in treating patients exclusively on your own with supervision by other physicians initially and then more - with less and less supervision. Teaching and training people who are coming up who don't have as much experience as you have. Being responsible for primary patient care on psychiatric units. Inpatient and outpatient, admitting, discharging, basically managing all aspects of care of -- of patients whose primary problems are psychiatric. They may have other problems. It also includes consultation for patients whose primary problems may be medical, but may have a psychiatric problem that their doctor wants a specialist's opinion on."

ROA: 002383, l. 7 - 002386, l. 9.

She also testified she wrote an article, not part of the record, about treating depression during pregnancy with medications, which she described as a "tricky business" and did consultations for other doctors on referrals and for treatment (ROA: 002397-99). She stated she had evaluated some adolescents in her hospital practice and fewer in private practice. She could only identify two such patients overall that

she interacted with that were pregnant (ROA: 002401-02). She had discussed pregnancy, however, with some of her adult patients, but no particulars of the discussions were identified (ROA: 002404-05). On cross-examination, she stated she has never consulted with a patient in reference to an abortion procedure or testified in an abortion context prior, with this being the first time she has done so (ROA: 002731-33). Further, she says she does not consider herself a specialist in evaluating psychiatric disorders in adolescents or children and holds no specialty designation as such (ROA: 002735). Further, she has had no specialized training or education in regard to abortion (ROA: 002736) nor has she ever evaluated any individual to determine whether an abortion would be consistent with preserving the mental or physical health of the mother (ROA: 002740).

Dr. Gold testified what the Board representatives had asked her to do was the following:

> "Q. You also had other items made known to you by the board?

A. Items other than the medical records?

Q. Yes, ma'am.

A. Yes.

Q. And what were those items?

A. There were certain statutes that were provided for my review.

Q. So let's talk about those. What statutes were provided for you?

A. Well, I don't know the numbers of them off the top of my head.

Q. Can you give the overall generalized --

A. There were - the statutes related to document -- documentation. There were statutes that related to abortion and statutes related to third trimester abortions. I'm not sure they were referred to as third-trimester, I think they were referred to as late term.

Q. Now, did you prepare an expert report on this situation -- or in this case?

A. I prefer - I prepared 11 expert reports, one for each case file.

Q. And did you document the items that were initially made known to you by the board --

A. Yes.

Q. -- within your patient -- or within your your expert reports?

A. Yes, I did.

Q. And how did you use those items in coming to your expert opinion?

A. I was asked to give an opinion on standard of care relative to documentation and evaluation and treatment. And in order to do that, you need to know what the legal framework for the standard of care is. Legal standard of care is statutorily defined. The - that's what is required by law. Medical standard of care often overlaps the legal standard of care, but it's not exactly the same thing. So just because something is written as a statute or a law doesn't mean that it's the standard of care medically, i.e. what the common and average practitioner does. So -

Q. Were you giving -- given a definition of the standard of care?

A. Yes, I was.

Q. And is that document in your expert reports?

A. Yes, it is.

Q. Is -- is how you used it documented in within your expert reports?

A. Yes.

Q. And you prepared written reports for Patients 1 through 11, is that correct?

A. That is correct."

ROA: 002413, l. 15 - 002415, l. 20.

She explained what constituted a mental health evaluation:

"Q. And what's -- what makes up a mental

health evaluation?

A. A mental health evaluation consists of a clinical interview where you review a patient's presenting problems, duration, frequency, intensity of current symptoms, their past history, if any, including treatment and response to treatment, family history, social history, occupational history. You know, and again, especially in adolescents, you would not look so much at occupational, but at academic history. Family history, medical history. You get a complete background and you do a mental status examination, which is a directed set of questions to determine psychiatric and cognitive functioning at that moment in time when you're actually seeing the patient. You may get -- you may refer for additional evaluation. For example, if it's a new onset disorder and someone with no previous history and you suspect there may be a medical problem, you may refer that person for a medical evaluation. You may refer for a -- a head CT or a -- a MRI. Lab tests are often, if not always, part of the initial evaluation. And medical records, if those are available.

Q. What about evaluating their behavioral and functional impact of their conditions?

A. Well, that's part of -- that's part of the conclusory part of the evaluation. And at the -- at the end of getting all that data, you come to certain conclusions. And part of the data -- when I say present symptoms, intensity, frequency, duration, et cetera, symptoms and their behavioral impact go together, so that's --

Q. And when do you perform these mental health evaluations?

A. At -- when I see the patients.

Q. Do you perform it every time that you see the patient?

A. Well, no. You do -- you do a -- certainly, the first one or two times, depending on how complex the case is, it might even be a few more times than that, you do an extensive evaluation. After that, the evaluations are less extensive. For example, their family history's not going to change necessarily. You know, their childhood history is not going to change. Those are things that are pretty stable. There are things you re-evaluate as you go along. For example, if someone's using drugs or alcohol, you re-evaluate that each time you see them, how much are you still using, et cetera. So and it doesn't have to be quite as formal, because once you come to know somebody, if that person's mental status changes, often, you know, it's observable. Just like the way once you come to know someone, you can tell a lot of stuff about them just by sitting and talking to them.

Q. Now, have you -- I believe you testified that you've had patients referred to you?

A. Yes.

Q. From another physician?

A. Yes. From -- I -- I've had consultations from primary care practice doctors, OB-GYN doctors and other psychiatrists regarding treatment of depression -- primarily, depression and anxiety to moods disorders and anxiety disorders in pregnant and postpartum women.

Q. And when you have those patients referred to you, do you do your own mental health evaluation?

A. Yes.

Q. Do you rely upon other physicians' mental health evaluations, if performed?

A. Well, their -- I rely upon their information to the extent that it informs --it's more data that informs my own evaluation. But depending on what I get and -- and how well documented it is and whether it looks like it was a -- an in-depth evaluation, the weight I give it varies."

ROA: 002405, l. 21 - 002409, l.1.

She explained how to use the DSM-IV and by whom:

"Q. And you also stated that you utilized the DSM. Can you explain what that is?

A. That's correct. Diagnostic and Statistical Manual, the current edition, is -- and it is referred to as DSM. The current edition is the fourth edition with some text revision, so it's DSM-IV TR is the shorthand way that people refer to it. And that is the resource published by the American Psychiatric Association that lists recognized psychiatric diagnoses. And it lists the diagnoses and it lists the criteria for the diagnoses. And also, a lot of data regarding, you know, the incidents and that kind of thing.

Q. How is the manual used?

A. Well, that manual is - is supposed to be used to assist diagnosis of psychiatric disorders by clinicians who are skilled and experienced in the application of -- of the -- of the criteria to come to diagnostic conclusions.

Q. Is it used locally or how is it -- how many --

A. It -- it is a national and international resource that is used locally, nationally, in other countries. It's used by medical and nonmedical entities. It is basically the -- the current taxonomy of psychiatric disorders.

Q. Do you know what year it came out?

A. The DSM-IV-TR came out in 2000. The original edition of DSM IV was 1996. The third edition was in 1980. And there's going to be a fifth edition next year.

Q. Can you tell us what the difference is between the DSM IV and the DSM-IV-TR is?

A. Yeah. The -- none of the diagnoses were changed between DSM-IV and IV TR. Some of the text was revised, so TR stands for text revision. So the text was revised to update some of the scientific data that had changed between 1996 and 2000 or that had not been included in the 1996 edition.

Q. Can you explain how you utilized the DSM in the review in your review of these patient records?

A. Well, in order to make a diagnosis, people have to -- in order to qualify for a diagnosis, patients have to meet certain criteria. And the DSM provides those criteria. So you you can't be -- with some exceptions, you generally can't be -- a diagnosis can't be applied to an individual who doesn't meet all the criteria of the diagnosis. So you use the DSM to compare, basically, those criteria.

Q. And in using the DSM-IV-TR, do you have to use clinical judgment?

A. Yes.

Q. And do you know whether the DSM-IV-TR states that?

A. Yes, it does. It -- it states very clearly in the beginning that it is not to be used either as a cookbook or as a diagnostic tool -- a die -- or as a diagnostic assessment just by

asking a list of questions, that clinical judgment has to be applied.

MR. HAYS: And if I could have a moment. And if I may approach?

PRESIDING OFFICER: (Nods head.)

MR. HAYS: Can you hand me the DSM-IV? May I approach?

. . .

BY MR. HAYS:

Q. Okay. Have you reviewed that page before?

A. Multiple times.

Q. And can you tell us what the meaning of that page is?

A. That it's -- it is a -- referred to as a cautionary - part of the cautionary statement about things that the DSM is not supposed to be used for or should be used cautiously for. One of things that the writers or the framers of the DSM worried about was that by providing a taxonomy -- a taxonomy of psychiatric diagnoses that involved counting certain symptoms, that people without clinical experience and training in understanding and interpreting symptoms would use the DSM as a cookbook. If you had this, this, this and this, then you had this disorder. And they put the caution in so that it's clear this developed classification of mental disorders developed through using clinical, educational and research settings that are meant to be employed by individuals with appropriate clinical training and experience in diagnosis. And the next sentence is, it is the key one, it is important that DSM-IV not be applied mechanically by untrained individuals.

The diagnoses are guidelines to be informed by clinical judgment and not meant to be used in a cookbook fashion.

Q. All right. Thank you, ma'am.

MR. HAYS: And we're going to make copies of this page and place it in. And I believe it's going to be Exhibit 84 if I'm not mistaken.

BY MR. HAYS:

Q. Now, how does the DSM recommend that you conduct - conduct a psychiatric evaluation?

A. The DSM recommends that you collect all of the information that I discussed previously. They do -- and I -- and I don't think they list it specifically, it's called the standard psychiatric examination and the presentation of your conclusions or data are suggested to be presented in what's called a -- a five axes or the axial system, which basically, is five categories referred to as Axis I, Axis II, Axis III, Axis IV and Axis V.

Q. And what are those axis?

A. Axis I is for major mental disorders. It's where you -- where you would write down the major mental disorders, i.e. the -- the diagnoses you would find in the DSM. Axis II is for personality disorders or mental retardation codes. Axis III is medical problems, any active or pertinent relevant medical problems. Axis IV is for listing and - and rating potentially of psychosocial stressors, that is environmental factors that might be relevant to the psychiatric presentation. And Axis V is a rating scale called the global assessment of functioning where it recommends that you assign a numerical score based on the data that's given.

Q. Can you explain that Axis V GAF a little

bit?

A. Yeah. GAF is a scale from zero to 100 which is meant to be used to reflect impairment in various aspects of psychological, occupational or social functioning due to psychiatric symptoms. It can also be used to describe severity of psych of psychiatric symptoms. It's an either/or, either severity of psychiatric symptoms or impairment in functioning. And it breaks down into 10 Sort of subgroups with specifiers. So how -- how an individual is functioning, did -- they give examples in the DSM and the evaluator looks at the examples, relies on their clinical training and experience and determines what's the most appropriate rating score.

. . .

BY MR. HAYS:

Q. And what I'm handing to you is a copy of the DSM-IV. Can you tell us, is that GAF information -- or is the Axis V information about the GAF located in the DSM-IV?

A. Yes, it is?

. . .

BY MR. HAYS:

Q. And is that material that you reviewed in for your review of these patient records?

A. Yes.

. . .

BY MR. HAYS:

Q. And what's the significance of those pages?

A. Well, that basically is a short description of how the global assessment of functioning scale is supposed to be used and is also the actual scale, so it's a -- a sample of the actual scale.

Q. And what is the function of the GAF?

A. Well, it there's a -- a few different functions of it. It is a way, a shorthand way to communicate among treatment providers of a variety of information, including current level of functioning, prior level of functioning, changes in level of functioning, from previous to current and then on forward with treatment whether the treatment is effective. If treatment is effective, theoretically, the level of functioning should improve. So it's a -- it's a shorthand way of tracking levels of impairment and symptoms and what changes there are backwards or forwards.

Q. Is it designed to be used as a stand-alone access -- axis?

A. No.

Q. Why is that?

A. Because it doesn't convey -- of itself, a number does not convey specific information. And even the general statements, if you look in, you know, what's associated- just pick a number -- No. 60, it says, moderate symptoms, and then it gives some general examples. But if you write down, 60 moderate symptoms on a patient's chart with nothing else, you really haven't communicated anything about that individual patient. What are those symptoms, how are they affecting functioning, et cetera. So as a stand-alone without any additional data, no."

ROA: 002418, l. 23 - 002430, l. 13.

Based on her analysis, she opined the following:

"Q. Are those complete reports for Patient 1 through 11?

A. Yes.

Q. Do they contain the relevant events that are contained in the records for your patient?

A. Yes.

Q. Do they contain your opinions about whether Doctor Neuhaus met the standard of care in performing an adequate patient interview for each patient?

A. Yes.

Q. Do they cane - contain your opinions about whether Doctor Neuhaus met the standard of care in performing an adequate review of the patient's history?

A. Yes.

Q . Do they contain your opinions whether Doctor Neuhaus met the standard of care in performing an adequate evaluation of the behavioral or functional impact of each patient's condition and symptoms?

A. Yes.

Q. Do they contain your opinions about whether Doctor Neuhaus met the standard of care in performing an adequate mental status examination?

A. Yes.

Q. For each patient, for Patient 1 through 11.

A. Yes.

Q. Do they contain your opinions about whether Doctor Neuhaus met the standard of care in meeting the minimum requirements for adequate patient -- for every documentation for patient -- Patients 1 through 11?

A. They contain my opinions regard -- regarding standard of care for documentation, I didn't address it to minimum requirement of documentation.

Q. Okay. Do they contain your opinions at -- on whether Doctor Neuhaus was performing an evaluation that a type by a medical -- that is performed by a medical doctor who has specialized training in the field of psychiatry?

A. Well, they -- they're mental health evaluations so they contain my opinion regarding mental health evaluation, which is typically with -- performed by a medical doctor, a psychiatric evaluation.

Q. Do they contain your opinions as to whether these mental health evaluations performed by Doctor Neuhaus on Patient 1 through 11 required specialized training?

A. Yes.

Q. Do the reports contain your opinions on whether Doctor Neuhaus met the standard of care in performing a mental health evaluation which served as her basis of determining a diagnosis for each patient?

A. Yes.

Q. Where present -- a diagnosis where present?

A. Yes, where present.

Q. For Patient 1 through 11, correct?

A. Correct.

. . ."

ROA: 002431, l. 15 - 002434, l.3.

Exhibit 68, Dr. Gold's report for patient #1, is as follows:

"Liza H. Gold, MD

Clinical Professor of Psychiatry
Georgetown University Medical Center

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

Kathleen Setzler-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.

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: GAP REPORT - Patient 1 is given a GAP (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 G AF 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 GAP 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. <u>If your opinion is that Licensee 2 did not</u>

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.

/s/ Liza H. Gold, MD"

ROA: 002050-58.

"BY MR. HAYS:

Q. After you submitted your reports to the Board of Healing Arts, did you review supplemental material that was sent to you by the board staff?

A. Yes, I did.

Q. And what did you review?

A. I reviewed the inqui -- Doctor Neuhaus' inquisition testimony from 2006, and Doctor Neuhaus' testimony in Doctor Tiller's trial in 2009.

Q. And did those items change your opinions in any way?

A. They strengthened my opinions, served to

strengthen my opinions.

Q. Have you reviewed the respondent's expert's reports?

A. Yeah. I'm sorry. Yes, I have also reviewed the respondent's expert's report, I've reviewed the respondent's expert's deposition, and I have reviewed the computer programs that generate the documents entitled DTREE Positive Report --

THE REPORTER: I'm sorry. Restate that. Entitled?

A. DTREE Positive Report Diagnosis and GAF.

BY MR. HAYS:

Q. And did Doctor Greiner's opinion letter change your opinion in any way?

A. No.

Q. What about his deposition?

A. No, it did not."

ROA: 002438, l. 2 - 002439, l. 7.

Dr. Gold opined as to the training needed to perform a mental health evaluation.

"Q. Could you please explain what a mental health evaluation is?

MR. EYE: Objection, asked and answered.

PRESIDING OFFICER: Sustained.

BY MR. HAYS:

Q. Now, you've already testified about

performing those. Can you - can you testify about the -- the training that a -- a physician would need to be able to perform those?

MR. EYE: Objection, I believe that was also asked and answered.

MR. HAYS: Sir, I believe I asked about her training and not specifically what a physician would need.

MR. EYE: I'll withdraw the objection.

PRESIDING OFFICER: Overruled, yes. Go ahead.

MR. HAYS: You can answer.

A. Well, in the sense that anybody can ask a series of questions, anybody could ask the series of questions if they're listed on a chart. How you -- the quality of the data you collect and how you interrupt it requires clinical training and expertise. And typically, a mental health examination is typically done by someone who's had more training than just general medical education. There are different levels of more training. There's training for social workers, training for psychologists, training for psychiatric nurses and training for doctors.

BY MR. HAYS:

Q. And how would a physician obtain this type of training?

A. Well, that's what psychiatric training is. You wouldn't necessarily have to be board-- a board certified psychiatrist in order to have specialized expertise, but you certainly have to have committed psychiatric structured training. It's not -- it's not something that can just be self-taught."

ROA: 002440, l. 14 - 002442, l.3.

She described her qualification she deemed necessary to evaluate patients 1-11.

> "Q. And in your reviewing of these patient records and other materials that you reviewed, have you come to an opinion as to what the level of training is as required to perform those mental health evaluations of Patients 1 through 11?
>
> A. Yes.
>
> Q. And what is that opinion?
>
> A. My opinion is that these are psychiatric -- complicated psychiatric evaluations of children and adolescents and should have been referred to a child and adolescent mental health professional, whether a psychiatrist, psychologist, licensed social worker.
>
> Q. And that's your expert opinion?
>
> A. Yes."

ROA: 002442, l. 20 - 002443, l. 9.

She was asked whether Dr. Neuhaus was qualified to perform the evaluations, but was not permitted to answer since she acknowledged that she had never heretofore in her reports or otherwise rendered such an opinion. (ROA: 002443-44).

During cross-examination she reiterated her opinion was based on a standard of care provided to her by the

Board (ROA: 002746). She used the Kansas statute to "inform" her as to the standard of care to be applied but not as establishing it and, in fact, none of the material supplied her specified a standard of care (ROA: 002747). She stated that it was *her opinion only* that an abortion necessitated for reasons of mental health of the mother would be "extremely rare and unusual" (ROA: 002747-49). She also indicated that the guidelines she referenced in her analysis from the American Academy of Child and Adolescent Psychiatry did not represent the standard of care but only "informed" it (ROA: 002750). She believed these guidelines would be adaptable to the circumstances as informed by "clinical judgment" (ROA: 002760) as similarly would the DSM-IV-TR (ROA: 002783). Dr. Gold further testified as follows on cross-examination:

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

not expect to see such a thing and there is not such a thing.

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

A. We could.

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

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

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

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

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

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

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

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

the question?

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

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

Q. Again, in your deposition of June 24, 2011, do you recall the question that says, have you ever reviewed the literature to determine whether there is empirical evidence to support the statements you've just made, and that statement was, you've never heard -- or there's no research on a circumstance when a psychiatrist would make a recommendation for a late-term abortion? Your answer continues, quote, I have reviewed -- having an issue in gender and psychiatry and reproductive and biological psychiatry, reviewed. One can't say all because that would be unreasonable, but an extreme amount of the literature regarding psychiatric interventions and problems regarding pregnancy, psychiatric illness during pregnancy, adoption issues, postpartum issues, lactation in postpartum, the effects of maternal illness on pregnancies on children already born -- born, there is a huge amount of literature out there and I have reviewed quite a bit of it. I have written about some of it. The late-term abortion issue is not a psychiatric issue. Do you remember that testimony that you gave?

A. Yes.

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

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

ROA: 002759, l. 8 - 002762, l. 10.

She later agreed that an internal medicine specialist (ROA: 002722) or an obstetrician and gynecologist (ROA: 002776) with training and experience could perform a mental health evaluation competently. Also see (ROA: 002795-96). She admitted that in preparing her reports as to each patient at issue, she did not consider any statements from Dr. Neuhaus what she, Dr. Neuhaus, did in terms of observation or interviews, only a review of her records notwithstanding that subsequent to providing her written reports she reviewed testimony that had been given by Dr. Neuhaus in an inquisition and at Dr. Tiller's criminal trial. (ROA: 002757-58; 002774-79). Although Dr. Gold was not familiar with the DTREE she agreed the DTREE would be useful to focus the necessary questions, but accuracy of the input information was necessary to its effectiveness (ROA: 002792-94). She admitted that psycho-social stressors such as an unwanted pregnancy can cause a mental disorder (ROA: 002798-99). It was her opinion that she did not believe an abortion would be recommended by a

psychiatrist since psychiatrists do not recommend "life choices" for patients. (ROA: 002796-97)

Dr. Gold was taken through the patients records as subpoenaed from both Dr. Tiller (Board Exhibits 34-44) and Dr. Neuhaus (Board Exhibit 23-33). In comparing the two sets of files, as reviewed by Dr. Gold, she noted that Dr. Tiller's records regarding his mental health evaluations revealed he had met the standard of care, even though one might disagree with the conclusion he reached in that his records reflected personal contact with the patient and the exercise of judgment (ROA: 002529-30), thus distinguishing what she believed was absent from the records of Dr. Neuhaus. In terms of the diagnoses rendered by Dr. Neuhaus, she only stated that "the standard treatments for those which have been found to be in many, many people effective, would imply . . . people recover from those." (ROA: 002853)

THE TESTIMONY OF ANN K. NEUHAUS, M.D.'s WITNESS JOAN ARMENTROUT (ROA: 002915-002955):

Dr. Neuhaus first presented Joan Armentrout who

testified that during the period in question she was the office manager for Dr. Tiller. She explained the patient scheduling process, which patient scheduling was contingent on information regarding their gestational circumstance and the information given according to a "MI" statement, which, before scheduling an appointment, Dr. Tiller would review and approve or not approve a scheduling. She and office staff had been trained in use of the MI statement by Dr. Tiller (ROA: 002918-22). Once scheduled, they would advise Dr. Neuhaus as well of the date and provide to her the MI statement. When the patient arrived and a medical history was taken, an additional MI, maternal indicators, statement, and a sonogram would be performed (ROA: 002923).

In regard to Dr. Neuhaus's presence at the clinic she testified as follows:

> "Q. And did Doctor Neuhaus come to the clinic in Wichita?
>
> A. Yes.
>
> Q. And, was there room provided for her to conduct the interviews?

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

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

MR. HAYS: Objection, speculation.

PRESIDING OFFICER: Overruled.

A. She would go through --

BY MR. EYE:

Q. Hold on, Ms. Armentrout, there is an objection that's pending.

PRESIDING OFFICER: Overruled.

BY MR. EYE:

Q. You may continue. You can go ahead and tell us

A. Okay.

Q. -- what the nature of Doctor Neuhaus' interviews were.

A. All right. She would take a patient with the patient's permission she could include after she interviewed the patient, could include patient family members or who had accompanied the patient and oftentimes would -- would meet with all of the support people that were with the patient, and the patient would have been told that -- what Kansas law was requiring a second Kansas doctor to, you know, approve them. So I was never present during the interviews so I can't tell you the nature of -- of the exam and the interview, but the patient knew, you know, what -- what to expect that it was required by law that -- that two Kansas doctors

approve them."

ROA: 002923, l. 17 - 002925, l. 2.

Ms. Armentrout responded also in regard to the records provided by Dr. Neuhaus at that time and Dr. Neuhaus's handling of them:

> "Q. All right. And, Ms. Armentrout, when Doctor Neuhaus would come to the clinic would the records that had been accumulated for a patient be available and provided to her?
>
> A. Yes. She would have access to the patient's chart and all of the records that it contained once the patient finished with the medical history, and she would have that available to her before she ever met the patients.
>
> Q. Ms. Armentrout, what would the usual compilation of patient information consist of that would be provided to Doctor Neuhaus?
>
> A. Okay. Well, the original what we called the top sheet which contained all the personal information and a few medical questions allergies et cetera, height, weight, the MI Statement that she would have already seen a copy of. Then the complete medical history front and back pages, about four pages that they would have filled out and that concerned, you know, any kind of previous illnesses, surgeries, it was a fairly complete medical questions that they had to fill out. They also would have filled out the consent form , the 24 hour consent, they would have filled out their MI Statement. And then the sonogram records would have been included in that because they would have had a sonogram prior to meeting with her.
>
> Q. Ms. Armentrout, and these records would be provided to Doctor Neuhaus prior to the

interview commencing, is that correct?

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

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

A. Yes.

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

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

ROA: 002925, l. 17 - 002927, l. 10.

She also testified that she had never heard complaints from patients nor from Dr. Tiller regarding Dr. Neuhaus's work. (ROA: 002927). Further, she testified that not all patient's interviewed by Dr. Neuhaus were approved by her as qualified for an abortion (ROA: 002928-29) and that all of the records generated prior to such non-approval were kept (ROA: 002931-32). She further testified that on occasions, generally weather related, some interviews with the patients by Dr. Neuhaus would be by phone, that she had

personally observed on occasion patients proceeding into the interview room and that the interview generally were one to two hours, and occasionally longer (ROA: 002932-33).

On cross-examination, Ms. Armentrout was questioned in regard to some previous testimony given in the criminal trial of Dr. Tiller, where she had referenced Dr. Neuhaus interviews at 30 minutes to an hour and she acknowledged that testimony by saying "Yes. It was - and it would vary." (ROA: 002942) She was also queried about a Tiller office file folder sticker with "MHC" on the front, which meant mental health consultation, which elicited the following:

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

ROA: 002939, l. 24 - 002940, l. 7.

She also affirmed that the staff of Dr. Tiller's clinic would not have been present in the room during

Dr. Neuhaus's patient interviews (ROA: 002949-50). On redirect, the only additional testimony in regard to the questions asked on cross-examination was whether the interview length nor any other office procedure was time limited which she replied it was not limited (ROA: 002953). She also stated further in regard to the "MHC" sticker as follows:

> "Q. Ms. Armentrout, you were asked some questions about the labels that would be on the front of charts, do you remember those questions?
>
> A. Yes.
>
> Q. I want to just make sure the record is clear on that. If the box where-- that would be next to Doctor Neuhaus' name, if that box is checked what does that mean to you?
>
> A. It would mean that she had met with the patient."

ROA: 002953, l. 16 - l. 25.

THE TESTIMONY OF ANN K. NEUHAUS, M.D.'s WITNESS SARA LOVE (ROA: 002955-002975):

Next Dr. Neuhaus's attorney called Sara Love a former Tiller office employee. Her testimony began essentially as Ms. Armentrout's did, but explained the extent of the records given to Dr. Neuhaus at the clinic prior to the interview, but at that point the

Board's attorney raised the issue of a sequester order in place though another Tiller office employee witness, Ms. Esquina, had clearly been noted as present in the room earlier with Ms. Armentrout (ROA: 002916) and Ms. Love's arrival had earlier been noted by the Court Reporter for the record (ROA: 002934). Notwithstanding, the hearing officer struck Ms. Love's testimony at that point (ROA: 002961 - 002966), although she was later permitted to testify about similar employment practices at another abortion provider's clinic and the significance Dr. Tiller placed on the training he gave his employees to take the MI statement (ROA: 002970-71).

THE TESTIMONY OF ANN K. NEUHAUS, M.D. (ROA: 002975 - 003315):

Dr. Neuhaus was called on her own behalf. She testified she graduated from K.U. Medical School, where, like all such medical training, she was schooled in psychiatry, which included a rotation in child and adolescent psychiatry under the instruction of a professor who was a specialist in childhood depression

and traumatic disorders. She also had OB/GYN rotation in a clinic in Wamego. As an undergraduate she had a degree in psychology. After her medical degree she worked in family medicine, where she was exposed to and performed mental evaluations. She migrated to a general medical practice in Westmoreland to satisfy a scholarship commitment to rural practice, whereupon she was called upon, as the occasion arose, to perform mental evaluations and, thereafter, in the student health center at K-State gaining the same character of experience. Thereafter, she returned to the Kansas City area to the family practice where she had first been, where the practice then was primarily pregnancy terminations and, where she was earlier trained in, and performed, mental health evaluations. She also worked outside of that practice with other clinics and at the time Dr. Tiller asked her to provide the necessary second opinion for late term abortions, she had taken over the principal practice of a physician who performed abortions in Lawrence. (ROA: 002975 - 003010). She believed through 2002 she had been so

involved with up to 10,000 pregnancy terminations (ROA: 002998).

While Dr. Neuhaus noted she was not a psychiatrist, she had been trained and was experienced in mental health evaluations, particularly, considerable clinical experience with mental health evaluations in regard to pregnancy termination. She testified she felt so confident in her approach to mental health evaluations that she characterized the performance of one now as like driving a car. (ROA: 003002-03). Thus in diagnosing an existing mental condition, her interview of these patients, particularly coupled with the fact she had access to Dr. Tiller's records which had an MI (maternal indicators), statement, a medical history, and a personal history, her role, she believed, was as an independent source, to find, confirm, deny, or expand, this information through an interview, and then use her clinical experience with mental health evaluations. Her testimony at the hearing was replete with her insistence she interviewed the patients at issue here, not only generally (ROA: 003051-54) but

tailored it to the individual (*e.g.* ROA: 003010-12; ROA: 003064-65). The records that were available for her to review were specifically identified (*e.g.* ROA: 003056-99). If there were discrepancies or omissions in her records, she provided answers as to why she believed they existed (ROA: 003118-21; 003127-3130; 003150-3153; 003156-3157). She intended the DTREE to be her documentation (ROA: 003033, 003305). She recommended follow-up care as needed (003097-99). She never retreated from this position on cross-examination.

THE TESTIMONY OF ANN NEUHAUS, M.D.'S EXPERT WITNESS K. ALLEN GREINER, JR., M.D. (ROA: 003316 - 003495):

Dr. Neuhaus's attorney then called K. Allen Greiner, Jr., M.D., a Board Certified family practitioner, who was also a professor at the University of Kansas Medical School. Dr. Greiner testified he practices in a family medical clinic maintained at the University and teaches clinical skills to medical students. He also serves as a consultant to the Center for Medicare and Medicaid

Services through a non-profit body engaged for that purpose to evaluate quality of care issues in the provision of those services. He acts, too, as a consultant to the Wyandotte County Health Department. (ROA: 003316-29). He testified it was in that latter context that he first met Dr. Neuhaus some 3 1/2 years prior to his testimony. Subsequently, he sheparded her into a fellowship program sponsored by the University in the area of public health, and acted as her mentor. While, Dr. Neuhaus was currently allowed to see patients at the University at the same clinic as Dr. Greiner, she held no University position. (ROA: 003353-61). He testified Dr. Neuhaus asked him and he consented, to review the patient files at issue and provide an expert report and that he did so without charge. She had told him she did not believe she had erred in any way (ROA: at 003362).

Dr. Greiner gave an opinion that Dr. Neuhaus had met a standard of care in conducting mental health evaluations, in fact, going beyond what any standard of care would require, testifying as follows:

"Q. Doctor Greiner, in terms of your experience as a clinician and also as a person who reviews charts in a peer review sense for Kansas Foundation for Medical Care, is it your experience that practitioners in Kansas, family practitioners in Kansas who make mental illness diagnoses use more diagnostic methods than used by Doctor Neuhaus in her work with the patients in this matter?

A. No.

Q. Do they frequently use less?

A. Yes.

Q. And is that one of the bases for your opinions in this regard, in this matter?

A. Yes.

Q. Is it within the standard of care, for instance, to arrive at a diagnosis of a mental illness, that is a diagnosis made by a family practitioner, without using -- formally using the GAF?

A. Yes.

Q. And same question for the DTREE?

A. Yes.

Q. Now, Doctor Greiner, the chart for Patient No. 8, I believe, does not have a GAF or a DTREE. Do you remember that chart? Do you remember one of the charts does not have a GAF or DTREE?

A. Yes.

Q. Did that chart have a SIGECAPPS or an MI?

A. I believe it had an MI Statement, yes.

Q. And is the MI Statement, which includes the SIGECAPPS review, is that a, a useful tool in determining the mental status and functioning of a patient?

A. Yes.

Q. Why?

A. Because it, it asks a series of questions that again over time and tested repeatedly in clinical environment have, have shown to provide valuable information about a patient's mental status, functioning, behavior, as well as various psychological and psychiatric pathologies.

Q. So, those are relevant questions that are being posed?

A. Yes."

ROA: 003343, l. 3 - 003344, l. 23.

He also described, as the Board affirmed by its question on cross-examination (ROA: 003494), that Dr. Neuhaus's role was that of a consultant. He had earlier testified about the context and limitations of her consult as follows:

"Q. Doctor Greiner, what -- what was your -- what's your understanding of the purpose of the evaluations that Doctor Neuhaus did for Doctor Tiller?

A. My understanding is that these evaluations occurred so that Doctor Neuhaus could determine if there was a substantial or irreversible potential for harm to these patients by continuing these

pregnancies. So it was a fairy -- fairly limited and narrow purpose to these encounters.

Q. And in that regard, given that, as you've described it, a narrow purpose, would there have been a necessity to a -- to develop a treatment plan?

A. No.

Q. Would there have been a necessity, given the purpose of the evaluation, to make a referral?

A. No. An outside referral no.

Q. Did the purpose of that evaluation define the nature of the examination that -- that would have been undertaken by Doctor Neuhaus?

. . .

A. Yes. I believe those -- the circumstances within which [s]he was operating and . . ."

ROA: 003488, l. 7 - 003489, l. 9.

THE "DTREE" AND THE "GAF" COMPUTER SOFTWARE PROGRAMS:

Dr. Neuhaus identified using the "DTREE" an aid in performing all her mental health evaluations for the eleven patients subject of the complaint against her. Her records reflect, in all but one instance (patient #8), the use of the "DTREE". One of the two manuals for the computer program employed by her was "The DSM-IV Expert" and the "GAF REPORT For the Global

Assessment of Functioning Scale".

As the Windows version software manual (Exhibit 54) it is a commercial product for "The DSM-IV Expert". In its "Publisher's Preface", the manual states, in relevant part, as follows:

> "DTREE is one tool in a series of DSM-IV products developed and published by Multi-Health Systems for use in PsychManager: Your Personal and Professional Organizer, and PsychManager Lite. As a member of this product family, DTREE provides enormous assistance to mental health providers making diagnostic decisions and ensures complete diagnostic assessment records. The program's connection with PsychManager enables DTREE to share patient and diagnostic information with other applications, to facilitate quick and easy practice and file management and maintenance."

Exhibit 54, p. xii.

Dr. Neuhaus used the DTREE as part of the "PsychManager Lite" software program (Exhibit 53). In its "Welcome to DTREE: The DSM-IV Expert" section:

> "Welcome to DTREE: The DSM-IV Expert, and thank you for choosing MHS to assist you in computerizing your practice.
>
> DTREE: The DSM-IV Expert is a computerized diagnostic decision-making assistant. A clinical aid, DTREE combines the accuracy and comprehensive nature of electronic decision trees with a clinician's judgment of a patient's symptomatology in order to determine a DSM-IV Axis I differential diagnosis. Like the SCID

> Screen Patient Questionnaire Computer Program (formerly Mini-SCID), the Computer-Assisted SCID II (for personality disorders) and the GAF Report FR the Global Assessment of Functioning Scale, DTREE helps make the diagnostic process quick and easy and facilitates complete and accurate documentation of patient records.
>
> DTREE comprises seven decision trees, each of which corresponds to a particular cluster of symptoms and diagnoses. To help mental health providers select the most pertinent trees to explore, DTREE is equipped with two screening tools-the brief Screening Questionnaire and the ability to import results form the SCID Screen PQ, an Axis I symptom and disorders patient questionnaire. The seven DTREE decision trees explore the areas of Mental Disorders Due to a General Medical Condition, Substance-Related Disorders, Psychotic Disorders, Mood Disorders, Anxiety Disorders, Somatoform Disorders, and eating Disorders. As a clinician makes his or her way through a tree, various diagnoses are ruled in and out until criteria are met for a specific or multiple diagnoses. The Summary report, one of two reports the program can generate, provides a complete picture of a patient's diagnostic assessment, including rationale for ruling in or out various diagnoses.
>
> It is essential that DTREE and other DSM-IV diagnostic tools be used in conjunction with a complete clinical examination, and that clinicians using this program enure proper and professional administration of the diagnostic process.
>
> . . ."

Id., p. xiii.

In the manual, its authors/developers tout credentials never impeached in this proceeding. (See,

Exhibit 54, p. XIV-XV.) How the DTREE operates is reflected in a section labeled "Diagnosing Patient's With DTREE: AN OVERVIEW":

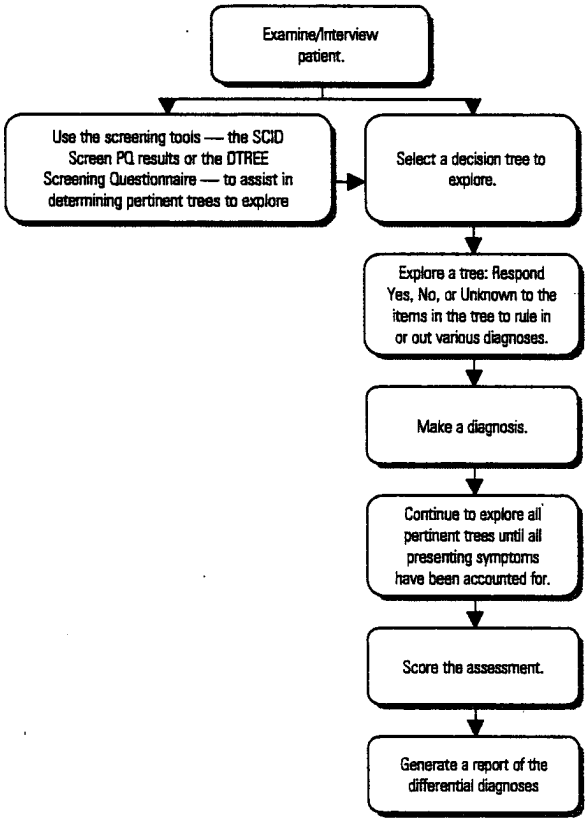
> "The DTREE diagnostic process involves the completion of three major steps: selecting a tree to begin exploring, exploring the trees, and making a diagnosis. Two screening tools assist with the first step: the brief Screening Questionnaire, consisting of 25 questions inquiring about the presence of key symptoms, identifies which of the seven decision trees need to be explored during the assessment process and, if installed, the SCID Screen PQ can advise the clinician on which trees need to be explored based on the results of a SCID Screen PQ self—report assessment. Once a tree is selected, the assessment will begin.
>
> As a decision tree is explored, various diagnoses will be ruled in and out until, based on responses to the items in the decision tree, the patient's presentation meets the criteria for a particular diagnosis. When a diagnosis is made, the clinician is prompted to identify the current severity of symptoms/status of disorder (i.e., mild, moderate, severe, in partial remission, in full remission, prior history) and, if applicable, indicate subtypes and specifiers, in order to ensure the most comprehensive representation of a patient's symptomatology is recorded.
>
> After making a diagnosis, a clinician can continue to explore the current tree, select another tree, or exit from the assessment andscore and generate a report. The Summary report provides a comprehensive picture of the diagnostic assessment, including rationale for ruling in or out specific diagnoses. The Positive Dx report lists the diagnoses that have been made and, for each diagnosis, provides the criteria met to determine the diagnosis.

The diagram below illustrates the DTREE diagnostic process from conducting the initial patient interview to making a differential diagnosis and generating a report of the results.

Id. p. 3.

"THE DTREE DECISION TREES

Each tree in DTREE represents a specific cluster of symptoms and diagnoses and consists of a batch of questions pertinent to that specific diagnostic area. The trees and the circumstances under which each tree should be explored are as follows:



Id. p. 4.

> "**Tree I** *Mental Disorders Due to a General Medical Condition Tree* - Consider this tree only if there is evidence from either the history, physical examination, or laboratory tests that presenting symptoms are due to the direct physiological effects of a general medical condition.
>
> . . .
>
> **Tree IV** *Mood Disorders Tree* — Consider this tree only if the presenting symptoms include depressed, elevated, expansive, or irritable mood.
>
> **Tree V** *Anxiety Disorders Tree* - Consider this tree only if the presenting symptoms include anxiety, fear, avoidance, increased arousal, obsessions, or compulsions.
>
> . . ."

Id. pps. 4-5.

The manual further states under the heading "DSM-IV Axis I Diagnoses Included in DTREE" as follows, and the "Trees" as relevant here:

> "Axis I of the DSM-IV comprises all disorders or conditions in the DSM-IV classification system, except for Personality Disorders and Mental Retardation (both of which are reported on Axis II). DTREE contains those DSM-IV diagnoses that are covered in the six decision trees included in Appendix A of the DSM-IV manual, as well as those included in one additional tree for diagnosing eating disorders. These diagnoses cover the vast majority of symptoms or problems that patients present with and are the basis for making a differential diagnosis. The following diagnostic areas are not included in DTREE: sleep disorders, sexual disorders, dissociative disorders, childhood disorders (other than separation anxiety disorders),

and impulse control disorders. Furthermore, the research categories included in DSM-IV Appendix B, Criteria Sets and Axes Provided for further Study, are not included in DTREE due to their 'unofficial' status. Note that Personality Disorders are covered comprehensively in the CAS II software package, available from MHS.

The following provides a complete list of the Axis I differential diagnoses that each tree in DTREE can produce:

Tree I *Mental Disorders Due to a General Medical Condition Tree*

. . .

s Mood Disorder Due to a General Medical Condition
s Anxiety Disorder Due to a General Medical Condition

. . .

Tree IV - Mood Disorders Tree
s Mood Disorder Due to a General Medical Condition
s Substance-Induced Mood Disorder
s Manic Episode
s Hypomanic Episode
s Major Depressive Episode
s Mixed Episode
s Bipolar I Disorder
s Bipolar II Disorder
s Schizoaffective Disorder, Bipolar Type
s Bipolar Disorder NOS (Superimposed on a Psychotic Disorder)
s Cyclothymic Disorder
s Major Depressive Disorder
s Dysthymic Disorder
s Schizoaffective Disorder, Depressive Type
s Depressive Disorder NDS (Superimposed on a Psychotic Disorder)
s Adjustment Disorder with Depressed Mood

Tree V - Anxiety Disorders Tree

s Anxiety Disorder Due to a General Condition

s Substance-Induced Anxiety Disorder
s Panic Disorder with Agoraphobia
s Panic Disorder without Agoraphobia
s Agoraphobia without History of Panic Disorder
s Separation Anxiety Disorder
s Social Phobia
s Specific Phobia
s Obsessive Compulsive Disorder
s Generalized Anxiety Disorder
s Posttraumatic Stress Disorder
s Acute Stress Disorder
s Adjustment Disorder with Anxiety
s Anxiety Disorder NOS
s Anxiety as an Associated Feature

. . ."

Id., pps. 6-8.

Under its "Program Uses", its "Continuing Remarks", and its "User Qualifications" denominated sections, it states, respectively:

> "**PROGRAM USES**
>
> DTREE is designed to be used in conjunction with a clinician's knowledge of a patient to assist in diagnosing adult patients with DSM-IV Axis I disorders. Therefore, DTREE assessments should be preceded by a complete clinical examination of a patient. Users of the SCID Screen PQ, a computer-administered patient questionnaire, which screens for Axis I symptoms, can use DTREE to finalize diagnostic assessments that begin with this patient questionnaire.
>
> DTREE can be used in a number of settings, including outpatient clinics, inpatient clinics, residential treatment centers, and private practice offices. Potential users of DTREE include psychiatrists, psychologists, social

workers, physicians, and counselors. DTREE is also a useful tool in education/ training and research settings.

The DTREE Summary report, which provides a comprehensive picture of a diagnostic assessment, including rationale for ruling in or out specific diagnoses, and the Positive Dx report can be exported to be used in managed care, treatment planning, peer reviews, substance abuse programs, clinical records, utilization reviews, and forensic reports.

CAUTIONARY REMARKS

When using DTREE: The DSM-IV Expert in clinical situations, the following limitations must be recognized.

First, the proper use of this program requires specialized clinical training that provides a large body of knowledge and clinical skills. The accuracy of output is strictly limited by the quality of the clinical observations that are used in addressing the DTREE questions.

Second, this program can only aid the clinician in making a diagnosis; a clinical diagnosis and all of its ramifications for junction with a clinician's treatment is the complete responsibility of the clinician, who must consider all available data.

Finally, many patients may have disorders not covered by DTREE. The authors and publisher are not responsible for any inaccurate diagnoses that may result from the use of this program.

USER QUALIFICATIONS

DTREE is designed to assist in diagnostic decision making. It is intended to be employed in conjunction with a complete clinical examination. The results from a DTREE assessment should not be

considered a substitute for sound clinical judgment based on various sources of information. It is the responsibility of the professional using this program to ensure that the diagnostic process be carried out properly and professionally.

Furthermore, untrained individuals are not equipped with the necessary knowledge to apply the DSM–IV in a clinical setting. The diagnostic categories and criteria are meant to be employed by individuals with appropriate clinical training and experience in diagnosis. The diagnostic criteria provided in the DSM–IV and in DTREE are guidelines that must be informed by clinical judgment.

Qualified users of DTREE should belong to professional associations that endorse a set of standards for the ethical use of psychological tests or possess a license to practice psychology, medicine, social work or an allied field. Individuals whose only exposure to psychiatric diagnosis or psychological assessment is this program are not qualified users of DTREE."

Id. pps. 10-11

Since differences in rating or report dates and asserted patient interview dates has been raised, the following reflected in the user manual is noted:

"The date and time you have set for your computer or network server appear in the DTREE History screen and the PsychManager Assessment History folder, as well as in reports generated from DTREE. To ensure your records are accurate, check periodically to see if your system date and time are correct."

Id., p. 92.

Further, questions have been impliedly raised about a patient's report or the time to complete a DTREE report. A sample report shown in Exhibit 4 Appendix B, at p. 112 reflects its example as follows:

"DTREE Positive Dx Report

Patient Name:	Ted E. Albany
Diagnosing Date and Time:	5/7/97 13:44
Report Date and Time:	5/7/97 13:55
Trees Explored:	Tree III

The following diagnosis in tree III has been made.

BRIEF PSYCHOTIC DISORDER

298.8 Brief Psychotic Disorder, With Marked Stressors, Mild

There have NOT been clinically significant periods of depressed, elevated, euphoric, or irritable mood.

The disturbance has NOT lasted at least one month (including prodromal, active and residual phases).

The duration of the disturbance has been for at least one day but less than one month.

The disturbance is NOT due to the direct physiological effects of a substance (e.g., a drug of abuse or a medication).

The disturbance is NOT due to the general

physiological effects of a general medical condition."

Id., p. 112.

Lastly, it should be noted that the DTREE instruction manual advised the following:

> "For all of the decision trees, except Tree III – the Psychotic Disorders tree, multiple diagnoses can be made within a tree for the same individual. Sometimes these represent concurrent co-morbidity (e.g., Panic Disorder and Obsessive–Compulsive Disorder present at the same time) and sometimes different disorders occurring at different periods in the individual's lifetime (for example, a person with lifelong alcohol dependence having multiple past episodes of Delirium, while having current Dementia secondary to the alcoholism)."

Id., p. 73.

Additionally, as noted above in the "Welcome to DTREE. . ." section, Dr. Neuhaus used the Global Assessment of Functioning Scale (GAF) computer program (Exhibit 57) in conjunction with the use of the DTREE. The user manual accompanying the GAF program describes the GAF Report as follows, in part:

> "The GAF scale is a 100-point scale that measures psychological, social, and occupational functioning. Based on the widely used Global Assessment Scale (GAS), the Global Assessment of Functioning Scale has been an element of the multiaxial system since 1987. The GAF Report assessment items presented to the clinician about a patient's psychiatric symptoms and functioning

ensure that all aspects of functioning—psychological, social, and occupational—are considered in patient assessment, and that both symptom severity and level of functioning are appropriately taken into account. An illustration of the decision tree, which forms the basis of the program, is provided in Chapter 5, in Figures 5-1 and 5-2."

Exhibit 57, p. 2.

The manuals "Program Uses" section advises the following:

"**Program Uses**

The GAF Report is a computerized diagnostic assistant that aids mental health professionals in determining a patient's over-all level of functioning according to the Global Assessment of Functioning Scale, which comprises DSM-IV Axis V. Specifically, the program is designed to guide clinicians through a methodical and comprehensive consideration of all aspects of a patient's functioning in arriving at a patient's rating on the GAF scale. This rating can be used in planning treatment, measuring its impact, and predicting outcome.

The GAF Report can be used to assess patients of all ages in a number of settings, including outpatient clinics, inpatient clinics, residential treatment centers, and private practice offices. Potential users of the instrument include psychiatrists, psychologists, social workers, physicians, counselors, and psychiatric workers. The program can also be used in research and training settings.

The GAF scale is particularly useful in managed care-driven diagnostic evaluations. The rating can be used to determine eligibility for treatment and disability benefits. Decisions such as whether an

individual's condition entitles him or her to mental health benefits depend not only on the patient's psychiatric diagnosis, but rather on a combination of factors. These factors include a consideration of how a disorder affects a patient's overall level of functioning, indicated by a low score on the GAF. As well, the scale can be used for determining type of treatment, level of care required, and duration of treatment. Some managed care companies, for example, require a GAP rating of below 40 in order for inpatient hospitalization to be considered, or one of below 65 for outpatient treatment.

Because of its increasing application in a wide number of clinic and research settings, the importance of making an accurate GAP rating has grown. The GAF Report's design ensures a clinician's consideration of all aspects of a patient's functioning in reaching a rating, and addresses the growing need for accuracy and reliability in reporting."

Id., p. 4.

Under the manual's "Cautionary Remarks" heading, it states, in part:

"The accuracy of the GAF score generated by the GAF Report is limited by the validity of the answers provided to its questions. Therefore, the GAF Report should only be used after a comprehensive clinical evaluation has been conducted by an individual with clinical skills."

Id., p. 5.

The "User Qualifications" the GAF states:

"Potential users of the GAF Report should be familiar with the standards for educational and psychological testing, developed jointly by the American Psychological Association, the American

Educational Research Association, and the National Council on Measurement in Education. Qualified users of the GAF Report should be members of professional associations which endorse standards for the ethical use of psychological or educational tests, or licensed professionals in the areas of psychology, education, medicine, social work, or an allied field. Individuals whose only exposure to diagnostic assessment is gained from this program will not, in general, be qualified as users of the GAF Report."

Id., p. 6.

What the GAF scale is and means is further detailed subsequent, as follows:

"The GAF Scale is a 100-point scale that measures a patient's overall level of psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. The decision tree, which forms the underlying basis for the GAF Report program, is designed to guide the clinician to a methodical and comprehensive consideration of a patient's functioning. The program's algorithm ensures that symptom severity and functional impairment are considered in reaching an appropriate range for a patient. For a complete description of the GAF Report algonthm, see Chapter 5, *Assessing Patients with the GAF Report.* The 10-point ranges identified below are those described in the *Diagnostic and Statistical Manual of Mental Disorders:*

91-100 Superior functioning in a wide range of activities; life's problems never seem to get out of hand; is sought out by others because of his or her many positive qualities. No symptoms.

81-90 Absent or minimal symptoms (e. g., mild anxiety before an exam); good

functioning in all areas; no more than everyday problems or concerns (e.g., an occasional argument with family members).

71-80 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in school work).

61-70 Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well; has some meaningful interpersonal relationships.

51-60 Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).

41-50 Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).

31-40 Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects

family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

21-30 Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communicating or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal, preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home or friends).

11-20 Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death, frequently violent, manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).

1-10 Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death."

Id. pps. 7-8.

How the GAF program works is detailed, in part, as follows:

"**GAF REPORT SCREENS**

There are two types of screens that appear during the GAF Assessment process. The GAF Assessment Screen presents you with a question about an aspect of the patient's symptom severity or functional impairment. Your answers to the "Yes/No" questions ultimately determine the

10-point GAF range that best captures the patient's overall level of functioning. Once a 10-point range is determined, it is indicated in the Final Rating Screen (see page 54). When this screen is presented, you must determine the specific GAF score within the 10-point range.

. . ."

Id., p. 50.

"**THE FINAL GAF RATING SCREEN**

The GAF Rating is determined in two phases; in the first phase, you are asked questions about the patient's psychiatric symptoms and impairment in functioning in order to determine the appropriate 10-point GAF range; in the second phase, you are asked to determine the specific GAF score within this range. The GAF Final Rating Screen is displayed once a 10-point range is determined. It resembles the Assessment screens and includes similar features. Note that you still have the option to return to earlier assessment screens in order to change your answers (and consequently change the 10-point range that has been determined)."

Id., p. 54.

"**GAF RATING SLIDING SCALE**

Use the Rating Sliding Scale to record a specific rating for a patient within the range indicated by the GAF Final Rating Screen. Your selection of the final GAF rating should be based on a clinical judgment as to whether the patient's symptoms and functioning fall in the upper or lower reaches of the range. The Explanation button provides some additional guidelines as well as examples of patients whose GAF ratings fall within each particular range. Click and drag with the mouse to move the gauge along the scale and change the rating value, which is displayed in the box to the

> right of the scale. You can also use the left and right arrow keys to move the gauge across the scale. If you do not designate a specific rating for the individual, the default rating, which is the middle rating in the range, will be recorded when you select the Exit button."

Id., p. 55.

Like the DTREE, unless changed manually, the rating and report date is reflected as that particular date when it was processed on the computer. *Id.*, p. 86. And like the DTREE, the time to input the information is not great as exampled on the sample report shown in the manual. *Id.*, p. 92.

THE RECORDS:

The listing and identification of the records on each of Dr. Tiller's and Dr. Neuhaus's files follows. Not every record in Dr. Tiller's files is noted, only those deemed relevant to patient information available, not substantially duplicated elsewhere, as to information or verifiable dates. However, as to Dr. Neuhaus's records, effort has been made to conclude every document there present.

PATIENT #1

A review of Exhibit 34, Dr. Tiller's records in regard to patient #1 reflects the following (ROA: 001306-1390):

The file reflects a "Certification of Informed Consent" dated July 22, 2003, at 4:10 p.m. (ROA: 001307); a Tiller office generated document indicating patient #1's appointment was 7/22/03 at 8:30 a.m. (ROA: 001332); a "MI", "maternal indicators", interview under date of July 22, 2003, apparently taken by staff Sara Phares (ROA: 001313-14); a medical history (ROA: 001338-40); a certification by Dr. Tiller dated July 22, 2003, which indicates qualification for an abortion (ROA: 001315) stating:

> "I have personally reviewed the patient's history as written in the chart. I have interviewed and examined the patient. I have reviewed the referral letter from a Kansas physician. I have examined the ultrasound reports and noted the LMP, if known. Based on my individual evaluation, it is my professional opinion that this pregnancy may be viable and that being forced to continue this pregnancy will cause severe and irreversible harm to this patient's major bodily function and/or her mental function."

There is a DTREE report dated July 21, 2003, finding a "300 anxiety disorder nos", which had been

faxed under date of July 28, 2003 (ROA: 001310-11); the first page of a GAF report reflecting a "45" rating dated July 21, again faxed 7/28/2003 (ROA: 001312); a letter from Dr. Neuhaus to Dr. Tiller advising patient qualified for an abortion (ROA: 001309) as follows:

> "Dear Dr. Tiller:
>
> 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,
>
> A. Kristin Neuhaus, M.D."

A file folder face sheet with "MHC", apparently meaning mental health consultation, initialed by "SP", presumably Sara Phares, with a check before each of Dr. Neuhaus and Dr. Tiller's names and with a sticker showing "minor" and "Pre AB 7/22 10/50" initialed "BC" (ROA: 1328); a duplicate of the latter page (ROA: 001330); a sticker on another page of the patient file, which sticker appears on each patient's record reflecting several line items, one of which is "MHC" and is initialed. A separate sticker on this page also

reflects "072203-17", an apparent date of July 22, 2003 (ROA: 00). The abortion procedure performance date itself was 7/24/03 (*e.g.*, ROA: 001336, 001390). The file also reflects another MI report dated July 15, 2003 (ROA: 001320-21); a mental health examination under date of July 15, 2003 (ROA: 001308); and a certification dated July 15, 2003, by a Nathan Harris, a physician in Dr. Tiller's office, but over Dr. Tiller's name, of a patient's qualification for an abortion (ROA: 001327). See also (ROA: 001407). However, it is clear in reviewing the separately dated "MIs" the patients are different individuals.

Dr. Neuhaus records (Exhibit 23) reflect for Patient #1, the following (ROA: 001197 - 001204):

An "authorization to disclose protected health care information" dated 7/22/03 to "A. Kristin Neuhaus M.D." signed by patient #1's mother 7/22/03 (ROA: 001200); the first page of the DTREE report dated 7/21/03 for both the rating and the report with a "300.00 Anxiety Disorder NOS" diagnosis ROA: 001200). Her file DTREE report has no second page to it which would be as shown

on page 2 in the DTREE report of same date in Dr. Tiller's file (ROA: 001310-11); and a full GAF report with a 7/21/03 date (ROA: 001202-03), of which only page 1 is reflected in Dr. Tiller's records (ROA: 001312).

PATIENT #2

Dr. Tiller's records for Patient #2 (Exhibit 35) reflect the following (ROA: 001391 - 001468):

The file reflects "certification of informed consent" dated July 8, 2003, at 4:20 p.m. (ROA: 001392); Tiller's office generated documents showing an appointment first for 7/3/03 at 3:30 p.m. (ROA: 001425); an office document reflecting the appointment was reset to 7/8/03 at 9:30 a.m. (ROA: 001423); a letter from Dr. Neuhaus dated July 8, 2003, finding the patient qualified for an abortion with the same language that is employed for all the Patients #1 - #11 (ROA: 001393); a GAF report dated July 9, 2003, faxed the same date, with a rating of "35" (ROA: 001394-95); a DTREE report of the same date reflecting a diagnosis of "296.23 major depressive disorder, simple episode"

(ROA: 001396-97); a certification by Dr. Tiller of qualification of patient #2 for an abortion with the same language employed as in Patient #1's file (ROA: 001398); a file folder face sheet with "MHC", initialed, and also checked, and checks on lines before each of Dr. Neuhaus's and Dr. Tiller's names with a further sticker reflecting "Pre AB:" of "7/8/03" at 11:45 a.m. and is initialed and "Post AB:" "7/11/03" and initialed (ROA: 001420-22); a health history (ROA: 001409-20); a letter from Dr. Neuhaus to Dr. Tiller dated July 8, 2003, finding patient #2 qualified for an abortion (ROA: 001454); a file sticker with "MHC consult" "among others" line items initialed. Also there is a separate file sticker noting "070803-20" on it. The medical documentation in the file, *e.g.*, ROA: 001437, reflects the abortion procedure was performed on July 8, 2003.

For patient #2, Dr. Neuhaus records (Exhibit 24) reflect the following (ROA: 001204-11).

An "authorization to disclose protected health care information" to "A. Kristen Neuhaus, M.D." dated 7/8/03

signed by patient #2's mother (ROA: 001206-07); the GAF report dated 7/9/03 (ROA: 001208-09) reflected in Dr. Tiller's records (ROA: 001394-95); and the 7/9/03 DTREE report (ROA: 001210-11) found in Dr. Tiller's records (ROA: 001396-97).

PATIENT #3

For patient #3, Dr. Tiller's records (Exhibit 36) reflect the following (ROA: 001469-001526):

The file reflects a "certification of informed consent" dated August 5, 2003 (ROA: 001470); Dr. Tiller's file document reflecting the appointment was for 8/5/03 at 8:30 a.m. (ROA: 001492); a mental health evaluation under the date of August 5th with a diagnosis of "296.23 single major depressive disorder, severe, with suicidal ideation" with a GAF score between 41-50 (ROA: 001472); a letter from Dr. Neuhaus, dated August 5th finding patient #3 qualified for an abortion (ROA: 001473); a DTREE report of the same date, faxed August 11th, indicating a diagnosis of "296.23 major depressive disorder, single episode, severe, without psychotic features (ROA: 0014774-75); a GAF report

under the same date, faxed as the date shown for the DTREE, with a 35 rating (ROA: 001476-77); an MI statement dated August 5th, apparently taken by Sara Phares (ROA: 001478-80); a certification by Dr. Tiller of this patient's qualification for an abortion dated August 5th noting gestation at "26w3d"; (ROA: 001481); another certification by Dr. Tiller under date of July 30, 2003, certifying qualification for an abortion noting gestation at "25w4d" (ROA: 001482); a "MI statement" with a typed "8/4" date noted as "Part 2 of [patient #3] statement" (ROA: 001488); another "MI Statement with a handwritten date of "7/31" (ROA: 001489-90). It is to be noted the responses to the questions are different, hence likely not the same patient, *e.g.*, answer to question "why is abortion a better choice for you than adoption?" is different; there are two medical records, one indicating "10.AGA 25w4D" under date of "7/30/03" (ROA: 001484) and another under date of "8/5/03" showing "10.AGA = 26w3d" (ROA: 001483), which documents correspond with the different certifications and MI statements noted above

(also see records at ROA: 001522-23); a file folder sticker with "MHC" initialed by "SP" with checks in the space before each of Dr. Neuhaus and Dr. Tiller names with a file sticker in the lower right corner reflecting "Minor" "Pre AB 8-5-03 11:45" "Post AB 8-7-03 1:20" and initialed (ROA: 001491); a medical history (ROA: 001498-1500); records indicating the abortion procedure was done on 8/7/03 (ROA: 001496, 001807-09, 001597); and a file folder sticker with "MHC" among other line items initialed and another separate file sticker with the "080503-19" affixed (ROA: 001526).

For patient #3, Dr. Neuahus's records (Exhibit 25) reflect the following (ROA: 001212-22):

Tiller generated a form reflecting an 8/5/03 appointment date with Dr. Neuhaus written on it (ROA: 001213); the DTREE rating and report of 8/5/03 (ROA: 001219-26) as reflected in Dr. Tiller's records (ROA: 001474-75); and the GAF report of the same date (ROA: 001221-22) reflected in Dr. Tiller's records (ROA: 001476-77).

PATIENT #4

For patient #4, Dr. Tiller's records (Exhibit 37) reflect the following (ROA: 001527-1597):

An informed consent dated 8/5/03 (ROA: 001528), an internal Tiller office document reflecting the appointment was on 8/5/03 at 8:30 a.m. (ROA: 001544); a form, as last noted, showing the appointment had earlier been set for 7/29/03 at 11:31 a.m. (ROA: 001545); a mental health evaluation by Dr. Tiller under date of August 5th diagnosing patient #4 as "296.23 single major depressive disorder, severe with suicidal ideation" with a GAF between 41-50% (ROA: 001530); a letter of August 5th from Dr. Neuhaus to Dr. Tiller finding the patient qualified for an abortion (ROA: 001531); a GAF report dated 8/5/03 with a GAF rating of 25 with a fax date of 8/11/03 (ROA: 001532); a DTREE report of August 5th, with a faxed date of 8/11/03, diagnosing this person as having a "308.3 Acute distress disorder, moderate (ROA: 001533-35); a MI Statement dated 8/5 (ROA: 001536-38); a certification by Dr. Tiller of qualification for abortion dated 8/5/03 (ROA: 001539); a file folder sheet with a "MHC"

on front that is initialed, but no checks are marked in the places for a check before the names of Dr. Neuahus and by Dr. Tiller as in the previously noted files and an additional sticker indicating "Pre AB 8/5/03" and "Post AB" 8/7/03 (ROA: 001543); a medical history dated 8/5/03 (ROA: 001548-50); medical and other records indicate the procedure was performed on August 5, 2003 (ROA: 001558-89); and a file sticker reflecting, among other line items, "MHC" initialed with another sticker indicating "08053-18" (ROA: 001597).

For patient #4, Dr. Neuhaus's records (Exhibit 26) reflect the following (ROA: 001723-001733):

An office record, again presumably from Dr. Tiller's files, reflecting a patient appointment date of 8/5/03 with a notation to "Dr. Neuhaus" handwritten in the upper right corner (ROA: 001224); a handwritten MI indicators report dated 7/26/03 (ROA: 001225) not found in Dr. Tiller's records; an authorization for disclosure of protected health care information dated 8/5/03 given to "A. Kristen Neuhaus M.D." signed by the patient's mother (ROA: 001229); two pages of the typed

MI Statement dated 8/5 labeled "copy" (ROA: 001227-28) found in Tiller's records with three pages (ROA: 001536-38); the 8/5 dated DTREE report (ROA: 001230-32) found in Dr. Tiller's records (ROA: 001533-35); and the GAF report (ROA: 001233) found in Dr. Tiller's records (ROA: 001532).

PATIENT #5

For patient #5, Dr. Tiller's records (Exhibit 38) reflect the following (ROA: 001598-001653):

An informed consent dated December 8, 2003 (ROA: 001599) which was dated by the patient, but appears to be, in comparison with the rest of the file, juxtaposed from 8/12/03; a Tiller office generated document reflecting the appointment was 8/12/03 at 8:30 a.m. (ROA: 001618); a same style document that would reflect a change of appointment from 8/5/03 (ROA: 001619); a letter dated August 12, 2008, from Dr. Neuhaus to Dr. Tiller finding the patient qualified for an abortion (ROA: 001601): a GAF report dated 8/7/03, faxed 8/13/03, reflecting a GAF rating of 25 (ROA: 001602-03); page 1 of 2 page DTREE report dated August 7th

reflecting a diagnosis of "296.23 major depressive disorder, single episode, severe w/o psychotic features" (ROA: 001604); a MI Statement dated 8/12/03 done by Sara Phares with aid of a French interpreter (ROA: 001605-07); a typed certification by Dr. Tiller of that patient #5 qualified for an abortion dated 8/12/03 with a handwritten portion, undated, by Dr. Tiller (ROA: 001608); an undated, but typed, MI Statement (ROA: 001613-15), which reflects a delay in contacting Dr. Tiller's office; a file folder face sticker with "MHC" initialed, with the space before Dr. Neuhaus's name checked and before Dr. Tiller's name appears the initials "GRT". Further, an additional sticker indicates "minor" "Pre AB 8/12/03" Post AB 8/14/03" with a duplicate of it following (ROA: 001616-17); a medical history dated and signed by the patient 12/8/03, but the date appears, again, to have been juxtaposed by the patient from 8/12/03 (ROA: 001622-25); medical records indicating the abortion procedure was performed on August 12, 2003 (ROA: 001632-34); and a file folder sticker with "MHC consult" initialed

among other line items, and sticker showing "minor" "081203-12".

For patient #5, Dr. Neuahus's records (Exhibit 27) reflect the following (ROA: 001234-1242):

A scheduling record (ROA: 001235) that appears the same as that of Dr. Tiller's record (ROA: 001618), which reflects "Kathleen notified"; a typed MI Statement (ROA: 001236-37) also reflected in Dr. Tiller's records (ROA: 001613-15), but his is not initialed as this one is; an authorization to disclose protected health records given to "A. Kristen Neuhaus" by patient #5's father dated 12/08/03, which date is similarly juxtaposed (8/12/03) as noted for Dr. Tiller's records, reflecting the form itself had been faxed to Dr. Neuhaus on May 21, 2003 (ROA: 001238-40); a two page DTREE report (ROA: 001240-41) which is reflected in Dr. Tiller's records only as page 1 of the report (ROA: 001604). Dr. Neuhaus's DTREE reflects a handwritten correction to 8/12/03 for the date of the rating and 8/13/03 for the report date, both initialed; page 1 of the GAF report with a hand corrected date

(ROA: 001242), which appears, in Dr. Tiller's file with its page 2 as well, except that his copy reflects no correction to its dates (ROA: 001602-03).

For patient #6, Dr. Tiller's records (Exhibit 39) reflects the following (ROA: 001654-001708):

A certification of informed consent dated 8/26/03 signed at 2:22 p.m. by the patient (ROA: 001655); a Tiller generated office record indicating an appointment date of 8/26/03 at 8:30 a.m. (ROA: 001674); a letter from Dr. Neuahus for Dr. Tiller dated 8/26/03 finding patient #6 qualified for an abortion (ROA: 001657); a DTREE report with a rating date of 8/26/03, a report date of 9/05/03 and a fax date of September 5th, finding patient #6 was diagnosed with "308.3 Acute distress disorder" (ROA: 0016588-60); a GAF report dated and faxed the same as the DTREE, above, giving a GAF rating of 35 (ROA: 001661-62), a MI statement, initialed, with "8" "26" on it (ROA: 001663-64); a certification by Dr. Tiller of patient #6's qualification for an abortion, with a handwritten note of explanation (ROA: 001665); what appears to be a

different MI Statement (ROA: 001671) from the one noted above (ROA: 00166-64) based on the answers, however, though different, appear to be substantively the same; a file folder face sheet with a "MHC" sticker, initialed, with a check before Dr. Neuhaus's name and Dr. Tiller's initials before his name and also with part of a file sticker below indicating "Pre AB 8/26/03" (ROA: 001673); a medical history (ROA: 001677-79); medical records indicating the abortion procedure was performed on 8/26/03 (ROA: 001687-89); a letter dated 8/26/03 to an out of state physician who referred patient #6 to Dr. Tiller confirming that doctor's belief of patient #6's qualification for an abortion (ROA: 001700); and a file folder sticker reflecting, among other line items, a "MHC consult", initialed, but the sticker omits initials on a Kansas physician referral line item. There is also a file sticker reflecting "082603-03" (ROA: 001707).

Dr. Neuhaus's records for patient #6 (Exhibit 28) reflect the following (ROA: 0012430-001263):

A letter from Planned Parenthood of August 21, 2003

to Dr. Tiller's clinic reference billing and reflecting an appointment date for patient #6 as August 25, 2003, (ROA: 001244); a copy of the Tiller office record reflecting the appointment date 8/26/03 noted above in Dr. Tiller's records (ROA: 001674), but with "Dr. Neuhaus" handwritten on it (ROA: 001245); a MI statement (ROA: 001246), which is the second MI statement noted in Dr. Tiller's file (ROA: 001671); a duplicate of the letter from Planned Parenthood as earlier noted in Dr. Tiller's records, but additionally with a fax sheet followed by the first page of the MI statement (ROA: 001247-49), which was first noted in Dr. Tiller's file (ROA: 001663-64); an authorization to disclose protected health information to "A. Kristen Neuhaus, M.D." signed 8/26/03 by patient #6 (ROA: 001250-51); a DTREE report (ROA: 001252-54), which is the same report reflected in Dr. Tiller's file (ROA: 001658-60), a GAF report (ROA: 001255-56) that is the same report as reflected in Dr. Tiller's records (ROA: 001663-64); a duplicate of the 8/26/03 disclosure form earlier noted (ROA: 001257-58); another copy of the

earlier noted DTREE report (ROA: 001259-61); and another copy of the earlier noted GAF report (ROA: 001262-63).

PATIENT #7

For patient #7, Dr. Tiller's records (Exhibit 40) reflect the following (ROA: 001709-001777):

A certification of informed consent dated 9/9/03 at 2:25 p.m. signed by patient #7 (ROA: 001710); a mental health evaluation of this patient signed by Dr. Tiller dated 9/9/03 (ROA: 001712); a letter from Dr. Neuhaus to Dr. Tiller finding patient #7 qualified for an abortion (ROA: 001713); a DTREE report of September 9th, faxed September 19th, expressing a finding of "298.23 major depressive disorder, single episode, severe without psychotic features" (ROA: 001714-15); a GAF report dated 9/9/03 finding a GAF rating of 15 (ROA: 001716); a MI statement, undated (ROA: 1717-18); a certification of patient #7's qualification for an abortion with an unidentifiable signature over the typed name of Dr. Tiller. A handwritten note on it refers to a detailed report of 9/9/03 identified to be,

it appears, by "Tiller" (ROA: 001719); a file folder face sheet with "MHC" initialed and before the names of each of Dr. Neuhaus and Dr. Tiller on the file appear their respective initials. A side sticker indicates "minor" "Pre AB 9-9-03" and is initialed. The notation "Post AB" is not filled out (ROA: 001725); a Tiller office generated form indicating an appointment date for patient #7 for 9/09/03 at 8:30 a.m. (ROA: 001726); a medical history (ROA: 1729-32); a second copy of the medical history just noted (ROA: 001749-52); medical records and office records indicating the abortion procedure was performed 9/11/03 (ROA: 001728, 001739-41, 001777), and a file sticker reflecting among other items, "MHC consult", initialed, and a side sticker indicates "090903-17".

Dr. Neuhaus's records for patient #7 (Exhibit 29) reflect the following (ROA: 001264-71):

An authorization to disclose protected health information dated 9/9/03 and signed by the patient authorization to "A. Kristen Neuhaus, M.D." (ROA: 001264-67); a copy of the MI statement (ROA: 001268) in

Dr. Tiller's file (ROA: 001717); but not the "Maternal Indications Termination of Pregnancy Protocol" form with answer as is in Dr. Tiller's file (ROA: 001718); a DTREE report (ROA: 001269-70) which is in Dr. Tiller's records (ROA: 001714-15); a GAF report (ROA: 001671), which appears in Dr. Tiller's records (ROA: 001716).

For patient #8, Dr. Tiller's records (Exhibit 41) reflects the following (ROA: 001778-001825):

A certification of informed consent dated November 4, 2003, at 12:49 p.m. signed by patient #8 (ROA: 001788); a letter of Dr. Neuhaus to Dr. Tiller dated November 4, 2003, finding patient #8 qualified for an abortion (ROA: 001780); a "Maternal Indications of Termination of Pregnancy Protocol" form with answer (ROA: 001781), which usually is included with the MI Statement: a statement by Dr. Tiller hand dated for 11/4/03 that patient #8 qualifies for an abortion (ROA: 001790); a MI statement, *i.e.*, "MI indicators", hand dated 9/4/03 (ROA: 001791-92); a certification by Dr. Tiller that patient #8 qualifies for an abortion with a written reference signed by "Tiller md" to see a

"detailed" note (ROA: 001793); a file folder face sheet with a "MHC" sticker initialed, with initials before each of Dr. Neuhaus and Dr. Tiller's names plus document has another side sticker indicating "minor counseling" "Pre AB 11/4/03" "Post AB 11/5/03" both initialed (ROA: 001800); an internal Tiller office form indicating patient #8's appointment was 11/4/03 at 8:30 a.m. (ROA: 001801); a medical history (ROA: 001805-08); medical records showing the abortion procedure conducted on or about 11/5/03 (ROA: 001815-19); a file folder sticker with "MHC consult", among other line items, initialed with a side sticker indicating "110403-05".

Dr. Neuhaus's records for patient #8 (Exhibit 30) reflect the following (ROA: 001272-001277):

A Tiller office form identifying patient #8's appointment for 11/4/03 at 8:30 a.m. with "Dr. Neuhaus" written in the upper right corner (ROA: 001273); a patient record of disclosure form dated 11/4/03 signed by the patient and her mother (ROA: 001274); an "authorization to disclose protected health

information" to "A. Kristen Neuhaus, M.D." dated 11/4/03 signed by patient #8 and her mother (ROA: 001275); and a MI statement/indicators, noted as done "11/4" and designated "copy" (ROA: 001276-77). No DTREE, or GAF report is in the file and no such report in Dr. Tiller's file.

PATIENT #9

For patient #9, Dr. Tiller's records (Exhibit 42) reflect the following (ROA: 001826-001878):

A certificate of informed consent dated 11-4-03 at 2:26 p.m. signed by patient #9 (ROA: 001834); a MI Indicators Statement dated 11-4-03 done by Sara Brown (ROA: 001836-37); then a "Maternal Indications Termination of Pregnancy Protocol" with handwritten answer to questions and handwritten notes in another's handwriting that is similar to handwriting seen elsewhere in records signed by Dr. Tiller, undated, but such a form generally follows/is part of an MI Statement (ROA: 001838); a certification of qualification for an abortion, signator unknown, over Dr. Tiller's typed name, but with handwritten notes to

side, unsigned, but, again similar to handwriting seen in file of Dr. Tiller, diagnosing a "296.23 major depressive disorder" (ROA: 001839); a letter from Dr. Neuhaus to Dr. Tiller dated November 04, 2003, finding patient #9 qualified for an abortion (ROA: 001843); an MI Indicators statement (typed) undated (ROA: 001846-47), which appears to be a typed version of handwritten MI noted above by question answers, *e.g.*, "*Interest.* I used to play basketball a lot. . .", a file folder face sheet with "MHC", initialed, with initials before both Dr. Neuhaus's and Dr. Tiller's names consistent with their initials and in separate handwriting. Also, a side sticker with "Pre AB 11/4/03" and "Post AB 11-7-03", both initialed by staff (ROA: 001848); an insurance claim "providers claim summary" form addressed to Dr. Neuhaus at Dr. Tiller's clinic address for services performed 11/4/03 (ROA: 001849-50); a GAF report both rating and report dated 11/5/03 with noted "time frame: past week" finding a 35 GAF rating, faxed Nov-10-03 (ROA: 001851-52); a DTREE report both rated and reported 11/05/2003, faxed Nov-10-03, finding

patient #9 was diagnosed with "296.23 major depressive disorder, single episode, severe without psychotic features (ROA: 001853-54); a Tiller office generated form showing patient #9's appointment date was 11/04/03 at 8:30 a.m. (ROA: 001855); a form as last noted to the same party (per address) showing an earlier appointment date for 10/28/03 (ROA: 001856); a medical history (ROA: 001862-65); other consent to abortion documents, but dated 10/4/03 (ROA: 001866-70); medical records indicating the abortion procedure was on 11/5/03 (ROA: 001872-75, 001877); a record noting procedure done, but noted as 11/7/03 and reflecting a portion of a file sticker reflecting "KS Phys Referral" initialed and "110403-02", but "MHC Consult" line item obscured by photocopy (ROA: 001878).

Dr. Neuhaus records for patient #9 (Exhibit 31) reflect the following (ROA: 001278-001288):

A Tiller office generated form noting 11/04/03 at 8:30 a.m. for patient #9 with "Dr. Neuhaus" handwritten in right corner (ROA: 001279), which is the same as the form found in "Dr. Tiller's records (ROA: 001855); an

"MI Indicators" statements typewritten (ROA: 001280-81), which comports with that document noted in Dr. Tiller's records (ROA: 001846-47); a "Patient Record of Disclosures" form dated 11-4-03 signed by patient #9 (ROA: 001282); an "authorization to disclose protected health information" form given to A. Kristen Neuhaus, M.D." dated 11/4/03 signed by patient #9, as well as, her mother (ROA: 001283); a handwritten "MI Indicators" statement, noted "copy" (ROA: 001284), which is the first page of the two-page document reflected in Dr. Tiller's records (ROA: 001836-37); a DTREE report dated 11/5/03 (ROA: 001285-86), being the same as reflected in Dr. Tiller's records (ROA: 001853-54); and a GAF report dated 11/5/03 (ROA: 001287-89), which is the same reflected in Dr. Tiller's records (ROA: 001851-52).

PATIENT #10

For patient #10, Dr. Tiller's records (Exhibit 43) reflect the following (ROA: 001879-001928):

A certification of informed consent dated 11-4-03 signed by patient #10 (ROA: 001888); medical records

indicating the abortion procedure was performed 11/7/03 (ROA: 001879-86); an evaluation and description it appears made on personal observation by Dr. Tiller of patient #10, noted separately in both typewritten and handwriting form on the same document, which is dated 11/4/03 and signed by Dr. Tiller, which diagnoses patient #10 as "308.30 acute stress disorder" and "296.22 single(?) maj dep. episode-moderate" with a GAF "50" rating and other notations (ROA: 001890); a handwritten statement by patient #10 of her opinion/circumstances with side notes which comport with the handwriting of Dr. Tiller, unsigned (ROA: 001891); a handwritten "MI Indicators" statement dated 11/4/03 for patient #10 (ROA: 001892-93); a certification by Dr. Tiller dated 11/4/03 that patient #10 was qualified for an abortion (ROA: 001894); a letter from Dr. Neuhaus to Dr. Tiller dated 11/4/03 finding patient #10 was qualified for an abortion (ROA: 001898); a typewritten "MI Indicators" statement (ROA: 001901-02), which does not comport with the handwritten one earlier noted (ROA: 001892-93), *e.g.* "(How long

have you known you are pregnant?) Have known for 1 week . . ." (typewritten) vs. answer to the same question handwritten "2 weeks yesterday. . .". The typewritten statement does not comport with Dr. Tiller's evaluation (ROA: 001890) since his handwritten notes indicate mother's opinion while this statement by 18 year old reflects parents do not know "(What would the consequences be if we told you we couldn't do it?) . . . Do your parents know that you are pregnant? No . . ."; a file folder face sheet with "MHC" initialed, plus appropriate initials before each of Dr. Neuhaus's and Dr. Tiller's names (ROA: 001903); a 2 page DTREE with the rating and report both dated 11/13/03 and noted as faxed 11/10/03 finding a "308.3 acute stress disorder, severez' (ROA: 001904-05), but also on second page at its end noting a "300 anxiety disorder NOS, in partial remission" (*Id.* 001905); a GAF report dated 11/13/03, but reflected faxed 11/10/03, finding a GAF rating of 25 (ROA: 001906); a Tiller office generated form showing patient #10's appointment was 11/4/03 (ROA: 001908); a Tiller office generated form

reflecting a prior appointment date of 10/22/03 (ROA: 001909); a medical history (ROA: 001913-16); various consent forms dated 11/04/03 which also carry the signature of the mother (ROA: 001917; 001919-21) or note the mother is present (ROA: 001915), which also note from patient #10 statements indicating she was from a small town, which poorly redacted documents in file confirm (ROA: 001913, 001921); medical records indicating performance of the abortion procedure on November 7 (ROA: 001880-87, 001923-27); a file sticker without the line item "MHC consult" initialed with a side sticker showing "110403-10" (ROA: 001927).

Dr. Neuhaus's records for patient #10 (Exhibit 32) reflect (ROA: 001289-001299):

A Tiller office generated form showing patient #10's appointment was 11/04/03 at 8:30 a.m. with "Dr. Neuhaus" handwritten in upper right hand corner. It also reflects in relation to the ambiguity in the MI statements that this patient came with her mother (ROA: 001290); typewritten "MI Indicators" statement (ROA: 001291-92) reflected in Dr. Tiller's records (ROA:

001901-03), which as there noted does not probably comport with patient #10; a handwritten "Maternal Indicators" form (ROA: 001293-94) conforming to that in Dr. Tiller's records (ROA: 001892-93); a "Record of Patient Disclosures" dated 11/04/03 signed by patient #10 (ROA: 001295); an "Authorization to Disclose Protected Health Information" to "A. Kristen Neuhaus, M.D." 11/04/03 signed by patient #10 (ROA: 001296); a DTREE report of 11/13/03 (ROA: 001297-98), the same as in Dr. Tiller's records except the faxed date shown on the latter of 11/10/03 (ROA: 001904-05); a GAF report of 11/13/03 (ROA: 001299), the same as reflected in Dr. Tiller's records except for the lack of the 11/10/13 fax date shown on Dr. Tiller's copy (ROA: 001906).

PATIENT #11

For patient #11, Dr. Tiller's records (Exhibit 44) reflect the following (ROA: 001929-1975):

Medical records reflecting the abortion procedure was performed on 11/20/03 (ROA: 001930-37, 001970-73, 001975); a certification of informed consent dated 11-18-03 at 6:45 p.m. signed by patient #11 (ROA: 001938);

a mental health evaluation dated November 18, 2003, initialed by Dr. Tiller over his typewritten name, finding patient #11 had a diagnosis of "296.33 recurrent depressive reaction, severe . . ." and has a GAF rating between 31-40 (ROA: 001940); a "Maternal Indications Termination of Pregnancy Protocol" containing patient #11's statement (ROA: 001941); a DTREE report rated and reported under date of 11/20/2003, faxed the same date finding patient #11 was suffering from a "296.23 major depressive disorder, single episode, severe without psychotic features (ROA: 001942-43); a GAF report dated as rated and reported on 11/20/03 faxed that date reflecting a rating of 15 (ROA: 001944); a letter from Dr. Neuhaus to Dr. Tiller dated November 18, 2003, finding patient #11 qualified for an abortion (ROA: 001945); a certification by Dr. Tiller dated 11/18/03 that patient #11 qualified for an abortion (ROA: 001946); a handwritten "MI Indicators" statement, undated (ROA: 001951-52); a file folder face sheet reflecting "MHC" initialed with initials before each of Dr. Neuhaus's and Dr. Tiller's names consistent

with their initials with a side sticker indicating "minor counseling" "Pre AB 11-18-03" "Post AB 11-20-03", both initialed (ROA: 001953); a Tiller office generated form indicating patient #11's appointment was for 11/18/03 at 10:00 a.m. (ROA: 001954); a note to Dr. Tiller re: the patient and her mother's state of mind (ROA: 001955); a medical history (ROA: 001960-63); a file sticker reflecting "MHC Consult" initialed and a separate sticker reflecting "111803-17 (ROA: 001975).

Dr. Neuahus's records (Exhibit 33) for patient #11 reflect the following (ROA: 001300-001305):

A Tiller office generated form showing patient #11's appointment was 11/18/03 at 10:00 a.m. (ROA: 001301); an "authorization to disclose protected health information" given to "A. Kristen Neuhaus, M.D." dated 11/18/03 signed by patient #11's mother (ROA: 001302); a DTREE report dated 11/20/2003 (ROA: 001303-04); which is the same as in Dr. Tiller's records (ROA: 001942-43) except for the fax notation; a GAF report (ROA: 001305), which is the same reflected in Dr. Tiller's records (ROA: 001944), except the fax notation.