

THE STATE OF SOUTH CAROLINA

In The Court of Appeals

APPEAL FROM LEXINGTON COUNTY

Court of Common Pleas

William P. Keesley, Circuit Court Judge

Case No. 2007-CP-00-01981

Martha Lewin Argoe,

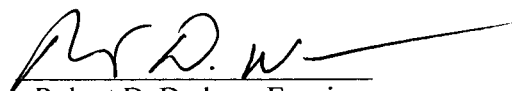
v.

Appellant,

Three Rivers Behavioral Health,
LLC and Psychiatric Solutions,
Inc., its successor; Phyllis Bryan-
Mobley, MD; David A. Steiner,
MD; Cheryl C. Dodds, MD;
Doris Ann Burrell, RN; and
Carolina Care Plan,

Respondents,

**RECORD ON APPEAL
VOLUME III**



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SC Court of Appeals

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STATE OF SOUTH CAROLINA
COUNTY OF LEXINGTON
IN THE CIRCUIT COURT OF COMMON PLEAS

MARTHA LEWIN ARGOE,

Plaintiff,

vs.

THREE RIVERS BEHAVIORAL
CENTER, LLC, PHYLLIS
BRYANT-MOBLEY, MD, AIKEN
REGIONAL MEDICAL CENTER,
DAVID A. STEINER, MD,
CHERYL C. DODDS, MD. DORIS
ANN BURRELL, RN, AND
CAROLINA CARE PLAN,

Defendants.

CIVIL ACTION

FILE NO.
2007-CP-32-1981

DEPOSITION OF

DAVE DAVIS, M.D.

Thursday, May 30, 2013
9:00 a.m.

1776 Peachtree Street, N.W.
Suite 230-S
Atlanta, Georgia

Mona Landry, CCR-B-1514



JPA REPORTING, LLC

CERTIFIED COURT REPORTERS

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- - -

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(Original Exhibits 1 through 4 and 6 and a photocopy of Exhibit 5 have been attached to the original transcript. Original Exhibit 5 has been retained by Dr. Davis.)

1 (Reporter disclosure made pursuant to
2 Article 10.B of the Rules and Regulations of the
3 Board of Court Reporting of the Judicial Council
4 of Georgia.)

5 DAVE DAVIS, M.D.,
6 having been first duly sworn, was examined and
7 testified as follows:

8 CROSS-EXAMINATION

9 BY MS. GANES:

10 Q. Dr. Davis, my name is Elloree Ganes and I
11 represent Dr. David Steiner in the lawsuit that has
12 been filed by Martha Argoe. Your name and materials
13 and affidavits have been provided to us by Mr. Dodson
14 as an expert witness on behalf of Ms. Argoe; is that
15 correct?

16 A. Yes.

17 Q. Okay. Are you still actively in your
18 clinical practice?

19 A. Yes.

20 Q. Okay. Where is your office located?

21 A. At the Piedmont Medical Center about two
22 blocks from here.

23 Q. And how did you first -- how were you
24 first contacted in this case, if you recall?

25 A. I believe I was first contacted by

1 Mr. Warner, Jan Warner.

2 Q. And when was that?

3 A. Well, sometime in 2008. You need the
4 date?

5 Q. No, sir, just generally what you remember
6 unless you have it in front of you.

7 Now, did you know Jan Warner before you
8 were contacted as a potential expert witness in this
9 case?

10 A. I don't think so.

11 Q. Do you know whether you had worked with
12 him before?

13 A. I don't recall working with him before,
14 but I can't be sure.

15 Q. Sure. Have you ever testified in
16 deposition or court in South Carolina?

17 A. Yes.

18 Q. How many times?

19 A. I'd say less than ten.

20 Q. And let's start with depositions. How
21 many depositions do you think you've given all total
22 in all states?

23 A. In all states?

24 Q. Yes, sir.

25 A. In my whole career?

1 Q. Yes, sir.

2 A. Hundreds.

3 Q. When was the last time you gave a
4 deposition before today?

5 A. Let's see, I'm looking at this list that
6 my office manager made up and it would appear that it
7 was in 2012 in the case of Anna Salter versus Terrance
8 Lee Alley, M.D.

9 Q. What type of case was that?

10 A. You know, I don't remember. It was some
11 kind of medical malpractice case which the Dr. Alley
12 was a -- I believe he was an attending physician at a
13 drug treatment center in Alabama.

14 Q. Okay. And is that list responsive to the
15 deposition subpoena that you received?

16 A. Yeah.

17 Q. We'll go through and mark all of that
18 stuff that you brought with you here shortly.

19 Have you ever -- tell me about the
20 attorneys that you've worked with in South Carolina,
21 if you recall.

22 A. This is a hard question for me because
23 I've been doing this for probably close to 50 years.

24 Q. We all think we're memorable and as soon
25 as we walk out the room, you won't remember us at all.

1 I know. It hurts us.

2 A. So it's really hard for me. I can tell
3 you that I know of I worked with Haynesworth firm in
4 Columbia on a number of cases.

5 Q. Okay.

6 A. And I remember that particular, but other
7 than that, it's -- you know.

8 Q. What type of cases have you worked with
9 the Haynesworth firm on?

10 A. You know, I don't -- I don't know. I only
11 remember one offhand was a lady, Mrs. Belk, who was an
12 heiress and she didn't like the terms of her estate
13 that she was given and she was suing in regards to the
14 estate. So it was a Probate Court -- I guess a
15 probate case.

16 Q. What about trial appearances in South
17 Carolina, can you remember any of those?

18 A. You know, I just don't have a good memory
19 for it.

20 Q. Have you ever been disqualified by any
21 Court that you recall, not allowed to testify in any
22 particular areas?

23 A. Well, I don't know whether it's
24 disqualification, but there are a number of cases in
25 Ringgold, Georgia, that are pending and these have to

1 do with alleged child molestation in cases where the
2 FBI undercover places an ad, you might say, or a
3 notice, whatever they call it, on Craigslist for women
4 over 18 seeking men. And, in fact, there's no women
5 and the men who respond to it, then are, in my
6 opinion, enticed into coming to Ringgold and at some
7 point they are informed that the woman who was posing
8 as 18 who sent the picture is actually maybe not 18.
9 So when they get there, there's not a woman and
10 they're arrested and some of them get 5, 10, 15 years
11 in prison.

12 So I have examined a number of them but
13 zero so far the judges haven't allowed me to testify
14 because they say it's the jury's decision whether or
15 not these people are pedophiles.

16 Q. Okay. So you're working with the accused
17 in that case -- in those cases?

18 A. Correct, with defense attorneys and those
19 are on appeal. So I'm expecting to get to testify.

20 Q. Okay.

21 A. I don't think -- is that a
22 disqualification? I don't know.

23 Q. No, that's kind of what I was asking, but
24 on the civil side of things, have you ever been
25 limited?

1 A. No, I've never been disqualified.

2 Q. Okay. Now, in civil cases, how many civil
3 cases do you think you have reviewed in the last ten
4 years as a potential expert witness?

5 A. Again, you know, it's going to be a best
6 guess, but I get a lot of calls from attorneys who on
7 the telephone will run something by me. And then a
8 lot of times, I don't think I can be helpful to
9 whatever their side is or case is. So it's sometimes
10 they meet with me and then pay a fee and when we get
11 to looking at it, I don't think I'm very helpful or
12 they don't think I'm going to be very helpful.

13 Then there are cases where I review and I
14 don't know what happens to it, never hear from them
15 again.

16 Q. Sure.

17 A. And sometimes they go to deposition or I
18 guess some of them get settled. So there are a lot of
19 them that seem open to me that may have been closed.
20 Like this one, when Mr. Warner, apparently, died, I
21 thought maybe the case had been settled because I
22 didn't hear from anybody for a while.

23 Q. Over the years, do you know whether you
24 have reviewed more civil cases on behalf of defendants
25 versus plaintiffs or vice versa?

1 A. I would guess -- again, it's a guess, but
2 I would get -- I probably get more calls from
3 plaintiffs' attorneys, but I end up probably I would
4 say it's about 60-40 in terms of defense.

5 Q. That you've testified 60 percent of the
6 time on behalf of the defense?

7 A. Well, again, you say testify, I don't know
8 about testifying.

9 Q. Or assisted with?

10 A. That I'm assisting the case because a lot
11 of them get settled before I ever get to give a
12 deposition or testify. Most of the cases I'm involved
13 in never go to court.

14 Q. I saw in this case that the last record I
15 had you had been paid about 13- or \$14,000?

16 A. Again, I brought those records, but I
17 haven't looked at them.

18 Q. Just what's your hourly rate for review of
19 the record?

20 A. 500.

21 Q. And I believe it was a \$4000 retainer? I
22 have some of that in front of me and we can mark what
23 I have, that might be more easily accessible. This
24 was your response to the subpoenas to Collins and
25 Lacy.

1 A. If you want to show me.

2 Q. Yeah, I can do that. And then we can just
3 mark this record that had the billing and you can tell
4 me what you billed beyond that.

5 In preparation of your deposition, did you
6 charge any increased fee or was it just the \$500 per
7 hour?

8 A. It's always the same whatever I do.

9 Q. And so what I have in front of me is a
10 ledger that looks like it's dated June 13th of 2012.

11 A. Well, this only goes through 2008
12 actually. So there's been a lot more since then.

13 Q. Do you have with you the additional
14 billing on the file?

15 A. Yeah.

16 THE WITNESS: Mr. Davidson, is that part
17 of it what you're looking it?

18 MS. GANES: This is Mr. Cole.

19 MR. COLE: You're welcome to look through
20 this if you want. This is the set of documents
21 sent to me in response to the subpoena.

22 THE WITNESS: That only goes through to
23 2008.

24 MR. COLE: You and I spoke on the phone
25 briefly. I'm the one that sent the subpoena and

1 we went through the whole rigamarole.

2 THE WITNESS: About the testing.

3 MR. COLE: Yeah, about the testing and
4 everything else and then after we sorted all that
5 out, this is the packet of stuff you sent to me.

6 Q. (By Ms. Ganes) We can keep moving and find
7 the initial billing on a break.

8 Do you think you brought it in response to
9 the deposition subpoena?

10 A. I know I had it.

11 Q. If you didn't, your office can send it to
12 us.

13 THE WITNESS: It's not in that packet, is
14 it, Mr. Cole?

15 MR. COLE: I don't think.

16 MS. GANES: I showed you a copy of what he
17 had.

18 MR. COLE: You're welcome to look through
19 this.

20 THE WITNESS: To answer your question, I
21 think it's a good deal more than that.

22 Q. (By Ms. Ganes) Take a look, this is the
23 fee schedule that we were given, and I just want to
24 mark this as an exhibit, as well. Have you had --
25 this was the fee schedule that you had with Jan

1 Warner. Have you made a new fee schedule agreement
2 with Mr. Dodson or are those rates still the rates on
3 the case?

4 A. I think we just continued the same.

5 Q. Okay.

6 A. Yeah. Back to your question, \$4000 was
7 the initial retainer.

8 Q. And \$500 an hour for your court testimony
9 and your deposition testimony?

10 A. Correct.

11 Q. Which means I think we're all paying for
12 our own, right?

13 MR. DODSON: That's my understanding.

14 Everybody is paying their own experts.

15 (Defendants' Exhibit 1 was marked for
16 identification.)

17 Q. (By Ms. Ganes) The CV that you provided to
18 us I saw had all the way through the Boston bombing.
19 So I assume that the 24-page CV revised in August
20 of -- well, it couldn't have been revised in August of
21 2013 because that hasn't come yet.

22 A. I've got one here March of 2013.

23 Q. Okay.

24 A. Did you all get copies of that?

25 Q. Yeah, right down here it says revised

1 August of 2013.

2 A. Okay.

3 Q. So this is what we marked and this is your
4 current CV?

5 A. Yes.

6 Q. Do you have any written materials that
7 involve involuntary commitment proceedings for any
8 seminars or lectures that you've ever given?

9 A. No.

10 Q. How about written materials for any
11 seminars or lectures that you've ever given related to
12 medical malpractice cases?

13 A. You know, I don't save the talks or things
14 like that. I don't have -- I don't save copies of
15 them.

16 Q. In this case, do you feel that you have
17 reviewed everything that you need to review as closely
18 as you need to review it in order to give us your
19 complete opinions today?

20 A. Yes.

21 Q. Is there anything that you have asked to
22 see that you haven't been provided?

23 A. No.

24 Q. Do you have any -- will your testimony be
25 specific to any documentation issues? And I don't

1 mean just this could say more, but have you done any
2 forensic analysis of documentation contained in any of
3 records in this case?

4 MR. DODSON: I object to the form.

5 THE WITNESS: Can you explain what you
6 mean?

7 Q. (By Ms. Ganes) Absolutely. I'm not
8 inferring at all that you should or that there is
9 anything. I just need to know if you have any
10 opinions related to any records being changed or
11 altered or added to?

12 A. Oh, the only thing I can think comes to my
13 mind was, I believe it was Dr. Steiner, I didn't
14 understand why he had, I believe, signed a document on
15 the 26th when he had done his exam a few weeks before
16 that. But I don't think that was a major issue.

17 Q. Sure. And that happens with physicians
18 when transcriptions come back at different times,
19 correct? It doesn't necessarily represent anything
20 sinister or against the standard of care?

21 A. No.

22 Q. The affidavits that you provided in this
23 case, did you draft those or were they drafted for you
24 by someone else?

25 A. I think we worked on this one together.

1 Q. And when you say "together," you mean you
2 and whom?

3 A. Yeah, I think we -- I don't recall
4 exactly, but it -- I think we talked about this when
5 I -- let me --

6 Q. You worked with Ms. Argoe's attorneys in
7 drafting the affidavit?

8 A. Yes.

9 Q. I have two affidavits in this case.

10 MS. GANES: We'll go ahead and mark them.

11 (Defendants' Exhibit 2 was marked for identification.)

12 (Defendants' Exhibit 3 was marked for identification.)

13 Q. (By Ms. Ganes) I think I actually have
14 three -- nope, two.

15 The first affidavit was sworn on May 6th
16 of 2008. I'll hand that to you or you have that in
17 front of you?

18 A. Let me see which one.

19 Q. Uh-huh.

20 A. Okay. Correct.

21 Q. And we'll mark this as 3 or whatever
22 number we're on. And that affidavit that we marked as
23 Exhibit 3, you worked with Ms. Argoe's attorneys in
24 drafting that affidavit?

25 A. Yes.

1 Q. Do you know whether there were any other
2 versions of this affidavit submitted to you before the
3 one that you actually swore on May 6th, 2008?

4 A. You know, I don't -- I don't recall, but
5 this one -- and again, I'm -- this has been a long
6 time since this was done, but I believe the way that
7 this one was done, I dictated a draft first. And then
8 Mr. Warner and I worked on it a little bit, and then I
9 executed it.

10 Q. When you say, "Mr. Warner and you worked
11 on it," did he ask you to change things or did you ask
12 him to change things?

13 A. I don't recall.

14 Q. Okay. Now, the second affidavit that I
15 have was sworn on June 24th of 2008. And this is the
16 one where you had then reviewed Dr. Leonhardt's
17 testing?

18 A. Correct.

19 MS. GANES: And we'll mark this as 4.

20 (Defendants' Exhibit 4 was marked for
21 identification.)

22 Q. (By Ms. Ganes) Did you also work with
23 Ms. Argoe's attorneys in drafting that affidavit?

24 A. Yes.

25 Q. And did you have any other versions of

1 that affidavit?

2 A. I don't think so.

3 Q. Have you ever been sued for medical
4 malpractice?

5 A. I had some threats and one suit that was
6 filed.

7 Q. And what did that lawsuit involve?

8 A. One of my patients who was a lawyer's son,
9 he was an alcoholic, substance abuser, and he had been
10 to several psychiatrists before and had depression,
11 anxiety, panic attacks, phobias. And when he came to
12 me, his father brought him, he was probably about 30,
13 something like that. He didn't work and his father
14 wanted him fixed. His father was supporting him. And
15 so, I continued him on this medicine, Prozac, that he
16 had been taking, and I put him on Antabuse that his
17 father had given it to him and got him to quit using
18 drugs and gave him some medicine to block his panic
19 attacks.

20 He started doing better, but he wouldn't
21 get a job. And finally, his father was, I thought,
22 enabling him, so suggested to his father that he cut
23 him off and quit giving him money. His father didn't
24 want to do that, but he finally did. And when he quit
25 giving him the money, unbeknownst to me, he went out

1 and started robbing people, he performed some
2 burglaries and holdups and tied some people up,
3 whatever that is. This went on for several weeks.

4 During that time, he came in for a visit
5 with me and he had on a Rolex. And I said, Where did
6 you get the Rolex. He said, Oh, I got a job. And he
7 hadn't, in fact, of course. And about two weeks
8 later, he got arrested and they put him in jail and
9 they got an attorney -- he was facing a long, long
10 imprisonment for multiple crimes. The attorney called
11 and asked if I would testify that he was not guilty by
12 reason of insanity. I told him no, I couldn't do
13 that. He wasn't insane at all.

14 So they got another attorney and he called
15 and said would I testify that Prozac made him do it.
16 It was Prozac and they wanted to sue Eli Lilly and I
17 told them again, no, I wouldn't do that. So then they
18 filed a lawsuit against Eli Lilly and me saying that I
19 had prescribed him the medicine that made him do it,
20 but he had been on it for six years. So it was kind
21 of ridiculous.

22 In any case, the attorney that they
23 finally ended up with was expert at suing Prozac,
24 apparently. He kept trying to get me to testify
25 against Prozac which I refused to do. And then they

1 finally dropped it.

2 Q. So no money was paid --

3 A. No.

4 Q. -- on your behalf?

5 A. No.

6 Q. Have you ever had any settlements --

7 A. No.

8 Q. -- related to your practice as a physician
9 that you know of?

10 A. No.

11 Q. Have you ever been involved in any other
12 lawsuits other than for patient care?

13 A. Oh, yeah. You mean like civil suits?

14 Q. Right.

15 A. Yeah, I sued my builder one time, the guy
16 that built my house. Let's see, you know, maybe some
17 collections, things like that.

18 Q. Have you ever had any complaints made
19 against your medical license that you know of?

20 A. Yeah. I had a fellow and he reported me
21 to the medical board said that I had sawed him into
22 pieces and I wouldn't saw him back together.

23 Q. Anything else?

24 A. That's the only one I can think of.

25 Q. Did you ever saw him back together?

1 A. Well, he was schizophrenic. I got him
2 back on his medicine and he came back together. He
3 had decompensated. He did a lot of LSD which is not
4 good for schizophrenics or anybody, but particularly
5 not good for him.

6 Q. In this case, you never saw Ms. Argoe
7 prior to 2008; is that correct?

8 A. Correct.

9 Q. Okay. And you never did an assessment of
10 her at the time that the physicians being sued in this
11 case did their assessment in 2005, correct?

12 A. Correct.

13 Q. Have you ever been involved as a
14 court-appointed examiner in involuntary commitment
15 proceedings?

16 A. Well, I've had -- testified for people
17 that were patients, so that's kind of the way it
18 usually works here.

19 Q. Have you provided treatment to
20 involuntarily committed patients?

21 A. Yes.

22 Q. Okay. Have you provided treatment to
23 involuntary committed patients in the role that
24 Dr. Steiner did in this case, meaning, the first
25 physician to see the individual in the inpatient

1 setting?

2 A. Yes.

3 Q. Okay. Now, is it -- do you have an
4 understanding in this case as to what Dr. Steiner's
5 role was in Ms. Argoe's clinical treatment?

6 A. I think so.

7 Q. How would you characterize Dr. Steiner's
8 role?

9 A. Well, I think first she saw Dr. Hooker and
10 was, you know, at the hospital, then released and then
11 came to Aurora and Dr. Steiner then did an evaluation
12 on her and signed the paper.

13 Q. Okay. Now, you agree with me that Dr.
14 Steiner did not have the ability to release Ms. Argoe
15 at the time that he saw her, correct?

16 A. He did not?

17 Q. He did not have or do you have an opinion
18 that he did?

19 A. I don't know why he couldn't have.

20 Q. Do you have any knowledge of the
21 commitment proceedings -- commitment procedures in
22 South Carolina?

23 A. Some.

24 Q. And based on that knowledge, you believe
25 that Mr. Steiner could have released Ms. Argoe at the

1 time that he saw her?

2 A. I don't understand why not.

3 Q. If there's a requirement that she be held
4 for a certain period until a hearing is conducted.

5 A. My understanding is any time you think
6 someone doesn't meet the criteria, you can release
7 them.

8 Q. Okay. So your opinion in this case
9 related to Dr. Steiner is -- tell me all the
10 criticisms that you have of Dr. Steiner related to
11 Ms. Argoe and then I'll ask you my follow-up
12 questions.

13 A. I don't think he did a proper assessment
14 of her to hold her against her will.

15 Q. Okay. What do you think a proper
16 assessment requires that Dr. Steiner did not do?

17 A. An in-depth evaluation of that individual
18 at the time to determine that the person is either
19 dangerous or so unable to take care of themselves
20 that -- a person first has to be mentally ill to hold
21 them. And then if they're mentally ill and dangerous
22 or so psychotic or ill that they can't take care of
23 themselves, then you can hold them.

24 Q. Isn't the history being provided to the
25 physician by the family and those closest to the

1 patient important in an initial assessment, especially
2 in an involuntary commitment process?

3 A. Certainly.

4 Q. Do you know what the history was that was
5 being provided with Ms. Argoe's involuntary
6 commitment?

7 A. Yes.

8 Q. What was that history?

9 A. Can we pull it out and take a look?

10 Q. Sure. Yeah. I'm not sure which volume
11 it's in. Some of this there's more than one copy
12 because --

13 MR. DODSON: Is that what you're looking
14 for, Doctor?

15 THE WITNESS: Well, that's part of it. Is
16 this signed by Dr. Steiner here?

17 MR. DODSON: You want Steiner's note, too?

18 THE WITNESS: Yes. Dr. Steiner has about
19 30 lines of history from the family and about two
20 lines of mental status -- excuse me, that's not
21 the right place. He has about 30 lines of
22 history, then he has mental status exam and you
23 want me to tell you what he was told by the
24 family?

25 Q. (By Ms. Ganes) Sure.

1 MR. COLE: Can you also at the bottom
2 Bates number tell us what page you're
3 referencing?

4 THE WITNESS: 427.

5 MR. COLE: That would be the record for
6 appeal on 427.

7 THE WITNESS: Partly, he's quoting also
8 from -- he has information from papers that were
9 sent to him from -- over from where Dr. Hooker
10 was.

11 Q. (By Ms. Ganes) Correct.

12 A. So he has that, too, but the information
13 that comes in is that: "She carries a handgun on her
14 left hip all the time. She's a danger to herself and
15 others. She is suspicious of others. As a result,
16 has moved silverware and other items out of the house.
17 She refuses to touch or clean anything in the house.
18 She locks herself in the room at night. She is
19 fidgety and drives late at night. She's fearful of
20 people. She is paranoid. She states her house is
21 bugged. She has hallucinations of seeing witches and
22 warlocks. She spends money excessively.

23 She accuses her husband of having an
24 affair and having another family. Clothes are stacked
25 everywhere. She refuses treatment. She denies any of

1 these problems. She says she has a license to carry a
2 gun and she has it in the car. She states she took a
3 course and that is why she carries a gun. She states
4 her husband told her that her house was bugged, then
5 he later denied it. She states that some things have
6 been removed from the house and that is why she took
7 things out to protect herself. She denies
8 hallucinations. She denies spending money
9 excessively. She is in denial of any problem.

10 In addition, the family -- I presume is
11 the family -- a list was sent in of her daily
12 behavior. This was dated 8/27/05 blank. It is in the
13 chart. There are about 20 different items listed.
14 I'm not going to read them all.

15 Some similar things were mentioned in the
16 commitment papers, but also things like watches TV
17 news and if Louis is present switches to religious TV
18 and Louis leaves. Louis is her husband. She is
19 apparently gone much of the day and comes home at 6:00
20 p.m. They do not know where she has been.

21 She will not eat from the refrigerator and
22 brings no food in the house that requires any
23 preparation. She also insists on playing gospel tapes
24 and CD's in the car. Apparently, this is different
25 than what she was like several years ago. Another

1 separate, she listed 22 different items, talks about a
2 lot of excessive spending. Wanted a \$19,000 watch
3 which is identical to the one she has. She,
4 apparently, had \$60,000 worth of jewelry on her when
5 she came to the hospital. She reported she has hidden
6 an antique Corvette from her husband. This is his
7 car.

8 She called her sister to come and get a
9 chest that is a family heirloom. She has removed the
10 curtains from certain parts of the house. She refused
11 to let anyone in the house to clean and apparently the
12 house is dirty. She denies any problems with sleep,
13 appetite, energy. She denies any hallucinations.

14 Q. So what, in your opinion, is lacking from
15 the assessment that Dr. Steiner did?

16 A. He's got to do his own assessment.

17 Q. Did you read Dr. Steiner's deposition in
18 this case?

19 A. Yes.

20 Q. And did you see his testimony about what
21 treatment -- what assessment he did of Mrs. Argoe?

22 A. Well, I read it because it's right here in
23 the record.

24 Q. Uh-huh.

25 A. "She is alert, well-groomed. Looks

1 younger than her stated age. She is oriented to
2 person, place and time. She has no insight as to why
3 she is here. Memory does appear intact, although, she
4 is inattentive. She denies any auditory, visual,
5 olfactory or tactile hallucinations. There are no
6 delusions, no paranoia, no grandiosity. Insight is
7 absent. Judgment is impaired. Speech is a little
8 pressured. She laughs and seems a little bit anxious.
9 She is rather guarded and will not talk much about
10 these allegations. She laughs off others and does not
11 talk much about some of the allegations -- excuse me,
12 she laughs off of others and denies any problems.
13 There's no losing of associations or flight of ideas.
14 Her note is that she requested her shower be cleaned
15 before she utilizes it. And during her physical
16 assessment, she would not put her bare feet on the
17 floor."

18 There's nothing in there to hold her.
19 There's not one thing in there to hold this person
20 against their will.

21 Q. To be fair, Dr. Davis, part of
22 Dr. Steiner's assessment was also the gathering of the
23 history that is included in his notes, correct?

24 A. Correct.

25 Q. Okay. Now, have you read the depositions

1 of Ms. Argoe's brother and sister that were taken in
2 this case?

3 A. Dr. Reed is it?

4 Q. That's right.

5 A. I don't think so. I don't think I have
6 that one.

7 Q. Are you aware that her brother and sister
8 stand by the fact that she needed psychiatric
9 treatment in 2005 at the time that she saw Dr. Steiner
10 and all of the other physicians that she has sued?

11 A. No.

12 Q. Does that have any bearing on your
13 opinion?

14 A. No.

15 Q. Is it your testimony -- is it going to be
16 your testimony to the jury in this case that
17 Dr. Steiner receiving a history on a patient that she
18 has a gun which doesn't make anyone -- doesn't present
19 a psychiatric problem, but it does present access to a
20 dangerous item, correct? Having a gun, do you agree
21 with me?

22 MR. DODSON: I object to the form.

23 Q. (By Ms. Ganes) That's a means to hurt
24 yourself or others, correct?

25 MR. DODSON: I object to form.

1 THE WITNESS: Sure.

2 Q. (By Ms. Ganes) So she has a gun. She has
3 a son and a husband who is giving this history to Dr.
4 Steiner and he sees her on an involuntary commitment;
5 is it your testimony to the jury that he should have
6 released her after his initial impressions?

7 A. Absolutely.

8 Q. What do you base that opinion on?

9 A. His examination of her shows no mental
10 illness.

11 Q. Would you ever examine -- well, you agree
12 with me that the clinical impression of actually
13 seeing a psychiatric patient is important, correct,
14 sitting across the table from them?

15 A. Sure.

16 Q. Looking at them?

17 A. Absolutely.

18 Q. And do you substitute your reading of
19 paperwork for Dr. Steiner's clinical judgment in June
20 of 2005?

21 MR. DODSON: I object to the form.

22 THE WITNESS: Yes.

23 Q. (By Ms. Ganes) So you want the jury to
24 believe you that there was no reason to hold Martha
25 Argoe based on your reading this paperwork instead of

1 believing Dr. Steiner who clinically assessed her at
2 the time?

3 A. Yes.

4 Q. Okay. Do you have any other criticisms of
5 Dr. Steiner other than the fact that he should have
6 released Martha Argoe the first time he saw her?

7 A. No.

8 Q. And what is your understanding of what
9 happened with Ms. Argoe after Dr. Steiner's
10 impressions?

11 A. She got transferred over to Three Rivers.

12 Q. Do have any opinions in this case that any
13 other clinical provider relied on anything Dr. Steiner
14 did for Ms. Argoe to continue to be held for the 41
15 days that she was involuntarily committed?

16 MR. DODSON: I object to the form.

17 THE WITNESS: Well --

18 MR. DODSON: If you hear me object, you
19 have to still answer.

20 THE WITNESS: I was thinking.

21 Q. (By Ms. Ganes) We don't even hear each
22 other anymore.

23 A. Yeah. I think that they -- assuming from
24 what I read later that they did to some extent rely on
25 the fact that Dr. Steiner sent her over. That would

1 be the usual thing.

2 Q. Dr. Davis --

3 A. He had her transferred over.

4 Q. It's your understanding that Dr. Steiner
5 had her transferred?

6 A. Yes.

7 Q. What is your understanding of why
8 Ms. Argoe left the Aurora Pavilion to go to Three
9 Rivers?

10 A. I don't think they had her insurance or
11 something like that.

12 Q. So that isn't really a transfer from
13 Dr. Steiner, is it?

14 A. Yeah.

15 Q. He didn't transfer her because she needed
16 care that couldn't be provided at Aurora, it was more
17 of an administrative transfer for payment purposes?

18 MR. DODSON: I object to the form.

19 THE WITNESS: If he didn't sign the paper,
20 she wouldn't be going.

21 Q. (By Ms. Ganes) Well, isn't it true that
22 she could have gone on the involuntary commitment
23 papers to Three Rivers to start with if the police
24 officers had taken her to Three Rivers rather than
25 Aurora --

1 A. I assume.

2 Q. -- they could have accepted her?

3 A. I assume, yeah.

4 Q. They could have accepted her as
5 involuntary commitment there at Three Rivers, correct?

6 A. Correct.

7 Q. Based on the same paperwork that she was
8 accepted at Aurora?

9 A. They could be, but they would have the
10 same duty to examine her and make an assessment right
11 then as to whether or not she needed to be held.

12 Q. And didn't they -- didn't the other
13 physicians still have the same duty to assess her on
14 their own and determine whether she needed to continue
15 to be held?

16 A. Yes.

17 Q. Have you seen any testimony about any
18 physician in this case that they relied on anything
19 Dr. Steiner did for her involuntary commitment at
20 Three Rivers?

21 A. I don't recall anything.

22 Q. Okay. Isn't it true that each clinical
23 provider relied on their own judgment in making the
24 determination of whether Ms. Argoe needed to stay at
25 Three Rivers?

1 MR. DODSON: I object to form.

2 THE WITNESS: Yes.

3 Q. (By Ms. Ganes) Isn't it also true that
4 Ms. Argoe had court hearings and was adjudicated as a
5 continuing involuntary commitment?

6 MR. DODSON: Objection to form.

7 THE WITNESS: Yes.

8 Q. (By Ms. Ganes) Are you aware that
9 Ms. Argoe's involuntary commitment has been upheld by
10 the South Carolina Supreme Court?

11 A. Yes.

12 MR. DODSON: I object to form.

13 Q. (By Ms. Ganes) It's been appealed all the
14 way up, so there's no argument in this case whether
15 her commitment was appropriate?

16 MR. DODSON: Objection to form.

17 THE WITNESS: From a legal point, as far
18 as I know, there isn't.

19 Q. (By Ms. Ganes) Now, do you have any
20 opinions about whether the actual clinical services
21 provided to Ms. Argoe by Dr. Steiner were appropriate?

22 A. Well, the assessment and transfer is a
23 clinical service, so, you know, I already don't think
24 that's appropriate at all.

25 Q. Okay. What about -- you agree with me

1 that Ms. Argoe didn't take any medication when she was
2 at Aurora, correct?

3 A. I don't think so. That's right.

4 Q. You don't think that she took medicine?

5 A. I don't recall. I'd really have to look
6 at the record, but I don't think so. I don't
7 remember.

8 Q. Sure. And so what is your -- do you have
9 any opinion as to any damages that Dr. Steiner caused
10 Ms. Argoe?

11 A. Yeah, he -- he put her into a psychiatric
12 hospital and had her transferred and that's damaging.

13 Q. Okay.

14 A. I don't think any of us in this room would
15 want that to happen to us.

16 Q. If the legal procedure did not allow for
17 Dr. Steiner to release Ms. Argoe, then would you agree
18 with me that Dr. Steiner didn't cause Ms. Argoe any
19 harm?

20 A. I think he would have -- I don't know that
21 the legal procedure didn't and I don't understand why
22 a doctor who doesn't think somebody needs to be in a
23 psychiatric hospital can't make that statement. So,
24 you know, I don't know exactly know how it works in
25 South Carolina. I know in most states that I've ever

1 been in, if the doctor doesn't think that the patient
2 needs to be in a psychiatric hospital or a general
3 hospital or any kind of medical treatment center, the
4 doctor can discharge the patient.

5 Q. Is it important to you in your assessment
6 that your patients cooperate so that you can make a
7 determination of diagnosis?

8 A. Yes.

9 Q. If a patient won't cooperate in an
10 assessment, the physician a lot of times can't make a
11 determinative diagnosis, correct?

12 A. Correct.

13 Q. And did you see in the records in this
14 case that Ms. Argoe wasn't cooperative in the initial
15 assessment?

16 A. Well, he -- he has here a mental status
17 exam. Doesn't say she didn't cooperate. He -- I
18 mean, what he put here is really an indication to me
19 that she was cooperating. I mean, he asked her,
20 apparently, it says she denies auditory, visual,
21 olfactory or tactile hallucinations. She was
22 cooperating. He tested her memory, apparently, and
23 she cooperated. She was talking to him. He says her
24 speech was a little bit pressured. She was laughing
25 and a little bit anxious. Well, I would think, you

1 know, if she wasn't anxious, I would be surprised.
2 She's rather guarded. Well, I mean, it seems to me
3 like she's being suspicious of them is not surprising.
4 There's nothing wrong with her. She's wondering why
5 this is happening.

6 She's told me that she had a lot of
7 reasons to be suspicious of her husband. So I just
8 don't think he did a very good job at all of doing
9 this evaluation on her to -- what did he have to back
10 up that she's psychotic. If you --

11 Q. Let me ask you this, Doctor --

12 MR. DODSON: Wait. Let him finish his
13 answer.

14 THE WITNESS: If you look in here, the
15 number one, based on the information given by the
16 family, that's not the way you do it. You
17 don't -- you don't commit somebody and take their
18 freedom away because someone else tells you to do
19 that. He says -- he even -- I think he indites
20 himself here based on information given by the
21 family, she's diagnosed psychosis, but he doesn't
22 back it up at all in his exam.

23 Q. (By Ms. Ganes) Doctor, if the patient who
24 you've never seen before who is coming on an
25 involuntary commitment procedure tells you that they

1 trust the family who is giving this history, isn't
2 that an important element of receiving historical data
3 from a family member?

4 A. Sure.

5 Q. And did you see in the record that
6 Ms. Argoe told Dr. Steiner she trusts her son? Did
7 you see that in the record?

8 A. Yes.

9 Q. Now, how can you now with the benefit of
10 hindsight be critical of Dr. Steiner for giving a
11 diagnosis of psychosis not otherwise specified, and
12 it's appropriate to have a rule-out diagnosis,
13 correct?

14 MR. DODSON: I object to form.

15 Q. (By Ms. Ganes) That's appropriate?

16 MR. DODSON: I object to form.

17 THE WITNESS: Sure.

18 Q. (By Ms. Ganes) So he had a rule-out
19 diagnosis of bipolar mania with psychotic features and
20 he had another rule-out diagnosis of a delusional
21 disorder.

22 MR. DODSON: I object to form.

23 Q. (By Ms. Ganes) It's appropriate to
24 operate from a rule-out diagnosis after an initial
25 assessment, correct?

1 MR. DODSON: I object to form.

2 THE WITNESS: That's fine.

3 Q. (By Ms. Ganes) It's appropriate to order
4 screening lab studies on an initial assessment,
5 correct?

6 A. Yes.

7 Q. What would those lab studies show you?

8 A. Probably nothing.

9 Q. No. What are you looking for? I
10 understand what you think they would show in
11 Ms. Argoe's case. So when you order lab studies on a
12 brand new involuntary commitment, what types of things
13 can those studies show?

14 MR. DODSON: I object to form.

15 THE WITNESS: I don't think they would
16 show anything. I don't know what he'd be looking
17 for.

18 Q. (By Ms. Ganes) You don't think that --

19 A. He doesn't say what he's looking for, why
20 he's doing it. There's no lab studies going to show
21 you whether she's delusional or not or bipolar or
22 whether she's psychotic or not. You do that from
23 examining the patient, doing the mental status
24 examination which he did in -- his mental status
25 examination doesn't jive with his diagnosis. There's

1 nothing in here that says this woman is bipolar or
2 delusional.

3 Q. (By Ms. Ganes) Dr. Davis, isn't spending
4 money excessively --

5 MR. DODSON: Stop. Did you finish your
6 answer?

7 THE WITNESS: Yeah. Thank you.

8 Q. (By Ms. Ganes) Isn't spending money
9 excessively a sign of mania?

10 A. We don't know that she was spending money
11 excessively except her husband says she is.

12 Q. And there's no way to test for it in a
13 clinical setting --

14 MR. DODSON: Hold on. Did you finish your
15 answer?

16 THE WITNESS: No, I hadn't. She needs to
17 ask her how much money are you spending, how much
18 shopping have you been doing. I don't know.
19 Does she have a lot of money and what's
20 excessive?

21 Q. (By Ms. Ganes) Isn't it true he has to
22 use --

23 A. Do husbands not occasionally think their
24 wives might be spending too much money?

25 Q. Isn't it true that he has to use his

1 clinical judgement --

2 MR. DODSON: Let me stop. Hold on. Stop.
3 Stop.

4 MS. GANES: Stop interrupting the
5 deposition.

6 MR. DODSON: I'm not interrupting the
7 deposition.

8 MS. GANES: Yes, you are.

9 MR. DODSON: You continue to cut off Dr.
10 Davis when he's giving his answer. Let him
11 finish his answer.

12 Q. (By Ms. Ganes) Dr. Davis, were you
13 finished with your answer?

14 MS. GANES: I can tell when he's finished.

15 MR. DODSON: You've cut him off numerous
16 times and that will be reflected on the record.
17 What I'm telling you is let him finish his answer
18 before you ask your next question.

19 MS. GANES: What will be reflected on the
20 record is your uncivil conduct.

21 MR. DODSON: I'm not being uncivil.

22 MS. GANES: Do not interrupt the
23 deposition again.

24 MR. DODSON: Do not interrupt the witness
25 when he is giving an answer that is responsive to

1 your question and you wanted to jump in with
2 another question. Let him finish his answer,
3 then you can ask other question.

4 Q. (By Ms. Ganes) Dr. Davis, it is not my
5 intention to interrupt you at all. If you're not
6 finished with your answer, would you please tell me
7 that so we don't have to have any more interruptions
8 from Mr. Dodson. I don't mean to have you in an
9 environment where there is screaming coming from your
10 right hand.

11 MR. DODSON: I'm not screaming at anyone.

12 MS. GANES: And I apologize for that.
13 Please don't interrupt the deposition again,
14 Robert.

15 MR. DODSON: I'm not interrupting.

16 Q. (By Ms. Ganes) Were you finished with your
17 answer?

18 A. I forgot.

19 Q. I apologize if you were not. And what we
20 were talking about is there's no way to test for
21 excessive spending in a clinical environment, is
22 there?

23 A. No, but you got to ask the patient, you
24 know. The things that are stated here that she's
25 just -- take the witches and warlocks. It's a simple

1 part of the mental status examination to ask the
2 patient have you been seeing witches? Have you been
3 seeing warlocks? What kind of spending have you been
4 doing?

5 Q. And then as the physician, you have to
6 make a clinical judgment of whether that patient is
7 being honest --

8 A. But you got to ask --

9 Q. I'm not finished with my question to be
10 fair, Dr. Davis, but I'm not going to yell at you
11 about that.

12 To be fair, in a clinical environment,
13 Dr. Davis, especially in a psychiatric setting, you
14 have to make a clinical judgment of whether that
15 patient is being honest with you, correct?

16 MR. DODSON: I object to the form.

17 THE WITNESS: It's not all about honesty.
18 It's about assessing the patient, you know,
19 what -- I mean, look, let's take the worst case
20 scenario here. All right. She's spending
21 excessively. So what? You going to put somebody
22 in a psychiatric hospital because they're
23 spending excessively? Come on.

24 Q. (By Ms. Ganes) To be fair, that wasn't the
25 only item listed, correct?

1 A. We got to take them one by one because
2 none of them hold up. Not one thing in Dr. Steiner's
3 evaluation holds up.

4 Q. Is it your testimony to the jury in this
5 case that in Dr. Steiner's shoes seeing Ms. Argoe
6 coming in on an involuntary commitment, already having
7 Dr. Hooker, another physician, sign off on the
8 involuntary commitment, that you would have done one
9 assessment of her with a history coming from a son who
10 your patient that you've never met before tells you
11 she trusts and with her family telling you that she
12 carries a gun and she's a danger to herself and
13 others. You would have discharged her?

14 MR. DODSON: I object to the form.

15 THE WITNESS: Yes.

16 Q. (By Ms. Ganes) Okay. Now, what would you
17 have done, Dr. Davis, if she left and killed herself
18 or someone else?

19 MR. DODSON: I object to the form.

20 THE WITNESS: I would have been really
21 sad.

22 Q. (By Ms. Ganes) And you would have
23 liability for that as a physician, wouldn't you?

24 MR. DODSON: I object to the form.

25 THE WITNESS: I don't think so because

1 nothing in here tells me that she needs to be
2 deprived of her liberty.

3 Q. (By Ms. Ganes) Dr. Davis, if the history
4 that is provided by the family is correct, those items
5 support psychosis nonspecific diagnosis, don't they?

6 MR. DODSON: I object to form. Go ahead.
7 I'm sorry.

8 THE WITNESS: They're not correct.

9 Q. (By Ms. Ganes) That's not my question.

10 A. He's got to find out if they're correct or
11 not. If the family came in and said that you were
12 hearing voices, then I would have to go to you and say
13 have you been hearing any voices? That's my job to
14 do. It's my job to evaluate you. I mean, do you want
15 to have a setup where other people can come and get
16 somebody committed to a psychiatric hospital against
17 their will just based on somebody else's word? Your
18 neighbor might come and say that. Your husband might
19 come and say that. I got to examine you.

20 Q. Dr. Davis, we have no way of knowing -- no
21 way of knowing with certainty whether the history
22 given to Dr. Steiner was correct?

23 A. That's right.

24 Q. You agree with me?

25 A. But -- but that's why you do the exam.

1 Q. And so my question to you was --

2 A. You don't go on -- excuse me, you don't go
3 on the history from someone else. You go on the
4 examination you do on that person.

5 Q. Dr. Davis, is it your testimony to the
6 jury in this case that in a psychiatric setting, a
7 physician is not to consider the history given by
8 family members who the patient trusts?

9 A. Of course, the doctor's going to consider
10 it.

11 Q. Okay. Then my question to get back to it
12 was: If the history -- and I understand you don't
13 think it was accurate -- if the history given to Dr.
14 Steiner was true, the items presented in that history
15 support his diagnoses of a psychotic disorder not
16 otherwise specified, don't they?

17 MR. DODSON: I object to the form.

18 THE WITNESS: Even taking what you're
19 saying is true, I mean, if they said all this,
20 she's still not dangerous to anybody. She's
21 potentially dangerous, but so is everybody else.
22 You know, when we're driving a car, we're
23 potentially dangerous. There's no reason to
24 think that Martha is dangerous. There's no
25 reason to think she can't take care of herself

1 even if this is true.

2 Q. (By Ms. Ganes) Okay. That wasn't my
3 question. My question is: If the history given to
4 Dr. Steiner was true, that history supports his
5 diagnosis of psychosis not otherwise specified,
6 doesn't it?

7 MR. DODSON: I object to form.

8 THE WITNESS: No.

9 Q. (By Ms. Ganes) Is it your testimony that
10 if the history of seeing witches and warlocks,
11 spending excessively, being paranoid, being fearful of
12 people, having delusions, among other things, do not
13 support a diagnosis of psychosis; that's your
14 testimony?

15 A. It could.

16 Q. That's my question to you.

17 A. It could not necessarily -- not
18 necessarily.

19 Q. Okay. That is all I'm asking you is that
20 if this is true, if the items presented to Dr. Steiner
21 on his very first meeting never seeing this patient
22 before, not calling and saying Martha Argoe, come see
23 me, I can do you a lot of good, but showing up for his
24 work at the Aurora Pavilion having an involuntary
25 commitment showing up walking in the door, if this

1 history is true, don't you agree with me that that
2 supports a diagnosis of psychosis? And I understand
3 that you don't agree that it's true.

4 MR. DODSON: I object to the form.

5 THE WITNESS: You're saying -- you're
6 saying if he just accepts what somebody tells him
7 and he doesn't examine her, he knows nothing
8 else, this is all he's got, it could.

9 Q. (By Ms. Ganes) Okay. Now --

10 A. But that's not the way you do it.

11 Q. I understand that. That's not the way Dr.
12 Steiner did it. He did an assessment of her.

13 And what services have you provided for
14 Martha Argoe clinically, if any?

15 A. None.

16 Q. Have you ever met with her face-to-face?

17 A. Yes.

18 Q. Prior to today?

19 A. Right.

20 Q. How many times?

21 A. Once.

22 Q. Okay. That's when you did some testing,
23 the Pearson testing on her?

24 A. Yes.

25 Q. And it was more than three years after she

1 saw Dr. Steiner?

2 A. Yes.

3 Q. Okay. And it was when significant
4 stressors had been removed from her life?

5 MR. DODSON: I object to the form.

6 THE WITNESS: Yeah, I think so. She got
7 divorced.

8 Q. (By Ms. Ganes) And are you critical of any
9 other physicians or medical entities that are not
10 named as defendants in this case?

11 MR. DODSON: I object to the form. You
12 can still answer that, though.

13 THE WITNESS: Yes.

14 Q. (By Ms. Ganes) Okay. Who are you critical
15 of?

16 A. The nurses at Three Rivers.

17 Q. Okay. What about -- are you critical of
18 the fact that Ms. Argoe underwent outpatient therapy
19 for a year?

20 A. I think she was forced to do that. And --
21 am I incorrect about that? Wasn't that part of the --

22 Q. Doctor, to be fair, you told me that if
23 the physician didn't think anything was wrong with
24 Ms. Argoe, he could have discharged her from services,
25 correct?

1 A. And I wondered why Dr. Remy didn't do
2 that.

3 Q. Are you critical of Dr. Remy for his care
4 and services?

5 A. Yeah.

6 Q. What about his prescription of medication
7 for Ms. Argoe?

8 A. Yeah, I didn't understand why he did that.

9 Q. And so why do you think he wasn't sued in
10 this case?

11 A. I don't know.

12 Q. Do you think he breached the standard of
13 care inasmuch as any defendant in this case did?

14 A. No.

15 Q. How not?

16 A. He didn't keep her in a hospital locked
17 up. But I wonder, he said he didn't see signs of
18 mental illness, so I didn't quite understand why he
19 kept prescribing this medication for her.

20 Q. Is it your understanding that Ms. Argoe
21 took the medication?

22 A. I think she did.

23 Q. I think I will -- well, do you have any
24 other opinions related to Dr. Steiner other than what
25 you've told me?

1 A. Let me look. No, that's all I have.

2 Q. Okay. If you don't mind, I know you guys
3 like to keep your original notes, but before we go, if
4 we could just make a copy of your notes and mark them
5 as an exhibit.

6 A. Certainly.

7 Q. And the tabs that you tabbed your notes
8 with, do the colors of the tabs have any meaning to
9 you?

10 A. No.

11 Q. Okay. And I took this out of your
12 notebook, I'm going to stick it back. But I just saw
13 this was just Dr. Steiner's note. I saw it after
14 Robert gave you a copy, so I'll stick it back in
15 there.

16 If you should develop any additional
17 opinions related to Dr. Steiner or any other defendant
18 in this case prior to the trial of this case that you
19 don't give us in your deposition today, will you
20 please let us know that so that we can have the
21 benefit of those opinions prior to trial?

22 A. Yes.

23 MS. GANES: I may have a couple more
24 questions. I don't think I have anything
25 significant.

1 MR. DODSON: Let's take a very short
2 break.

3 MS. GANES: Sure.

4 (Recess from 10:11 a.m. to 10:27 a.m.)

5 CROSS-EXAMINATION

6 BY MR. HAILE:

7 Q. Dr. Davis, my name is Shelton Haile. I
8 represent Aiken Regional Medical Centers. Do you have
9 any opinion that Aiken Regional deviated from the
10 standard of care in this case?

11 A. No, I don't think they did.

12 Q. Okay.

13 MR. HAILE: Well, that was easy. That's
14 my only question for you. Thank you.

15 MR. DODSON: Chip, are you still there?

16 CROSS-EXAMINATION

17 BY MR. HICKS:

18 Q. Dr. Davis, my name is Chip Hicks. Can you
19 hear me just fine?

20 A. Yes.

21 Q. I can hear you, you're a little bit soft,
22 so I have to ask you to speak up.

23 A. Can you hear me okay?

24 Q. I can hear you just fine.

25 I represent Carolina Care Plan in this

1 matter. Do you know who they are?

2 A. Yes.

3 Q. Okay. Do you have any opinions whatsoever
4 about Carolina Care Plan as it relates to this case?

5 A. No.

6 MR. HICKS: I'll ditto Shelton Haile and
7 say that was easy. Thank you, sir.

8 MR. COLE: I guess I'll take over, then,
9 after that long -- unless you need to take a
10 break after that.

11 CROSS-EXAMINATION

12 BY MR. COLE:

13 Q. Doctor, my name is Andrew Cole. I'm here
14 on behalf of Three Rivers and Nurse Burrell. I'm
15 going to ask you some questions about them and ask you
16 your opinions, I guess, basically, since the time
17 period after you were finished with the questions this
18 morning. I might jump around a little bit but just
19 try to bear with me. We'll try to get through this as
20 quickly as possible.

21 First, what is the actual name of your
22 facility that you are currently employed at?

23 A. The Piedmont Psychiatric Clinic.

24 Q. And do you have any other physicians or
25 other clinicians that are members of that?

1 A. Yes.

2 Q. And who are they?

3 A. My psychiatric partner is Dr. Annie
4 Cooper. And a social worker works there is Mr. Tom
5 Dixon.

6 Q. Anyone else?

7 A. Just the staff.

8 Q. Okay. Did Dr. Cooper or Mr. Dixon play
9 any or take any role in the review of any of the
10 records that you have reviewed in this case?

11 A. No.

12 Q. Did either of them take any role in the
13 visit that Ms. Argoe had to your facility a couple of
14 years ago?

15 A. No.

16 Q. So the only person that saw Ms. Argoe and
17 has any opinions regarding Ms. Argoe is you?

18 A. Yes.

19 Q. And there are no one else on the name on
20 the door or part of the group or anything like that?

21 A. No.

22 Q. There was a test that was administered
23 when you saw Ms. Argoe?

24 A. Correct.

25 Q. Can you tell me how was that test

1 administered?

2 A. The test is done on a computer. It's
3 true-false and she's simply instructed to answer the
4 questions as best she can and honestly. And then we
5 feed it into a computer and it prints out a report.

6 Q. And the computer generates a report or --

7 A. Yes.

8 Q. Okay. Is there anyone else that goes
9 behind that and interprets the results of that report?

10 A. Well, you know, I read it and we do these
11 reports fairly frequently, so I look to see if it
12 matches with the clinical examination that I'm doing.

13 Q. Is the report administered at the
14 beginning or the end of the visit that you have?

15 A. It varies.

16 Q. Okay. In this case, was the report done
17 first or last when you were visiting Ms. Argoe?

18 A. It was done later in the day. I had
19 already talked with her. As I recall now, you know --
20 actually, I don't remember the exact order of what she
21 did. I think she -- I'm trying to recall. I believe
22 she got to the office late that day and the usual
23 procedures is for her to fill out the database
24 forms -- the patient to fill out the database forms
25 or, in this case, I'm going to call her a client.

1 She's not a patient of mine. So the client would fill
2 out the database forms, and then I would have that to
3 look at before I started to interview the client and
4 at some point we take a break and they would do the
5 testing. And if need be, I would talk to them about
6 the results.

7 Q. When Ms. Argoe came to your office -- I
8 think you put that in your affidavit when she came
9 down. Do you remember when that was?

10 A. 4/24/08.

11 Q. Okay. So in April -- the end of April
12 2008 when she came here, was she alone or did she have
13 someone with her?

14 A. I only remember seeing her.

15 Q. Okay. And do you know did she drive
16 herself or did someone drop her off?

17 A. I don't know.

18 Q. Do you know how long you spent with her
19 that day?

20 A. She was in there pretty -- she was in
21 there quite a bit that day. No, I don't remember
22 exactly, but she was -- she was there four, five, six
23 hours, something like that.

24 Q. You said typically someone would fill out
25 the database forms?

1 A. Right.

2 Q. Is that something that, like, when you
3 show up at the doctor, they give you a clipboard, then
4 you fill in the background information, is that what
5 you're talking about?

6 A. Correct. This is a series of forms that I
7 made up myself for the kind of evaluations that we do
8 and we ask every patient -- every client to fill out
9 the database forms.

10 Q. How did you develop, then, the forms that
11 you've asked the --

12 A. Gradually over many years from experience
13 and reading other people's forms, getting suggestions
14 from people that worked at our clinic.

15 Q. Is there any like publication or any
16 specific form or other practice that was the -- I
17 guess the principal part of your inspiration on what
18 questions you need to ask?

19 A. No. No. This is a proprietary document.

20 Q. Proprietary for your clinic?

21 A. Yes.

22 Q. And the forms you're talking about in the
23 stuff that was produced with the subpoena that I sent,
24 are you talking about I think handwritten pages 43
25 through -- well, what pages are you talking about?

1 A. I think it's 43 through 62.

2 Q. Okay. And do those include like on page
3 55 -- I guess no, that's not the testing on the
4 computer, right, that's still your internal form?

5 A. Correct.

6 Q. You said earlier that you called Ms. Argoe
7 a client rather than a patient, do you perform an exam
8 any different if you have someone a client versus a
9 patient?

10 A. Well, most of it would be the same. If
11 somebody's coming for some kind of legal examination,
12 then a lot of times I'll be going over some kind of
13 documents with them that the attorney sent me or the
14 court sent me and so that one is different. Usually
15 when a patient comes, I don't have any records to
16 review with them. Otherwise, pretty much the same.

17 Q. Was the intent of your visit with
18 Ms. Argoe to try to figure out a diagnosis of her or
19 perform an independent medical examination or anything
20 like that?

21 A. Yeah. I think so. You know, I wanted
22 to -- you know, with the information that I had been
23 receiving, I thought it would be helpful to me to take
24 a look at her. I asked to do that.

25 Q. Have you ever performed an IME before?

1 A. Many, hundreds.

2 Q. I don't want the two-hour version, but
3 give me the condensed version of how you perform an
4 IME.

5 A. Usually it depends on who's requesting and
6 what the purpose is, because some of them are fairly
7 brief and may be a simple question like is this person
8 disabled or not from performing their job at the Post
9 Office, let's say. And that is not necessarily a real
10 in-depth; but if it's say a neurosurgeon who is --
11 let's say he or she is thought to be abusing the
12 nursing staff and that's much more complex and usually
13 requires several visits and several days and we would
14 do extensive testing, neuropsych testing,
15 computerized testing.

16 I would have several people examine that
17 person. I usually have a psychologist examine them
18 independently and a social worker independently and
19 probably would get an outside history, too, if we call
20 people in to talk to us. As a matter of fact, we let
21 pretty much anybody who wanted to talk to us come in
22 and give us information.

23 Q. Prior to seeing Ms. Argoe in April of
24 2008, had you received any documents from Mr. Warner?

25 A. Yes.

1 Q. Do you know what documents -- I'm not
2 going to ask you to specifically name them -- but do
3 you know generally what documents you've received?

4 A. We could probably figure it out, but I
5 don't. I don't. There's so many documents here.
6 I've got several copies. It came in over a period of
7 time that I don't remember. As you can see, it's five
8 volumes here, I think.

9 Q. We've got four copies of the same
10 documents with four different Bates numbers on each
11 document.

12 One thing I am going to do, on the front
13 of your first volume notebook is an index, I'm going
14 to make that a record when we take a break the next
15 time.

16 Is this an index that shows everything
17 that you've received or do you know?

18 A. No. No. No. These are all different
19 volumes.

20 Q. Okay. So this index here --

21 A. It's not all in one place, no. This
22 came -- this, I think, was the last volume that was
23 sent to me. Yeah. It is.

24 MR. DODSON: If I might interrupt. It's
25 the same one that was prepared by my office and

1 it was the same information.

2 MR. COLE: Let's go off the record a
3 second.

4 (Off the record.)

5 MR. COLE: Go back on the record. Off the
6 record, we just clarified to try to figure out
7 what information you received and the volume I
8 was looking at with the index is actually Volume
9 3 and Mr. Dodson clarified this is the same
10 volume he sent to all of his experts recently.

11 Q. (By Mr. Cole) So, obviously, everything
12 in this notebook, you didn't get before you saw
13 Ms. Argoe; but there is some duplication of the
14 medical records that you have in some of the other
15 volumes?

16 A. Yeah. I would have had some of the
17 records in here (indicating) over here (indicating).
18 In other words, I had some of them before she came.

19 Q. Okay. And when you saw Ms. Argoe, she had
20 already gone through the involuntary commitment
21 proceeding in Probate Court and finished her treatment
22 at Three Rivers, finished her year in treatment out of
23 Three Rivers and finished additional treatments of
24 some additional doctors after that; is that correct?

25 A. Right.

1 Q. Generally, do you believe that you
2 received copies of those prior treatment records
3 before you saw Ms. Argoe in April of 2008?

4 A. I know I would have -- I'm pretty sure I
5 had the hospital record. I don't know about the
6 others.

7 Q. When you say, "hospital records," are you
8 saying Aiken and Three Rivers?

9 A. Yes.

10 Q. And then, obviously, there are some
11 depositions that you received recently that are part
12 of this index that we have here?

13 A. Right.

14 Q. That were taken after your visit with
15 Ms. Argoe, so, obviously, you didn't have the benefit
16 of those before you saw her?

17 A. Correct.

18 Q. Did you have any depositions that were
19 taken in prior iterations of this case that you
20 received before you saw Ms. Argoe in 2008?

21 A. Yeah, the only way to answer that would be
22 either to look at the billing sheets or go through the
23 records, because a lot of times, I scribble the date
24 when I reviewed them --

25 Q. Okay.

1 A. -- on the record, but sometimes I don't,
2 so.

3 Q. Okay. That brings me in the third volume,
4 I just flipped to the third page and that was an Aiken
5 Regional Medical record, and handwritten at the top of
6 that is 3/15/13?

7 A. That's when I started on this volume right
8 here (indicating).

9 Q. So if we see that handwriting date on -- I
10 noticed that on depositions and things like that,
11 that's generally when you reviewed it?

12 A. Yes.

13 Q. Is that a common practice that you have to
14 let you know when you've actually looked at something?

15 A. Yes.

16 Q. Prior to your visit with Ms. Argoe, had
17 you reviewed the prior records from the hospitals?

18 A. Yes.

19 Q. And prior to that visit, had you made or
20 had you developed an opinion as to the involuntary
21 commitment in this case?

22 A. I know I was developing an opinion, you
23 know, as it went along.

24 Q. If you're performing an IME, is it
25 important to have that history and review that history

1 before you see a patient?

2 A. Yeah. I think in any -- any case, you
3 know, the more information you have, the better. Now,
4 you know, there's, certainly, always a limit of how
5 much you can get, but, you know, sometimes the limit
6 has to do with where records are or whether they're
7 made available to the examiner or sometimes it has to
8 do with the budget that -- for a lot of examinations
9 we do, we ask about IME's, whoever is requesting the
10 IME will say, you know, you got to do this for this
11 amount. And so, we're only going send you these many
12 records which from the examiner's point of view can be
13 ticklish.

14 Q. Do you know if in this case you were sent
15 all of the existing records or if any were withheld?

16 A. I think I was already asked about did I
17 get the deposition of the brother and the sister and I
18 don't -- I didn't get those, so I assume --

19 Q. Let me --

20 A. I didn't know they existed, actually.

21 Q. Let me clarify. Thank you for that answer
22 to help me clarify the question. I was thinking when
23 you received the records before you saw Ms. Argoe, do
24 you believe that you received all of the records or if
25 anything was withheld at that point?

1 A. I wasn't aware that anything was withheld.

2 Q. What was the specific purpose or intent
3 that you had with visiting with Ms. Argoe?

4 A. To see for myself if I thought she had any
5 kind of mental illness.

6 Q. If someone has periods of manic episodes
7 or is bipolar, do they have periods where they are --
8 I'm going to use nonclinical terms -- but high and low
9 where they seem to be good in some instances and they
10 seem to be bad in other instances?

11 A. Yes.

12 Q. And so there's not a constant of a manic
13 session if you visit somebody, you can see them one
14 day and they could be fine and you can see them the
15 next day or even an hour later and they could be not
16 fine?

17 A. Well, I guess the answer to that would
18 have to be yes, but that wouldn't be common. The
19 episodes are usually longer than an hour or a day.
20 Anything is possible, but in a manic state, usually
21 that lasts for days or weeks, even months, rarely
22 lasts for years. And the same for depression, so
23 speaking in general terms, those episodes are
24 self-limiting even without treatment.

25 Q. You can't tell me today exactly what

1 condition Ms. Argoe was in on June 9, 2005, can you?

2 MR. DODSON: I object to the form.

3 THE WITNESS: Only from reading the
4 record. No, I wasn't there, so I couldn't.

5 Q. (By Mr. Cole) How long did you spend with
6 Ms. Argoe?

7 A. Yeah, I don't remember. I might have
8 written it in my notes here. Let's see. Well, I
9 don't have it written down; but as I already said, I
10 think she was in my -- in my office a good part of
11 that day. So shoot, I don't remember, but I'd say
12 four to six hours.

13 Q. So she was in the office you think four to
14 six hours?

15 A. Right. Part of the time she was filling
16 out papers and she was -- but from our point of view,
17 that's part of the examination, how the person fills
18 out the forms, how they do it or whether they do it or
19 whether they do it completely or neatly or -- for
20 example, I'll just give you an example.

21 If a patient comes in and they cover the
22 forms, write all over them back and front and all, it
23 makes us suspicious that they might be manic, right?
24 Or if they don't fill out the forms very much, it
25 could be that they're depressed. Or it could be

1 they're just resisting the evaluation for some reason.
2 They don't want to do it or they're guarded,
3 apparently. So the way they fill it out is important
4 and the staff observes that.

5 And so let me give you another example.
6 We tell the person, we want you to fill this out, not
7 your family. You know, this is part of the
8 examination. But then sometimes they'll start having
9 their family -- in other words, they resist doing the
10 exam the way we need them to do it. So the manner
11 they do it is important. And, of course, the content
12 is also important.

13 Q. How long does it usually take for someone
14 to fill out this --

15 A. One to two hours.

16 Q. Do you know how long it took Ms. Argoe to
17 fill it out?

18 A. I don't recall, but I can just say this,
19 it wasn't -- it wasn't a remarkable amount because if
20 it's a remarkable amount, the staff will come and tell
21 me. You know, they only spent ten minutes filling
22 these papers out or she's not finished, it's been
23 three hours, they bring that to my attention. But
24 they didn't bring it up.

25 Q. So since we don't have an indication in

1 your record it was a high or low time period, you
2 assume it was an average of those times?

3 A. Yeah. I can tell you the modal is about
4 an hour to an hour and a half.

5 Q. Okay. Is this filled out in the waiting
6 room or do you have like a separate room that they can
7 fill it out?

8 A. Either one. If they don't want to do it
9 in a waiting room, they can do it in a separate room.

10 Q. And are you observing her as she's filling
11 this out?

12 A. Partly.

13 Q. How do you observe her as she's filling it
14 out?

15 A. Through a window.

16 Q. Is she aware that you're observing her?

17 A. She might be.

18 Q. What are you looking for?

19 A. Any unusual behavior.

20 Q. And if you see anything like that, would
21 you document that in your notes? Do you document
22 anything like that in your notes?

23 A. No.

24 Q. Is there anything remarkable from the way
25 this document was filled out that you have or that you

1 used as part of your interpretation or opinions in
2 this case?

3 A. Let's see.

4 Q. I've got another copy of it here if you
5 want it.

6 A. I have so many papers in front of me here.
7 Here it is. Well, there's nothing unusual. It's --
8 it's pretty much what I'll call usual, except for the
9 symptom checklist and most people check a good bit
10 more than that (indicating). So this was the only
11 thing that was unusual.

12 Q. And that's a handwritten circled number at
13 the bottom of page 53 and 54?

14 A. Right.

15 Q. Okay. So would you expect that she would
16 have wanted to or had filled out more of this
17 checklist of conditions?

18 A. Yeah.

19 Q. Did you talk to her about that?

20 A. Not directly, but, you know, when I do the
21 interview, I'm thinking about it. In other words, she
22 didn't reveal much on this form. Most people will
23 check -- let's say most people check that they're
24 considerate or that they're trustworthy or ambitious
25 or confident or something like that. She didn't.

1 Q. And what, if anything, is that -- or let
2 me try to ask that as an actual question.

3 Why is that significant?

4 A. She just didn't reveal much about it.

5 Q. Does that reveal anything about how the
6 rest of the document was filled out?

7 A. No. The rest of the documents were filled
8 out fine.

9 Q. So if she doesn't check trustworthiness,
10 then that doesn't mean that we can't trust the rest of
11 the document?

12 A. Correct.

13 Q. This paperwork that you were just
14 reviewing, has this been peer reviewed or evaluated to
15 see if it is a psychiatric evaluation or anything like
16 that?

17 A. Yes and no. I mean, this is a proprietary
18 form, so I made it up; but at one time, the clinic --
19 there were -- at one time, eight psychiatrists in the
20 clinic and so, you know, other psychiatrists have
21 looked at this and had input into it. And they're
22 also -- in the literature, there will be similar
23 things and there are actual doctors who will put their
24 name on it, you know, to make speeches or promote
25 their practice or something and they'll call it the

1 Davis Checklist or something. But, I mean, it's peer
2 reviewed in that expense.

3 Q. Earlier I asked who was in your office and
4 you gave me two other names. In April of 2008, did
5 you have more people at the office?

6 A. Yes.

7 Q. Do you remember who they were?

8 A. Not exactly. I had a nurse practitioner
9 and she got married and moved to New York. And I
10 think she was there at that time. We were in a
11 different location, and I may have had another social
12 worker there at the time, but I'm not for sure about
13 that.

14 Q. And did any of those other people that are
15 no longer with you have any part in the visit or
16 diagnosis --

17 A. No.

18 Q. -- or anything with Ms. Argoe?

19 This paperwork that we're going over, does
20 that help you formulate your opinions in this case?

21 A. Yes.

22 Q. How long does it typically take to
23 complete the computer test?

24 A. Let's see, can we find it?

25 Q. I've got a copy here.

1 A. Yeah.

2 Q. It starts at handwritten page circled 26.

3 A. This one can take anywhere from usually --
4 again, the modal time is probably about 40 minutes,
5 but some people do it in a half hour, some people take
6 an hour.

7 Q. And that's you just sit at a computer and
8 hit a button true false?

9 A. Right.

10 Q. Why did you pick that particular test?

11 A. This is a great test. This psychologist
12 who developed this test, Ken Molline, probably the
13 best at developing these kinds of tests of anybody
14 I've seen so that -- we have a lot of choices, but --
15 and we've tried many of them, but this one is more of
16 a personality test helping -- for the kind of practice
17 that we do, it gives us more information about the
18 patient or the client than say the MMPI which is
19 probably more commonly used. So we pick it because we
20 find it helpful and reliable.

21 Q. And what were you hoping to learn as a
22 result of administering that test?

23 A. Well, you know, I was -- I was getting
24 I'll say mixed information about her that these
25 doctors have kept her in a psychiatric hospital for 41

1 days. Yet, having reviewed the record -- I'll just
2 give you an example. When I reviewed her medical
3 record from Three Rivers, I was really surprised that
4 in 41 days, nobody documented any specific delusions,
5 hallucination symptom, anything like that that -- and
6 there were no new symptoms. In other words, she
7 didn't develop -- from the day she came until her
8 discharge, it looked like the same thing day after
9 day.

10 Now, that's not the way people do it in
11 psychiatric hospitals. You can call it a copy and
12 paste, just the same thing, right? Some days she
13 wasn't even examined, right? So there's no note at
14 all, apparently, didn't see a doctor. That surprised
15 me, but, I mean, I'm thinking, okay, why would these
16 doctors keep her in the hospital 41 days. And yet,
17 where are the symptoms? What's going on here?

18 Q. Did you ever answer that?

19 A. I think. I think so.

20 Q. What is your opinion about that?

21 A. I think they -- I don't know. I think
22 they were holding her for money, frankly.

23 Q. Can you explain that to me? What do you
24 mean?

25 A. Well, I can't think of any other reason

1 why they would keep her there.

2 Q. And who do you think was holding Ms. Argoe
3 for the money?

4 A. I guess the doctors there, they're the
5 ones who make the decision every day. They have to
6 decide whether to keep this person in the hospital or
7 not. For example, there's nothing in there that made
8 me think she's going to hurt anybody or she's going to
9 hurt herself or that she's psychotic or that she can't
10 take care of herself. And that's what we have to
11 decide every day that we're holding somebody against
12 their will. This is like holding somebody in a jail.

13 Q. You have not had the opportunity to review
14 the depositions of Ms. Argoe's brother and sister when
15 they testified that they were concerned that she would
16 hurt herself or hurt her now ex and deceased husband
17 or that they were afraid that she was not able to take
18 care of herself, correct?

19 MR. DODSON: I object to form.

20 THE WITNESS: Correct.

21 Q. (By Mr. Cole) You would agree that her
22 brother and sister know a lot about her history
23 because they grew up with her?

24 MR. DODSON: I object to the form.

25 THE WITNESS: I would assume they do.

1 Q. (By Mr. Cole) You know from the history in
2 this case that her family was involved with her
3 initial treatment for the reason why she got the
4 initial treatment in this case?

5 A. Yes.

6 Q. Okay. And you're aware that the family
7 members were present when there was the hearing with
8 the probate judge about the continued treatment,
9 correct?

10 A. Right.

11 Q. And that the probate judge made the
12 decision that she needed to stay in the facility to
13 seek additional treatment and when she's released, she
14 has one year of continued treatment?

15 A. Yes, but the probate judge based that on
16 what the doctors told the Probate Court. And I did a
17 study one time on these hearings in Georgia in DeKalb
18 County of a hundred stray cases. The judge always did
19 what the doctor said 100 percent of the time. So I'm
20 not going to blame the judge for this, but I don't
21 know why these doctors went to court and testified
22 this woman needed to be in a hospital.

23 Q. You know that Ms. Argoe blamed her probate
24 judge and sued the probate judge earlier in these
25 cases?

1 A. I don't blame her.

2 Q. Are you aware of any studies in South
3 Carolina about the same thing you were just talking
4 about with the --

5 A. No.

6 Q. Have you ever practiced in South Carolina?

7 A. No. Well, let me come back. I did in
8 Columbia in the military, but that -- I mean, I was an
9 Army doctor.

10 Q. You were at Fort Jackson?

11 A. Yes.

12 Q. How long were you there at Fort Jackson?

13 A. Three or four months.

14 Q. And that was a while ago, I would assume?

15 A. That was in nineteen sixty -- 1965.

16 Q. And your treatment at that time, it was
17 just on the base?

18 A. Yes.

19 Q. And while you were there in South
20 Carolina, were you involved in any voluntary
21 commitment proceedings?

22 A. No.

23 Q. I forget what your answer was earlier this
24 morning or if you were actually asked. Have you been
25 involved in an involuntary commitment proceeding as a

1 designated examiner?

2 A. Yeah, I don't think we used that term
3 here.

4 Q. When you say "here," you're saying
5 Georgia?

6 A. Georgia. I don't think we call it
7 designated examiner. The way it's done here is if I
8 think somebody needs to be committed against their
9 will and held, then I sign a form for that. And the
10 patient is informed in writing that we're going to
11 have another examiner come and the patient may also
12 request anyone that he or she wishes to also come and
13 examine them. So there's going to be at least two
14 examinations. Sometimes the patient themselves will
15 bring in a third person or I've seen it one time a
16 fourth person came. So then there's a hearing with
17 due process and everything.

18 Q. Okay.

19 A. All the testimony, cross-examination,
20 everything.

21 Q. So --

22 A. Represented by counsel, everything.

23 Q. I'm not trying to cut you off.

24 A. I keep thinking of things.

25 Q. Are you finished?

1 A. Yeah.

2 Q. So in Georgia, the example it sounds like
3 you're giving, if you have a patient that you're
4 seeing and as you are evaluating them you think this
5 person needs more restrictive treatment in an
6 involuntary commitment setting, then you, basically,
7 fill out the initial paperwork that starts the ball
8 rolling to have a second examination and perhaps a
9 third or fourth opinion or however many they want to
10 get into?

11 A. In the meanwhile trying to talk to them to
12 do this voluntarily. Nobody wants to go to court.

13 Q. If you're talking to a client or patient
14 of yours and you think that they need to have the
15 involuntary commitment in order to get, I guess, that
16 type of treatment, do they say, oh, you're right. I'm
17 going to go a hundred percent of the time?

18 A. Almost always they don't object. As a
19 matter of fact --

20 Q. Okay.

21 A. -- the hearing -- to actually have a
22 hearing is almost rare in my experience.

23 Q. So you're able to convince them, you need
24 to voluntarily be involuntarily committed?

25 MR. DODSON: I object to the form.

1 THE WITNESS: The way -- yeah, kind of
2 like that. Usually what I will say is, Look, do
3 you want to go voluntarily? And if they say yes,
4 fine, they go. If they say, Well, no, I don't
5 really want to go because some reason, then I try
6 to talk them into it, right, to go voluntarily.

7 If -- a common scenario in my current
8 practice would be somebody who's made an overdose
9 and made a suicide attempt. Okay. And then I'm
10 called to determine whether or not they can be
11 treated as an outpatient, partial hospitalization
12 or they need to be an inpatient, right? So I
13 make that recommendation.

14 Now, if I think they can be treated as an
15 outpatient, I make that recommendation. But if I
16 think partial hospitalization, then I make that.
17 But when I recommend inpatient, if they disagree,
18 then that's when I would sign the form. We call
19 it 1013, that's the same in Alabama and
20 Massachusetts when I practiced up there. So you
21 sign that form. Then the patient is transported
22 and once they go in the hospital, another
23 doctor's going to make a determination right
24 away, that day they're going to make a
25 determination. I sent them over, but the doctor

1 at the hospital makes her independent assessment
2 right then to determine can this person be
3 released.

4 Now, sometimes the patient gets to the
5 hospital they say, Well, I'm willing to stay. Or
6 they say just let me be an outpatient, I'll come
7 and the doctor let's them go.

8 Q. Are you familiar with the process in South
9 Carolina?

10 A. Somewhat, yeah.

11 Q. How are you familiar with the process in
12 South Carolina?

13 A. Just from hearing about it in different
14 places.

15 Q. I mean, like you hear about it overhearing
16 some people talking in the corner or is that your --

17 A. No. We used to have this society called
18 the Southern Psychiatric Association and the
19 psychiatrists of what I call the southeast as far as
20 Texas, we would meet a couple of times a year and
21 things like this would be discussed.

22 Q. Are you still a member of that?

23 A. No, I'm not.

24 Q. When was the last time you ever went to
25 one of those --

1 A. 15 years ago.

2 Q. Have you heard or spoken to anybody about
3 the more modern procedures for involuntarily
4 commitments in South Carolina?

5 A. No.

6 Q. And you haven't read the case that was
7 handed down from the South Carolina Supreme Court
8 dealing with the commitment?

9 A. No.

10 Q. Has anyone else interpreted the test
11 results from the Millon that you administered?

12 A. No. You mean on Martha?

13 Q. Yes.

14 A. No.

15 Q. What is your opinion or impressions or
16 whatever you want to say from that test?

17 A. This test does not show that she's
18 mentally ill. As a matter of fact, it says that she
19 doesn't have an Axis 1 diagnosis.

20 Q. And does that mean that she never has had
21 any episode of mental illness or does that mean that
22 when she took the test, she did not show any incidents
23 of mental illness?

24 A. Well, definitely the second. Definitely
25 means when she took the test -- during this test, she

1 does not have mental illness. It can't tell that she
2 never did. In other words, if, in fact, she were
3 bipolar and she went into remission, then this test
4 might not pick it up; but it's a sensitive test and it
5 -- usually it will make a suggestion because even
6 though a person goes into remission, they may have
7 some symptoms that they -- the test is very sensitive.
8 So it might pick that up, probably would pick it up
9 but not necessarily.

10 Q. So --

11 A. Because the way it asks the questions, the
12 question is, have you ever had this? Have you ever
13 had a period of time when you couldn't -- you didn't
14 need to sleep and you only needed three or four hours
15 of sleep and, boy, it was a wonderful time. And did
16 you ever, you see, so that's one.

17 Q. I remember in high school and college,
18 they wanted to tell you to take these tests and then
19 we'll be able to tell you what profession you should
20 go into.

21 A. That's a different kind of test.

22 Q. Those questions it was -- they asked the
23 same question eight different ways in different parts
24 of the test. Is that similar to Millon?

25 A. Yes, but this test -- this is standardized

1 tests. You know what that means?

2 Q. Well --

3 A. Standardized means we're going to take a
4 bunch of -- let's say we're going to take a bunch of
5 real obsessional doctors and we're going to take a
6 bunch of easy-going attorneys and we want this test to
7 be able to discriminate between those two groups.
8 Easy-going. Okay. But we're going to norm it and
9 we're going to ask the questions -- we're going to
10 take a whole lot of questions and we're going to see
11 which ones tells us -- give us the answer. It's not
12 just I think it's going to do it, it actually does it.
13 You do that for various mental disorders. So you
14 would do it for schizophrenia, bipolar disorder,
15 obsessive compulsive personality disorder, obsessive
16 compulsive disorder, depression, panic attacks,
17 anxiety, all that.

18 Q. I was going to ask the question to have
19 you define for me when you said mental illness in that
20 list that you just gave me, is that, basically, the
21 short laundry list of what the tests can test for?

22 A. People -- excuse me. People use the term
23 mental illness in different ways. And it's loosely
24 used. It just like paranoid. I'm paranoid about
25 going downtown in Atlanta which really means I'm

1 anxious or fearful looking. It's a slang use. People
2 use mental illness. The way I'm thinking about mental
3 illness would be a major disorder like not just I'm
4 depressed some days, I have a depressive disorder, a
5 depressive illness or I have schizophrenia or I have a
6 manic attack and have bipolar disorder, that's
7 different from somebody who is worried about whether
8 they're having a nasty shower.

9 Q. Okay. I take it your example of the nasty
10 shower comes from some of the clinical notes, I think
11 that was from Aiken when she said that she wanted to
12 make -- Ms. Argoe said wanted to make sure the shower
13 was clean before she used it?

14 A. Sure.

15 Q. And you're differentiating a desire for
16 cleanliness there with a phobia for cleanliness, I
17 guess?

18 A. Correct. And can I add one thing?

19 Q. Yeah.

20 A. In part, you think of a mental illness as
21 being functional, too. The main thing that a
22 psychiatrist has to determine about any person is
23 their functioning. I mean, a lot of us have weird
24 thoughts, but that doesn't make us mentally ill.

25 Q. When you say "functioning," can you define

1 that for me?

2 A. What we do. How does this person get his
3 work done. How does this person interact with his
4 colleagues and family. Does this person have the
5 ability to enjoy his life. So really three major
6 areas of functioning.

7 Q. Do you believe that Mr. Argoe, her former
8 husband, was enabling her for the time period?

9 A. I don't know. You know, she told me about
10 her relationship with him and, I mean, some of the
11 things she said that he was -- he, you know,
12 threatened her, that he drank too much, that she
13 thought he probably ran around. I mean, I don't know
14 if he enabled her. I don't know.

15 Q. And I ask that in part because part of the
16 testimony from Ms. Argoe's brother was that he said
17 that Mr. Argoe came to him concerned and that for
18 years he had been restricting when they went out and
19 things, like to try to protect Ms. Argoe and my
20 terminology is, essentially, enabling her and trying
21 to protect her?

22 MR. DODSON: I object to the form.

23 THE WITNESS: He said-she said thing to
24 me. I also see couples in therapy and some are
25 very intelligent people who tell me -- I mean,

1 these are doctors, lawyers, very successful
2 people. He says one thing, she says another
3 thing, right? These two people, obviously, are
4 having a lot of trouble getting along. I don't
5 think she loved her husband for a long time
6 before they got divorced.

7 Q. (By Mr. Cole) Are you talking specifically
8 about somebody?

9 A. About --

10 Q. Ms. Argoe?

11 A. I don't think she loved him. I think she
12 wanted to divorce him. She told me she was happy she
13 got divorced from him. You know, how much can you
14 believe of what either one of them says. But that
15 doesn't have anything to do with -- it doesn't have
16 anything to do with deciding whether somebody is
17 mentally ill or not because that's not part of mental
18 illness at all. Not getting along with the spouse is
19 so common, if we label that, almost everybody will be
20 mentally ill.

21 Q. With regard to Three Rivers as a defendant
22 in this case, what opinions do you have about Three
23 Rivers that you intend to offer?

24 A. Well, you know, the hospital in one sense
25 is at the mercy of the doctors. It's not the job of

1 the hospital to be riding on the doctor's shoulder and
2 going around and seeing everything they do. So, you
3 know, in this particular case, I just wonder about the
4 nurses. You know, here's this woman who's not having
5 any trouble in this hospital. I wonder why the nurses
6 didn't bring it up somehow to the doctors. You know,
7 I'm used to practicing as a team. I go to the
8 hospital just about every day and if the nurses have a
9 question about what doctors are doing, they bring it
10 up to us. And I don't know that the nurses here ever
11 brought up to these doctors, you know, why is this
12 woman in the hospital.

13 Q. How do you know the nurses never brought
14 that up to the doctors?

15 A. Well, okay, I don't, but it's not in the
16 record.

17 Q. In your clinical practice, is it typical
18 for a nurse to write in a record Dr. Jones is wrong?

19 A. No.

20 Q. Okay.

21 A. No. Much more likely they come and speak
22 to me.

23 Q. And so, is there anything in any of the
24 documentation you've reviewed, any of the depositions
25 you reviewed or any conversations you've had with

1 anybody that suggests to you that the nurses did not
2 speak to the doctors about Ms. Argoe's treatment?

3 A. No, I don't know whether they did or not.

4 Q. Okay. Would you agree with me that when
5 you read the records, we have the handwritten notes
6 and we have computer-generated notes that are put into
7 the system and that generally the purpose for that is
8 that if someone comes in after, you know, the next day
9 and they're trying to work on the treatment, they can
10 go back and review what was done the day or few days
11 before?

12 A. That's one of the purposes, yes.

13 Q. Okay. So when a nurse is writing down
14 whatever things they are observing in the record,
15 subsequent nurses or subsequent doctors can look and
16 see what that is previously?

17 A. That's one of the purposes.

18 Q. So if they are putting down what they
19 observe at that moment in time as to how Ms. Argoe's
20 effect is, do the nurses then have a duty to make
21 additional reports or additional notes, you know, I
22 think she's fine. She would let her go or anything
23 like that?

24 A. I understand. I understand. Well, if
25 they don't agree to what's happening, yes.

1 Q. In your practice and experience, how many
2 times has a nurse been able to discharge a patient on
3 her own?

4 A. None.

5 Q. Okay. And so who does the discharge?

6 A. The doctor.

7 Q. Okay. So in your opinion in this case,
8 what should the nurses -- and we'll keep it general
9 right now -- what should they have done or what could
10 they have done?

11 A. I would have just liked to see the nurses
12 raise a question with -- this is an extremely long
13 stay. And there's nothing in this whole record, not
14 one single piece of information that tells me that she
15 needs to be in the hospital today. And day after day,
16 nothing.

17 Let me give you an example. When I'm
18 teaching the residents, right, these are doctors who
19 are trained to be psychiatrists, right, and I say to
20 them, Look, if this patient is in the hospital because
21 of being suicidal, every day when you make your
22 progress note, every single day, you've got to see the
23 patient every day they're in the hospital. You have
24 to write a progress note contemporaneously, but you
25 have to address are they suicidal. Now, you can

1 address other things, whether they're hallucinating,
2 whether they're delusional, whether they're washing
3 their feet, you know, but we got to address that.

4 Just like a cardiologist, if somebody goes
5 into the hospital with a heart attack, you got to
6 address their heart every day. That's the main issue.
7 There are other issues, but you got to address that.
8 Now, there's nothing in here that addresses why she's
9 in the hospital.

10 Q. And your opinion is that the first doctor
11 that saw her should have evaluated her and said, You
12 can go home?

13 A. Yes.

14 Q. And the second doctor that saw her should
15 have evaluated her and sent her home?

16 A. Yes.

17 Q. And the third doctor that saw her should
18 have evaluated and her sent her home?

19 A. Well, there was one doctor, I can't
20 think -- remember the name, I think he covered on the
21 weekend or something like that. I'm not going to --
22 I'm not going to make that statement about the
23 covering doctor on the weekend, although, that doctor
24 could have raised that question and -- but I'm much
25 more critical of the doctor that's seeing them day

1 after day and doing this.

2 Q. Your affidavit, the first affidavit --
3 actually, both affidavits that you issued in this case
4 and were made records here reference the additional
5 testing by Dr. Leonhardt?

6 A. Yes.

7 Q. Can you tell me what is your opinion about
8 that testing that was performed by Dr. Leonhardt?

9 A. What Dr. Leonhardt comes up with doesn't
10 fit with what -- keeping anybody in the hospital. She
11 didn't make a diagnosis. And I read in her note over
12 and over again and she's pretty much saying there's no
13 mental illness here.

14 All right. Now, when you have an outlier
15 like that in a medical record, let's just say it's a
16 laboratory test, you can't ignore it. You've got to
17 explain it on the record why didn't this fit with the
18 rest of the data and there was -- it was ignored,
19 really. There was a note in there, but there's no
20 explanation as to why is this one doctor over here
21 finding she's okay. I'm sure that's why Dr. Leonhardt
22 is not being named in this lawsuit.

23 Q. Have you ever spoken with Dr. Leonhardt?

24 A. No, but I'd like to meet her because she,
25 at least, put it in the record. Now, I know that she

1 is probably dependent to some extent on these doctors
2 to ask for psychological testing and is, you know,
3 basically, she probably doesn't want to cross them,
4 but she put it in there. She's the only one of the
5 doctors who really examined Ms. Argoe.

6 Q. And why do you say that?

7 A. Because she's got the examination right
8 there. She doesn't make any diagnosis.

9 Q. When you say "examination," you're talking
10 about the test and are you then --

11 A. Yes.

12 Q. -- equating that the written test as the
13 only type of examination?

14 A. It's the best examination that's reported
15 in her record is Dr. Leonhardt's.

16 Q. Tell me if I'm wrong on this, but when I
17 read through Dr. Lynn heart's notes, I thought one of
18 her conclusions was that the questioning did not score
19 high enough on the reliability scale and, therefore,
20 the test was not a valid test for any conclusions?

21 A. Let's get it out.

22 Q. I know we've got her notes. I don't know
23 if I've got a copy of the test easily accessible.

24 A. Well, the report.

25 Q. For the record -- let's see, for the

1 record, what you're looking at is the handwritten
2 consultation form for Dr. Leonhardt, the bottom of the
3 page that you're looking at has a record No. 116 which
4 is part of one of the records on appeal and it also
5 has a reference at the bottom to a Bates number and
6 the Bates number is 3 Rivers 0019. So the general
7 question was: What have you -- looking to this report
8 and what is your interpretation of it?

9 A. Dr. Leonhardt says -- she interviewed
10 Ms. Argoe and she says, At the time of this
11 assessment, Mrs. Argoe presented as an attractive
12 woman with spontaneous affect and euthymic exhibit."
13 That means she's not at this time manic or depressed
14 euthymic means she has a normal -- has a happy, normal
15 mood. Okay. And she's spontaneous. So I mean, this
16 is normal. Thought process during interviewer, clear
17 coherent and goal directed. She denied any
18 experiences auditory or visual hallucinations, lewd
19 ability, sleep or appetite disturbances or increased
20 suspiciousness.

21 She alleges her husband was abusive, a
22 heavy drinker. He put her in the hospital. Well,
23 that's true, I think. She reports that she drew a
24 line in the sand approximately one-and-a-half years
25 ago moving into her own room, putting a lock on the

1 door and no longer cooking for spouse but instead
2 going out to eat. She acknowledged the mistrust of
3 her husband and marital conflict, but denies acute
4 distress or psychological symptoms or problems.

5 Now, I think this is about a month after
6 her son has falsely used his power of attorney to get
7 some of her property. This is not some delusional
8 thing that Mrs. Argoe is having. They're out to get
9 her stuff, right? She reports she is refusing
10 medication because she doesn't need them. And
11 concerned that her husband would use that against her.
12 Well, that's pretty good thinking. I think that she's
13 not mentally ill and she doesn't need these
14 medications and he would potentially use that against
15 her.

16 Let's see, throughout the interview,
17 Mrs. Argoe was pleasant, cooperative and appropriate.
18 I mean, wow, she really needs to be in a psychiatric
19 hospital, huh? Nothing. Nothing.

20 Q. Is it your opinion that every record
21 that's there needs to have some reference to a mental
22 disorder or infirmity or something like that --

23 A. Yes.

24 Q. -- and that --

25 A. You're holding a person in the hospital

1 dependence her will. Of course, every single day you
2 got to validate why am I holding this person in the
3 hospital except to get her money.

4 Q. If someone is experiencing a psychotic
5 episode --

6 A. Uh-huh.

7 Q. -- and enough to require treatment and
8 medication, do they all of a sudden overnight just get
9 cured?

10 A. Not usually.

11 Q. So if somebody is in a hospital and they
12 have periods where they are not exhibiting all of
13 those symptoms, that's not out of the ordinary?

14 A. Would you try that one again?

15 Q. Well, I mean, if somebody has symptoms
16 that would require hospitalization and then while
17 they're hospitalized, they have periods where they're
18 not exhibiting those symptoms, that would be a typical
19 high and low but just because they're not exhibiting
20 those symptoms, does not mean that all of a sudden
21 they're cured?

22 MR. DODSON: I object to the form.

23 THE WITNESS: Okay. I need to dissect
24 that because we're not really talking about a
25 cure, right? We're talking here about is this

1 person going to hurt somebody, themselves or
2 somebody else or can they take care of
3 themselves. It's not about curing them. It's
4 about do I need to keep this person locked up
5 against their will. That's -- curing them is not
6 even the issue.

7 Q. (By Mr. Cole) What is your position on how
8 long a person needs to remain in a hospital facility
9 after they've been admitted?

10 MR. DODSON: I object to the form.

11 THE WITNESS: You mean against they're
12 will?

13 Q. (By Mr. Cole) Just generally. How long
14 does a person need to be in a hospital facility after
15 they're admitted?

16 MR. DODSON: I object to form.

17 Q. (By Mr. Cole) Can you give me a date or a
18 timeline?

19 MR. DODSON: Same objection.

20 THE WITNESS: You're talking a person who
21 goes into any hospital?

22 Q. (By Mr. Cole) Yeah.

23 A. You have to keep them there as long as
24 they can't function well enough to be an outpatient.
25 If you're in a general hospital, let's say you go in

1 with kidney failure, all right, you stabilize that
2 person and you send them home so they can come in and
3 be treated as an outpatient. Let's say they need
4 dialysis, they can come in and get dialysis. Let's
5 say they need intravenous antibiotics, so you only
6 keep them in the hospital the briefest time, the least
7 restrictive alternative, you might say. You don't
8 want somebody in a hospital. Who wants to be in a
9 hospital unless they're really sick.

10 Q. (By Mr. Cole) Is part of a discharge from
11 a hospital to evaluate whether or not someone can
12 function in an outpatient setting, a determination of
13 whether or not you think they're going to be compliant
14 with a treatment plan that is set up for them?

15 A. Well, you hope they're going to be
16 compliant, but you can't necessarily determine that.

17 Q. If somebody is noncompliant with the
18 treatment plan while at the hospital, is that an
19 indication that they would be noncompliant when
20 they're released?

21 A. Sure.

22 Q. So if somebody is not --

23 A. Could be. Look, it depends on the reason.
24 The person is saying, Hey, I'm not sick. I'm not
25 going to take this medicine because I'm not sick, and

1 I don't need it. Well, you need to determine do they
2 really need this. That's a -- that's a common
3 determination in hospitals that people come in
4 voluntarily and the doctor may think this is good for
5 you and the patient says, I don't want that surgery.
6 I don't want that. So we're going home.

7 Q. Isn't it true in this case that a court of
8 law determined that Ms. Argoe required treatment?

9 A. No, that doesn't have anything to do with
10 it. The doctors told the judge, the judge -- what's
11 the judge going to do? The judge can't perform a
12 psychiatric examination. She's going to listen to
13 doctors. If the doctors give misleading testimony
14 which they did in court, I'm not going to blame the
15 Court, I'm going to blame the doctors.

16 Q. And you believe it's misleading testimony
17 because --

18 MR. HICKS: Andy, this is Chip. I'm sorry
19 to interrupt you guys. I'm going to have to hop
20 off this call probably for about 45 minutes or
21 so. I've asked the question I needed to ask, so
22 if you guys are ready to wrap it up and Madam
23 Court Reporter, take note of the fact that I'd
24 like an E-Script. Okay?

25 Q. (By Mr. Cole) So we were talking about

1 that -- you just said that you believe the doctors
2 misled the Court?

3 A. Absolutely.

4 Q. And what is the basis for that?

5 A. She didn't need to be in the hospital.
6 She's not mentally ill. She's not -- look, even if
7 she's mentally ill, she doesn't have to be in a
8 hospital. Most mentally ill people who are getting
9 treatment get it as an outpatient, probably 99 percent
10 of them. She's -- I mean, look, the basis in North
11 Carolina -- in South Carolina is you're dangerous,
12 you're mentally ill and/or you can't take care of
13 yourself. There's nothing in here that says that
14 ever.

15 Q. With regard to --

16 A. As a matter of fact, she denies all of
17 that. I mean, what are they thinking? What are these
18 doctors thinking? This woman's there denying
19 suicidal. She, obviously, can take care of herself.

20 Q. But you have seen mental patients that you
21 believe showed symptoms of some sort of a psychosis or
22 something else and you might confront them on it and
23 they may say, I never did that, so they deny it,
24 correct?

25 A. Okay.

1 Q. That's not out of the ordinary to have --

2 A. I don't put them in a hospital, throw them
3 in the hospital against their will.

4 Q. I'm just saying it's not out of the
5 ordinary if you have a patient showing symptoms of a
6 certain diagnosis and then they deny it, correct?

7 A. Not at all. That's common.

8 Q. So the simple fact that she is denying
9 that she has all these doesn't mean that that answers
10 the question of whether or not she, in fact, has
11 those?

12 A. They're looking at her every day. Is she
13 walking around hearing voices talking to her? Is she
14 seeing witches and warlocks in the hospital? Show me
15 one place where there's any evidence at all that she
16 has hallucinations or delusions, none, not one. Dr.
17 Mobley and Dr. Dodds never ever recorded one iota of
18 it. Where does it say I interviewed her and she was
19 hearing voices or she saw things?

20 Q. Do I understand from your testimony that
21 you would expect Ms. Argoe who says she's denying all
22 these things to all of a sudden tell the doctors, oh,
23 by the way, I just saw Superman run down the hallway?

24 A. Why not, if she's seeing warlocks and
25 things. Yeah, she's going to tell somebody probably.

1 She's there 41 days. If this is really the issue,
2 what if she did see warlocks, so what?

3 Q. Your opinion is she should have been
4 discharged?

5 A. The first day she was there.

6 Q. Is it your opinion that if somebody shows
7 up at a facility involuntarily that if they say, I
8 didn't do it or I don't have any problems, that you
9 should just listen to them and let them go?

10 A. No. No. No. I'm not saying that. I'm
11 saying the doctor observes the patient and asks the
12 questions, right? Okay. I mean, I can give them two
13 days. Let them get two chances to examine her.

14 Q. With regard to the nurses, your testimony
15 is that they -- although you don't have any proof that
16 they didn't, you believe that they should have said
17 that she needs to be discharged?

18 A. Yeah, at least go to the doctor and say,
19 Why we got this woman here? Why are we holding her?
20 They know. They do this every day, that's their job.

21 Q. Do you have any other opinions regarding
22 the nursing staff at Three Rivers about what they
23 should have done or what they didn't do in this case?

24 A. I wonder about Nurse Burrell who goes and
25 testifies.

1 Q. Anything else, nurses in general?

2 A. No.

3 Q. Okay. So --

4 A. Because if you look at the nurses' notes,
5 they were examining her, they were recording the data
6 and what were they saying, she's normal.

7 Q. So you don't fault them for entering that
8 information?

9 A. No. No. No.

10 Q. And putting it in the record?

11 A. No, that's their job. That's good.

12 Q. With regard to Nurse Burrell, what is your
13 knowledge about the second designated examiner?

14 A. They're independent. The reason you have
15 two examiners is each one makes up their own mind and
16 gives their own testimony.

17 Q. Do you fault Nurse Burrell for not giving
18 a diagnosis?

19 A. At the Court?

20 Q. What do you mean?

21 A. You mean at the Court at the hearing?

22 Q. Well, let me back up. Maybe my question
23 wasn't clear.

24 A nurse, she can't make a diagnosis of the
25 condition of Ms. Argoe, correct?

1 A. She's going to Court to testify and I
2 don't know what the Court asks her. If the Court
3 asked her, you know, is this woman suicidal, is she
4 going to hurt somebody -- I don't have a transcript of
5 the Court.

6 Q. We don't either.

7 A. Okay. So if they ask her is she suicidal,
8 she would have to say no. Is she homicidal, she would
9 have to say no. Can she take care of herself, she
10 would have to say yes. Now, as far as that being a
11 diagnosis, that is a diagnosis in a way.

12 Q. But the nurse can't -- she's not making
13 the ultimate decision as to whether or not Ms. Argoe
14 has bipolar disorder or schizophrenia or anything like
15 that?

16 A. She can.

17 Q. But the nurse is not the one that makes
18 that diagnosis?

19 A. She's -- you're using the word diagnosis
20 in the most limited sense. Okay. But she can make a
21 diagnosis.

22 Q. And what specifically are you critical of
23 Nurse Burrell about in this case?

24 A. That she went to Court and testified that
25 Martha Argoe needed to be in the hospital against her

1 will.

2 Q. So if Nurse Burrell had said, I don't
3 think she needs to be here, then that would comport
4 with your opinion and, therefore, she would be right?

5 A. Absolutely.

6 Q. And since she did not report what your
7 opinion is right now, she's wrong?

8 MR. DODSON: I object the form.

9 THE WITNESS: I think so, yeah.

10 Q. (By Mr. Cole) The notes that you have in
11 the --

12 A. She didn't base her opinion -- it's not
13 whether I think she's wrong, she didn't base it on
14 anything that she saw. I mean, what could she have
15 seen? What could she have seen? How could she have
16 thought that Martha Argoe needed to be in there
17 against her will? What could she have based it on,
18 nothing in this record. Zero. Read it.

19 Q. You don't know what the requirements for
20 the designated examiner are, correct, in South
21 Carolina?

22 A. No.

23 Q. Okay. And all you know is that the
24 paperwork and the two pages that were filled out by
25 Nurse Burrell?

1 A. Yes.

2 Q. I'm going to show you -- this is from the
3 third volume of materials and it's at -- Plaintiff 22
4 is the Bates number on this which is the designated
5 examiner notations there.

6 First, is that the DE note that Nurse
7 Burrell executed, as far as you know?

8 A. If -- yeah.

9 Q. Now, there is a different type of
10 handwriting on the bottom of the page. Do you know
11 whose handwriting that is?

12 A. No, I don't.

13 Q. Are those your notes at the bottom of the
14 page?

15 A. No.

16 Q. Okay. Did that handwriting that was added
17 that looks different from everything else on the
18 bottom of the page impact your opinion at all in this
19 case?

20 A. No.

21 Q. Okay.

22 A. But I agree with whoever wrote it.

23 Q. Apparently, that handwriting is on several
24 of the records that were supplied to Ms. Argoe's
25 witnesses in this case and Mr. Dodson says it's not

1 his handwriting and the last witness said it wasn't
2 her handwriting. It wasn't your handwriting. We're
3 trying to figure out who wrote that. It was not part
4 of the original record.

5 MR. DODSON: It was the witches and
6 warlocks.

7 MR. COLE: You're going to stipulate that
8 on the record?

9 (Recess from 11:52 a.m. to 12:05 p.m.)

10 MR. COLE: Back on the record.

11 Q. (By Mr. Cole) With Nurse Burrell, the only
12 involvement she had in the process was that designated
13 examiner, correct?

14 A. As far as I know.

15 Q. And so, after the hearing with the probate
16 judge, she was not involved with Ms. Argoe's
17 treatment, correct?

18 A. As far as I know, yeah.

19 Q. We've discussed generally your opinion
20 about the nurses' notes and generally --

21 A. Right.

22 Q. -- an unspecified nurse you would have
23 hoped would have reported something. Do you have any
24 specific names of any other nurses that you would call
25 out or is your testimony in general --

1 A. We can look in the record and see because
2 here's what I was thinking as I was going through,
3 there are a lot of different nurses that documented
4 that she wasn't really mentally ill, if you look at
5 the document. They don't say she's not mentally ill,
6 but there are nurses' notes that pretty much indicate
7 there's no reason here to be holding her. There's no
8 documented -- not -- there's not -- primarily, it's
9 holding her against her will that we're talking about.
10 Okay. There's really not documentation that she's
11 mentally ill.

12 Q. So is it your opinion Ms. Argoe should
13 have sued all of the nurses that worked?

14 MR. DODSON: I object to the form.

15 THE WITNESS: I guess she is in a way.

16 You mean individually?

17 Q. (By Mr. Cole) Yes.

18 A. I don't know. You'd have to ask
19 plaintiff's attorney.

20 Q. Regarding your opinions about the Three
21 Rivers facility itself and the nursing staff in
22 general and then Ms. -- Nurse Burrell specifically, do
23 you have any other opinions that we haven't already
24 discussed?

25 A. No. I want to just mention this, as a lot

1 of times in these hospitals, there's a medical
2 director and maybe Dr. Mobley is the medical director,
3 I don't know, but there's usually a medical director
4 that overlooks or a psychiatric director who overlooks
5 everything and I couldn't find if there was one here.
6 But it would be nice for a hospital like this to do --
7 to have a medical director who looks over what the
8 other doctors -- I've been a medical director of a
9 couple of hospitals which I looked over what the other
10 doctors were doing. It was also easy for a staff
11 member to come and talk to me if they didn't want to
12 confront that doctor and say would I confront the
13 doctor about what they were doing.

14 In other words, this doctor's not spending
15 enough time with his patients or this doctor's
16 carrying a gun on rounds and she shouldn't be doing
17 that or something like that. Those are real
18 instances.

19 Q. Okay. I don't understand if that's an
20 opinion or if that's a --

21 A. I'm just saying I think they wouldn't have
22 been in this -- if there is a medical director -- is
23 there a medical director? I don't know.

24 Q. You've reviewed the record.

25 A. I couldn't find it. I couldn't find if

1 there was.

2 Q. So are you saying that that is or is not
3 an issue in this case?

4 A. Not an issue.

5 Q. Okay. Some of the -- well, let me ask
6 this first: You were asked about the colors of the
7 tabs in your documents.

8 A. Uh-huh.

9 Q. There are highlights --

10 A. Uh-huh.

11 Q. -- throughout the documents that you have.

12 A. Uh-huh.

13 Q. There are your handwritten dates that we
14 talked about that you identified when you reviewed --

15 A. Right.

16 Q. -- those particular records. And then
17 there are tabs that are installed on the side of the
18 records of various colors that I assume are tabs that
19 you put into the record, correct?

20 A. Correct.

21 Q. What was your criteria on why you
22 highlighted something and why you tabbed something?

23 A. When I'm reviewing this record, this has
24 been over -- I've been doing this over a five-year
25 period on this -- with these records, so I'm reviewing

1 them at different times. Some of them I reviewed more
2 than once because years went by between -- and I get
3 another pack of records, I couldn't remember it all.
4 So I may have been on a plane or I may have been
5 really sleepy at night doing it and sometimes it's
6 just what I've got available at the time.

7 You know, sometimes I sit down, and I've
8 got an hour and I'm going to review. I'm sitting at a
9 desk and sometimes I'm sitting waiting for my wife to
10 come out of shopping or something. I'm marking them,
11 so I'm trying to get the work done. There's no
12 particular reason for it being red or blue or pink or
13 circling or underlying. It's just so I can try to go
14 back at a time like this and review all these records
15 and have some memory of it so I don't have to go
16 through like we've been going here.

17 Q. Are there any specific tabs that you have
18 in your records that you would state are the most
19 significant features for your opinion? I'm,
20 basically, asking you are there one or two of these
21 that you think are the most significant?

22 A. Well, you'll see that on the Three Rivers
23 record there's lots and lots of tabs and so each one
24 of those is significant. Now, what are the things
25 that are stuck out, certainly, Dr. Line heart's

1 evaluation, that sticks out. Because it was the -- I
2 think really the only good one. It was well done. A
3 lot of them are just because I thought they just
4 didn't do a good job recording. If you want to pick a
5 couple or pass that over to me, I'll tell you why I
6 tabbed them.

7 Q. I'm thinking what I might do is let some
8 other people ask some questions before I get into
9 that, that will be the least exciting part of the
10 deposition. I'll let other people do it while
11 everyone is awake. I'll come back to it.

12 I do have one last short series of
13 questions. In the Three Rivers' documents, you have
14 copies of some of the policies that have confidential
15 written across them and they're at the beginning of
16 that, I guess, second tab section in Volume 3 of the
17 notebook?

18 A. Uh-huh.

19 Q. You have some of those tabbed and some of
20 those highlighted. Obviously, you reviewed those.
21 Have you used any of those policies and procedures
22 documents to help formulate your opinions?

23 A. Yes.

24 Q. And from those policies and procedures,
25 what opinions have you derived from those? You're

1 welcome to take that if you want to sit down, you
2 don't have to stand up. I don't want you to be
3 uncomfortable.

4 A. Okay. All right. I'll just go through
5 these.

6 Q. Okay.

7 A. The first one I highlighted was: "The
8 admitting physician has directly communicated with the
9 transferring physician to establish the need for
10 transfer and has agreed to accept responsibility for
11 the patient's continuing treatment."

12 I didn't see that that was done. And had
13 that been done, maybe they would have figured out this
14 doesn't need to take place.

15 The next one was: "Admission
16 documentation on all transfers who clearly indicate
17 the specific criteria met for admission in the
18 clinical admission of patient upon arrival."

19 Well, I don't think that's in there
20 either, why they specifically thought she needed to be
21 here. We've already talked about this over and over.

22 Q. We talked about your opinion that she
23 didn't -- you think she didn't exhibit any of those.
24 We do have an initial diagnosis for the bipolar and
25 for the panic, correct?

1 A. It's not backed up. It's really not
2 backed up at all. As a matter of fact, it's counter
3 backed up.

4 Q. That's your opinion that it's not backed
5 up, but that is there, correct?

6 A. It's not documented. It's not documented.

7 Q. The --

8 A. You can't just make a diagnosis without
9 backing it up. If I'm going to diagnose a heart
10 attack, I've got to have some criteria to make that
11 diagnosis. There's nothing in here to back up her
12 being bipolar or being psychotic.

13 Q. What is the actual policy number that
14 you're looking at so we have it for the record?

15 A. No. 2.

16 Q. At the top?

17 A. Oh, CC.005.

18 Q. Okay.

19 A. "It is the policy of Three Rivers -- this
20 is CC.004 -- it is the policy of Three Rivers
21 Behavioral Health that prior to admission, during the
22 course of treatment, each patient will be assessed and
23 determine the medical necessity for psychiatric
24 services based on established criteria."

25 I don't see it.

1 Q. Wasn't she actually assessed when she got
2 to Three Rivers?

3 A. Some days. On some days she was assessed.

4 Q. And your opinion is that that
5 assessment --

6 A. But it doesn't document that she needs to
7 be here for some reason. What's the medical necessity
8 for her to be held here? I don't see that. I don't
9 see that one time.

10 Q. I mean, the policy says that she needs to
11 be assessed which was done, correct?

12 A. No, I don't think it is done really.

13 Q. Well, she was assessed, but you're
14 critical of how --

15 A. I think if you're going to do an
16 assessment, it has to be a proper assessment, not just
17 cut and paste.

18 Q. An assessment was done, you're just
19 critical of how that assessment was done?

20 A. I don't even know if it was done. She
21 told me -- Mrs. Argoe told me they hardly spent any
22 time with her.

23 Q. You say "they," who do you mean?

24 A. The doctors.

25 Q. Which doctors?

1 A. Dodds and Mobley.

2 Q. Okay.

3 A. This is No. 2B, "The patient continues to
4 have the acute disturbances of mood behavior or
5 thinking that required the initial admission."

6 That's what I'm talking about every day.
7 Every day. How do they document that she has an acute
8 disturbances of mood behavior thinking every day?
9 They don't.

10 Okay. We're going to RL.013. "Any
11 restriction of the patient's rights as set forth in
12 the patient's bill of rights must be pursuant to a
13 physician's order and clinically justified for reasons
14 of physical or emotional well being, safety and
15 security."

16 No. 2: "Any restriction of the patients
17 rights shall be incorporated in the patient's
18 treatment plan."

19 Can't do it.

20 No. 4, the patient --

21 Q. Wait. Wait. Wait. What do you mean,
22 "can't do it"?

23 A. There's nothing in there to back that up,
24 to restrict the rights. Tell me. You show me. I
25 didn't find any.

1 Q. So your opinion is that the documentation
2 is not sufficient to continue her inpatient treatment?

3 A. Correct.

4 "The physician shall document by
5 physician's order in the progress notes of patient's
6 medical record the reasons for such a restriction."

7 Not given.

8 "An explanation to the patient."

9 Not given.

10 "And the duration of the restriction."

11 How about until the insurance runs out.

12 Is that it?

13 Five: "Any order for restriction must be
14 reviewed at least every 24 hours."

15 Q. So your opinion was that was not complied
16 with?

17 A. That's correct.

18 Q. After reviewing those policies and
19 procedures that you have right there, does that change
20 your testimony at all of what we talked about before
21 with regard to Three Rivers, generally the nurses or
22 Nurse Burrell?

23 A. No.

24 Q. All right.

25 MR. COLE: I'm going to stop asking

7 BY MR. DAVIS:

12 A. Yeah.

19 MR. DODSON: I object to the form.

22 Q. (By Mr. Davis) And how is that determined?

23 A. By a good clinical examination of the
24 patient, by a thorough examination documented in the
25 record of how -- how is this person a substantial

1 risk. For example, she's been threatening someone to
2 kill them. She's been threatening to kill herself or
3 she has tried to kill herself. She has tried to kill
4 someone. Certainly not; she's ever had thought of it
5 which means there's some risk, I guess, but...

6 Q. Okay. Can it also be based on the history
7 from family or close --

8 A. Sure. I mean, we're going to take in any
9 information that you can get your hands on and put
10 that at in your equation, but the main thing is the
11 examination of that person at the time now. It's not
12 the -- there was substantial risk two weeks ago.

13 Q. Okay. We have talked or you have talked a
14 good bit about the medical recordkeeping in this case.
15 My question is: As far as the standard or medical
16 recordkeeping, does it require the doctor to record
17 everything that happens?

18 A. No.

19 Q. Okay. What does it require? What does
20 the standard require?

21 A. The standard requires that -- we were
22 talking about this a minute ago -- that the physician
23 put in the record pertinent data about the reason this
24 person is being treated; in this case, being held
25 against her will, right? That's got to be in there.

1 Any changes in treatment plan which will include
2 medication and any, you might say, other collateral
3 data that's really pertinent to what's happening at
4 the time.

5 Q. Tell me what is --

6 A. Let me give you an example.

7 Q. Okay.

8 A. I'm not interested necessarily that the
9 patient's smoked marijuana 15 years ago. But the
10 patient's smoking marijuana last night in the
11 hospital, that would go in the notes. So it's a
12 pertinent current information, got to be in there.

13 Q. Okay. What is a definition of a
14 provisional diagnosis?

15 A. I'm still thinking about whether this is
16 the diagnosis or not. I'm going to put it down so I
17 can record it. Other people can note it. We're
18 considering this diagnosis, but we haven't made up our
19 mind yet.

20 Q. Is another way to say that a working
21 diagnosis?

22 A. Yeah, I think they -- they overlap.
23 They're not exactly the same term, but it's kind of,
24 you know, the same part of the room.

25 Q. Okay. What would be the difference

1 between them?

2 A. Provisional diagnosis, I think I'm still
3 working on it. I may not be treating it yet. But
4 then with a working diagnosis, probably going to want
5 to start some treatment.

6 Q. Okay. All right. Could either the
7 provisional or the working diagnosis change as you get
8 more information?

9 A. Yeah.

10 Q. And is that common?

11 A. Yes.

12 Q. Now, would you agree that two medical
13 professionals could assess someone and see the same
14 patient and determine or assess the patient
15 differently, have a different provisional diagnosis
16 for that patient?

17 A. You say could that happen?

18 Q. Sure.

19 A. Sure.

20 Q. Is that common that that happens?

21 A. Fairly common.

22 Q. Okay. On the flip side of that, if two
23 medical professionals assess a patient and they both
24 come to the same provisional diagnosis, does that lend
25 credence to that diagnosis?

1 A. Certainly.

2 Q. You have mentioned Dr. Mobley's name a few
3 times, but what I want you to do now is go ahead and
4 tell me what opinions you have of how Dr. Mobley
5 deviated from the standard of care --

6 A. Okay.

7 Q. -- there, if in any way.

8 A. All right. Let's take Plaintiff 00020.

9 Q. If you can just tell me what that is.

10 A. That is the report of designated examiner
11 for mental illness.

12 Q. Okay.

13 A. This date is 6/16/05. It states -- this
14 is Dr. Mobley's writing: "Patient continues to
15 exhibit floridly psychotic symptoms, mainly extreme
16 paranoia and delusional thinking."

17 I don't see anything to back that up.

18 Q. Okay.

19 A. That's a major deviation from the standard
20 of care.

21 Q. Okay. And just -- so?

22 A. It's -- florid means anybody can see it.
23 In other words, it would be obvious to anybody is
24 florid.

25 Q. Okay. So your -- just to make sure I

1 understand your opinion is that when she wrote that --
2 could you tell me what the number on that is one more
3 time?

4 A. 00020.

5 Q. Okay.

6 MR. DODSON: My Bates number.

7 Q. (By Mr. Davis) So, basically, just so I
8 understand your opinion is that Dr. Mobley did not
9 back up what she wrote on this exhibit that you were
10 just --

11 A. She couldn't. She couldn't back it up.

12 Q. Why do you say, "she couldn't back it up"?

13 A. There's nothing in this whole record that
14 indicates that Ms. Argoe was floridly psychotic,
15 extremely paranoid and had delusional thinking.
16 Where's the -- what's the delusion?

17 Q. You testified earlier that you weren't
18 there in 2005, so you don't know how she appeared,
19 correct?

20 A. I got the record. Where's the
21 documentation that says delusional?

22 Q. Okay. If you'll answer my question.

23 A. I wasn't there, no, I wasn't.

24 Q. And you do understand that the family had
25 given a history?

1 A. That doesn't have anything to do with it.
2 We've gone over and over that. Your wife could come
3 in and say that you are floridly delusional and you
4 want the Court to send you off to a psychiatric
5 hospital against your will just because your wife says
6 that?

7 Q. So your opinion is that because she wrote
8 that -- that on the report of designated examiner for
9 mental illness and did not explain it, that was a
10 deviation from the standard?

11 MR. DODSON: I object to form.

12 THE WITNESS: Right.

13 Q. (By Mr. Davis) Other than that, is there
14 anything else that you have --

15 A. She wasn't there. She couldn't explain
16 it. There's nothing in the record.

17 Q. I understand your opinion there. My
18 question is: Do you have any other opinions as
19 relates to Dr. Mobley of how she deviated from the
20 standard of care?

21 MR. DODSON: I object to form.

22 THE WITNESS: We got a lot of these.

23 That's Dr. Dodds. Oh, there is a medical
24 director here. Okay. Let's go to 61705, and you
25 want the number here. Let's see.

1 Q. (By Mr. Davis) If you can give me a
2 number.

3 MR. DODSON: It's the 7456-N -- as in
4 Nancy -- 68. I don't know whose Bates numbers
5 all these are.

6 MR. DAVIS: I think those are ours. 068
7 you said?

8 MR. DODSON: Yes.

9 Q. (By Mr. Davis) Okay.

10 A. Progress note: "9:30 a.m., patient seen;
11 discussed with staff affective mood, euthymic, speech
12 not as brisk, thought process is logical, goal
13 directed, sleep, appetite good."

14 Okay. Now, why can't she be discharged?
15 It says -- then it says still delusional and paranoid.
16 How? How is she delusional and paranoid? If your
17 thought processes are logical and goal directed, it
18 doesn't follow to me.

19 Q. All right.

20 A. Next -- go ahead.

21 Q. I was going to say, so again, as you're
22 spelling out for me the violations of the standard by
23 Dr. Mobley --

24 A. Why can't she be discharged? Why does she
25 have to be in the hospital?

1 Q. Let me finish the question. As you're
2 spelling these out for me, this one that you just
3 talked about, the 61705 one, again, you're saying she
4 wrote down delusional and paranoid but she didn't
5 identify why?

6 MR. DODSON: I object to form.

7 Q. (By Mr. Davis) Is that what you're --

8 A. Or how. How does that make her have to be
9 in the hospital?

10 Q. That's your criticism?

11 A. That's not the standard of care, yes.

12 Q. Okay. All right. Anything else?

13 A. Next page.

14 Q. Okay. 069?

15 A. 62005, yeah. Okay. "Affect and mood
16 euthymic. That's not bipolar. "Continues to sleep
17 well." That's not bipolar. Okay. "Thought process
18 is logical. Goal directed. Appropriate. Overtly
19 psychotic symptoms." None. None. "Speech is normal.
20 Still assuming what husband and son report as
21 delusional thinking and paranoid on her part."

22 This is what -- what is she thinking? I
23 mean, am I going to take my -- am I going to take what
24 I see and let this lady out of the hospital? Why not?
25 Because her husband is making up this stuff about her.

1 Q. Let me ask you this: You were just
2 referring to some things in this list that you said
3 were not bipolar. What is bipolar?

4 A. When people -- when they are manic which
5 is what they were claiming she might be, they are --
6 don't sleep. They're very active. They're not
7 euthymic, elevated mood.

8 Q. Elevated what?

9 A. Mood.

10 Q. You say they do have that or don't have
11 that?

12 A. They do. Do. It doesn't take a doctor to
13 tell when somebody is manic.

14 Q. Okay. Anything else that just as far as
15 what your -- what you would be looking for in manic?
16 I'm not asking you about the record right this second.

17 A. They could be delusional, could be
18 paranoid, but that's -- again, that's not backed up.
19 It says the husband and son report she's delusional
20 and she's paranoid. And the doctor doesn't see it.
21 What's the doctor thinking? I don't -- I don't get
22 it.

23 Q. Okay. Anything else?

24 A. Let's go to 621.

25 Q. 621 you said?

1 A. Uh-huh.

2 Q. All right.

3 A. This is 070.

4 Q. Right.

5 A. "Patient represents a danger to self and
6 others secondary to her paranoia and fear of husband
7 and the fact that she always carries a gun to protect
8 herself from him."

9 I don't think that requires you to be in a
10 hospital. You see at the bottom of the page?

11 Q. I'm sorry.

12 A. Go to the bottom of the page: "Patient
13 represents danger to self and others --

14 Q. Okay. I go it.

15 A. -- secondary to her paranoia and fear of
16 husband. And the fact that she always carries a gun
17 to protect herself."

18 I don't think so.

19 Q. So again, so I understand what your
20 criticism is, she is writing things down that she is
21 not explaining?

22 A. Well, it's -- yeah, she's not documenting
23 it. She's saying the husband says it, but she doesn't
24 see it. Now, at the end of that --

25 Q. This is 071?

1 A. "She will place the patient on phone
2 restriction at the family's request."

3 Q. Just for the record, you're -- that's the
4 bottom of 071, right?

5 A. Yes.

6 Q. Okay.

7 A. That doesn't make any sense to me either.
8 Why did she do that? Why doesn't the family just not
9 answer the calls if they don't want it?

10 Q. Anything else for Dr. Mobley?

11 A. It doesn't even say they can call an
12 attorney.

13 Q. Do you know if she had an attorney --

14 A. Yeah.

15 Q. -- at that time?

16 A. I bet she did.

17 Q. But do you know that?

18 A. No. Might have been Mr. Walsh. I don't
19 remember when he came on. I think she's making it
20 really clear to Dr. Mobley that she and her husband
21 have lots of problems. She doesn't want to go back to
22 live with him. And is Dr. Mobley taking this into
23 consideration? That -- I mean, I guess we know after
24 the fact that they're taking her property --

25 Q. Okay.

1 A. -- illegally, right?

2 Q. Okay. Do you know if there was any
3 indication that Dr. Mobley knew that?

4 A. No, I don't know.

5 Q. Let me ask you something about this.

6 A. Yeah.

7 Q. You were talking about her relationship
8 with her husband.

9 A. Uh-huh.

10 Q. Assume for me that a person does have
11 paranoia and delusions. Okay. If a person has
12 paranoia and delusions and they have a gun, carry a
13 gun, could they be a danger to themselves or others?

14 A. Sure. Anybody that carries a gun is a
15 danger to themselves or others whether they're
16 delusional or not.

17 Q. Are they more likely to be a danger to
18 themselves or others if they carry a gun and they're
19 delusional and paranoid?

20 A. Probably a little bit more.

21 Q. Okay.

22 A. But the odds on that are not high. The
23 odds are clear that if you carry a gun, you're much
24 more likely to get shot with it than if you don't
25 carry a gun. That, we know for sure. That's

1 predicted.

2 Q. Any other criticisms you have of
3 Dr. Mobley?

4 A. We're still working.

5 Q. All right.

6 A. All right. Now, yeah. Let's go to 053.

7 Q. Is that a number?

8 A. That's the number that this sheet says,
9 7456-N-053.

10 Q. Okay.

11 A. At the top, "diagnosis: Psychosis NOS,
12 rule out manic."

13 She just described how she's not manic.
14 She doesn't have the symptoms of it. So I don't know
15 why she's ruling it out because it's not there. Then
16 it says: "Phone restriction, patient's received no
17 incoming calls."

18 Q. Where are you reading?

19 A. Under the orders.

20 Q. Okay. I see. And what's your criticism
21 there?

22 A. Why?

23 Q. Why what?

24 A. Why is she cutting off her calls from
25 people?

1 Q. Oh. Okay.

2 A. No reason given. And it says: "May --
3 may place no calls."

4 Why can't she call people up? Give me a
5 reason.

6 Q. Anything else? Any other criticisms?

7 A. Okay. Now, we have on this one says Three
8 Rivers Burrell 000255. Let's see, okay.

9 Q. You got a number at the bottom?

10 A. Yeah. 256. It says: "Dr. Mobley says
11 she brandishes a gun."

12 I'd like to know where did she brandish a
13 gun.

14 Q. So what's your criticism, she didn't say
15 where she did it?

16 A. I don't know that she did it. Who said --
17 did she brandish a gun at Dr. Mobley?

18 Q. Okay.

19 A. Who says she did?

20 Q. So again, your criticism is that she
21 didn't write down where she brandished the gun?

22 MR. DODSON: I object to form.

23 THE WITNESS: I don't think she did. I
24 asked her if she brandished a gun and the patient
25 says she didn't. How does this doctor know that?

1 Why does she put in the medical record that she
2 brandishes a gun? You know, that -- that's a
3 pretty strong thing to put in somebody's record,
4 they're brandishing a gun.

5 Q. (By Mr. Davis) Okay. Anything else? What
6 was the date of that?

7 A. I don't see it down here.

8 Q. Could I look at it?

9 A. Sure. This is one we're on right here
10 (indicating).

11 Q. Let me back it up.

12 A. Now, on the same page, "Permanent fixed
13 delusions."

14 Q. What does that mean?

15 A. It means they don't go away. What
16 delusions do we have here, that her husband is after
17 her? I mean, has anybody checked this out? Has
18 anybody checked the police record that she's called
19 the police five times because her husband has
20 threatened her?

21 Q. Is there --

22 A. She's saying "permanent fixed delusions."
23 What delusions is it and how are they permanent and
24 what are the delusions?

25 Q. Is there a requirement or a standard that

1 says that a doctor who, let's say, they get
2 information like the -- there's spouse issues, there's
3 violence, there's assault or whatever, is there any
4 standard requirement the doctor check into that?

5 A. If she puts in here husband says that
6 so-and-so and so-and-so. Let's say you go to your
7 doctor, the doctor writes in there lawyer Jim Davis
8 smokes marijuana every night. All right. Is that
9 okay?

10 Q. My question is: Is there a requirement
11 that a doctor follow up on that -- on that
12 information?

13 A. You don't write something in the record
14 that you can't back up. This is damaging to this
15 person. You don't just put something in a person's
16 medical record unless you know it's true.

17 Q. How do you know it's true?

18 A. You can put it there I was told that Jim
19 Davis smokes marijuana every night by his partner down
20 the road who used to work with him and they broke up.
21 Now they're not partners anymore, they hate each
22 other. You can put that in there.

23 Q. My question is: Is there a duty on the
24 doctor to follow up on that type of information?

25 A. In a way there is. You don't write stuff

1 in there unless you observe it or you know it's true.

2 Q. So if a family tells you something, you
3 can't write that down?

4 A. You can write down there a family told me
5 that she thinks Lou is going to have the FBI follow
6 her around and they've been following her around and
7 she's told Lou that that's going to happen. You can
8 put that in there.

9 Q. So getting back to my original question.
10 When I say is there a standard that requires a doctor
11 to follow up, you said in a way. What does that mean?
12 What does it mean?

13 A. You got to back up what you put in there.

14 Q. I understand.

15 A. Yes. The answer is yes. The doctor's got
16 to make sure that what -- that's true.

17 Q. Okay. How do they do that?

18 A. Don't put it in there if you can't.

19 Q. That's what I'm saying. How could you
20 verify it?

21 A. I'd do a drug test on you to see and that
22 will give you some information.

23 Q. But as far as brandishing a gun, how can
24 you verify that?

25 A. Well, it didn't say her husband says she

1 brandishes a gun.

2 Q. So there it just has to be a qualifier?

3 A. It's got to be the truth.

4 Q. How do you know if it's the truth or not?

5 A. You don't.

6 Q. So you can't put anything in somebody's
7 medical record?

8 MR. DODSON: I object to form.

9 THE WITNESS: I wouldn't. I wouldn't.

10 Q. (By Mr. Davis) Okay. Anything else with
11 Dr. Mobley, any opinions that you have that she
12 deviated from the standard of care?

13 A. And this one is kind of a -- I'm not going
14 to be able to tell you exactly where, but how many
15 times has Dr. Mobley been told that she doesn't like
16 her husband? You know, that he -- he's got all these
17 problems and she just ignores him, apparently, and
18 calls him delusional.

19 Q. Why do you think that she ignored him?

20 A. She keeps saying that she's paranoid when,
21 in fact, she's not paranoid.

22 Q. Did you read her deposition?

23 A. Yeah.

24 Q. Did you see where she talked about
25 observing them together?

1 A. Observing who together?

2 Q. Mrs. Argoe and Mr. Argoe.

3 A. Not --

4 Q. You don't remember that?

5 A. No.

6 Q. If she did observe them together, is that
7 a way that she can try to verify the information?

8 A. Yeah.

9 Q. Okay. Any other opinions that you have as
10 it relates to Dr. Mobley?

11 A. Now, I'm kind of interested in other
12 things she didn't check out. I mean, how is -- how is
13 Mrs. Argoe hyper religious? I spent pretty much time
14 with her one day, she never brought up anything about
15 her religion. I mean, how is it documented in here
16 that she's hyper religious? That's one of the things
17 Dr. Mobley used to say that she was mentally ill.
18 How? How is she hyper religious?

19 Q. You don't recall her saying anything about
20 how she was hyper religious?

21 A. I don't.

22 Q. Any other criticisms of Dr. Mobley?

23 A. How was she spending huge amounts of
24 money?

25 Q. Let me ask you this: As you mention those

1 last couple of things that she didn't check out, how
2 would -- how would a doctor normally check out things
3 like that?

4 A. Well, first thing I would do would be to
5 ask the patient.

6 Q. Okay. How else? If a patient either
7 denies it or --

8 A. If a patient denies --

9 Q. -- or doesn't want to cooperate?

10 A. Look. I got money and I like to buy
11 jewelry. Well, okay. Tell me what you bought. How
12 much money you got? What's your income? Lady owns a
13 beach house. She has other property. She has her own
14 money. She inherited it. She can spend it on as much
15 jewelry as she wants to, as far as I'm concerned.
16 That doesn't put her in a psychiatric hospital. And
17 then I want to ask her husband, well, tell me how
18 she's hyper religious. How is she spending huge
19 amounts of money?

20 Q. Okay. So in addition to --

21 A. If you want to check it out.

22 Q. That's what I was going to ask you. In
23 addition to talking to the patient, you can also talk
24 to their family to try to verify or check it out?

25 A. But you got to talk to them. You got to

1 find out. Does Dr. Mobley have some reason to be
2 suspicious that these people might be doing what she
3 says they're doing? What's the old saying, it's not
4 paranoia if they're actually out to get you?

5 Q. Any other criticisms you have of
6 Dr. Mobley?

7 A. I think that the witches and warlocks one,
8 that's another one, too. We've already talked about
9 this.

10 Q. What do you mean, "that's another one"?

11 A. We already talked about it, I think, with
12 Mr. Cole, but did Dr. Mobley ever ask her about
13 witches and warlocks?

14 Q. Okay. Anything --

15 A. When a patient is delusional or they have
16 hallucinations, they usually tell you. They'll
17 usually answer your question.

18 Q. Do they always do that?

19 A. Not always, but you observe them, too.

20 Q. If you're delusional, are you delusional
21 all the time?

22 A. Not about everything.

23 Q. Okay. If you're delusional, are you
24 delusional about anything all the time? Bad question,
25 let me try that again.

1 A. Most people who are delusional are
2 delusional about something all the time unless they
3 get cured --

4 Q. Okay.

5 A. -- treatment or whatever.

6 Q. By medications?

7 A. Cured of that. Well, that's one way,
8 shock treatment, psychotherapy, you know.

9 Q. Any other criticisms you have of
10 Dr. Mobley?

11 A. That she gave her medicine.

12 Q. That what? What?

13 A. Gave her medicine.

14 Q. And what's your -- you're saying she
15 shouldn't have given her medicine?

16 A. Absolutely not.

17 Q. Why not?

18 A. No indication for it. She gave her
19 dangerous medicine. These are not medications that
20 don't have any side effects or long-term side effects.
21 They do. And I don't know what she was giving them to
22 her for.

23 Q. Are you aware of any side effects
24 Ms. Argoe had as a result of medications?

25 A. No.

1 Q. Any other criticisms you have of Dr.
2 Mobley?

3 A. Well, we've got on the list, I'm sure, but
4 just to make sure, that she got her committed.

5 Q. You got what now?

6 A. Got her committed to the hospital, that's
7 on your list.

8 Q. You talking about initially?

9 A. Yeah.

10 Q. What do you mean that's on my list?

11 A. My criticism.

12 Q. Okay. So, basically, that she was -- she
13 was committed in the first place?

14 A. She went to Court and got this lady
15 committed for -- I think illegally.

16 Q. And we've already answered a bunch of
17 questions about this, we're not going to go back into
18 that.

19 A. I think that's all the ones I have.

20 Q. Let me ask a few other questions. In your
21 opinion, can stress bring on a psychotic event?

22 A. Sure.

23 Q. And if stress does bring on a psychotic
24 event and once the stress is relieved or removed or
25 gets less, will the psychotic event get better?

1 A. A lot of the times.

2 Q. Will it even go away?

3 A. Yes.

4 Q. Now, you've already talked a lot about
5 assessments and testing. I want to make sure I
6 understand. Is it true that psychologists actually
7 perform tests?

8 A. Anybody can perform tests. Psychiatrists
9 can do it, too.

10 Q. From a standard of care, is it your
11 opinion that psychiatrists should perform testing on
12 patients or should they refer them to a psychologist?

13 A. Either one.

14 Q. Either way?

15 A. Either way.

16 Q. So it's not your opinion that only
17 psychologists can perform testing?

18 A. Of course not.

19 Q. Is it your opinion that in this case, that
20 any of these psychiatrists should have performed
21 testing on Ms. Argoe?

22 A. No, Dr. Mobley ordered Dr. Leonhardt to do
23 it. That's fine.

24 Q. You're okay with that?

25 A. Sure. But I think her dismissal of it and

1 not -- when you put all of this together, you add the
2 testing to it, why didn't she let her go? You got no
3 reason to hold her. Then you got testing that doesn't
4 diagnose any mental disorder at all except marital
5 problems. You got all these observations by the staff
6 that she's fine.

7 Q. Let me ask you a question about this
8 testing. As far as testing goes, tell me if this is
9 correct because I'm not sure -- the testing that we're
10 talking about like a psychologist performs in testing,
11 in essence, that is, basically, a snapshot of where
12 that person is at the time of testing, correct?

13 A. Yeah; but as we talked about with
14 Mr. Cole, the tester is designed to pick up things
15 than what's more than a snapshot because it's designed
16 to pick up things that have happened in the past, too.

17 Q. Okay. But a test is not going to be a
18 diagnosis; is that fair?

19 A. Well, you can say the test can make a
20 diagnosis.

21 Q. It can?

22 A. Sure. You saw the one that I did.

23 Q. Okay.

24 A. Where I tested her, it makes a diagnosis.
25 Now, obviously, it's a machine that's programmed and

1 it warns you in you got to look at the patient
2 yourself, this is to help you.

3 It's just like a blood test. All right.
4 If you go and you have a blood test and you come out
5 with a hemoglobin of 7. All right. That's not -- you
6 can look at that as a diagnosis, you got low
7 hemoglobin is your diagnosis. If you want to know
8 more, the cause of it, are you bleeding in the bowel,
9 do you have an iron deficiency, something.

10 Q. Okay. Let me ask you this: If you have
11 someone whose affect was expansive and euphoric,
12 speech was brisk and they were paranoid, you had
13 someone that exhibited those things, what would be
14 your provisional diagnosis of them?

15 MR. DODSON: I object to the form.

16 THE WITNESS: I mean, there are -- there
17 are -- there are many possible diagnosis. There
18 is --

19 Q. (By Mr. Davis) Is bipolar one of them?

20 A. Yeah. But it can be substance abuse. It
21 could be a personality disorder. It could be
22 delirium. It could be dementia.

23 Q. And --

24 A. It's probably 25 different things that
25 could cause that configuration of symptoms.

1 Q. All right. Let me ask you this: Just
2 from strictly a standard of care, would you say it's
3 appropriate when you -- when someone comes in to you
4 and you're assessing them, are you going to try and
5 rule out an organic problem, a drug problem, as well
6 as possibly some type of psychiatric problem?

7 A. Yes.

8 Q. Okay. And so it would be appropriate
9 to -- to run some testing just to check on if there's
10 any organic issue going on in addition to doing the
11 psychiatric testing?

12 A. Yes.

13 Q. All right. Dr. Davis, have you told me
14 everything -- all the opinions you have or all the
15 criticisms you have as relates to Dr. Mobley and her
16 dealings with Ms. Argoe?

17 A. Yes. Now, if I think of any more, I'll be
18 glad to let you know.

19 MR. DAVIS: I appreciate that. That's all
20 the questions I have. Thank you.

21 CROSS-EXAMINATION

22 BY MR. PARHAM:

23 Q. You've read Dr. Dodds' deposition?

24 A. Yeah.

25 Q. And is it your opinion that within one day

1 of assessing Ms. Argoe at any time, that a reasonable
2 psychiatrist would be able to reach a conclusion that
3 she was not mentally ill and did not need inpatient
4 commitment?

5 A. Yes, but I don't -- I'm not going to
6 criticize Dr. Dodds' first day that she saw her. You
7 know, I'll give her a day or two. Okay. Because
8 she's coming on duty here, the first look is probably
9 going to be why is this woman in the hospital. But
10 maybe she's just having a great day or something.
11 I'll see how she is tomorrow. But within one or two
12 days, I don't know why she didn't let her go.

13 Q. So you'll give a reasonable, competent
14 psychiatrist one or two days to determine --

15 A. Yeah.

16 Q. -- that she is not mentally ill and needs
17 to be discharged.

18 A. Well, in this particular situation, yeah.
19 Right.

20 Q. Sure. Now, at one time -- in your
21 affidavit -- the first affidavit you filed years ago,
22 Exhibit 3, end of page 2 of the affidavit, you,
23 essentially, criticize Dr. Hooker for the initial
24 commitment, correct?

25 A. Yeah.

1 Q. Do you still have that opinion?

2 A. Yeah.

3 Q. If Dr. Hooker had performed within the
4 parameters that you think he should have performed,
5 then we wouldn't even be here today?

6 MR. DODSON: I object to the form.

7 THE WITNESS: I don't think we would be.

8 (Defendants' Exhibit 5 was marked for
9 identification.)

10 Q. (By Mr. Parham) So he had the first
11 chance --

12 A. He got the ball rolling.

13 Q. He got the first chance and he didn't take
14 it and it went on down the road after that, correct?

15 A. Right. Right.

16 Q. And that's still your opinion today,
17 correct?

18 A. Yes.

19 Q. Now, as I understand it, in the testing
20 you performed in your office in -- on April 24,
21 2008 --

22 A. I have a correction. Can I --

23 Q. Yes, sir.

24 A. I see in my notes here that the attorney
25 came with her that day.

1 Q. I'm going to ask you about that.

2 A. Okay.

3 Q. And this Millon test that was performed,
4 it was determined from that test or at least based on
5 that test that she did not have an Axis 1 mental
6 illness, correct?

7 A. Yes.

8 Q. However, I think the test did determine
9 that she may have had an Axis 2 diagnosis; is that
10 right?

11 A. Correct.

12 Q. And as I understand it from my experience
13 in these cases, and what I think you described, an
14 Axis 2 diagnosis technically isn't a mental illness as
15 defined in your profession, right?

16 A. Correct.

17 Q. The mental illness we're talking about are
18 the Axis 1, bipolar, schizophrenia, major depressive
19 disorders, etcetera?

20 A. Right.

21 Q. But at least this testing decided that she
22 was --

23 A. Narcissistic, obsessive compulsive,
24 histrionic.

25 Q. She had at least according to this --

1 A. Traits. Traits of.

2 Q. -- traits of personality disorder with
3 histrionic personality features and narcissistic
4 personality features?

5 A. Right.

6 Q. I think most people know obsessive.
7 What's histrionic personality features?

8 A. A little bit what you call dramatic.

9 Q. What about narcissistic personal features?

10 A. Selfish.

11 Q. Now, I think in earlier questions you said
12 that if someone came in and was filling out your
13 proprietary forms that you created over the years and
14 either didn't fill them out completely or needed help,
15 that would be something that would raise a flag to you
16 to at least investigate, right?

17 A. Right. And she was -- I think the
18 attorney was helping her with that.

19 Q. What does that tell you?

20 A. I guess he wanted to get it right or
21 something like she wanted it --

22 Q. A possibility --

23 A. I guess he was trying to influence the
24 database.

25 Q. That would be a possibility, you got an

1 attorney representing a client?

2 A. That's what I said, yeah.

3 Q. Okay. And before I forget, Doctor, I
4 think you had referenced a list of cases or case
5 reviews that your staff had put together.

6 Can we mark that as an exhibit, please?

7 Is it one page back and front, is that
8 what you have today?

9 A. I think that's for the Federal Court that
10 they require it and it's five years. Deborah keeps
11 that list.

12 Q. Yes, sir.

13 MR. DAVIS: We'll make this 6.

14 (Defendants' Exhibit 6 was marked for
15 identification.)

16 THE WITNESS: And let me mention while
17 we're on that that some -- what do you call it
18 when the judge takes a jury out and asks you
19 about opinions?

20 Q. (By Mr. Davis) Proffer. When you
21 proffer.

22 A. She didn't put proffers on there. We
23 weren't sure whether we needed to do that or not.

24 Q. That's fine. Yes, sir.

25 A. Those are left off. Is that the way

1 you're supposed to do it?

2 Q. Doctor, do you believe that a licensed
3 professional counselor has the same level of
4 education, training and experience that a board
5 certified psychiatrist has?

6 A. No.

7 Q. Do you think a licensed professional
8 counselor would be able to properly and with the right
9 qualifications be able to testify as to appropriate
10 standard of care for a psychiatrist?

11 A. You mean legally or --

12 Q. What's your personal opinion?

13 MR. DODSON: I object to the form. You
14 can still answer.

15 THE WITNESS: Well, I think if I were to
16 hear an LPC testifying, I would take it into
17 consideration. Now, I would, certainly, consider
18 that it was an LPC and not another psychiatrist;
19 but in the interest of getting to the truth, I
20 wouldn't -- personally, I wouldn't not listen.

21 Q. (By Mr. Parham) Now, when you have a
22 patient in a hospital whether voluntary or involuntary
23 committed, in addition to stabilizing that patient,
24 that's the first thing you want to do, correct?

25 A. Right.

1 Q. The second thing you want do to is to make
2 sure if discharged, they're discharged to someplace
3 where they have a safe environment to continue to
4 remain stable; is that right?

5 A. Correct.

6 Q. Is it a consideration in this case with
7 Ms. Argoe and the things that she was stating about
8 her husband, would that be an appropriate place --
9 let's just say that she went in for one day -- that
10 one or two days of assessment and, according to your
11 opinions, someone said you need to get out of here,
12 you don't need to be inpatient, would it be proper to
13 discharge her home to Mr. Argoe whom she has made
14 numerous statements in the record about trying to kill
15 her or poison her, et cetera?

16 A. She's a grown woman. As far as I'm
17 concerned, she's able to make that decision herself.

18 Q. But isn't that putting her at risk to be a
19 danger to herself?

20 A. Hey, look, if we put everyone in a
21 psychiatric hospital that had poor judgment, it would
22 be so crowded we wouldn't have enough people to clean
23 the streets.

24 Q. So you think it's okay as a psychiatrist
25 to discharge Ms. Argoe back to an environment where

1 she has made numerous statements to numerous health
2 care professionals that her husband has been trying
3 kill her, take her money, take her property, poison
4 her?

5 MR. DODSON: I object to the form.

6 THE WITNESS: I don't see any reason she
7 can't decide where she wants to go. She doesn't
8 have -- she's not incompetent. And she's doesn't
9 have a guardian, you know, why can't she make up
10 if she wants to do that? That's up to her.

11 Q. (By Mr. Parham) If you give these whether
12 it's an MMPI or the Millon that you use and it is
13 determined by either the computer or by your
14 assessment or your staff's assessment of the testing
15 results as being unreliable, it wouldn't be
16 unreasonable not to be able to make a diagnosis from
17 those test results, is it?

18 A. Even if it says that the -- all the tests
19 have a built-in validity scale. All right. That
20 doesn't mean you can't consider what the test says,
21 right? In other words, you could still consider it.

22 Q. But if you determine that the validity is
23 to a level of being --

24 A. Less.

25 Q. -- highly unlikely being a valid test

1 result because of actions or decisions made on the
2 part of the patient, could you make a valid diagnosis
3 or reasonable diagnosis from that?

4 MR. DODSON: I object to the form.

5 THE WITNESS: That alone?

6 Q. (By Mr. Parham) Yes, sir.

7 A. That would be risky to do that.

8 MR. DAVIS: Let's take a break.

9 (Recess from 1:17 p.m. to 1:25 p.m.)

10 MR. DAVIS: Back on.

11 Q. (By Mr. Davis) Doctor, when you saw
12 Ms. Argoe in April of 2008, your testing and your
13 assessment determined, in your opinion, that she did
14 not have an Axis 1 diagnosis?

15 A. Right.

16 Q. And, in fact, do you find anything
17 wrong -- that's a bad word -- anything abnormal about
18 her mental health at all during that visit?

19 A. Well, yeah, you know, we don't really use
20 the term "normal" because --

21 Q. I understand that, that's why I was trying
22 to find a better word.

23 A. So the word that we try to -- the way we
24 try to look at is how functional is that person. And,
25 you know, all of us are dysfunctional a little bit at

1 the best. But, I mean, she seemed pretty functional
2 to me. Seemed happy and she said she was enjoying
3 herself. She has some friends. She was -- she won an
4 award at her job. I think it was one of these
5 restaurant places. She got some award that they gave
6 her for doing a great job. Yeah, she seemed fine to
7 me.

8 Q. Did you see anything or assess anything
9 that you felt required that she needed any type of
10 counseling or any kind of therapy?

11 A. No.

12 Q. Did you see anything or find anything
13 through the tests or your assessment that required her
14 to have any medication?

15 A. Oh, absolutely not.

16 Q. And I think you were asked earlier in the
17 deposition, maybe Ms. Ganes, the Court required her to
18 have that one year of out patient therapy and
19 medication, correct?

20 A. Yes.

21 Q. Is that right?

22 A. Yes.

23 Q. I think your opinion was that the
24 physicians that were treating her during that year
25 should have immediately seen that she didn't need

1 either and discharged or petitioned the Court to get
2 her discharged?

3 A. Right.

4 Q. Other than the fact that when she was in
5 Three Rivers she is involuntary and can't leave with
6 her own decision, at Three Rivers she was getting
7 therapy and getting medications, correct?

8 A. Right.

9 Q. The only difference between that and a
10 year of outpatient is that she could come and go as
11 she pleases after she had the visits, correct?

12 A. Right. Oh, yeah, while we're talking
13 about that, let me say something else I just thought
14 of. This is about Dr. Mobley. I'm really wondering
15 why she gave her a shot of medication right before she
16 went to court. That seemed inappropriate to me.
17 Okay.

18 Q. And I may have misunderstood when you were
19 asked some questions at the beginning of the
20 deposition, but did you say that it's your experience
21 that, essentially, in the legal aspect of these
22 involuntary claims, the judge always admits people?

23 A. I just said I did a study some years ago
24 in DeKalb County, the next county over, they did -- in
25 that hundred cases, they did every time what the

1 psychiatrists recommended.

2 Q. So that's your experience?

3 A. Yeah. Now, I have a since then had -- I
4 did get involved with one case where the judge -- this
5 was a young paranoid schizophrenia man -- that the
6 judge -- we were trying to get an outpatient
7 commitment on him and the judge ruled against making
8 him do that as an outpatient, but advised him to do
9 it. But that was the only time that I've ever been
10 involved in one that you can say overturned.

11 Q. And you've used the words more than once,
12 this is a due process proceeding for the patient,
13 correct?

14 A. Yes, right. Correct, it is.

15 Q. And it is allowing the patient to have the
16 opportunity to have the ability through an attorney or
17 even his or her own witnesses to defend not being
18 committed?

19 A. That's right.

20 MR. DODSON: I object to form.

21 Q. (By Mr. Parham) I think you said you
22 understood that during that process for Ms. Argoe when
23 she went for full probate hearing on June 21st, 2005,
24 that she did have an attorney representing her?

25 A. Yeah. I don't remember who it was.

1 Q. Now, I think you also made -- it may have
2 been -- in all due respect to you, it may have been a
3 flippanant comment, you did mention that you didn't
4 really see anything wrong with her suing the judge
5 that committed her, right?

6 A. I didn't see anything wrong with it.

7 Q. And, certainly, if she felt like she
8 was -- I think she's even used the term in your
9 database records -- illegally committed, that she
10 could have even sued her attorney that represented
11 her, too, couldn't she?

12 A. For improper assistance?

13 Q. Yes, sir.

14 A. Yes.

15 Q. And do you know that that attorney never
16 appealed those --

17 MR. DODSON: Objection.

18 Q. (By Mr. Parham) -- commitment proceedings
19 at all?

20 MR. DODSON: I object to form.

21 THE WITNESS: No, I did not.

22 Q. (By Mr. Davis) If she felt illegally
23 admitted, she could have sued him, right?

24 MR. DODSON: I object to form.

25 THE WITNESS: Correct.

1 Q. (By Mr. Parham) And again, I may have
2 misunderstood, but I believe you testified earlier
3 that you couldn't think of any other reason why even
4 Dr. Dodds would want to keep Ms. Argoe in Three Rivers
5 involuntary other than to make money?

6 A. I mean, I don't know why she did it.

7 Q. That's the only thing you can come up
8 with?

9 A. That's the only thing I can think of.

10 Q. Do you know how much money Dr. Dodds was
11 paid to treat Ms. Argoe?

12 A. That wouldn't be a lot. She had
13 insurance. That wouldn't be a lot.

14 Q. And you understand that Dr. Dodds,
15 fortunately or unfortunately, only got involved with
16 Ms. Argoe's care because Dr. Mobley went on vacation?

17 A. Right.

18 Q. As I understand it and correct me if I'm
19 wrong, you don't want to bounce a patient whether
20 inpatient or outpatient from doctor to doctor, you
21 want to kind of keep some continuity of care and
22 consistency of care, right?

23 A. Right.

24 Q. As I understand it, Dr. Dodds didn't take
25 care of Ms. Argoe when Dr. Mobley came back from

1 vacation to keep that consistent care?

2 A. She did.

3 Q. That would be reasonable, correct?

4 A. Yes.

5 Q. And I know your opinion about still being
6 there?

7 A. Right.

8 Q. And you said earlier with questions from
9 me that you'd give Dr. Dodds a day or two to get
10 acclimated to, okay, what's going on here, why is she
11 not discharged, but after two days you would expect
12 her in your opinion to have discharged Ms. Argoe?

13 A. Correct.

14 Q. Other than the fact that Dr. Dodds kept
15 Ms. Argoe in the Three Rivers facility longer than two
16 days when she took over care, I believe, on June 27th,
17 2005, do you have any other criticisms of her?

18 A. I think she took over like the 25th.

19 Q. I think the 27th.

20 A. 27th?

21 Q. Yes, sir.

22 A. Okay. Let's go to her progress notes.

23 She keeps saying -- okay. Let's look at 62905. This
24 is 077, history per family consistent with bipolar
25 disorder. That's the same thing we were talking about

1 a minute ago. All right. So family gives this
2 history, but what do you see right now? You got to
3 treat what you're seeing. Is there any disease here
4 regardless of what the family says?

5 Q. And, Doctor, I don't want to belabor this,
6 I understand your opinion that these -- the notes --
7 the progress notes written by Dr. Dodds, in your
8 opinion, do not support a bipolar diagnosis much less
9 inpatient admission, correct?

10 A. Right.

11 Q. Other than that, can you tell me any other
12 criticisms you have of Dr. Dodds? I don't need you to
13 go through each note.

14 A. I got you. I got you. I think it's all
15 just as we said the same thing.

16 Q. Yes, sir. And I think we have talked
17 about this. If Dr. Dodds had discharged Ms. Argoe
18 after two days which would have been around maybe June
19 29th, she's still going to have the medications she
20 had -- she was going to be given the medications for
21 at least a year, according to the Court Order,
22 correct?

23 A. Yeah.

24 Q. Although, it's your opinion that those
25 doctors could have petitioned her to stop the

1 medication?

2 A. Sure.

3 Q. You may have answered this earlier, but do
4 you have any evidence that the fact she was on these
5 antipsychotic medications has caused her any physical
6 or mental damage?

7 A. No.

8 Q. And I didn't see anything in your
9 assessment of Ms. Argoe in April of 2008, either
10 through your database or your interview with her or
11 even the testing, did you see any residual problems
12 they she had from being involuntary committed for 41
13 days?

14 A. Yeah, she was mad as hell.

15 Q. Other than mad? I'm mad that I'm sitting
16 here.

17 A. Well, she had to go through all this
18 litigation. Endless expenses.

19 Q. I'm talking about physically or mentally,
20 any residual problems from the admission other than
21 anger?

22 A. I think stress, a lot of stress from
23 having to, you know, go through the Court system and
24 have to keep being involved in all this long,
25 drawn-out litigation.

1 Q. Other than stress from this litigation,
2 anything else?

3 A. I guess -- I guess we mentioned expense,
4 correct?

5 Q. Yes, sir.

6 A. No.

7 Q. Okay. So as I understand it, there are no
8 residual damages from medications? There's no
9 physical or mental damages from the inpatient
10 admission for 41 days other than anger, stress from
11 the litigation she's filed as a result of that
12 inpatient admission and the expense?

13 A. Well, I mean --

14 MR. DODSON: I object to form.

15 THE WITNESS: -- she was deprived of her
16 liberty.

17 Q. (By Mr. Davis) I understand the inpatient
18 admission itself. I'm talking about afterward.

19 A. Well, having to go through all that
20 outpatient treatment, you can count that.

21 Q. Does Dr. Dodds have any responsibility for
22 that?

23 A. I think that at any point Dr. Hooker, Dr.
24 Steiner, Dr. Mobley, even the doctors that are on
25 call, Dr. Heath and Dr. Dodds and Dr. Rema and

1 Dr. Quinton, they could have ended her treatment and
2 they could have said to the Court, you know, she -- no
3 need to force her to have treatment.

4 Q. And again, once Dr. Dodds discharged her
5 into the outpatient care, whoever took over, in your
6 opinion, that first day, if they reviewed the records,
7 they would have said what are you doing here, why are
8 you on medication?

9 A. No. No. No. Not reviewing the records
10 but examining her. And again, I would give them more
11 than one visit. A person is coming into kind of
12 unknown with this record that she just got out of 41
13 days -- 41 days in a psychiatric hospital is a long
14 time. And so I'd have to, you know, say give them a
15 visit or two or three if you want to, but to -- to --
16 to make sure that I'm right about this and I'm going
17 to tell the Court she doesn't need to be forced to do
18 this. She can take care of herself. I mean, my point
19 here is that you got the right to be mentally ill if
20 you want to. That's the worst case here.

21 Q. Did you see where she -- other than the
22 fact that she's involuntary committed, in your opinion
23 which she shouldn't have been, any indication other
24 than the medication that she was harmed or abused in
25 any way during those 41 days?

1 A. At this point, we've talked about it.

2 Q. Okay. And you've given me all the
3 opinions about Dr. Dodds, correct?

4 A. Yeah.

5 MR. PARHAM: I'm done. Let's go off the
6 record for a second.

7 (Off the record.)

8 RECROSS-EXAMINATION

9 BY MS. GANES:

10 Q. Do you have any correspondence between you
11 and Mr. Dodson or you and Mr. Warner that you didn't
12 provide for us yet?

13 A. No.

14 MS. GANES: That's all I wanted to know.

15 RECROSS-EXAMINATION

16 BY MR. DAVIS:

17 Q. Well, Doctor, I'll just ask you: Do you
18 have an opinion about a shot that Dr. Mobley gave?

19 A. I think it was right before they went to
20 the hearing, they gave her a shot and it was no reason
21 I could think of to give somebody a shot before
22 they're going to a hearing like that unless the --
23 unless they're just so -- they're going to disrupt the
24 Court and, you know, the doctor wouldn't want --
25 wouldn't want the patient to disrupt the Court. Even

1 then, I mean, I'd be real reluctant to give somebody a
2 shot. If I think the patient is that mentally ill.
3 I'd want the Court to see it, frankly.

4 Q. Do you know how close in time the shot
5 was?

6 A. I can't remember.

7 Q. Okay.

8 A. It wasn't that far ahead of going to
9 court, it was after they knew they were going.

10 Q. Right. Do you know if that impacted
11 Ms. Argoe at all as far as what she told the Court?

12 A. No, I don't.

13 Q. Or how she appeared before the Court?

14 A. I would assume that was the intent.

15 Q. But do you know that?

16 A. No.

17 Q. Okay. Also, one other question, in your
18 examination of Ms. Argoe, did you know any concerns or
19 issues about her faking?

20 A. Faking?

21 Q. Faking.

22 A. Faking what?

23 Q. Faking symptoms, faking anything. That
24 she was faking as you were dealing with her?

25 A. She wasn't faking any symptoms, no. She

1 was trying to appear as good as she could, as healthy
2 as she could, I assume that she was.

3 Q. Okay.

4 A. She wasn't -- certainly, wasn't faking bad
5 things. I think she was on good behavior.

6 Q. If a patient is faking, who is that --
7 from a doctor's perspective, what does that --

8 A. A patient might malinger bad for a lot of
9 reasons.

10 Q. I didn't hear what you said.

11 A. A patient might malinger, fake bad for
12 reasons. Like somebody asked me about an IME, a
13 patient's coming for an IME, there might be some gain
14 for them to appear sick or unhealthy.

15 Q. And similarly, I guess if somebody has a
16 lawsuit, they can be trying to appear good?

17 A. That's right.

18 MR. DAVIS: That's all I have, Doctor.

19 THE WITNESS: Probably a little bit
20 harder.

21 Q. (By Mr. Davis) A little bit harder for
22 what?

23 A. To fake good, fake healthy. It's hard for
24 a mentally ill person to fake healthy. A mental
25 illness comes through. I don't think a person who is

1 manic can think good is going to come through.

2 MR. DAVIS: Okay. Thank you.

3 MR. COLE: You went through all those,
4 Doctor, with the two doctors' testimony, so I'm
5 not going to go back through all of that.

6 MR. DAVIS: Let's go off the record.

7 (Off the record.)

8 MR. DODSON: Let's go back on the record.
9 I've got a few questions for you, Doctor.

10 DIRECT EXAMINATION

11 BY MR. DODSON:

12 Q. Dr. Davis, at any point during this 41-day
13 involuntary commitment, did you see any clinical basis
14 to hold Martha Argoe against her will?

15 A. No.

16 Q. As a psychiatrist, what are the reasons
17 that you would hold a patient involuntary or
18 involuntarily admit a patient?

19 A. If they're mentally ill and as a result of
20 their mental illness, they're an eminent risk to harm
21 themselves or harm someone else or be unable to care
22 for themselves enough to survive.

23 Q. Okay.

24 A. And they can use their friend to help
25 them. I mean, they don't have to do it by themselves.

1 Q. Anything in the medical record that you
2 reviewed from Three Rivers or Pavilion, any of the
3 sworn deposition testimony to suggest that during this
4 41-day involuntary commitment, Martha was a danger to
5 herself or other people to such an extent that she
6 needed to be involuntarily committed?

7 A. None.

8 Q. Anything in those records or sworn
9 deposition testimony to suggest that during this time
10 she could not take care of her daily needs such as
11 feeding herself, that kind of thing?

12 A. None.

13 Q. Do you have any opinions on whether Drs.
14 Steiner, Mobley, and/or Dodds should have discharged
15 her at any point during this 41-day involuntarily
16 commitment?

17 A. Yes.

18 Q. And what are those opinions?

19 A. That that was their duty to -- to not hold
20 her against her will. That they could have discharged
21 her.

22 Q. And what about the psychiatric
23 medications, do you have any opinions about whether or
24 not Martha should have been forced to take the
25 psychiatric medications that were prescribed to her

1 and mandated that she take?

2 A. I do have an opinion.

3 Q. And what is that opinion?

4 A. The standard of care did not dictate them
5 to make her take this medication. There was nothing
6 that I saw in the record to force her to take
7 medication.

8 Q. And that was sort of going to be my next
9 question: In your professional judgment, was it a
10 breach in the standard of care for the treating
11 psychiatrists to not discharge her timely and to
12 continue to require her to take these psychiatric
13 medications?

14 A. Yes.

15 Q. Now, you indicated that you believed when
16 this process initially started that Dr. Hooker should
17 have discharged her?

18 A. Right.

19 Q. He, essentially, started this process?

20 A. Right.

21 Q. Given that, even when she -- when Martha
22 saw Dr. Steiner and then Mobley and then Dodds, did
23 they get a fresh and new look at this?

24 A. Yes, every time. Every day you get a new
25 look.

1 Q. So in your mind and in your professional
2 judgment, does the fact that Dr. Hooker didn't meet
3 the standard of care, does that in any way change the
4 standard with regard to Drs. Steiner, Mobley and Dodds
5 with regard to what they should have done when they
6 saw Martha?

7 MR. DAVIS: I object to form.

8 THE WITNESS: No.

9 Q. (By Mr. Dodson) Now, in your interaction
10 with Martha, did you see anything that would suggest
11 that she was faking or malingering?

12 A. No.

13 MR. DODSON: I don't have any further
14 questions.

15 MR. PARHAM: I just have two follow-up
16 before we read the notes.

17 RECROSS-EXAMINATION

18 BY MR. PARHAM:

19 Q. Doctor, did I misunderstand you when you
20 said earlier that you thought she wasn't seen every
21 day in the hospital?

22 A. Yeah, we have to look through that. I had
23 the idea that there might have been days that a doctor
24 didn't come see her, but some of these I couldn't
25 read.

1 Q. The dates?

2 A. Well, I couldn't read what they said, who
3 they were or couldn't read their signature or who they
4 were.

5 Q. Your statement about not being seen every
6 day is your review thinking there's not a progress
7 note for each day?

8 A. That -- yeah, we can go through.

9 Q. I don't want -- is that what it's based
10 on?

11 A. Right.

12 Q. So if we determine there was a progress
13 note for each day, you would be satisfied?

14 A. Right. You may know the names of some of
15 these people. If she was seen every day, that meets
16 the standard of care.

17 Q. And do you understand from your review of
18 the record that Ms. Argoe made a decision -- let me
19 back up.

20 In your opinion, she was competent and
21 lucid to make decisions in that involuntarily
22 commitment, correct?

23 A. Correct.

24 Q. So if Ms. Argoe made a voluntary decision
25 to take the medication, that's within her right, isn't

1 it?

2 A. It is.

3 Q. And you reviewed the record where she did
4 start voluntarily taking those medicines?

5 A. Yes, she did.

6 Q. Okay.

7 MR. DAVIS: Do we really want to read
8 these notes?

9 (Off the record.)

10 THE WITNESS: This answers the first
11 question that you asked me, the first time I was
12 contacted was 3/25/08 by Mr. Warner. He said
13 call him back, have him interrupted, that is a
14 note from my office manager. Possible new case.
15 Argoe versus Three Rivers. Behavioral facility
16 and about three doctors. That's signed by
17 Deborah.

18 And then I talked to him on the telephone
19 3/25/08, these are my notes. Martha Argoe, 65.
20 Husband alcoholic. Son 40. Affluent
21 inheritance. Marital problems. 2005 took POA
22 made son her agent. Husband and son went to
23 attorney together to put her into a mental
24 hospital. Parenthesis, no history, end
25 parenthesis. Husband took her to a mental health

1 center in Orangeburg. Husband big fish. Took
2 list. Go to attorney, use power of attorney to
3 transfer assets, trust for him. Parenthesis,
4 violation, end parenthesis.

5 This says it looks like after dead record.
6 Admitted wife there, probate court. CT negative.
7 Pick her up. Aiken Pavilion -- goes to Aiken
8 Pavilion. Goes to Three Rivers. She refuses
9 meds. Strip search at Three Rivers.

10 Clinical assessment, quotes, bipolar, end
11 quotes shots, 6/14 clinical psychologist. Better
12 check history. Marital stress. Defers
13 diagnosis. Page 22, now up in the right hand
14 corner, this is my writing. It says new case.
15 Send CV and contract \$4,000. Debra writes,
16 nonrefundable working contracts. Other side of
17 the page, 20 days of insurance. Looks like -- I
18 don't know, tell insurance so bad. I can't read
19 that. I can't read my writing here. Keep about
20 a year or something. I don't know. Down her to
21 Beaufort 2006. He's talking on the phone. I'm
22 trying to take notes here.

23 MR. DAVIS: Could that be referring to the
24 one-year outpatient for 2006.

25 THE WITNESS: It could, you know. I can't

1 read the next one. No guardian ad litem.
2 Dr. Remy decreased her meds. Nothing wrong with
3 her. Husband threatens psychiatric nurse. Set
4 off PROB action aside, probate action, I guess.
5 Three Rivers give medical records to husband's
6 attorney to get guardian ad litem. Sent probate
7 judge Three Rivers psychiatrist attorney,
8 husband. Husband and son settle. Two clinical
9 psychiatrists. Psychiatric examiner. She's
10 okay. 41 days. Diagnosis bipolar. Onset. Now
11 functioning alone. John --

12 MR. DAVIS: DeWitt.

13 THE WITNESS: -- DeWitt, psychiatrist
14 local. \$4000.

15 MR. COLE: All that stuff came from your
16 conversation with Mr. Warner.

17 THE WITNESS: Yeah. Okay. This is page
18 37.

19 MR. DAVIS: Doctor, you have a note, April
20 7 would be before that visit, wouldn't it?

21 THE WITNESS: Yeah. That's No. 42. You
22 want to do that next?

23 MR. DAVIS: Yes, sir. Let's get them in
24 order.

25 THE WITNESS: Okay. 42. Argoe. Up in

1 the right-hand corner, 7/7/42, date of birth.

2 April 20th, '05, evaluated at Orangeburg
3 Mental Health Center. Files something.

4 April 22, '05, husband files patient
5 involuntary emergency hospital. He's filing for
6 involuntary emergency hospitalization by Lewis
7 Argoe. Husband gives history compatible with
8 mental illness. Dr. Hooker evaluates, date,
9 question mark, illegible. Did he see the
10 patient, question mark. Two copies, date added
11 to one.

12 It says 6/7/05, CT, MRI. Aiken Regional
13 Medical Center, 6/8/05. Three Rivers, 6/9/05.
14 Dr. Steiner evaluated 6/9/05. Dr. Mobley (Dr.
15 Dobbs' vacation) equals mental illness in
16 parenthesis. And 6/10/08-6/16/08, I guess I'm
17 not sure.

18 June 14th, '05, second opinion. Farni
19 Leonhardt, clinical psychologist. Invalid.
20 Carry Washington, no mental illness. Tested her.

21 In court depo, Mrs. Trow, RN; Dr. Remy, no
22 mental illness; Dr. DeWitt; Dr. Quinn, no mental
23 illness.

24 2/9/06, Dr. Washington, Ph.D.

25 9/26/06, brother, sister, sister-in-law,

1 statements against her. Says M.D. SA.

2 7/28/06, at Coastal Empire. Closed case.
3 Coast Empire Mental Health Center. Closed case.

4 On the back Mr. Barron, guardian ad litem.

5 MR. DAVIS: Doctor, was this where you
6 were reviewing records that you had been sent?

7 THE WITNESS: I would assume I was,
8 probably trying to get a handle on kind of a
9 chronology there is what it looks like.

10 MR. DAVIS: What do you mean by the
11 word -- under June 14th with Dr. Leonhardt,
12 "invalid"? Do you remember what that meant?

13 THE WITNESS: Probably that the testing
14 was invalidated or something like that because
15 she mentioned in there that the personality
16 assessment inventory that she did was not that
17 or --

18 Okay page 37, Argoe, Martha. Oh, this is
19 when she comes to visit. I put in the right-hand
20 corner her attorney helped her with database.

21 4/24/08, arrived one hour late, so no
22 paperwork. I started the interview without
23 having the paperwork. Says North Myrtle Beach,
24 lived there at marriage, I think. Married in
25 '64, August 22nd. Clermont, New Hampshire. 65.

1 Who I am. Want freedom. Mother and husband told
2 me everything to do. Parenthesis, you let them.
3 Oh, I know -- I know what that means. She told
4 me that her husband and her mother both told her
5 everything to do. And I just pointed out that
6 she let them. She didn't have to do what they
7 were saying. Noticed other females didn't take
8 order. Inheritance at '90s early. Get my own.
9 Depend on Lewis until then. Own taxes. Father
10 M.D., local M.D. Paul something. Land with
11 forester. Lewis married in '64 while student at
12 USC. Met in '61. She did two years. Not
13 pregnant. Child born '67. Compliant person.
14 Married more or less 30 years. And change
15 occurred. Resents Lewis. Different philosophy.
16 Lewis traveled. Quotes, business trips, end
17 quotes. Attended general office. Bitter.
18 Believed he had other women. No evidence.
19 Caught him with his secretary. L meaning Lewis,
20 fired from attorney general because of women
21 rumors. He's drunk all the time. Excessive.
22 Martha's parents picked Lewis out. Mad with
23 myself. And I put in parenthesis, bitter.

24 He would remove me from my friends.
25 Allowed me to go to garden club. Quotes,

1 anything I said in garden club, he'd find out,
2 end quote. So I resigned. Mother and father set
3 it up. Mother role model. She quotes, ruled the
4 roost. He called me fucking stupid. He'd hit
5 me. I never went to M.D. Aurora, Aiken, Three
6 Rivers Dr. Carey Washington, clinical
7 psychologist, Ph.D., after the hospital.
8 Dr. Hooker, ten minutes with Lewis and social
9 worker. Deputy nearby. Ate out daily.
10 Parenthesis, question religiosity.

11 Orangeburg ER with --

12 MR. DAVIS: Sheriff's department.

13 THE WITNESS: -- sheriff's department.

14 Dr. Hooker came in. Didn't introduce himself.
15 Brackets, he made no report. Pictures. Okay.
16 Victim outlook, but could be a victim.
17 Parenthesis, borderline features, question mark.
18 She didn't know who Hooker was. You're neurotic,
19 psychotic, ill. Hooker, what should we do with
20 her? To hospital for MRI. Question of a stroke.
21 Then in the right-hand corner, referring to
22 her -- to Ms. Argoe, she's pleasant, smiling,
23 bitter. MRI within normal limits. Lewis
24 threatened to kill me. He's a drunk. Went home
25 with patrolman. Lots of -- lot of complaints

1 about Lewis on and on, but why didn't you the
2 leave. She didn't think any attorney would take
3 Lewis on. She didn't read her tax returns. She
4 presents herself as controlled by him. She
5 presents herself as relatively helpless.
6 Tremendous amounts of liquor.

7 At Aurora, Dr. Steiner, a male. Selective
8 in what he tells me. Pleads. I didn't know.
9 Splits question mark. Said take drugs or stay
10 hospital. She refused medicine. Saw Steiner two
11 times on consecutive days. And over in the
12 right-hand corner, some victim martyr outlook.
13 Sheriff's department, said call them often.
14 She'd call them often. But the reports were
15 against me. I finally drew a line in the sand
16 and then got committed.

17 Next to Three Rivers, Columbia, South
18 Carolina. Lewis showed up. She was outraged. I
19 put that on the right-hand side. We took a
20 break.

21 Next page. Joan Graves friend. Not
22 religious. Joyce Meyers. Looks like religion
23 teacher, an abused woman, televangelist. Likes
24 singledom. Doubts will remarry. Dated a little.
25 Doesn't intend to date. Joan flooded out of

1 Tyler, Texas. Lives in my house. Nobody else.
2 Best friend. Only friend. No regular contact.
3 Buss, estranged. Chose father. Never been able
4 to reconcile.

5 Then the right-hand side, question mark,
6 over productive, slightly pressured speech,
7 dramatic, defiant.

8 Dr. Mobley, that's a female. Never said I
9 was bipolar. Had something of Geodon after one
10 week at Three Rivers.

11 Dr. Dodds, maximum 10- to 15-minute
12 sessions. Threatened. Assisted -- threatened
13 assisted living. Unreadable word, looks like
14 circumstantial or something. Gives more than I
15 ask. Son's custody.

16 Court order outpatient treatment,
17 Dr. Reamy. Beaufort. Dr. Washington, Ph.D.
18 Brother. Drugs. M.D. Dr. Elmore something
19 records. Notice. I feel it. It's true.

20 Next page. She rarely answers questions
21 directly. Nothing about herself she could
22 change. No history and physical on admission.

23 Now we're going -- this is five --

24 MR. COLE: Before we go to that. What you
25 read through, can you figure out how long you

1 spent with her off of those dates? I don't see
2 any times or dates -- well, I see the dates, I
3 don't see any times.

4 THE WITNESS: A couple of hours.

5 MR. COLE: Thank you.

6 THE WITNESS: Usually it's generally set
7 up for three hours and -- you know, so it could
8 have been three, could have been two.

9 MR. COLE: Is that three hours --

10 THE WITNESS: Three-hour segment with me.

11 MR. COLE: Not including what she did with
12 the computer?

13 THE WITNESS: Not including the database
14 and the testing.

15 MR. COLE: Okay. Thank you.

16 THE WITNESS: 5/29/13. Argoe. This is
17 mentions Mr. Dodson yesterday. Attorneys' names.
18 Excuse me, that's doctors' names, Mobley, Dodds,
19 Reamy, Steiner, Quinn, clinical psychologist;
20 Steiner.

21 Says 6/06/05, let go home. 12, starts
22 with Hooker. Husband and son pick her up.
23 Orangeburg Regional. Then went to Aurora
24 involuntary. Aiken.

25 6/8, picked up to Aurora.

1 6/9, Three Rivers.

2 Probate judge, 6/24. Obtained by improper
3 evaluation based on false testimony. Copy and
4 paste. No spelling out. 6/24, order individual
5 evaluation. And then the names of the attorneys.

6 Next page, 3/25/13. Argoe. Dr. Reamy
7 depo and Nurse Trow, question mark. Never
8 himself saw evidence of mental illness. Husband
9 affidavit. Dr. Quinn agreed with Reamy and Trow.
10 No evidence Mrs. Argoe needs or had needed
11 psychiatric hospitalizations for mental illness.
12 Dr. Elmore, looks like -- I don't know what that
13 word is -- individual expert. Husband
14 threatened -- threatening, demanding, entitled.
15 Burrell depo. Went along with it with
16 Dr. Mobley.

17 Next page. 3/15/13. Argoe case. Husband
18 Lewis. Son Buss. Dr. Reamy never saw bipolar or
19 impairment. Property at marina transferred
20 before commitment. Nurse Trow, no evidence of
21 mental illness. Mr. Argoe, III, received
22 regarding guardianship. George Lewis Argoe, Jr.,
23 husband. Affairs. Drinking. Martha Argoe
24 inherited from mother beach house, New Hampshire
25 property. Husband took stuff. Threatened to

1 kill her and threatened to kill her. Attorney
2 Walsh used illegal POA to assign over her
3 property. Conspiracy. George Lewis Argoe, III,
4 son. James Walsh, attorney. Cheryl Dodds, M.D.,
5 psychiatrist, believes she is bipolar.
6 Dr. Leonhardt psychiatric evaluation, no
7 diagnosis made.

8 Illegal deed transferred in May '05.
9 Commitment, 6/06/05. Dr. Hooker without exam
10 sent patient to ORMS, I guess Orangeburg Regional
11 Medical Center. Signed commitment without exam.
12 Aurora, Dr. Steiner saw her. Transferred to
13 Three Rivers 6/7/05. Husband filed to be
14 guardian and conservatory. 7/20/05, discharged.
15 That's what that is, 7/20/05 when she was
16 discharged.

17 Dr. David Steiner, H&P on Ms. Argoe
18 6/9/05. Signed on 6/26/05 question mark.

19 Now, on the left, says Argoe filed one
20 black binder end at 7 p.m.

21 Next page is blank.

22 3/16/13, the top says Mr. Dodson. It says
23 incarcerate. Argoe case. Jan Warner died.
24 South Carolina Supreme Court remanded. Medical
25 malpractice M.D. and hospital. Hooker got out

1 procedural. No. 1, not danger to sell and
2 others. No. 2, repeating application for
3 involuntary commitment. Witches and warlocks,
4 hallucinations, not reported. Individual
5 evaluation needed. Good insurance money. Least
6 restrictive. Orangeburg sent her home. Next day
7 back again. Dodds increased dose. Her depo.
8 Husband said -- I don't -- can't read it.
9 Husband told mother he had. I got Mr. Dodson's
10 phone number.

11 Next page.

12 MR. DAVIS: What do you mean by "good
13 insurance money"?

14 THE WITNESS: I guess she had insurance
15 coverage.

16 This says 3/16/13. Argoe. Dr. Mobley
17 depo. Designated examiner at probate. First saw
18 Mrs. Argoe 6/10/05. Last notes 6/24/05. Didn't
19 evaluate OCD. Second opinion, Dr. Heath. Not
20 seen two days. Maybe that's why I thought that
21 she wasn't seen every day.

22 3/16/13, Dr. Dodds depo. Saw Mrs. Argoe,
23 6/27/05.

24 3/16/13, looks like Regena Sellers, RN
25 depo.

1 3/16/13 Doris Burrell, RN. 3/17/13,
2 admitting at Three Rivers.

3 3/17/13, Barbara (Indiscernible) depo.
4 Friends, close. Husband verbally abusive. Never
5 saw any more (Indiscernible.)

6 3/17/13, Depo Jim Zupan, Carolina Care
7 Plan. Kent Whitfield, Applebee's. Lou drank.
8 Took control.

9 3/17, Greg Colley, dermatologist. She's a
10 patient, saw number of times 1989 on. January
11 2006, July 5th, 2006, September 26th, 2006.

12 MR. COLE: Doctor, real quick, on the
13 left-hand side, the dates are given, the March
14 2013 dates, those are the dates you actually read
15 through these different depositions?

16 THE WITNESS: Yes. Yes.

17 MR. COLE: Thank you.

18 THE WITNESS: Next page. 3/17/13. Argoe
19 case. Shelby Ross depo, LPC, regarding Aiken
20 Medical Center. Oh, okay. Late-life onset. No
21 family history. You want to know what that
22 refers to because I remember what that is?

23 MR. PARHAM: I do.

24 THE WITNESS: It would be very unusual for
25 anybody to have an onset of bipolar at her age.

1 It's possible. And there's no family history
2 which I just thought I'd raise the questions in
3 my mind about any diagnosis for her being
4 bipolar. It made it real unlikely. Possible
5 though.

6 Rachel Regus depo. CM. Saw Mrs. Argoe
7 once on 6/9/05. I can't read that next word.

8 Depo Heather Hanner, CTR. Another one on
9 6/9/05.

10 Line.

11 3/18/13, Martha Argoe depo. Brother Reed,
12 M.D., ENT. No relationship. Divorced times,
13 three. Sister, Donna, no relationship. Divorced
14 October 2007. Verbal and physical abuse with
15 alcohol. Rages from 2000 on. Push, threatened,
16 called police five times. To marriage she
17 brought Corvette, 1964, and property in New
18 Hampshire. Told husband wanted a divorce,
19 2003/2004. Things disappeared. Son, Buss, no
20 relationship. No complaints versus Dr. Reamy.
21 And parenthesis, outrageous, end parenthesis.
22 She got an injection ten -- huh?

23 MR. PARHAM: Ten hours before.

24 THE WITNESS: I don't know if that's ten
25 hours or ten minutes. I think it's ten minutes

1 before her trial via Dr. Mobley. Attorneys: Got
2 the attorneys names.

3 Next page. 3/23/13. Argoe. Meds for
4 psychosis and OS, parenthesis, they knew she
5 wasn't manic. All based on what husband said.
6 PN, progress notes are never descriptive of any
7 further symptoms, underlined, three asterics.
8 This should have told me. Also described are
9 just repeats of what symptoms husband told them.
10 Four a week, she was on suicide watch.

11 Then another star, Leonhardt, 6/14/05,
12 evaluation was huge. Attractive. Spontaneous
13 affect. Euthymic mood. Thought process clear.
14 Coherent. Goal-directed. Denied audiovisual
15 hallucinations. Denied labile mood. Sleep okay.
16 Appetite okay. Denied increase in
17 suspiciousness. PAI normal. Defensive.
18 Unlikely valid. But the -- something scale
19 showed no elevation. Nurse time out.

20 MR. DAVIS: What does that mean?

21 THE WITNESS: I don't know. Argoe. Aiken
22 6/8/05. 6/6/05, husband gets order of detention
23 by Judge Jones Glover. Dr. Steiner had
24 Dr. Hooker's note with no evaluation.

25 6/9/05 transfer to Three Rivers.

1 Dr. Steiner evaluates, 6/8/05. She denied
2 all. 30 lines what they said, two lines of exam.
3 On mental status exam: Alert, well groomed,
4 orientation times three, looks younger, intact
5 memory. Denies history of -- oh, denies auditory
6 visual. No paranoia. No delusions. No
7 grandiosity. Speech a little pressured. Laughs.
8 Denies problems. No loose associations. No
9 flight of ideas. He based his diagnosis on the
10 history given by family. GAF, 22 question mark,
11 question mark. Her past history, negative,
12 parenthesis at her age, end parenthesis. No
13 sleep problems ever documented.

14 Saw Dr. Washington February '06 to October
15 '07, parenthesis Dr. Quinn and Dr. DeWitt.
16 Nominated employee of the year at Cracker Barrel.
17 Parenthesis, she saw no illness, end parenthesis.

18 Next page. Didn't perceive her life
19 story. Her temperament. The provocations. Her
20 responses and dimensions.

21 Where did the doctors collaborate?
22 Complex case. Observation not well documented.
23 Uneven descriptions. Ambiguous. Vignettes not
24 backed up by clinical observation. Cultural
25 ingredients. Etiopathogenic explanations.

1 Bereavement. No suicidal ideations. No history
2 or question -- no -- wait, no hallucinations or
3 delusions. No homicidal ideations. Where's the
4 psychosis?

5 Some attempt to assure the accuracy of
6 collateral information obtained or provided is
7 indicated. Was she ever asked to provide other
8 collateral information?

9 MR. DODSON: Anybody have any other
10 questions?

11 MR. DAVIS: I think I have one on that.

12 FURTHER RECROSS-EXAMINATION

13 BY MR. DAVIS:

14 Q. This last page that you read from, are
15 those just your thoughts when you finished reading the
16 deposition?

17 A. Yeah. Yeah.

18 Q. Just jotting things down?

19 A. Yeah, I remember this. It was late at
20 night I was thinking about the case and putting down
21 some of my ideas so I wouldn't forget them.

22 Q. What do you mean by "cultural
23 ingredients," if you remember?

24 A. What comes to mind is what she told me
25 about her mother directed her life and that she

1 married a man like her mother who directed her life.
2 And that -- she had been a submissive woman until she
3 reached this point where things got intolerable to her
4 and she began to -- she began to set boundaries
5 because she had told me about not having sex with him,
6 locking the door at night, keeping things to herself,
7 joining up with a church or religious group without
8 him, doing things without him which she didn't do
9 before.

10 Q. These things you listed above, didn't
11 perceive her life stress, temperament, provocations
12 and responses, and I can't remember the last word --
13 are you referring to the doctors that they didn't
14 perceive these?

15 A. Yes. Right. Yeah. Okay. I was thinking
16 that, yeah, Dr. Mobley and to some extent Dr. Dodds.
17 I mean, was there anything in the record that they put
18 this together and -- about this patient's life story
19 of how they can understand her and then included in
20 that would be her temperament and the provocations
21 that she had to be where she was. I mean, it seemed
22 to me that they just assumed that what her husband and
23 son had said was true and didn't consider -- they may
24 have contributed to the way she was changing and the
25 way she was behaving.

1 And that her temperament also was a part
2 of why she was presenting the way she was rather than
3 her being mentally ill, that this was a once
4 submissive woman who's forming her new identity of
5 being able to take care of herself without being
6 dependent on her husband and that culture background
7 she had was women are dependent on their husbands and
8 that her responses and the dimensions of her responses
9 might have been a healthy thing. In other words, what
10 she was doing could have well been not mental illness
11 but getting better, getting healthier.

12 REXCROSS-EXAMINATION

13 BY MR. COLE:

14 Q. You met with Mr. Dodson yesterday?

15 A. Yes.

16 Q. Was Mrs. Argoe there, as well?

17 A. No.

18 MR. COLE: Thank you.

19 MR. DAVIS: No questions.

20 MR. DODSON: We're done.

21 (Deposition concluded at 2:41 p.m.)

22 (Pursuant to Rule 30(e) of the Federal
23 Rules of Civil Procedure and/or O.C.G.A. 9-11-30(e),
24 signature of the witness has been reserved.)
25

C E R T I F I C A T E

STATE OF GEORGIA:

COUNTY OF FULTON:

I hereby certify that the foregoing transcript was taken down, as stated in the caption, and the questions and answers thereto were reduced to typewriting under my direction; that the foregoing pages 1 through 192 represent a true, complete, and correct transcript of the evidence given upon said hearing, and I further certify that I am not of kin or counsel to the parties in the case; am not in the regular employ of counsel for any of said parties; nor am I in anywise interested in the result of said case.

This, the 6th day of June, 2013.

Mona Landry

MONA LANDRY, CCR-B-1514

COURT REPORTER DISCLOSURE

Pursuant to Article 10.B of the Rules and Regulations of the Board of Court Reporting of the Judicial Council of Georgia, I make the following disclosures:

1. I am not disqualified for a relationship of interest under the provisions of O.C.G.A. Section 9-11-28(c).
2. I am a Georgia Certified Court Reporter.
3. I am present as a representative of JPA Reporting, LLC.
4. JPA Reporting, LLC was contacted by James M. Davis, Jr., to provide court reporting services for this deposition.
5. I will not be taking this deposition under any contract prohibited by Georgia law.



MONA LANDRY, B-1514
May 30, 2013

1 DEPOSITION OF: DAVE DAVIS, M.D. /MRL

2 I do hereby certify that I have read all
3 questions propounded to me and all answers given by me
4 on May 30, 2013, taken before Mona Landry, and that:

- 5 _____ 1) There are no changes noted.
6 _____ 2) The following changes are noted:

7 Pursuant to Rule 30(e) of the Federal Rules of
8 Civil Procedure and/or the Official Code of Georgia
9 Annotated 9-11-30(e), both of which read in part: Any
10 changes in form or substance which you desire to make
11 shall be entered upon the deposition...with a
12 statement of the reasons given...for making them.
13 Accordingly, to assist you in effecting corrections,
14 please use the form below:

15 Page No. _____ Line No. _____ should read: _____

16 Page No. _____ Line No. _____ should read: _____

17 Page No. _____ Line No. _____ should read: _____

18 Page No. _____ Line No. _____ should read: _____

19 Page No. _____ Line No. _____ should read: _____

20 Page No. _____ Line No. _____ should read: _____

21 Page No. _____ Line No. _____ should read: _____

22 Page No. _____ Line No. _____ should read: _____

23 Page No. _____ Line No. _____ should read: _____

24 Page No. _____ Line No. _____ should read: _____

1 DEPOSITION OF: DAVE DAVIS, M.D. /MRL

2 Page No. _____ Line No. _____ should read: _____

3 Page No. _____ Line No. _____ should read: _____

4 Page No. _____ Line No. _____ should read: _____

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8 Page No. _____ Line No. _____ should read: _____

9 Page No. _____ Line No. _____ should read: _____

10 If supplemental or additional pages are necessary,
11 please furnish same in typewriting annexed to this
12 deposition.

13 _____
14 DAVE DAVIS, M.D.

15 Sworn to and subscribed before me,
16 This the _____ day of _____, 20____.

17 _____
18 Notary Public
19 My commission expires: _____

20 Please forward corrections to:

21 JPA Reporting, LLC
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23 Atlanta, Georgia 30309
24 404-853-1811
25

LUCINDA L. DEBRUCE - 5/24/2013

1	STATE OF SOUTH CAROLINA	)	IN THE COURT OF
2	COUNTY OF LEXINGTON	)	COMMON PLEAS
3	Martha Lewin Argoe,	)	116TH JUDICIAL
4	Plaintiff,	)	CIRCUIT
5	vs.	)	Civil Action No.:
6	Three Rivers Behavioral	)	07-CP-32-1981
7	Health, LLC and	)	
8	Psychiatric Solutions,	)	
9	Inc., Its successor;	)	
10	Phyllis Brant-Mobley, MD;	)	
11	Aiken Regional Medical	)	
12	Center-Aurora Pavilion;	)	
13	David A. Steiner, MD;	)	
14	Cheryl C. Dodds, MD;	)	
15	Doris Ann Burrell, RN;	)	
16	and Carolina Care Plan,	)	
17	Defendants.	)	

ORAL DEPOSITION OF LUCINDA L. DEBRUCE
FRIDAY, MAY 24, 2013 - 8:37 A.M., CST
TEXARKANA, TEXAS

Reported by Amanda J. Leigh, CSR No. 3791
Job No. 13-0524

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1	STATE OF SOUTH CAROLINA	)	IN THE COURT OF
2	COUNTY OF LEXINGTON	)	COMMON PLEAS
3	Martha Lewin Argoe,	)	116TH JUDICIAL
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10	Phyllis Brant-Mobley, MD;	)	
11	Aiken Regional Medical	)	
12	Center-Aurora Pavilion;	)	
13	David A. Steiner, MD;	)	
14	Cheryl C. Dodds, MD;	)	
15	Doris Ann Burrell, RN;	)	
16	and Carolina Care Plan,	)	
17	Defendants.	)	

18 DEPOSITION OF LUCINDA L. DEBRUCE,
 19 taken at the Holiday Inn Express Hotel & Suites,
 20 Conference Room, 4545 Cowhorn Creek Road,
 21 Texarkana, Texas 75503, on Friday, May 24, 2013,
 22 from 8:37 a.m. until 10:51 a.m., CST, sworn by
 23 and taken before Amanda J. Leigh, Certified
 24 Shorthand Reporter in and for the State of
 25 Texas, and the following proceedings were had:

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LUCINDA L. DEBRUCE - 5/24/2013

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MS. RENEE BOUYE, CAROLINA CARE PLAN (VIA
WEB-CONFERENCE)

LUCINDA L. DEBRUCE - 5/24/2013

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EXHIBIT INDEX

EXHIBITS

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LUCINDA L. DEBRUCE - 5/24/2013

P R O C E E D I N G S

FRIDAY, MAY 24, 2013 - 8:37 A.M., CST

TEXARKANA, TEXAS

* * *

(Exhibit 1 marked.)

THE COURT REPORTER: Ma'am, do you realize that the testimony you give today will have the same force and effect as if you were in a court of law before a judge and jury?

THE WITNESS: I do.

THE COURT REPORTER: Will you raise your right hand, please?

THE WITNESS: (Complies.)

THE COURT REPORTER: Do you solemnly swear or affirm that the testimony you give today will be the truth, the whole truth, and nothing but the truth?

THE WITNESS: I do.

MR. DODSON: All right. I'll stipulate that Ms. DeBruce will not offer any expert opinions on standard of care or anything else with regard to defendants Carolina Care Plan, Aiken Regional and/or Aurora Pavilion, Dr. Mobley, Dr. Dodds, or Dr. Steiner. So the only opinions she's going to be offering are going to

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LUCINDA L. DEBRUCE - 5/24/2013

1 be as to the nurses at Three Rivers, and that
2 would include Doris Ann Burrell.

3 * * *

4 LUCINDA L. DEBRUCE,
5 having been duly cautioned and administered the
6 oath, testified as follows:

7 EXAMINATION

8 BY MR. COLE:

9 Q. Ms. DeBruce, again my name is Andrew
10 Cole. Thank you for accommodating us like this,
11 doing the video deposition; and hopefully this
12 will not take too long, but we need to make sure
13 we go through all of this.

14 My first question to you is: you have
15 a notebook of information that was supplied to
16 you by Mr. Dodson, correct?

17 A. Correct.

18 Q. When was that actually supplied to
19 you?

20 A. Probably three weeks ago, four weeks
21 ago, something like that.

22 Q. Okay.

23 We've marked as Exhibit Number 1 a
24 notice of your deposition, and that includes a
25 subpoena for documents, for you to bring those.

LUCINDA L. DEBRUCE - 5/24/2013

1 Did you bring everything that you have
2 in your file, with you there?

3 A. Yes.

4 Q. Okay. And can you just briefly -- so
5 that I have it and we know what we're going to
6 talk about today: what information do you
7 actually have? Just give me the, you know,
8 executive summary of that.

9 A. Okay. I brought the timeline, of
10 which you have a copy.

11 Q. Yeah.

12 A. And then I've marked a couple of
13 places in the notebook that was provided to me.

14 Q. And what specifically is in that
15 notebook, just so that we have that on the
16 record?

17 A. The medical records from Aiken
18 Regional; the medical records from Three Rivers;
19 the deposition of Martha Argoe; the deposition
20 of Dr. David Steiner; the deposition of Dr.
21 Phyllis Mobley; the deposition of Dr. Cheryl
22 Dodds; the deposition of Regena Sellers; the
23 deposition of Doris Burrell; the deposition of
24 Barbara Seignious, Seignious; the deposition of
25 Jim Zupon; the deposition of Kent Whitfield; the

LUCINDA L. DEBRUCE - 5/24/2013

1 deposition of Dr. Gregg Colle; the deposition of
2 Shelby Ross; the deposition of Rachel Ryan; and
3 the deposition of Heather Hanner.

4 Q. Who is the one after Shelby?

5 A. Rachel Ryan.

6 Q. Thank you.

7 A. And then Heather Hanner.

8 Q. And -- go ahead.

9 A. And then Heather Hanner, was the last
10 one.

11 Q. All right.

12 Both those -- which have -- or did you
13 mark any spots in any of those depositions? And
14 if you did, which depositions?

15 A. I don't believe I did in any
16 depositions. Mine are limited to the medical
17 record. I think it's all the medical record.

18 Q. Was that in both the Aiken records as
19 well as the Three Rivers records?

20 A. No. It was just Three Rivers.

21 Q. Okay.

22 Can you tell me, at the bottom of your
23 records, do those have numbers that we call
24 Bates numbers? Are you familiar with what those
25 are?

LUCINDA L. DEBRUCE - 5/24/2013

1 A. Yes, I'm familiar.

2 The medical record I would assume,
3 maybe it was entered all together, but I don't
4 see the Bates number for it.

5 Q. Okay. I was just trying to -- we've
6 got, like, three or four different times that
7 the same stuff were produced --

8 A. Okay.

9 Q. -- and so we have a bunch of different
10 reference numbers at the bottom; and I was
11 seeing if I knew which ones those were, so we
12 could figure it out. Okay.

13 And when were you first contacted to
14 help out in this case?

15 A. Approximately eight, nine months ago.

16 Q. Have you ever been to South Carolina?

17 A. I think I did one time, to see my son.

18 Q. And do you have any relatives that are
19 in Lexington County?

20 A. No.

21 Q. Okay.

22 Other than -- I would assume that was
23 a vacation. Other than that, have you ever been
24 to South Carolina, for any professional reasons?

25 A. No.

LUCINDA L. DEBRUCE - 5/24/2013

1 Q. Okay.

2 Your resume listed that in 2013 you
3 left the Vista Health Services and went to the
4 Haven Behavioral Healthcare.

5 A. Correct.

6 Q. When exactly did that happen?

7 A. February, the first week of February,
8 this year.

9 Q. And what were you doing at Vista
10 Health Services?

11 A. I was the chief operating off -- I
12 mean chief executive officer.

13 Q. As the chief executive officer, were
14 you seeing patients?

15 A. That wasn't part of my primary
16 responsibility.

17 Q. Okay. What do you do presently with
18 Haven Behavioral Healthcare?

19 A. I work in operations and oversee
20 various psychiatric hospitals throughout the
21 United States.

22 Q. Now, that one says it's based in
23 Nashville, Tennessee. Have you moved to
24 Nashville, or is this something you can sort of
25 telecommute to?

LUCINDA L. DEBRUCE - 5/24/2013

1 A. I can telecommute to. I -- I usually
2 fly to one of those locations and occasionally
3 then go to Nashville, as well; but my home is
4 still here in Texarkana.

5 Q. Okay.

6 The Haven Behavioral Healthcare, where
7 do you-all have facilities?

8 A. Reading, Pennsylvania; Denver,
9 Colorado; Phoenix, Arizona; Albuquerque, New
10 Mexico. We just are finishing one in
11 Philadelphia. We have one in Pueblo, Colorado.
12 I believe that's it.

13 Q. All right. And what -- if you had to
14 describe to me what Haven Behavioral Healthcare
15 does, how would you describe that?

16 A. They own psychiatric hospitals that,
17 for the most part, are geared toward the
18 treatment of geriatric patients.

19 Q. And the same question for Vista: how
20 would you describe what they do?

21 A. It's a freestanding psychiatric
22 hospital that offered treatment for all ages:
23 children, adolescents, adults, and geriatrics.

24 Q. Okay.

25 When did you get your nursing degree?

LUCINDA L. DEBRUCE - 5/24/2013

1 A. 1977.

2 Q. And where was that?

3 A. It was at the University of
4 Arkansas-Fort Smith. At that time, it was
5 called West Ark Community College.

6 Q. All right. And you have -- does
7 Arkansas require you to have any particular
8 licensing for nursing?

9 A. Yes. I mean, you have to pass the
10 state board for nursing and then you receive
11 your license.

12 Q. And when did you pass your boards?

13 A. In 1977.

14 Q. Have you obtained a license anywhere
15 else?

16 A. Yes. When I worked in Texas, in
17 Houston, I had to get a Texas license.

18 Q. Anywhere other than Texas or Arkansas?

19 A. No.

20 Q. Okay. And did you ever have any
21 claims or issues with those licenses, anybody
22 complain about --

23 A. No.

24 Q. -- that?

25 A. No issue.

LUCINDA L. DEBRUCE - 5/24/2013

1 Q. Okay. When is the last time you
2 actually saw a patient in a clinical setting?

3 A. Tuesday of this week.

4 Q. Was what?

5 A. Tuesday of this week.

6 Q. Okay.

7 Now, you said earlier that the --
8 seeing the patient is not in your job
9 description. Are you actually treating people
10 presently?

11 MR. DODSON: Object to the form.

12 A. I believe I said it wasn't a primary
13 part of my job; but I do see patients from time
14 to time, usually just in passing, to observe
15 them, see how they're doing. And then I do
16 chart reviews while I'm in these hospitals.

17 Q. (BY MR. COLE) Okay. So are you
18 presently working with any patients for any
19 length of their treatment, or are you just
20 coming in for the reviews, like you were
21 describing?

22 A. I'm not working with them for any
23 length of their treatment.

24 Q. Okay. So while you're at a facility,
25 you may see patients; but the primary care for

LUCINDA L. DEBRUCE - 5/24/2013

1 those patients are for -- are with the nurses at
2 that facility or the doctors at that facility.

3 A. Correct.

4 Q. As a nurse, do you make diagnoses --

5 A. No.

6 Q. -- of anybody?

7 A. No.

8 Q. Okay. Do you ever attempt to make a
9 diagnosis of anybody, as a nurse?

10 A. No.

11 Q. Who makes the diagnosis of patients in
12 the facilities where you have worked?

13 A. That's the physician responsibility.

14 Q. Okay. In any of the facilities that
15 you have worked, have you, as a nurse, ever told
16 a doctor "I think you've got a wrong diagnosis"?

17 A. I don't recall that I've ever done
18 that.

19 Q. Okay. Do you believe it's your
20 position, as a nurse, to question the doctor who
21 is treating the patient with their diagnosis and
22 prognosis?

23 A. I think it's my role, as a member of
24 the treatment team, to give input.

25 Q. Okay. And the ultimate decision is on

LUCINDA L. DEBRUCE - 5/24/2013

1 who?

2 A. The physician.

3 Q. Okay.

4 Have you ever served as a designated
5 examiner?

6 A. No, I have not.

7 Q. Do you know what that is?

8 A. Yes.

9 Q. Okay. How do you know what a
10 designated examiner is?

11 A. Well, in looking at the documents,
12 where it says the "REPORT OF THE DESIGNATED
13 EXAMINER," it basically outlines what's needed
14 and what's involved.

15 Q. All right. So have you done any other
16 research other than reading through the report
17 of the designated examiner, in this case?

18 A. No.

19 Q. Okay. And with your report you're
20 talking about -- do you get the exhibits with
21 the depositions when those are supplied to you?

22 A. I believe it was.

23 Q. Okay. So are you looking at Exhibit 1
24 to Ms. Burrell's deposition? Is that what you
25 were referring to?

LUCINDA L. DEBRUCE - 5/24/2013

1 A. It was part of the medical record, and
2 so that's where I have it marked.

3 Q. Okay. I think it's the same thing;
4 but it's easier for me to know if you're looking
5 at Exhibit 1, and tell me if that's the same
6 thing you're talking about.

7 A. Okay.

8 I don't see it as part of her
9 transcript and testimony.

10 Q. Okay. Here, let me -- so we're on the
11 same page (indicating).

12 A. Hang on one second. (Pause.)

13 Yes, it appears to be.

14 Q. Okay.

15 MR. COLE: Can you still see
16 us? because you look like you're frozen right
17 now. I hope that's not a problem.

18 THE WITNESS: Sorry. You're not
19 frozen.

20 MR. COLE: All right. Well, I'm
21 not going to worry about it right now. We'll
22 see if it kicks back in.

23 Q. (BY MR. COLE) Okay. So that's --
24 that's the thing you were talking about, then,
25 correct?

LUCINDA L. DEBRUCE - 5/24/2013

1 A. Yes.

2 Q. Okay.

3 And, again, to clarify: other than
4 reading through this report, have you read
5 anything dealing with designated examiners in
6 South Carolina?

7 A. No.

8 Q. Have you ever seen a document similar
9 to this before in your practice?

10 A. I believe I have from other states..

11 Q. What other states?

12 A. I don't recall any detail.

13 Q. In what context did you see reports
14 similar to this in the other states?

15 A. Just anything that might have to do
16 with a patient that had been involuntarily
17 committed.

18 Q. Okay. Have you ever been involved in
19 the treatment team of a patient who was
20 involuntarily committed to a facility?

21 A. Yes.

22 Q. When have you been involved in that?

23 A. It's really been so frequently, I -- I
24 couldn't begin to tell you how many. In every
25 position I've been in, there have been

LUCINDA L. DEBRUCE - 5/24/2013

1 court-ordered or involuntarily committed
2 patients, in every facility.

3 Q. And were you actually part of the
4 treatment team or were you part of a review team
5 or something else?

6 A. No. I would serve in an
7 administrative capacity. I would not be a
8 hands-on caregiver. That would be the people
9 that were on the treatment team.

10 Q. And you've never filled out a form
11 similar to this.

12 A. No.

13 Q. When somebody came in and is
14 involuntarily committed, do they all say, "Yes,
15 you're right, I should be committed," or do they
16 deny?

17 MR. DODSON: Object to the form.

18 A. We have some of either way.

19 Q. (BY MR. COLE) It's not unusual for
20 somebody that's involuntarily committed to deny
21 that they should be there, correct?

22 A. It's not unusual.

23 Q. In the exchange of various discovery
24 in this case, one of the things Mr. Dodson
25 provided to us was a letter, when he named you

LUCINDA L. DEBRUCE - 5/24/2013

1 as an expert; and in that letter, he said--I'm
2 just going to quote from it--that "Ms. DeBruce
3 is expected to testify that the care and
4 treatment rendered to Ms. Argoe by Nurse Burrell
5 and the other nurses involved in her care and
6 treatment was below accepted standards of care."

7 Have you ever heard or seen that
8 statement before?

9 A. I don't know that I've heard or seen
10 it, but it's correct.

11 Q. Okay. What are your opinions in this
12 case?

13 A. Well, involving Nurse Burrell, my
14 concern is that in her designated examiner
15 report, that she details that the patient is
16 alert and oriented and denies any suicide or
17 homicide ideation, denies any hallucinations;
18 and those are really part of the key threshold
19 that would be involved with committing a patient
20 against their will to a psychiatric facility.

21 And, further, she does indicate that
22 it is her opinion that the patient needs to be
23 retained for her safety and to get stable and
24 become more educated on her diagnosis; and it is
25 my opinion that it is inappropriate to indicate

LUCINDA L. DEBRUCE - 5/24/2013

1 that having someone be more educated on their
2 diagnosis is justification for holding them in
3 an involuntary commitment.

4 Q. So what, in your opinion, should Nurse
5 Burrell have done when she did the examination?

6 A. I believe that she should have
7 indicated directly the evidence that supported
8 her findings, as well as I just don't think that
9 she should have been indicating that the patient
10 should be involuntarily held for purposes of
11 education.

12 Q. And what's the basis of that opinion?

13 MR. DODSON: Object to form.

14 A. Holding someone against their will
15 involuntarily, removing their rights, is the
16 highest threshold of interacting with a
17 psychiatric patient. You have to make sure that
18 it is truly appropriate. And in my years of
19 experience, I have never seen anyone indicated
20 to be appropriate for psychiatric
21 hospitalization on an involuntary basis with a
22 nursing summary that indicates that she should
23 become more educated on her diagnosis.

24 Q. (BY MR. COLE) Is your opinion that
25 the sole reason that Ms. Argoe was involuntarily

LUCINDA L. DEBRUCE - 5/24/2013

1 committed was because of these two pages that
2 Nurse Burrell filled out?

3 MR. DODSON: Object to the form.

4 A. I think Nurse Burrell had a role and
5 responsibility in that decision-making process
6 and fell below the standard of care in her
7 nursing assessment.

8 Q. (BY MR. COLE) What, in your opinion,
9 is the standard of care for the designated
10 examiner in this case?

11 MR. DODSON: Object to the form.

12 A. Can you repeat the question?

13 Q. (BY MR. COLE) I was asking you -- you
14 said you believe she fell below the standard of
15 care, and I want to know what you believe the
16 standard of care for Nurse Burrell was in this
17 situation.

18 A. I believe that the standard of care is
19 that she should subsidize or explain or pursue
20 more detail regarding why she felt like it was
21 appropriate for this person to be held against
22 their will. What she has indicated is
23 insufficient.

24 Q. Do you take her report completely
25 separate from all of the records that were

LUCINDA L. DEBRUCE - 5/24/2013

1 produced from the facility before Three Rivers,
2 and Three Rivers, up to the time that this
3 report was generated?

4 MR. DODSON: Object to form.

5 A. I take her report as being a part of
6 that decision-making process; and as a
7 registered nurse, she had a role and
8 responsibility to perform that function
9 appropriately.

10 Q. (BY MR. COLE) And, again, what basis
11 do you have to say what her exact role was at
12 this point as the designation -- designated
13 examiner?

14 MR. DODSON: Object to form.

15 A. Her role and responsibility as an RN
16 obviously played into the decision-making
17 process that was a part of information given to
18 the Court.

19 Q. (BY MR. COLE) Well, I need something
20 more than just "she's a nurse, so she should
21 know better." I mean, what books, what
22 treatises, what -- what classes have you taken,
23 that would point me to that?

24 MR. DODSON: Object to form.

25 A. In almost 25 years of supervising

LUCINDA L. DEBRUCE - 5/24/2013

1 psychiatric facilities, including those that
2 have involuntarily committed patients, I have
3 never seen anything like this that would have
4 been acceptable.

5 Q. (BY MR. COLE) You've never practiced
6 in South Carolina, right?

7 A. Correct.

8 Q. Where have you practiced?

9 A. Arkansas, Texas. I've supervised
10 facilities in Louisiana. And at this current
11 time, then, I'm overseeing facilities in all
12 those locations I previously mentioned.

13 Q. Okay. Colorado, Arizona?

14 A. New Mexico, Pennsylvania.

15 Q. Isn't your criticism more of the
16 commitment process than it is of Nurse Burrell?

17 MR. DODSON: Object to the form.

18 A. No. I think that her role and
19 responsibility, as a registered nurse, plays a
20 part in that; and how she delivered that
21 responsibility is below standard.

22 Q. (BY MR. COLE) And, again, I ask you:
23 what is that standard?

24 A. The standard is that -- that it should
25 be evident through her assessment, her nursing

LUCINDA L. DEBRUCE - 5/24/2013

1 assessment, that the patient still meets -- does
2 meet a level of care that would justify an
3 involuntary commitment.

4 Q. Nurse Burrell is not giving a
5 diagnosis, correct?

6 A. It doesn't appear to be so, no.

7 Q. Okay. And she would not, as a nurse,
8 be the person to give a diagnosis, correct?

9 A. Correct.

10 Q. Okay. And would you agree with me
11 that the nurse relies on, in part, the input
12 from the physicians that see the patient, as
13 well?

14 A. In part.

15 Q. Okay. And that this decision is one
16 that starts with the original commitment
17 proceedings and then all these different people
18 play parts in that role, correct?

19 A. I think everyone does have a role.

20 Q. And in this case, you gave us a
21 timeline. Why do you pick these eight dates?
22 What make these significant?

23 A. I felt like they were just critical
24 junctures in the timeline so I could keep it in
25 perspective.

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1 Q. Okay.

2 The probate court hearing, did you
3 read -- is that from the records that you got
4 from Three Rivers?

5 A. I believe so.

6 Q. And what was the ultimate decision
7 from that probate court hearing?

8 A. I believe she was at that point
9 involun -- her involuntary commitment was
10 continued, and it was designated that outpatient
11 treatment would follow.

12 Q. And did -- was that order actually
13 complied with? Do you know?

14 A. Well, she was involuntarily committed
15 for as long as she was there in the hospital. I
16 don't believe she ever became a voluntary
17 patient. And to my knowledge, she completed the
18 outpatient portion that was required, as well.

19 Q. And who was the person that actually
20 made the decision at the probate court hearing
21 to involuntarily commit Ms. Argoe?

22 MR. DODSON: Object to the form.

23 A. Obviously it's the judge's decision,
24 that's based on medical staff and psychiatric
25 staff input.

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1 Q. (BY MR. COLE) And it's based off the
2 records, as a whole, that were known at that
3 point, leading up to that date of the hearing,
4 correct?

5 A. I really don't know what the judge
6 would have based it on. I would be guessing if
7 I did that.

8 Q. Okay.

9 Nurse Burrell, the only contact she
10 had in this case was with the designated
11 examiner, correct?

12 A. Say that again.

13 Q. She was only the designated examiner.
14 She didn't do any intake, she didn't do any
15 treatment, and she didn't do any follow-up with
16 Ms. Argoe after the probate court hearing,
17 correct?

18 A. That's my understanding.

19 Q. Okay. So your opinion about her is
20 solely limited to you think she should have had
21 more details in her report.

22 MR. DODSON: Object to the form.

23 A. Yes, that's her only interaction.

24 Q. (BY MR. COLE) Okay.

25 Your opinion generally says that you

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1 also have criticism of other nurses.

2 A. Correct.

3 Q. Do you have any other nurses in mind,
4 or are you just saying nurses in general?

5 A. Nurses in general.

6 Q. All right. What is your opinion about
7 the nurses in general and what they did wrong?

8 A. My opinion is that this patient was
9 involuntary -- involuntarily committed from June
10 the 6th to July the 20th; and during that period
11 of time, she would have had nursing care 24/7.
12 And at some point in time, I believe that
13 somebody should have said, "Time out here. Does
14 this person still meet the threshold that
15 justifies an involuntary commitment?"

16 The nursing notes in the chart
17 indicate on numerous dates and occasions she has
18 good affect, she's socializing, she has good eye
19 contact, she's interacting with her peers, she's
20 up on the unit. In my opinion, the reason why
21 we have RNs as a part of that care team is
22 because they are the highest level of nurses and
23 they are the only ones that can truly do an
24 assessment. And the RN assessment seems
25 rubber-stamped through this process, all the way

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1 to the end, without anyone actually saying,
2 "Time out. This is still a person that we've
3 taken away their patient rights. Is her
4 behavior still appropriate to justify that
5 level?"

6 Q. And what is the basis for that
7 opinion?

8 A. Well, as a nurse and as overseeing
9 numerous cases in hospitals that I have been
10 responsible for, this is what I consider to be a
11 substandard nursing care.

12 Q. Can you point me to any books, any
13 treatises, any reports, any studies, or anything
14 that you used to base that opinion?

15 A. No, other than my experience in
16 psychiatric facilities for almost 25 years.

17 The other area that I have an issue
18 with is in the nursing care plan. As part of a
19 care plan, you set goals for the patient to
20 achieve and you have nursing interventions that
21 deal with those problems that are identified.

22 My issue with the nursing care plan is
23 that she had -- the patient had numerous
24 interventions listed on their care plan,
25 everything from identifying self-care deficits,

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1 that she would verbalize the importance of
2 medication compliance, that she would have
3 education regarding the side effects of the
4 medication. There's -- there's a page and a
5 half of interventions and goals that were part
6 of the care plan for this patient. All of the
7 goals magically were achieved on the patient's
8 discharge date.

9 Q. So what do you -- I mean, I don't
10 understand that. What are you saying, that she
11 should not have reached those goals before she
12 was discharged?

13 MR. DODSON: Object to the form.

14 A. No. I'm saying that in a working care
15 plan that follows a patient's progress and their
16 goals, it is highly unlikely that after that
17 long of a period of time, she magically achieved
18 everything on her date of discharge.

19 The care plan --

20 Q. (BY MR. COLE) And the basis for this
21 is because you're a nurse who's worked before?

22 MR. DODSON: Objection.

23 A. Because I have worked in psychiatric
24 facilities; I have had numerous surveys from
25 regulatory entities, that look at these things;

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1 and so I'm familiar with the expectation of how
2 it's supposed to work, clinically.

3 Q. (BY MR. COLE) All right. So the
4 nurses --

5 (Technical assistance.)

6 THE WITNESS: Am I frozen?

7 MR. COLE: Well, you're frozen,
8 and Sean, a guy who works in my office, you see
9 in the bottom corner here, is trying to fix it.

10 THE WITNESS: Okay. I see him.

11 MR. COLE: Unless it's too
12 distracting, I was just going to keep going.

13 Q. (BY MR. COLE) All right. So the two
14 things with the nurses is that: generally the
15 nurses should have had better notes and that you
16 think that the care plan should have been not
17 noted in the (inaudible) area.

18 MR. DODSON: Object to form.

19 THE COURT REPORTER: Could you
20 repeat that question, please? We lost you in a
21 part of it.

22 MR. COLE: We did? Okay.

23 Q. (BY MR. COLE) Well, I'm trying to
24 just get you -- as the two opinions with the
25 nurses and so I understand it. And the first

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1 one is that the nurses should have noted a time
2 out in the records. Is that, essentially, what
3 you're saying?

4 MR. DODSON: Object to the form.

5 A. I'm saying that for this whole period
6 of time, the nursing assessment that's
7 documented on a daily basis seems to just review
8 a patient that is not still meeting the level of
9 care that would be required for an involuntary
10 commitment. I feel like the nurses, as their
11 assessment, should have not continued to just
12 document that the patient was pleasant and up
13 and around and interacting and so forth, that at
14 some point someone during this entire long, long
15 involuntary commitment, should have said, "Time
16 out. Does this still make sense, that we're
17 holding her against her will?" Could it have
18 been accomplished in a lower level of care.

19 Q. (BY MR. COLE) And the second part
20 was...?

21 A. The second part is regarding the
22 treatment plan and that all the goals and
23 interventions were documented to have been
24 simultaneously achieved on the date of
25 discharge.

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1 Q. You're not doubting that she reached
2 those goals and then was able to be discharged,
3 are you?

4 A. I don't know that I would know that.

5 Q. As a nurse, how many times have you
6 made the decision and been able to discharge
7 somebody from a care facility?

8 A. Never.

9 Q. Who makes that decision?

10 A. The physician.

11 Q. And the nurses' notes, are those
12 nurses' notes just for the nurses, or are they
13 documented in the file so that the physicians
14 can then use that for their evaluation?

15 A. It's part of the patient record that
16 the physician would have access to.

17 Q. So the nurses are documenting this so
18 that the treatment from the physicians can be, I
19 guess, monitored from that level, correct?

20 A. I'm not sure I understand your
21 question.

22 Q. Well, I mean, it's the -- who is the
23 person that's actually in charge of the
24 patient's care in the facility?

25 A. It's the physician's responsibility,

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1 ultimately, for the patient.

2 Q. Okay. Do you see anything in these
3 records that suggest that the nurses are not
4 documenting information as they were operating
5 in the facility?

6 A. I'm not real sure about what you just
7 asked. Can you repeat it?

8 Q. All right. Well, let me try to
9 clarify it.

10 Do you have any problem with the
11 entries themselves, into the record?

12 A. I don't know if you mean clinically or
13 legally.

14 Q. Well, I mean do you think that any of
15 the entries are incorrect or are --

16 A. I don't have any -- I don't have any
17 reason to believe that they're untrue.

18 Q. Okay. And, again, the nurses are not
19 making any diagnosis, correct?

20 A. They are not making the diagnosis; but
21 as RNs, they have a responsibility in the care
22 and treatment of the patient, and their
23 assessment capability -- which, again, that
24 assessment responsibility lies with the
25 registered nurse. Otherwise, we'd just have

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1 techs taking care of patients.

2 Q. All right. Anything else besides
3 those two things that we've -- we've talked
4 about, that you have -- critical of the nurses
5 at Three Rivers?

6 A. No.

7 Q. And you said that -- the stipulation
8 earlier was you have opinions about the nurses
9 and about Three Rivers. From the testimony we
10 were just talking about, is your testimony about
11 Three Rivers the same, or is there anything
12 different that you would allocate to the
13 Three Rivers facility itself?

14 A. I think Three Rivers, as the employer
15 of these nurses and as the hospital taking care
16 of this patient, has that responsibility to
17 oversee the care that's delivered.

18 MR. PARHAM: Andrew, this is
19 Jim.

20 MR. COLE: Yeah?

21 MR. PARHAM: Can we take a short
22 break? I just got a text message that a judge
23 needs to talk to me. Can we take a five-minute
24 break, please?

25 MR. COLE: We can take a

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1 five-minute break, and I'm going to see if Sean
2 can get Ms. DeBruce moving again, because she's
3 been a statue for a while.

4 (Recess taken from 9:16 a.m.
5 until 9:27 a.m., CST.)

6 Q. (BY MR. COLE) Ms. DeBruce, have you
7 ever testified in a court of law before?

8 A. Yes.

9 Q. Where?

10 A. In Little Rock, Arkansas. It's
11 probably been seven or eight years ago.

12 Q. In what capacity were you giving
13 testimony?

14 A. I was CEO at Pinnacle Pointe Hospital
15 and we had a collective case that had been filed
16 against the State and I testified on behalf of
17 Pinnacle Pointe.

18 Q. What was the general dispute that you
19 were the witness for?

20 A. It was -- it was regarding a managed
21 care company and administration of Medicaid
22 funding.

23 Q. Okay. So that was nothing to do with
24 treatments or anything like that.

25 A. No.

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1 Q. Were you a fact witness for that?

2 A. I don't know if that would be the
3 correct terminology or not.

4 Q. Well, were you qualified as an expert?

5 A. No. It was not as an expert witness.

6 Q. Have you ever been qualified as an
7 expert witness?

8 A. I have not testified in a court of law
9 as an expert witness, no.

10 Q. Have you ever given depositions where
11 you were hired as an expert?

12 A. Not in that role, no.

13 Q. Well, let me clarify that. When you
14 say "not in that role," are you talking about in
15 the role that we were just talking, of the case
16 in Little Rock, or are you talking about as an
17 expert?

18 A. As an expert. I have given numerous
19 depositions before.

20 Q. How many cases have you given
21 depositions in?

22 A. I'm going to guess six to eight.

23 Q. And were all of those as, basically, a
24 management of a company giving testimony on
25 behalf of the company?

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1 A. I believe so.

2 Q. So you have not given any testimony
3 sitting as somebody opining about treatment or
4 treatment and care, have you?

5 A. Not as an expert witness, no.

6 Q. All right. Let's go through the notes
7 that are in the documents that you've got; and
8 before we do that, let me ask this question.

9 We had a discussion off the record
10 before this, where apparently some of the
11 supplemental handwritten notes on some of the
12 records were done by somebody other than you.
13 Is that correct?

14 A. Correct.

15 Q. Do you have any notes and highlights
16 that you personally did in these records?

17 A. Yes. I have highlights.

18 Q. Did you do any handwritten personal
19 notes yourself?

20 A. I think there was only one place where
21 I said -- yes. I have one notation that I did
22 myself. Everything else, I did not write.

23 Q. Do you know who wrote those other
24 notes that don't appear to be part of the
25 original record?

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1 A. I don't know. I know that this
2 notebook came to me intact, and that's what I
3 have.

4 Q. Okay. So those not-your-handwriting
5 of the supplemental notes that are on some of
6 the records that you have come to you when you
7 got that notebook.

8 A. Correct.

9 Q. Okay. And you don't know if that was
10 anyone else that was either retained by
11 plaintiff's counsel or plaintiff's counsel or
12 anybody else put those on there.

13 A. I would have no idea.

14 Q. Do those notes, by whoever this other
15 person or persons were, do those have anything
16 to influence your opinions in this case?

17 A. No.

18 Q. Okay.

19 So we were talking off the record
20 about a note that was added on the bottom of the
21 first page of the report for the designated
22 examiner.

23 A. Yes.

24 Q. And the note as read--I'll just
25 summarize--basically said it was a comment on

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1 what somebody interpreted the text above was.

2 Is that a fair summary?

3 MR. DODSON: Object to the form.

4 A. I -- it's a comment. I don't know how
5 they meant it.

6 Q. (BY MR. COLE) Okay. And that comment
7 on there has nothing to do with -- or does not
8 influence your opinions in this case.

9 A. Oh. Absolutely not.

10 Q. So based on that answer, I think -- I
11 want to just talk about whatever highlights you
12 personally did in the record --

13 A. Okay.

14 Q. -- and whatever notes you personally
15 did in the record and know where you did that
16 and the reason why you wanted to either make
17 that note or make those highlights.

18 A. Okay.

19 Q. So, obviously, I don't have a copy of
20 that in front of me; so could you just direct me
21 to where you are in your first note, and we'll
22 go through it that way?

23 A. Okay. Starting at the first, I
24 highlighted a Three Rivers policy that is
25 TX.038.

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1 Q. All right. Hold on, let me find that.
2 All right. So which one was that?

3 A. It's called "Medications: Patient
4 Refusal, Clinical Services," TX.038.

5 Q. All right. And what did you highlight
6 on this?

7 A. The policy statement at the top where
8 it states "...the policy of Three Rivers...that
9 psychoactive medications will not be
10 administered to patients admitted to this
11 hospital under the voluntary or involuntary
12 status without informed consent, except in
13 emergency situations as defined below." And
14 then I highlighted the four situations.

15 Q. Okay. The four, 1, 2, 3, 4,
16 underneath that?

17 A. Yes.

18 Q. Okay. Anything else in that document?

19 A. Yes. On the second page of that same
20 document, number 3 (as read): "Physician
21 issues --"

22 Q. Okay.

23 A. "Physician issues an order to
24 administer psychoactive medication without
25 patient's consent." And A, underneath that,

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1 where it says, "The physician shall document in
2 the patient's clinical record, specific medical
3 or behavioral terms, the necessity of the
4 order," et cetera.

5 Q. Okay.

6 A. Number 4 (as read): "When
7 administering medications ordered by the
8 physician, the nurse shall."

9 Q. Okay.

10 A. And number C (as read): "Document in
11 the patient's clinical record the justification
12 for the administering of the medication,
13 including the assessment of the emergency
14 situation."

15 Q. Okay.

16 So you highlighted the policy at the
17 first and then parts of 3 and parts of 4.

18 A. Correct.

19 Q. Okay. Why did you choose to highlight
20 those particular sections?

21 A. I was reviewing to see if -- if --
22 what their policy was regarding psychoactive
23 medications and what the nurse's role was with
24 that; so I was looking at their documentation in
25 the clinical record, for that, which I don't

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1 have any issue with.

2 Q. Okay. So you highlighted it, but you
3 don't have any issue with the documentation --

4 A. Correct.

5 Q. -- according to policy?

6 A. Correct.

7 Q. Okay.

8 All right. Anything else with this
9 policy?

10 A. No.

11 Q. All right. What's the next thing that
12 you highlighted?

13 A. The report of the designated examiner,
14 Nurse Burrell, I just highlighted what she
15 wrote.

16 Q. When you say "what she wrote," that's
17 the paragraph on the first page?

18 A. Yes. It's page 1.

19 Q. Okay. Starting with "Patient" and
20 ending with "diagnosis"?

21 A. Correct.

22 Q. Okay.

23 Anything about that other than what we
24 spoke about earlier this morning?

25 A. No.

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1 Q. All right, so nothing else to add from
2 what we talked about this morning, from that
3 highlighting.

4 A. No.

5 Q. Okay. What's the next one you did?

6 A. I marked but I didn't highlight the
7 "COMPREHENSIVE ASSESSMENT TOOL."

8 Q. All right. Can you hold that one up
9 for me so I can see it? I think my records
10 might be in a different order than yours.

11 A. (Complies.)

12 Q. Okay.

13 Why did you mark that particular
14 document?

15 A. My observation was on the second page
16 of that. This is the "NEEDS ASSESSMENT"; I
17 guess you would call it the intake document.

18 Halfway down that second page it lists
19 "PSYCHOSIS," and there's some documentation
20 about that. And under "HALLUCINATIONS," on the
21 right side, it is written "Referral source
22 states patient sees witches and warlocks." And
23 on the page before that, page 1, it states that
24 the referral source is UBH Managed Care.

25 I was just noting that it was

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1 incongruent.

2 Q. What do you mean "incongruent"?

3 A. Well, I doubt if UBH was the one who
4 actually stated that the patient sees witches
5 and warlocks.

6 Q. Who do you understand is UBH? Is that
7 the Aurora Pavilion?

8 A. No. It's the payor, United Behavioral
9 Health.

10 Q. The insurance company?

11 A. Yes.

12 Q. Oh.

13 A. That's why I doubt if they are the
14 ones that said that.

15 Q. Okay. So you doubt that there was
16 somewhere that somebody provided the information
17 to whoever took down this information that it
18 was reported that Ms. Argoe was seeing witches
19 and warlocks?

20 A. It is noted that that was a
21 third-party observation, in various places.

22 Q. Okay. So other than you questioned
23 whether or not the insurance company was
24 providing that information, do you have anything
25 else about that particular notation?

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1 A. No.

2 Q. Okay.

3 What does that notation -- or how does
4 that notation fit within your opinions in this
5 case?

6 A. It's just an observation that --
7 ideally, everyone should be on the same page and
8 garnering the same information accurately, and
9 this is obviously a case where that did not
10 occur.

11 Q. What is your understanding that the
12 comprehensive assessment tools attempted to
13 provide?

14 A. It is the front-end assessment and
15 intake, if you will, of all the components that
16 have led to and contribute to the reason for
17 that person to need the level of care that they
18 receive.

19 Q. Is this a document that you have seen
20 in your practice and management?

21 A. Hundreds of times.

22 Q. And do you have any problem with the
23 document itself?

24 A. No.

25 Q. Okay. And do you have any problem

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1 with noting on the document that a third party
2 has reported that there were incidents where Ms.
3 Argoe was, apparently, seeing witches and
4 warlocks?

5 A. I have a problem that I think it's
6 inaccurate, and that the intake document should
7 be accurate in order for all the information to
8 roll forward correctly.

9 Q. Well, how do you know that that's
10 inaccurate?

11 A. I don't. It could be that UBH did say
12 that.

13 Q. Okay. So that's just a question that
14 you can't say, sitting here today, whether or
15 not it is or isn't inaccurate.

16 A. I can just say that it's highly
17 unlikely, but I can't say that it did not.

18 Q. Okay.

19 What would be the next highlight or
20 notation?

21 A. This is the -- there are numerous
22 pages that, basically, are -- yeah, page 3 of
23 the monitor patient chart.

24 MR. PARHAM: Andrew, this is
25 Jim.

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1 MR. COLE: Yeah?

2 MR. PARHAM: What Bates stamp do
3 you have on your copies?

4 MR. COLE: Well, the one I'm
5 looking at are the ones I supplied to the
6 Three Rivers-Burrell Bates numbers; but if we
7 don't need that one, I've also got -- I've got a
8 set that has the Bates numbers from Davidson's
9 office.

10 MR. PARHAM: Yeah, I -- well, if
11 you go to that one, it's 7456-N-092.

12 THE WITNESS: Okay.

13 MR. COLE: N dash what?

14 MR. PARHAM: 092.

15 MR. COLE: Oh, 92, okay. Okay,
16 that makes it a lot easier.

17 MR. PARHAM: Yeah. She'll be in
18 this computer section from now on, so we can
19 follow that way.

20 THE WITNESS: Yeah.

21 MR. COLE: Okay, good.

22 THE WITNESS: And I think
23 they're all in numerical order.

24 Q. (BY MR. COLE) All right. So you said
25 page 3, and this is the document -- and just for

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1 the record, since we have the Bates numbers,
2 this series starts with the Bates number, if you
3 go back a couple of pages, 7456-N-090, is where
4 these computer monitor charts start, correct?

5 A. Yes.

6 Q. Okay. And you're on page 3. That
7 gets us to the end page, number 92.

8 A. And it does say page 3 at the top,
9 right-hand corner.

10 Q. Yeah, okay.

11 All right. What are we -- what are
12 you looking at and what did you highlight on
13 this page, so we can talk about it?

14 A. Under the section that starts on the
15 left-hand side with "Assessments," about
16 two-thirds to three-fourths of the way down
17 there, it says, "Anticipated outcomes, treatment
18 and interventions."

19 Q. Okay.

20 A. And then in capital letters (as read):
21 "PATIENT WILL BE SAFELY STABILIZED ON
22 MEDICATION. ATTEND GROUPS, GAIN INSIGHT INTO
23 ISSUES AND COPING SKILLS FOR STRESS. UPON
24 PATIENT" -- "UPON DISCHARGE PATIENT WILL DENY
25 SUICIDAL AND HOMICIDAL IDEATION AND BE SAFELY

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1 DISCHARGED HOME."

2 Q. Okay. Anything else on that page?

3 A. Not that I did.

4 Q. Okay. Were there notes from somebody
5 else on that page, as well?

6 A. Yes, at the top.

7 Q. And those notes, similar to before,
8 you don't know who made whatever handwritten
9 notes are on that page?

10 A. No.

11 Q. And did those handwritten notes on
12 that page, do those -- or do you base your
13 opinion, in any part, on anything that those
14 handwritten notes say?

15 A. No. It didn't say anything --

16 Q. Okay, we can ignore the handwritten
17 notes as if they're not there?

18 A. Right.

19 Q. Okay.

20 All right. So you highlighted that
21 anticipated outcome, and what was the purpose of
22 that?

23 A. My concern is that -- that part of her
24 goal is that she'll deny any suicidal or
25 homicidal ideation. She always denied suicidal

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1 or homicidal ideation, and it was clearly
2 documented consistently through the record. She
3 was never suicidal or homicidal throughout this
4 entire period of time. It seems odd that that
5 would be a goal for her to achieve.

6 Q. Well, if she consistently denies it,
7 how could she not achieve that goal?

8 A. Then why put it as a goal?

9 Q. Anything else with that treatment
10 plan --

11 A. Not on that -- not on that page.

12 Q. Okay.

13 Do you know where the source of that
14 treatment plan or anticipated outcome came from?

15 A. I don't know who documented that.

16 Q. Do you know if that came from the
17 nurse or a nurse or from a doctor?

18 A. I don't know that. Right underneath
19 that, it goes on and says "Comprehensive
20 Assessment Tool Nursing"; but with -- with this
21 printout, I don't know -- if there's somebody's
22 initials on it, I wouldn't know who that was.

23 Q. Okay. So you don't know what the
24 source of that treatment plan that we just
25 talked about, that you highlighted, came from.

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1 A. I don't.

2 Q. Okay. And your criticism is that if
3 she's not claiming suicidal or homicidal
4 thoughts, having a goal to have her not claim
5 suicidal and homicidal thoughts is not a real
6 goal.

7 A. Correct.

8 Q. Okay. Anything else with that?

9 A. No.

10 Q. All right. What's the next page that
11 we should look at?

12 A. The next page is page 4.

13 Q. Okay. Get some of the stuff out of my
14 way here.

15 Okay, we're on page 4 now.

16 A. Okay. And this is just spots that I
17 underlined, and I referenced it earlier in this
18 deposition. Under the section entitled "Care
19 Plans" --

20 Q. Okay.

21 A. -- it lists the problem. And then
22 underneath that, "Outcome," "Intervention." And
23 you go on to the right-hand side of the page,
24 other goals, outcomes, interventions. And you
25 can see that all the way through the entire

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1 page.

2 Q. All right. So you, basically,
3 highlighted the care plan for those two
4 sections?

5 A. I highlighted -- or I underlined where
6 it notes on each one of those (as read):
7 "ACHIEVED-Bobbie Norris, RN, 7/20."

8 Q. Okay.

9 A. And -- I mean, there's numerous times.
10 I can count them if you want. But, basically,
11 this goes to my point originally, which said
12 it's odd that out of this treatment plan, all
13 her goals and interventions, everything, was
14 achieved on the date of discharge.

15 Q. Now, can you sit here and tell me that
16 all of those were definitively only achieved on
17 the date of discharge, or they were just
18 documented that they were achieved on the date
19 of discharge?

20 A. You wouldn't have -- if it was doc --
21 if it was achieved earlier, it would have been
22 noted as such.

23 Q. So this page on page 4, that goes to
24 your opinion earlier that they should have shown
25 achievements periodically, not just at the last

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1 day.

2 A. Yes.

3 Q. The phone didn't pick that up. Did
4 you say yes?

5 A. I said yes. I'm sorry.

6 Q. Okay.

7 Do you have any criticisms of Bobbie
8 Norris, RN, who is the one filling in these
9 notes?

10 A. I don't know anything other than her
11 documentation of this.

12 Q. So your opinion and criticism is a
13 general criticism, not a specific criticism
14 about Ms. Bobbie Norris.

15 A. Correct. I don't know if -- I don't
16 know when she dropped into this picture.

17 Q. And you don't know what capacity
18 Bobbie Norris is involved in this case.

19 A. Other than she was a registered nurse
20 and obviously involved with the care plan for
21 this patient, no.

22 Q. And do you have any opinion about
23 whether or not these spots that are marked as
24 being achieved were, in fact, at least achieved
25 at that point in her treatment?

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1 A. I -- I wouldn't know that.

2 Q. Okay. You don't have an opinion on
3 that?

4 A. No.

5 Q. And you don't have an opinion on when
6 in the course of Ms. Argoe's treatment she
7 achieved any of these benchmarks, correct?

8 A. I would not know that. I just think
9 that, in my opinion, it's unlikely that all
10 these were achieved simultaneously.

11 In a true working care plan, it is --
12 it is reflective and ongoing and updated and
13 changed all through a patient's stay; and since
14 this patient stayed for so long, it's odd that
15 they all were achieved on that date.

16 Q. Do you have an opinion as to what the
17 standard of care, when a patient should mark
18 improvement on their treatment plan?

19 MR. DODSON: Object to the form.

20 A. A patient -- if they're not achieving
21 their goal, the goal needs to be restated,
22 rewritten, and updated, so that it can be
23 achievable and realistic for that patient.

24 Q. (BY MR. COLE) So if they can't make a
25 touchdown, you move the goal post?

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1 A. Yes.

2 MR. DODSON: Object to the form.

3 Q. (BY MR. COLE) Anything else on these
4 two pages that you have comments or opinions or
5 highlights on?

6 A. Not on those.

7 The same thing continues on page 5,
8 again the same thing at the top; and I've just
9 highlighted "ACHIEVED," where she's noted
10 interventions there.

11 Q. Okay. So other than more entries
12 showing the achievement, no new testimony about
13 that?

14 A. No.

15 Q. Okay. Anything else on page 5?

16 A. Yes.

17 Q. Okay.

18 A. Probably three-fourths of the way down
19 there, the date is 7/19; the time is 9:27. It
20 states (as read): "OUT OF CONTACT WITH REALITY:
21 SENSORY/PERCEPTUAL" -- "PERCEPTUAL ALTERATION";
22 and underneath that it says, "TREATMENT TEAM:
23 SW," which would be social worker, "WAITING FOR
24 CALL BACK TO ARRANGE FAMILY SESSION. POSSIBLE
25 PLACEMENT IN AN ASSISTED LIVING FACILITY.

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1 FAMILY NEEDS TO GET POA IN PLACE. WILL
2 DISCHARGE AFTER EVERYTHING IS IN ORDER."

3 Q. All right. Why did you highlight that
4 note?

5 A. It just seemed to indicate that the
6 discharge plan was still pretty fluid at that
7 point. I don't know that -- they had talked
8 about a POA at this juncture, they had talked
9 off and on about assisted living facility; but
10 the social worker indicates that discharge would
11 happen after everything is in order, and then
12 the next morning, she goes home.

13 Q. Okay. So what is your criticism,
14 then?

15 A. My criticism is that it appears as if
16 the treatment team isn't operating cohesively,
17 with the same set of information. If the plan
18 the day before discharge was for her to go to an
19 assisted living facility and that the family had
20 to get a power of attorney in place and then
21 suddenly neither one of those things happen and
22 she's discharged the next morning, it seems odd.

23 Q. Okay. Other than seeming odd, do you
24 have any opinion about that?

25 A. It indicates that the treatment team

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1 is not functioning cohesively.

2 Q. So is your opinion that Ms. Argoe
3 should have stayed in the facility at that
4 point?

5 A. I don't have an opinion about that.
6 That would be a physician's decision.

7 Q. Okay. And can you sit here and say
8 whether or not either the issues dealing with
9 the POA and the facility that they might have
10 let Ms. Argoe go to, with assisted living,
11 whether or not that was resolved for her to
12 either go to that or resolved that she didn't
13 need that and, therefore, they just went forward
14 with the discharge?

15 A. It indicates that she went home.

16 Q. Okay. So it appears that that got
17 resolved at some point.

18 A. It appears that way.

19 Q. Okay. Anything else on that page?

20 A. Nope.

21 Q. All right. What's the next page?

22 A. Six.

23 Q. All right.

24 A. On page 6, on the left-hand side --
25 and all these that I've highlighted are under a

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1 section that's named "RN ASSESSMENT," so it'd be
2 "RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND
3 MEDICATION EFFECT," which is --

4 Q. Okay.

5 A. -- I believe, to be the RN assessment.
6 And so there are, one, two, three, four, five of
7 those that I've highlighted, but they're all
8 indicated as "RN ASSESSMENT."

9 Q. We're on page 6?

10 A. Yes.

11 Q. Okay. So which did you highlight,
12 then?

13 A. Under 7/16 at 9:43, "RN ASSESSMENT,"
14 (as read): "APPROPRIATE AFFECT, OBSERVED
15 SOCIALIZING WITH PEERS, GOOD EYE CONTACT,
16 NURSING CONSULTATION, GROUP SUPPORT
17 ENCOURAGEMENT, REPORTS" -- do you see where I
18 am?

19 Q. Yes, I do. You're at the bottom of
20 the page.

21 A. Yes.

22 Q. Okay.

23 A. (As read): "ATTENDING GROUPS, REPORTS
24 FEELING SLUGGISH WHEN TAKING HER MEDICATIONS,
25 CONTINUE TO ENCOURAGE PATIENT TO CONTINUE

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1 WORKING ON HER CARE PLAN, GOALS AND GOALS THAT
2 SHE SETS IN GROUPS," so forth.

3 Q. Okay.

4 A. And then the next --

5 Q. Anything else on that page? We'll
6 just go through that, and then I'll ask you
7 questions about it.

8 A. On the same page, 21:48 (as read):
9 "PATIENT UP ON UNIT, PLEASANT AFFECT, QUIET
10 MOOD, INTERACTS WITH PEERS." Basically that
11 whole entry there.

12 Q. Okay.

13 A. And then at 7/14 -- see, this is going
14 backwards in time because that's the way the
15 printout happens.

16 Q. Right.

17 A. So 7/14 at 22:26--this is the RN
18 assessment--(as read): "UP ON THE UNIT WITH
19 PLEASANT MOOD AND AFFECT, INTERACTING WELL WITH
20 PEERS, SLIGHTLY DROWSY BUT PLEASANT,
21 COOPERATIVE, MINIMIZING HER PROBLEMS, ATTENDS
22 ALL GROUPS AND ACTIVITIES."

23 And then the last one I highlighted is
24 at 21:01, again (as read): "RN ASSESSMENT,"
25 "PATIENT UP ON UNIT WITH BRIGHT, FRIENDLY

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1 AFFECT, INTERACTING WITH PEERS, ONE ON ONE TO
2 ASSESS, LAUGHING AND JOKING, RESPONSES REMAIN
3 THE SAME, BLAMING HUSBAND FOR ADMISSION, APPEARS
4 DROWSY, ATTENDS GROUPS AND ACTIVITIES AND IS
5 COMPLIANT WITH MEDICATIONS."

6 Q. Okay.

7 A. Those are all my highlights on that
8 page.

9 Q. Okay. Why did you highlight those
10 entries?

11 A. My point being: here we have the 13th,
12 the 14th, the 15th, and the 16th, and, again, no
13 one -- everyone is documenting to the fact that
14 this person is pleasant, interacting, that her
15 medications make her slightly drowsy. There's
16 nothing in those RN assessments, those RN daily
17 assessments, to indicate that it would justify
18 an involuntary-commitment patient. My opinion
19 is that they should have done some time-out to
20 say -- even if it's just one more day that a
21 patient is involuntarily committed, I think it's
22 important that, as we review this and take away
23 a patient's rights, that we continually document
24 and ensure that they are still appropriate for
25 that level of care. And from what this

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1 documentation indicates from the nurses, I don't
2 see that as being appropriate for an involuntary
3 commitment. I think that the nurses, in their
4 role and responsibility, should have relayed
5 that information so that the treatment team
6 could incorporate that.

7 Q. What is your basis to say what is and
8 is not proper for an involuntary commitment?

9 A. Well, judging from the information in
10 the commitment here and the 25 years of
11 experience that I have, we should not take away
12 patient rights and involuntarily commit people
13 that are pleasant, affecting, interacting. It
14 just doesn't fit.

15 Q. Do you know what some of the diagnoses
16 from the doctors of Ms. Argoe were?

17 A. Yes.

18 Q. Okay. And what were those?

19 A. That she was manic and that she had a
20 psychosis.

21 Q. And manic behavior has characteristics
22 of highs and lows, correct?

23 A. Yes.

24 Q. Okay. So a patient who has manic
25 propensities could have days that are very bad

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1 and days that are very good, right?

2 A. Sure.

3 Q. Okay. And if the patient is in the
4 high, you might describe them as being happy and
5 laughing and things like that, correct?

6 A. True.

7 Q. Okay. And then something could affect
8 them and they could be complete opposite of
9 that, correct?

10 A. True.

11 Q. Okay. So if you have somebody that's
12 diagnosed with manic problems, one day or two
13 days where they seem to be high, does that
14 indicate that they're cured?

15 A. That's probably a physician question
16 and not a nursing question.

17 Q. Okay.

18 A. My fault to this is that, based upon
19 the nursing assessment, that this person is
20 interacting and functioning at a level that does
21 not seem to require involuntary hospitalization
22 and that they have a responsibility to relay
23 that information and, basically, say time out in
24 this whole process.

25 Q. Well, didn't the nurses that put in

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1 these assessment notes relay that information by
2 putting it down into the chart?

3 A. I don't know who read the chart.

4 Q. Well, we've got the -- look at the
5 7/13 one that you have: VLG performed the RN
6 assessment for mood, mental status, and
7 medication affect.

8 A. Uh-huh.

9 Q. So whoever VLG is, she performed that
10 and then she wrote up here's-what-my-
11 observations-were, correct?

12 A. Yes.

13 MR. DODSON: Object to the form.

14 Q. (BY MR. COLE) And so that then went
15 into Ms. Argoe's chart and, obviously, this part
16 of the chart was in the computer, correct?

17 MR. DODSON: Object to the form.

18 A. Yes.

19 Q. (BY MR. COLE) Okay. Sitting here
20 today, do you have any reason to believe that if
21 somebody came up on July 14th, 2005, that they
22 would not have been able to pull up the chart
23 and see the note that was put in by VLG the day
24 before?

25 A. I really don't know how their charting

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1 operates. It's obviously an electronic medical
2 record. I can't speak to who would or would not
3 have access to it.

4 Q. Okay. And I know you can't tell me
5 how it worked, but you also can't tell me that
6 this information isn't available for whoever
7 comes in to continue the treatment for Ms.
8 Argoe.

9 A. I can't tell you that, correct.

10 Q. Okay. And I think you already said
11 before that you don't have any reason to believe
12 that, for the example we had here, when VLG came
13 in, that those are the actual observations that
14 she made, correct?

15 MR. DODSON: Object to the form.

16 A. I don't disagree with that that was
17 accurate. My point is: if it is accurate, it
18 doesn't rise to the threshold to continue
19 involuntary commitment.

20 Q. (BY MR. COLE) Now, are you telling me
21 that you would have expected that VLG should
22 have added to that note "In my opinion, I think
23 that Ms. Argoe should be discharged"?

24 A. I'm saying that -- well, I don't even
25 know who VLG is, so I can't -- I'm assuming

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1 they're an RN.

2 Q. Yes, well, we're going by the same
3 initials that we have here.

4 A. Right.

5 So if they are an RN, my expectation
6 would be that they are going to say, "Due to the
7 fact that patient is still interacting very
8 well, has pleasant affect, quiet, interacting
9 well," on and on, "will refer to treatment team,
10 to reevaluate." Somebody need --

11 Q. Okay. In your opinion --

12 MR. DODSON: Hold on.

13 Ms. DeBruce, did you finish your
14 last answer?

15 THE WITNESS: Yes -- well, I was
16 going to say: somebody--and I believe the RN has
17 a role in that--needs to say, "Time out. This
18 is not the picture of a patient that needs
19 involuntary commitment."

20 Q. (BY MR. COLE) Now, the RN that's
21 making this assessment, she can't say -- or give
22 any opinions as to what the diagnosis should be,
23 correct?

24 A. Correct.

25 Q. And her job is to follow the orders

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1 from the doctors that are in charge of the care
2 and treatment, correct?

3 A. Correct.

4 Q. And her job, or the nurses' jobs, are
5 also to -- or to write down what they see and
6 put it into the chart so that people can then
7 look at the chart later on and make those
8 further evaluations, correct?

9 A. Correct. But it's also their role and
10 responsibility to ensure that their assessment
11 information, which evidently indicates the
12 patient is, like I said, up and about, pleasant,
13 so forth, they need to, basically, do a time-out
14 and refer that back to the treatment team, to
15 say, "Does this patient still need an
16 involuntary level of hospitalization?"

17 Q. And where anywhere in these records
18 can you point to me to say that there was not a
19 referral to the treatment team to say, "Hey,
20 this is the way she is presenting right now.
21 Look at her again"?

22 MR. DODSON: Object --

23 A. I don't -- I don't know that. All I
24 can do is go off of the documentation, which
25 does not indicate that occurred.

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1 Q. (BY MR. COLE) Okay.

2 THE COURT REPORTER: One moment,
3 please. One moment, please. I'd just ask the
4 witness to just wait one second before answering
5 because I believe when someone says objection,
6 it cuts them off --

7 THE WITNESS: I'm sorry.

8 THE COURT REPORTER: -- when you
9 come right in after his question.

10 Okay, proceed.

11 Q. (BY MR. COLE) And the notes we're
12 looking at now are as they're leading up to the
13 eventual discharge of Ms. Argoe from the
14 facility, correct?

15 A. These are the dates that line up about
16 seven days before her discharge.

17 Q. And we would hope, at least, that Ms.
18 Argoe has shown improvement and is showing that
19 she is ripe for discharge at the point that she
20 actually is released from the facility.

21 MR. DODSON: Object to the form.

22 A. I'm not sure what you're asking me.

23 Q. (BY MR. COLE) Let me try to clarify
24 that.

25 We would hope that the documentation,

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1 as it shows here, shows that she has reached a
2 level where what you were saying, she does not
3 have the symptomology that would justify keeping
4 her there, that she would show that she doesn't
5 have that symptomology as she's being
6 discharged.

7 MR. DODSON: Object to the form.

8 A. Yes, we would not want her to have
9 anything that was not appropriate for her
10 discharge. My concern is that an independent RN
11 assessment on an everyday, every-24-hour basis,
12 as this is documented, someone should have
13 stepped back and said, "We are still withholding
14 this person's rights. This doesn't fit. Let's
15 talk about it and see what else needs to be
16 done."

17 Q. (BY MR. COLE) And here's -- here's
18 the problem I have, is you keep giving me this
19 somebody-should-have-done-this, and I don't know
20 who you think that person is. I mean, generally
21 you said, I think, the nurses should have said
22 something; but who is it that you think should
23 have been that person to say, "Hey, stop. Let's
24 reassess"?

25 A. I think any nurse that gave a written

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1 RN assessment during this period of time had the
2 right and the responsibility, if this is what
3 they're documenting, to ask for the treatment
4 team to revisit the level of care that this
5 person is receiving.

6 We always, in any psychiatric
7 facility, have a responsibility to treat the
8 patient at the least level of care possible.

9 Q. And your opinion is: because you don't
10 see a note from one of the nurses in here that
11 they actually referred back to the treatment
12 team, that you are assuming that there was no
13 actual referral as you just discussed?

14 MR. DODSON: Object to the form.

15 A. All I can go off of is what's
16 documented.

17 Q. (BY MR. COLE) Okay. And you don't
18 know if there was a discussion from any of the
19 nurses to anyone on the treatment team, to say,
20 "Hey, let's reevaluate Ms. Argoe."

21 MR. DODSON: Object to the form.

22 A. I don't know that because it's not
23 documented.

24 Q. (BY MR. COLE) With this testimony, do
25 you have any specific nurses that you say would

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1 be responsible for this?

2 A. As I said, any RN that documented this
3 independent RN assessment on a daily basis is
4 who I would have an issue with; but I don't know
5 them personally, to know what their names are.

6 Q. Okay.

7 And if Nurse Burrell was not involved
8 in Ms. Argoe's actual treatment after the --
9 well, she wasn't involved in her treatment and
10 she was not participating in any of the care for
11 Ms. Argoe after the judicial hearing, she would
12 not be one of those nurses that you were just
13 talking about, correct?

14 MR. DODSON: Object to the form.

15 A. Correct. My only issue with Nurse
16 Burrell is what we've already covered.

17 Q. (BY MR. COLE) Okay.

18 Anything else on these two pages,
19 Bates -- that are two sides on page 6?

20 A. No.

21 Q. You blanked out. Was that a no?

22 A. It was a no.

23 Q. All right.

24 What's the next section we need to
25 talk about?

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1 A. On page 7.

2 Q. Okay.

3 A. Again, I have a couple of highlights
4 there. Starting at the top, it says, "DURING
5 GOAL'S GROUP WHEN ASKED ABOUT SWEEPING NEGATIVE
6 THINGS OUT OF HER LIFE SHE STATED AN ABUSIVE
7 HUSBAND."

8 Q. Okay. Anything else on those pages?

9 A. Yes. Beneath that, on 7/9 at 19:52,
10 the RN assessment for mood, mental status, and
11 medication (as read): "MARTHA'S BEEN INTERACTING
12 WITH HER PEERS. SHE'S PLEASANT AND COOPERATIVE.
13 STILL IN DENIAL REGARDING HER ILLNESS. BLAMES
14 EVERYTHING ON HUSBAND. 1:1 INTERACTION TO
15 ASSESS MOOD, AND MEDICATIONS AS ORDERED.
16 ATTENDING GROUPS AND ACTIVITIES. CONTINUE TO
17 MONITOR."

18 Q. All right. Anything else?

19 A. At the bottom, the date is 7/6, 22:35,
20 RN assessment (as read): "UP ON UNIT WITH CALM
21 PLEASANT MOOD AND AFFECT. HUSBAND AND SON
22 VISITED, WITH PATIENT REFUSING TO TALK WITH
23 HUSBAND. ONE TO ONE ASSESSMENT. PATIENT STATES
24 HUSBAND HAS EVERYONE FOOLED, THAT HE IS ABUSIVE
25 AND SHE WILL DIVORCE HIM WHEN RELEASED. ALL

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1 SAID WITH A CALM SMILE."

2 Q. All right. Anything else?

3 A. On the right side, 7/04/05 at 12:40
4 (as read): "MARTHA HAS" -- this is RN assessment
5 again. (As read): "MARTHA'S ATTENDING GROUPS
6 TODAY, IS MEDICATION COMPLIANT, ONE ON ONE
7 ASSESSMENT, ALERT AND ORIENTED TIMES THREE,
8 STATES SHE'S FEELING OKAY TODAY, AFFECT BRIGHT,
9 INTERACTING WELL WITH SELECT PEERS, SPENDING
10 MOST OF HER TIME IN DAY AREA, ENCOURAGED TO
11 PARTICIPATE IN GROUPS, CURRENT" -- "CONTINUE
12 CURRENT TREATMENT PLAN."

13 Q. Anything else on those pages?

14 A. No. It has a written note on there.

15 Q. Okay. And that written note, is that
16 by you?

17 A. No.

18 Q. And does that written note have any
19 impact on your opinions in this case?

20 A. No.

21 Q. The written note, which one of those
22 that you have highlighted does it reference?

23 A. It doesn't. It references some other
24 area of the page.

25 Q. Okay. But you didn't take that

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1 written -- handwriting into account.

2 A. No.

3 Q. Okay. So we can disregard that
4 handwriting on the page.

5 A. Correct.

6 Q. Okay. So what is your position on
7 the, I guess, four locations that we just talked
8 about that you highlighted?

9 A. Again, as a continuation of the RN
10 assessment issue that I have.

11 Q. So what -- because we have different
12 language in these notations than we had on the
13 ones we were looking at before. What is
14 significant about these?

15 A. My issue is just that it continues to
16 say she's interacting well, she's pleasant,
17 cooperative, that she is alert and oriented
18 times three, she's feeling okay. Again, it
19 speaks to the fact that now we're going back as
20 far as 7/4. Still she was seen -- her
21 documenta -- the documentation seems to indicate
22 that this is not a person that merits the level
23 of care needed for an involuntary continued
24 hospitalization, that the RN had a
25 responsibility through this period of time to

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1 say, "Due to this observation, we'll refer to
2 the treatment team for further evaluation
3 and" -- same thing that, basically, I've already
4 stated.

5 Q. Do you have an opinion as to how many
6 days somebody should remain in an involuntary
7 commitment after a valid court order is issued
8 by the probate court and says that the patient
9 needs treatment and needs to follow up after
10 that with a year of outpatient treatment?

11 MR. DODSON: Object to the form.

12 A. I don't have an opinion about that.
13 It would be individualized.

14 Q. (BY MR. COLE) And you can't give me a
15 date that if you're involuntarily committed, you
16 should get out in two days or two weeks or two
17 years, right?

18 A. No, I can't.

19 Q. And that's because it depends on each
20 individual patient.

21 A. Correct.

22 Q. Okay.

23 Anything else on these two pages?

24 A. No.

25 Q. All right. Next section that you

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1 might have highlighted.

2 A. Page 9.

3 Q. Okay.

4 A. On the left-hand side, 6/27/05, 14:48,
5 RN assessment (as read): "OBSERVED IN DAYAREA
6 INTERACTING WITH PEERS. ONE TO ONE ASSESSMENT.
7 PLEASANT AND COOPERATIVE. STATES HER SPOUSE
8 VISITED THIS WEEKEND ON SUNDAY AND SHE RAN HIM
9 OUT OF HERE. ALSO STATES HER SON VISITED AND
10 PATIENT FEELS HE'S ALLOWING THE FATHER TO GET
11 THINGS HE SHOULDN'T. SHE BECAME AGITATED. SHE
12 ALSO STATES MARRIAGE IS OVER. SHE'S MADE A
13 DECISION THAT GOD GAVE HER PERMISSION FOR A
14 DIVORCE. SHE'S PLEASANT, VERY MATTER OF FACT.
15 SHE STATES IT'S PRETTY MUCH STRESS FREE AT
16 PRESENT BECAUSE SHE'S NOT HAVING TO DEAL WITH
17 BILLS. SHE ALSO STATES THAT HER FAMILY PUT HER
18 HERE BECAUSE SHE WAS SHOPPING AND GOING OUT TO
19 EAT ALOT, OUT OF CHARACTER FOR HER; SHE'D JUST
20 BEGUN TO LIVE. SHE ATTENDS GROUPS AND MEALS
21 AS" -- as is? Oh, "SHE ATTENDS GROUPS AND MEALS
22 AND IS MEDICATION COMPLIANT. SHE'S AWARE OF
23 MEDICATIONS TAKEN AND ASKS PATIENT-PERTINENT
24 QUESTIONS. DENIES SUICIDAL IDEATION, HOMICIDAL
25 IDEATION. FOLLOWS TREATMENT PLAN."

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1 Q. All right. Anything else on those
2 pages?

3 A. No.

4 Q. All right, so just that one note
5 highlighted?

6 A. Yes.

7 Q. All right. And why is that note
8 highlighted?

9 A. Again, RN assessment speaks to a
10 patient that does seem to have some
11 understanding, is speaking coherently, is
12 pleasant and cooperative. We don't
13 involuntarily commit and hospitalize people
14 because they are going out to eat, that -- that
15 they are religious or not religious. I mean,
16 she seems to be supportive and participatory
17 with her groups; with her medications, she's
18 compliant. It does not paint the picture of
19 someone that we would have to withhold all their
20 patient rights and keep them hospitalized. And
21 my opinion is that the RN that is responsible
22 for this daily assessment should have intervened
23 at some point, to say, "This person needs to be
24 reexamined, referred to the treatment team, and
25 let's all talk about this together."

LUCINDA L. DEBRUCE - 5/24/2013

1 Q. And what is the basis of -- from your
2 testimony, that you typically don't commit
3 somebody for activities like this?

4 A. In 25 years, I've never seen anyone
5 hospitalized against their will for things like
6 that.

7 Q. Do you know that that same or similar
8 list of information was the same that the
9 probate judge based on his opinion in order to
10 order the continued commitment of Ms. Argoe?

11 MR. DODSON: Object to the form.

12 A. I don't know what all he took into
13 consideration.

14 Q. (BY MR. COLE) Okay. Well, let me ask
15 you: if the judge took that into consideration,
16 is this anything new for the consideration, at
17 this point, in the treatment plan?

18 MR. DODSON: Object to the form.

19 A. Can you rephrase the question?

20 Q. (BY MR. COLE) Well, I'm trying to
21 think of -- or trying to figure out if you are
22 saying that this is a brand-new basis for
23 whether or not Ms. Argoe was at the facility, or
24 if this was the same basis that was used by the
25 probate judge.

LUCINDA L. DEBRUCE - 5/24/2013

1 MR. DODSON: Same objection.

2 A. Again, I'm not real sure what you're
3 asking. My point is the same one consistently
4 through this period of documentation which
5 indicates that this person is interacting well;
6 has some insight; is medication-compliant; is
7 pleasant, cooperative. Those are not typical
8 features that you find with someone that you're
9 going to strip their patient rights away from
10 them and withhold them against their will. And
11 as an independent RN doing these assessments, I
12 believe they had the responsibility to refer
13 that to the treatment team.

14 Q. (BY MR. COLE) All right. Again, can
15 you tell me what books, treatises, classes,
16 whatever, Internet websites, or anything that
17 you used to help base that opinion?

18 A. Just 25 years of psychiatric hospital
19 operation.

20 Q. All right.
21 Anything else on those pages?

22 A. No.

23 Q. All right. Next page.

24 A. The last one is page 11.

25 Q. Okay.

LUCINDA L. DEBRUCE - 5/24/2013

1 A. I didn't highlight any of the
2 transcript here. I made a note, myself, at the
3 top, that said, "APS never called," which was
4 just an internal note to myself that Adult --
5 they did not document that Adult Protective
6 Services was called.

7 Q. Anything else?

8 A. There are notes on that page that are
9 not mine.

10 Q. Okay.

11 And when you wrote that the Adult
12 Protective Services was not called, on this
13 particular page, were you referencing or
14 pointing to any particular note on this page?

15 A. No. It was just a general comment to
16 myself.

17 Q. All right. And why did you write that
18 general comment?

19 A. I was just questioning if -- if they
20 had a responsibility to notify Adult Protective
21 Services because of the allegation of spousal
22 abuse.

23 Q. And did you research that?

24 A. I did not, and I don't have an opinion
25 about it.

LUCINDA L. DEBRUCE - 5/24/2013

1 Q. Do you intend to have an opinion about
2 that when we try this case?

3 A. Not that I'm aware of.

4 Q. Okay.

5 All right. Anything else that you
6 highlighted or marked -- oh, wait, let me --
7 before we do that.

8 You said there were other notes on
9 this particular page, 11, of these records, that
10 are not in your handwriting, correct?

11 A. Correct.

12 Q. And did you use any of those other
13 notes, wherever they came from, to help the --
14 or base any part of your opinion?

15 A. No.

16 Q. Okay. So, again, we can assume that
17 the handwriting was not on the page and didn't
18 influence your opinion.

19 A. Correct.

20 Q. Okay.

21 Any other highlights or handwritings
22 that you contributed to the records?

23 A. No.

24 Q. Are there any opinions that we have
25 not discussed so far during your testimony?

LUCINDA L. DEBRUCE - 5/24/2013

1 A. I'm sorry, what?

2 Q. Are there any other opinions that you
3 have in this case that we have not discussed
4 during your testimony?

5 A. No.

6 Q. Do you know how Mr. Dodson got your
7 name?

8 A. I don't.

9 Q. Have you ever worked with Mr. Dodson
10 before?

11 A. No.

12 Q. Do you advertise your services as a
13 witness for trials, in any magazines or websites
14 or anything like that?

15 A. I think there is one legal nurse
16 database that includes my name, as having
17 experience in psychiatric hospital operations.

18 Q. When did you start that advertisement?

19 A. I don't know that it's an
20 advertisement. I think my name is just listed
21 as part of a database, but it would have been in
22 2007.

23 Q. What's significant about 2007?

24 A. That's when I became a legal nurse
25 consultant.

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1 We do have, also, a website that we
2 operate for legal nurse consulting.

3 Q. Okay. What is that website?

4 A. DeBruce & DeBruce Legal Nurse
5 Consulting.

6 Q. All right. I kind of missed some of
7 that. The --

8 A. I'm sorry. The name of our company is
9 DeBruce & DeBruce Legal Nurse Consulting. The
10 website is debrucelegalnurse.com.

11 Q. Where are you-all based?

12 A. Here in Texarkana.

13 Q. On the Arkansas or the Texas side?

14 A. Well, actually, my business address is
15 the P.O. box and it's on the Arkansas side, and
16 I live on the Texas side.

17 Q. Okay.

18 How do you-all advertise your
19 services? What do you say you do? What is the
20 type of work that DeBruce & DeBruce is marketing
21 itself as?

22 A. That we're available to consult on
23 cases that have psychiatric clinical questions
24 involved.

25 Now, also on the website -- my husband

LUCINDA L. DEBRUCE - 5/24/2013

1 is a legal nurse consultant, and his is all
2 cardiac. So we only work in those two realms:
3 cardiac nursing and psychiatric.

4 Q. You do the psychiatric. He does the
5 cardiology.

6 A. Correct.

7 Q. Okay. Any other employees?

8 A. No.

9 Q. Is your husband working somewhere
10 else, as a nurse, as well?

11 A. Yes. He's a cardiac nurse.

12 Q. Okay. I take it in the Texarkana
13 area?

14 A. Correct.

15 Q. Has he ever testified as an expert in
16 South Carolina?

17 A. It's possible, but I don't know.

18 Q. Okay.

19 A. If he did, it would obviously be only
20 related to cardiac cases.

21 Q. Do you and your husband sort of talk
22 about the cases or consult each other about the
23 cases that you're dealing with?

24 A. No. My knowledge of cardiology is
25 extremely limited and his knowledge of

LUCINDA L. DEBRUCE - 5/24/2013

1 psychiatry is extremely limited, so there's
2 really not much point.

3 Q. About how many cases since 2007, when
4 you started your business, have you consulted on
5 psychiatric matters?

6 A. Probably six or seven.

7 Q. And that's since 2007?

8 A. Yes.

9 Q. Now, obviously I can't ask you about
10 any specifics about any of those cases; but
11 generally, what were the topics of those other
12 cases that you dealt with?

13 A. A death in a psychiatric hospital.
14 Actually one was an employment issue in a
15 psychiatric hospital. I can't really remember
16 the details of all the rest.

17 Q. And are you retained by -- or when you
18 did those, were you retained by plaintiffs or
19 defendants?

20 A. Both.

21 Q. How many plaintiffs? How many
22 defendants?

23 A. It's about 50/50, but I can't -- I can
24 just approximate.

25 Q. Okay.

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1 Is it fair to say that your consulting
2 work is not your primary source of income?

3 A. It's fair to say.

4 Q. Okay. About how much time and, I
5 guess, money, income, do you have with your
6 consulting business versus your management of
7 the healthcare facilities?

8 A. If you look at my total income, how
9 does it divide out percentagewise?

10 Q. And maybe I should have broken those
11 into two questions. I'm trying to figure out
12 how much time do you spend consulting versus
13 working your regular job.

14 A. Well, working my regular job is
15 full-time. On top of that, then I probably
16 spend an additional ten hours a week, eight to
17 ten hours a week, probably, on my own time,
18 dealing with cases. And that ebbs and flows
19 depending upon what's going on with a case.

20 Q. Have you ever been retained by anyone
21 else in South Carolina?

22 A. No, I haven't.

23 Q. Have you ever taught any nursing
24 classes anywhere?

25 A. Not in a university setting, but I've

LUCINDA L. DEBRUCE - 5/24/2013

1 taught numerous cases in a hospital setting.

2 Q. Is this at one of the hospitals where
3 you were one of the managers -- or management, I
4 guess?

5 A. Yes. In every facility that I've been
6 in, I've had a role with employee education.

7 Q. All of the hospitals you've worked
8 with, have all those been psychiatric treatment
9 facilities, or at least the area where you were
10 working in them?

11 A. Yes, for the last, like I said, almost
12 25 years, it has been. Before that, I worked in
13 a med/surg hospital.

14 Q. All right.

15 MR. COLE: Why don't we take a
16 quick break and let me think about if I have any
17 other questions.

18 THE WITNESS: Okay.

19 MR. COLE: And then I might not.

20 THE WITNESS: All right.

21 (Recess taken from 10:34 a.m.
22 until 10:41 a.m., CST.)

23 MR. COLE: Just for the record,
24 Exhibit 2 is going to be the pages that we went
25 over before this last break, that Ms. DeBBruce

LUCINDA L. DEBRUCE - 5/24/2013

1 highlighted and then the one that she put her
2 handwriting on, will be -- the collection of
3 those pages as Exhibit 2. And I think since she
4 let us make a copy of her driver's license,
5 Exhibit 3 will be her driver's license.

6 (Exhibits 2 and 3 marked.

7 Exhibit 2 returned to witness;
8 copy substituted.)

9 Q. (BY MR. COLE) All right. I just have
10 a couple of quick follow-ups -- well, not
11 follow-ups, but additional questions.

12 A. All right.

13 Q. First, the deposition transcripts that
14 you received in that notebook --

15 A. Yes.

16 Q. -- which of those did you read?

17 A. I read all of them.

18 Q. Okay.

19 And are there any depositions that --
20 of the ones that you would highlight, help to
21 form your opinions in this case?

22 MR. DODSON: Object to the form.

23 A. No.

24 Q. (BY MR. COLE) Okay. You but you
25 didn't do any actual highlights or write on any

LUCINDA L. DEBRUCE - 5/24/2013

1 of the deposition transcripts or anything like
2 that, correct?

3 A. No.

4 Q. Is there anything in any of the
5 depositions that you believe you should
6 reference in your deposition now, to help
7 explain your opinions in this case?

8 A. No.

9 MR. DODSON: Object to the form.

10 Q. (BY MR. COLE) All right. That's all
11 the questions I have. Thank you very much.

12 MR. COLE: Jim, do you want to
13 go?

14 MR. PARHAM: Andrew, did you put
15 that exhibit in?

16 MR. COLE: Which one?

17 MR. PARHAM: About the extra
18 pages.

19 MR. COLE: Yes. That's
20 Exhibit 2, the extra pages.

21 EXAMINATION

22 BY MR. PARHAM:

23 Q. Ms. DeBBruce, Jim Parham. I represent
24 Dr. Dodds.

25 What do you charge per hour to review

LUCINDA L. DEBRUCE - 5/24/2013

1 a case?

2 A. \$150 an hour.

3 Q. And what do you charge for deposition
4 time?

5 A. It's all the same: \$150 an hour.

6 Q. Do you know how many hours you have
7 spent working on this case up to the point you
8 walked in the deposition room today?

9 A. I don't off the top of my head.

10 Q. Can you give me a good estimate?

11 A. Twenty to 25 maybe.

12 Q. Have you sent a bill to Mr. Dodson
13 yet?

14 A. I've sent one.

15 Q. Do you remember what was on that bill?

16 A. You mean the amount?

17 Q. Well, the hours or the amount.

18 A. I want to say it was around \$1500.

19 Q. Okay. But you think totally, up to
20 the time you walked into the room today for the
21 deposition, it was 20, 25 hours?

22 A. That's a guesstimate.

23 Q. And what will you charge if you have
24 to come to South Carolina to testify in the
25 trial in October of this year?

LUCINDA L. DEBRUCE - 5/24/2013

1 A. Still \$150 an hour, including travel
2 time.

3 Q. So from the time you leave your house
4 to the time that you arrive there, testify, and
5 then come back --

6 A. Uh-huh.

7 Q. -- at \$150 an hour?

8 A. For travel time and for the actual
9 deposition, not -- not sleeping time or
10 anything.

11 Q. And I guess -- I think you've answered
12 this for me, but it looked like your CV starts
13 around 1994, with Behavioral Health. So from
14 the time you got your RN license in 1977 until
15 1994, you worked in a med/surg hospital?

16 A. Correct.

17 Q. Is that all you did, was med/surg
18 work?

19 A. Yes.

20 Q. And either in Texas or Arkansas,
21 what -- how is the involuntary-commitment
22 procedure different than what you have reviewed
23 or seen in these records, than it is in
24 South Carolina?

25 A. I am not sure how it's different other

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1 than -- the similarities are that you would have
2 to have a threshold of suicidality,
3 homicidality, or what we call gravely disabled,
4 your inability to function, reason, so forth,
5 that one or a combination of those would have to
6 be appropriate to initiate and to continue an
7 involuntary hospitalization.

8 Q. And on the initial part of it, does
9 your system in Texas and Arkansas require two
10 examiners, one being a physician, to start the
11 process with the legal paperwork?

12 A. No. It's different.

13 Q. What do you do here?

14 A. In Arkansas, it's a single person that
15 can initiate that. And in Texas, when I was
16 practicing down there, it was -- it was a
17 different process, but it was similar.

18 Q. And do you have to have a physician
19 sign off on the paperwork for the initial
20 involuntary commitment?

21 A. Uh-huh.

22 Q. So that single person has to be a
23 physician.

24 A. Yes.

25 Q. Okay.

LUCINDA L. DEBRUCE - 5/24/2013

1 A. One of the two. But I think one of
2 the states requires two and the other one not be
3 a doctor.

4 Q. But either way, there's a physician
5 that needs to sign off on the paperwork.

6 A. Uh-huh.

7 Q. Is that correct?

8 A. Uh-huh.

9 Q. Say yes.

10 A. Yes.

11 Q. All right. And in South Carolina, we
12 have a 72-hour period, you may have seen, and
13 then a formal hearing at some point. I think
14 within two weeks.

15 A. Yes.

16 Q. Is it the same type of time frame in
17 the two states?

18 A. The 72 hours is. And then the initial
19 hearing is usually, like, the third business day
20 after that. That's in one state, and it's
21 different in the other state. But it's similar
22 as to form and process.

23 Q. And I think the list of things that
24 were sent to you were the same as a prior
25 deposition we took last week, and I believe --

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1 and someone else may have to correct me, but I
2 think missing from that set of records and
3 depositions are the depositions of Ms. Argoe's
4 brother and sister.

5 MR. PARHAM: Is that right,
6 guys?

7 MR. COLE: Yes.

8 Q. (BY MR. PARHAM) Do you have those?

9 A. No. I have not seen those.

10 Q. And I know Mr. Dodson put this on as a
11 stipulation at the beginning, but I just wanted
12 to have you say it.

13 Do you intend to render any
14 standard-of-care opinions against Dr. Dodds, who
15 is a psychiatrist?

16 A. No.

17 Q. Do you have any opinions about
18 proximate cause and damages to Ms. Argoe in this
19 case as a result of this commitment?

20 A. No.

21 MR. PARHAM: That's all I have.
22 Thank you.

23 MS. GANES: Okay, just for
24 housekeeping and to keep everything in order,
25 I'll go ahead and ask -- this is Elloree Ganes,

LUCINDA L. DEBRUCE - 5/24/2013

1 and I represent Dr. Steiner.

2 EXAMINATION

3 BY MS. GANES:

4 Q. Do you have any intention of giving
5 opinions to the jury in this case related to
6 Dr. Steiner's care and treatment of Ms. Argoe?

7 A. No.

8 Q. Thank you.

9 EXAMINATION

10 BY MR. BEIGHLEY:

11 Q. I'm George Beighley for the Aiken
12 Regional-Aurora.

13 I understand, Ms. DeBuce, from what
14 Mr. Dodson said, you will not be offering
15 opinions about Aiken Regional or Aurora
16 Pavilion. Is that correct?

17 A. Correct.

18 Q. Thank you.

19 EXAMINATION

20 BY MR. DEMASTERS:

21 Q. Good morning, Ms. DeBuce. My name is
22 David DeMasters, and my law firm represents Dr.
23 Phyllis Mobley.

24 And just to follow up: do you have any
25 opinion or are you going to testify to an

LUCINDA L. DEBRUCE - 5/24/2013

1 opinion regarding the care and services that Dr.
2 Mobley provided?

3 A. No.

4 Q. Thank you.

5 EXAMINATION

6 BY MR. HICKS:

7 Q. Ms. DeBruce, my name is Chip Hicks. I
8 represent the payor, Carolina Care Plan, in this
9 case.

10 Are you going to offer any opinions or
11 do you have any opinions about Carolina Care
12 Plan?

13 A. No.

14 Q. Thank you.

15 MR. DODSON: I don't have any
16 questions. Ms. DeBruce, this is Robert Dodson,
17 I don't have any questions.

18 MR. PARHAM: We're done.

19 MR. DODSON: Anyone else have
20 anything?

21 MS. GANES: Nothing.

22 MR. COLE: That concludes this
23 deposition.

24 (End of proceedings; record
25 resumes as follows:)

LUCINDA L. DEBRUCE - 5/24/2013

1 MR. DODSON: Ms. DeBuce, you
2 still there?

3 THE WITNESS: Yes.

4 MR. DODSON: You have the right,
5 at least in South Carolina, to what's called
6 read and sign your deposition, which just means
7 that the court reporter will send you a copy of
8 the transcript and you can make changes to
9 what's written; and your changes are generally
10 limited to, you know, spellings and scrivener's
11 errors and that type of thing. Most people
12 waive that, but you have that right; and you can
13 tell the court reporter whether or not you would
14 like to do that or not. Makes no difference to
15 me one way or another.

16 THE WITNESS: Okay.

17 THE COURT REPORTER: Would you
18 like to?

19 THE WITNESS: No, I'm fine with
20 that; I do not need a copy to review.

21 MR. COLE: Okay.

22 MR. DODSON: All right.

23 MR. COLE: Thank you very much.

24 (End of proceedings, 10:54 a.m.,
25 CST.)

LUCINDA L. DEBRUCE - 5/24/2013

1	STATE OF SOUTH CAROLINA	)	IN THE COURT OF
2	COUNTY OF LEXINGTON	)	COMMON PLEAS
3	Martha Lewin Argoe,	)	116TH JUDICIAL
4	Plaintiff,	)	CIRCUIT
5	vs.	)	Civil Action No.:
6	Three Rivers Behavioral	)	07-CP-32-1981
7	Health, LLC and	)	
8	Psychiatric Solutions,	)	
9	Inc., Its successor;	)	
10	Phyllis Brant-Mobley, MD;	)	
11	Aiken Regional Medical	)	
12	Center-Aurora Pavilion;	)	
13	David A. Steiner, MD;	)	
14	Cheryl C. Dodds, MD;	)	
15	Doris Ann Burrell, RN;	)	
16	and Carolina Care Plan,	)	
17	Defendants.	)	

REPORTER'S CERTIFICATION
 ORAL DEPOSITION OF LUCINDA L. DEBRUCE
 MAY 24, 2013

I, Amanda J. Leigh, Certified Shorthand
 Reporter in and for the State of Texas, hereby
 certify to the following:

That the witness, LUCINDA L. DEBRUCE, was duly
 sworn by me and that the transcript of the oral
 deposition is a true record of the testimony given by
 the witness;

That the amount of time used by each party
 at the deposition is as follows:

FOR PLAINTIFF (VIA WEB-CONFERENCE):

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LUCINDA L. DEBRUCE - 5/24/2013

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6 That signature of the deponent was waived.

7 I further certify that I am neither counsel for,
related to, nor employed by any of the parties in the
8 action in which this proceeding was taken, and further
that I am not financially or otherwise interested in
the outcome of the action.
9

10 Certified to by me this, the 17th day of June,
2013.

11 Digitally signed by Amanda J. Leigh
Date: 2013.06.17 07:08:30 -07:00
Reason: Official Electronic
Signature
Location: Longview, TX
12

13 Amanda J. Leigh, CSR 3791
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LUCINDA L. DEBRUCE - 5/24/2013

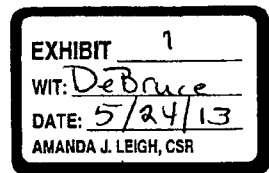
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STATE OF SOUTH CAROLINA)
COUNTY OF LEXINGTON)
Martha Lewin Argoe,)
Plaintiff,)
vs.)
Three Rivers Behavioral Health, LLC and)
Psychiatric Solutions, Inc., Its successor;)
Phyllis Brant-Mobley, MD; Aiken Regional)
Medical Center-Aurora Pavilion; David A.)
Steiner, MD; Cheryl C. Dodds, MD; Doris)
Ann Burrell, RN; and Carolina Care Plan,)
Defendants.)

IN THE COURT OF COMMON PLEAS
11th JUDICIAL CIRCUIT
Civil Action No.: 07-CP-32-1981

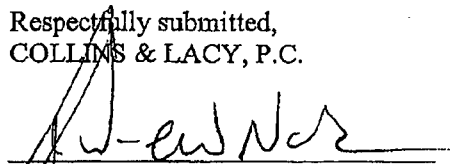
**NOTICE OF DEPOSITION
OF
LUCINDA L. DEBRUCE**

TO: ROBERT D. DODSON, ESQUIRE, ATTORNEY FOR PLAINTIFF:

YOU WILL PLEASE TAKE NOTICE that the attorney for Defendants Three Rivers Behavioral Health, LLC, and Doris Ann Burrell, RN., will take the deposition of **Lucinda L. DeBruce** on **Friday May 24, 2013**, beginning at 8:30 am (central standard time), 9:30 (eastern standard time) at the Holiday Inn Express Hotel & Suites, Conference Room, 4545 Cowhorn Creek Road, Texarkana, Texas 75503 accordance with the provisions of Rule 30 of the South Carolina Rules of Civil Procedure. This deposition will be taken before a Notary Public or some other official authorized by law to take depositions for the State of South Carolina. The oral examination will continue from day to day until completed. You are invited to attend and take such part as is fit and proper.

Respectfully submitted,
COLLINS & LACY, P.C.

By:


Andrew N. Cole,
1330 Lady Street, Suite 601 (29201)
Post Office Box 12487
Columbia, South Carolina 29211
(803) 256-2660
(803) 771-4484 (f)

**ATTORNEY FOR DEFENDANTS
THREE RIVERS BEHAVIORAL
HEALTH, LLC AND DORIS ANN
BURRELL, RN**

Columbia, South Carolina

May 16, 2013

CERTIFICATE OF SERVICE

The undersigned employee of Collins & Lacy, P.C., Attorneys at Law, 1330 Lady Street, Sixth Floor, Post Office Box 12487, Columbia, South Carolina, 29211, does hereby certify that the following named individual(s) were served with a copy of the pleading(s) indicated below via e-mail and by mailing a copy of same to said person(s) in the United States Postal Service, with sufficient postage affixed thereto and return address clearly marked on the date indicated below:

COUNSEL SERVED:

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Columbia, SC 29201
rdodson@rdodsonlaw.com
TSmith@RDodsonLaw.com
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sjohnson@jparhamlaw.com
Counsel for Cheryl C. Dodds, MD

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ashaw@nmhlawfirm.com
Counsel for Carolina Care Plan

PLEADINGS:

- NOTICE OF DEPOSITION OF LUCINDA L DEBRUCE

Susan R. M. D.

Columbia, South Carolina

May 13, 2013

STATE OF SOUTH CAROLINA

ISSUED BY THE COURT OF COMMON PLEAS IN THE COUNTY OF LEXINGTON

Martha Lewin Argoe,

Plaintiff,

vs.

SUBPOENA IN A CIVIL CASE
CIVIL ACTION NO.: 07-CP-32-1981
Pending in Lexington County

Three Rivers Behavioral Health, LLC and Psychiatric Solutions, Inc., its successor; Phyllis Brant-Mobley, MD; Aiken Regional Medical Center-Aurora Pavilion; David A. Steiner, MD; Cheryl C. Dodds, MD; Doris Ann Burrell, RN; and Carolina Care Plan

TO: Lucinda L. DeBruce
c/o Robert D. Dodson, Esquire
Law Offices of Robert Dodson, PA
1722 Main Street, Ste. 200
Columbia, SC 29201

☐ YOU ARE COMMANDED to appear in the above named court at the place, date and time specified below to testify in the above case.

PLACE OF TESTIMONY:

COURTROOM:

☒ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify at the taking of a deposition in the above case.

PLACE OF DEPOSITION:

DATE AND TIME:

Holiday Inn Express Hotel & Suites,
Conference Room
4545 Cowhorn Creek Road,
Texarkana, Texas 75503.

Friday, May 24, 2013
8:30 am (central standard time)

☒ YOU ARE COMMANDED to produce and permit inspection and copying of the following documents or objects in your possession, custody or control at the place, date and time specified below (list documents or objects):

A COPY OF YOUR CURRENT CV AND COMPLETE COPY OF YOUR ENTIRE FILE RELATING TO TREATMENT AND SERVICES PROVIDED TO MARTHA LEWIN ARGOE

(PLEASE BRING THE ORIGINAL OF SAID FILE TO THE DEPOSITION)

PLACE:

Collins & Lacy, P.C.
1330 Lady Street, Suite 601
Columbia, SC 29201

DATE AND TIME: ON OR BEFORE
May 22, 2013

☐ YOU ARE COMMANDED to permit inspection of the following premises at the date and time specified below:

PREMISES:

DATE AND TIME:

ANY SUBPOENAED ORGANIZATION NOT A PARTY TO THIS IS HEREBY DIRECTED PURSUANT TO RULE 30(b)(6), SOUTH CAROLINA RULES OF CIVIL PROCEDURE, TO FILE A DESIGNATION WITH THE COURT SPECIFYING ONE OR MORE OFFICERS, DIRECTORS, OR MANAGING AGENTS, OR OTHER PERSONS WHO CONSENT TO TESTIFY ON ITS BEHALF, AND SHALL SET FORTH FOR EACH PERSON DESIGNATED, THE MATTERS ON WHICH HE WILL TESTIFY OR PRODUCE DOCUMENTS OR THINGS. THE PERSON SO DESIGNATED SHALL TESTIFY AS TO MATTERS KNOWN OR REASONABLY AVAILABLE TO THE ORGANIZATION.

ISSUING OFFICER'S NAME, ADDRESS AND PHONE NUMBER:

Andrew N. Cole, Esquire
COLLINS & LACY, P.C., P.O. BOX 12487, COLUMBIA, SC 29211
803/256-2660

I CERTIFY THAT THE SUBPOENA IS ISSUED IN COMPLIANCE WITH RULE 45(c)(1) AND THAT NOTICE AS REQUIRED BY RULE 45(b)(1) HAS BEEN GIVEN TO ALL PARTIES.

Issuing Officer's Signature and Title

DATE: May 16, 2013

ATTORNEYS FOR DEFENDANTS Three Rivers Behavioral Health, LLC and Doris Ann Burrell, RN

STATE OF SOUTH CAROLINA

ISSUED BY THE COURT OF COMMON PLEAS IN THE COUNTY OF LEXINGTON

Martha Lewin Argoe,

Plaintiff,

vs.

SUBPOENA IN A CIVIL CASE
CIVIL ACTION NO.: 07-CP-32-1981
Pending in Lexington County

Three Rivers Behavioral Health, LLC and Psychiatric Solutions, Inc., its successor; Phyllis Brant-Mobley, MD; Aiken Regional Medical Center-Aurora Pavilion; David A. Steiner, MD; Cheryl C. Dodds, MD; Doris Ann Burrell, RN; and Carolina Care Plan

TO: Lucinda L. DeBruce
c/o Robert D. Dodson, Esquire
Law Offices of Robert Dodson, PA
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PLACE OF DEPOSITION:

DATE AND TIME:

Holiday Inn Express Hotel & Suites,
Conference Room
4545 Cowhorn Creek Road,
Texarkana, Texas 75503.

Friday, May 24, 2013
8:30 am (central standard time)
1

☒ YOU ARE COMMANDED to produce and permit inspection and copying of the following documents or objects in your possession, custody or control at the place, date and time specified below (list documents or objects):

A COPY OF YOUR CURRENT CV AND COMPLETE COPY OF YOUR ENTIRE FILE RELATING TO TREATMENT AND SERVICES PROVIDED TO MARTHA LEWIN ARGOE

(PLEASE BRING THE ORIGINAL OF SAID FILE TO THE DEPOSITION)

PLACE:

DATE AND TIME: ON OR BEFORE

Collins & Lacy, P.C.
1330 Lady Street, Suite 601
Columbia, SC 29201

May 22, 2013

☐ YOU ARE COMMANDED to permit inspection of the following premises at the date and time specified below:

PREMISES:

DATE AND TIME:

ANY SUBPOENAED ORGANIZATION NOT A PARTY TO THIS IS HEREBY DIRECTED PURSUANT TO RULE 30(b)(6), SOUTH CAROLINA RULES OF CIVIL PROCEDURE, TO FILE A DESIGNATION WITH THE COURT SPECIFYING ONE OR MORE OFFICERS, DIRECTORS, OR MANAGING AGENTS, OR OTHER PERSONS WHO CONSENT TO TESTIFY ON ITS BEHALF, AND SHALL SET FORTH FOR EACH PERSON DESIGNATED, THE MATTERS ON WHICH HE WILL TESTIFY OR PRODUCE DOCUMENTS OR THINGS. THE PERSON SO DESIGNATED SHALL TESTIFY AS TO MATTERS KNOWN OR REASONABLY AVAILABLE TO THE ORGANIZATION.

ISSUING OFFICER'S NAME, ADDRESS AND PHONE NUMBER:

Andrew N. Cole, Esquire
COLLINS & LACY, P.C., P.O. BOX 12487, COLUMBIA, SC 29211
803/256-2669

I CERTIFY THAT THE SUBPOENA IS ISSUED IN COMPLIANCE WITH RULE 45(c)(1) AND THAT NOTICE AS REQUIRED BY RULE 45(b)(1) HAS BEEN GIVEN TO ALL PARTIES.

Issuing Officer's Signature and Title

DATE: May 16, 2013

ATTORNEYS FOR DEFENDANTS Three Rivers Behavioral Health, LLC and Doris Ann Burrell, RN

**THREE RIVERS
BEHAVIORAL HEALTH**

**POLICY / PROCEDURE
STATEMENT**

POLICY: TX.038

SUBJECT: Medications: Patient Refusal
Clinical Services

EFFECTIVE DATE: October, 2000
Revised: February, 2005

APPLICABILITY: Facility Wide

Number of Pages: 2

POLICY:

It shall be the policy of Three Rivers Behavioral Health that psychoactive medications will not be administered to patients admitted to this hospital under the voluntary or involuntary status without informed consent, except in emergency situations as defined below:

Imminent probable death or substantial bodily harm to the patient because the patient:

1. Overly or continually is threatening or attempting to commit suicide or serious bodily harm; or
2. Is behaving in a manner that indicates that the patient is unable to satisfy the patient's need for nourishment, essential medical care, or self-protection; or
3. Imminent physical or emotional harm to others because of threats, attempts, or other acts the patient overly or continually makes or commits.
4. Is younger than 16 years of age and the patient's parent, managing conservator, or guardian consents to the administration on behalf of the patient, per state guidelines.

PROCEDURE:

1. When a patient refuses medication, whether verbally or by other indications or means, the licensed nurse shall ask the patient the reason for refusal and document the refusal on the MAR by circling the time on the MAR and entering a progress note in the medical record.
 - A. Refusal to consent to administration of psychoactive medication is defined as:
 - (1) The individual or legally authorized representative communicates orally, through sign language, or in writing that he/she refuses psychoactive medication.
 - (2) The patient communicates through behavior that he/she refuses psychoactive medication, e.g., refusing to swallow oral medication, refusing to submit to hypodermic injection of psychoactive medication.
 - (3) The individual pretends to swallow oral psychoactive medications, and the attending physician determines that the pretending behavior is due to an unwillingness to take the medication.
 - (4) The individual gives an unacceptable response, which is a lack of response, no response, or an inadequate or a noncommittal response from the individual after he/she received the standard risk/benefit explanation.

2. The licensed nurse will notify the physician as soon as possible, either by phone or in person.
3. If a physician issues an order to administer psychoactive medication to a patient without the patient's consent because of an emergency situation:
 - A. The physician shall document in the patient's clinical record, in specific medical or behavioral forms, the necessity of the order and that the physician has evaluated but rejected other generally accepted, less intrusive forms of treatment, if any; and
 - B. Treatment of the patient with the psychoactive medication shall be provided in the manner, consistent with clinically appropriate medical care, least restrictive of the patient's personal liberty.
4. When administering medications ordered by the physician in an emergency situation, the licensed nurse shall:
 - A. Inform the patient of the reason for administering the medication.
 - B. Obtain physician's order for administering medication, including alternate route or form of medication as necessary, i.e., injectable or concentrate.
 - C. Document in the patient's clinical record the justification for the administering of the medication, including an assessment of the emergency situation.

REPORT OF DESIGNATED EXAMINER FOR MENTAL ILLNESS

PAGE 1

Name of Person Examined <i>Naitha Arge</i>	Sex <i>F</i>	Height	Weight	Age <i>42</i>	Hair	Eyes	DOB	SS#	County of Residence <i>St. Louis</i>
Place of Examination <i>Three Rivers</i>				Hour and Date of Examination <i>6/15/05 8:20 AM</i>					
Name of Designated Examiner <i>Ann Durrell</i>		Degree <i>DN</i>		Place of Professional Employment <i>THREE RIVERS CENTER FOR BEHAVIORAL HEALTH 2900 SUNSET BOULEVARD WEST COLUMBIA, SC 29169</i>					

I, THE UNDERSIGNED EXAMINER, having been directed by Probate Court Order to do so, have examined the above-named person, considered previous hospitalization records and am of the opinion that the said individual:
(Check appropriate boxes.)

I. ☒ IS MENTALLY ILL, NEEDS INVOLUNTARY TREATMENT AND BECAUSE OF THIS MENTAL ILLNESS:

Lacks sufficient insight or capacity to make responsible decisions with respect to his/her treatment;

AND / OR

There is a likelihood of serious harm to self or others:

AND THEREFORE,

(1) ☒ INVOLUNTARY HOSPITALIZATION IS RECOMMENDED.

(2) ☐ INVOLUNTARY OUTPATIENT TREATMENT IS RECOMMENDED.

My recommendation is based on the following symptoms and specific examples of behavior:

*Patient is alert & oriented to person place. Denies suicide / Homicide - denies any hallucination
Patient is very adamant about nothing wrong with her and she doesn't need any meds. She is constantly refusing any meds. They had to start forcing her meds on 6/13/05. At this time I feel that patient needs to be retained for her safety to get stable and become more educated on her diagnosis.*

sure she is - wouldn't you be if you got locked up

Why? she is not suicidal?

(See reverse side which must be completed.)

All Information MUST be typed or clearly printed.

PLAINTIFF-00022

REPORT OF DESIGNATED EXAMINER FOR MENTAL ILLNESS

PAGE 2

II. ☐ IS NOT MENTALLY ILL to such an extent that involuntary treatment is presently required.

My recommendation is based on the following observations and opinions:

[Handwritten signature and large 'X' mark across the lines]

My recommendation for additional treatment on a voluntary basis is:

[Handwritten signature and large 'X' mark across the lines]

PLAINTIFF-00023

[Handwritten signature: D Ann Burrell RN]
 SIGNATURE OF DESIGNATED EXAMINER DEGREE MEDICAL OR PROFESSIONAL LICENSE NO

[Handwritten name: D Ann Burrell]
 TYPED OR PRINTED NAME OF DESIGNATED EXAMINER

W. RIVERS CENTER FOR BEHAVIORAL HEALTH
 2900 SUNSET BOULEVARD
 WEST COLUMBIA, SC 29130

STREET ADDRESS CITY COUNTY ZIP

NOTE: (1) "Mentally ill person" means a person afflicted with a mental disease to such an extent that, for his own welfare or the welfare of others or of the community, he requires care, treatment or hospitalization;

(2) "Likelihood of serious harm" means because of mental illness there is (1) a substantial risk of physical harm to the person himself as manifested by evidence of threats of, or attempts at, suicide or serious bodily harm; (2) a substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior and serious harm to them or (3) a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that the person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community;

All Information MUST be typed or clearly printed.

THREE RIVERS CENTER
FOR BEHAVIORAL HEALTH

COMPREHENSIVE ASSESSMENT TOOL

ARGOE MARTHA L SS#
062 W F P MR#: 000024396
Adm date: 2005-06-09 DOB
MOBLEY PHYLLIS I
Act#: 1018795

DATE: 6-9-05 TIME: Start: 1700 End: 1955

PATIENT IDENTIFICATION

PATIENT NAME Martha Argoe IDENTIFICATION SECTION AGE 62 DATE OF BIRTH: 7-17-42
MARITAL STATUS: M LEGAL STATUS: ☒ Involuntary ☐ Voluntary Sex: F Allergies: NKA
OCCUPATION: Housewife PRIMARY CARE PHYSICIAN: PHONE NO.
ACCOMPANIED BY: N/A REFERRAL SOURCE: UBH / managed care - Aurora

CHIEF COMPLAINT (In patient's own words)
WHY ARE YOU HERE TODAY? The Sheriff came and got me. my husband had it in for me. I moved out of the bedroom because I worried diseases

PRECIPITATING EVENTS
EVENTS WHICH OCCURRED IN PREVIOUS 24 - 72 HOURS WHICH PROMPTED ASSESSMENT:
my husband is an abusive alcoholic. my husband will not go anywhere with me. I do not feel for him. He has abused me other ways. married 40 years.

PRESENTING PROBLEMS / SOMATIC SYMPTOMS

1. MAJOR LIFE AREAS

	ADMITTS	DENIES	D.N.A.*	AS EVIDENCED BY FREQUENCY, INTENSITY, DURATION
PROBLEMS AT WORK OR SCHOOL	-			I'm not doing any housework.
DETERIORATION IN HYGIENE AND/OR GROOMING				I did it for 40 years.
LOSS OF ENERGY OR INTEREST IN ACTIVITIES				"no more"
SOCIAL WITHDRAWAL				"I'm never, ever"
ABILITY TO PARENT				37 yr old son who has power of attorney
OTHER				I did not trust my husband.

2. BEHAVIOR CHANGES

	ADMITTS	DENIES	D.N.A.*	AS EVIDENCED BY FREQUENCY, INTENSITY, DURATION
i.e., IRRITABILITY, POOR IMPULSE CONTROL	-			excessive spending
OTHER				

3. SLEEP

	ADMITTS	DENIES	D.N.A.*	AS EVIDENCED BY FREQUENCY, INTENSITY, DURATION
NOT SLEEPING	em			
DIFFICULTY GOING TO SLEEP (Initial Insomnia)				
FREQUENT AWAKENING DURING NIGHT (Mid Insomnia)				
EARLY MORNING AWAKENING (Terminal Insomnia)				
SLEEPS ALL DAY				
USUAL NUMBER OF HOURS OF SLEEP				10 hrs

OTHER patient will go out later to eat if husband does not go. states she is usually home at midnight.

COMPREHENSIVE ASSESSMENT TOOL

ARGOE MARTHA L
062 W F P
Adm date: 2005-06-09
MOBLEY PHYLLIS
Act#: 1018795

SS#
MR#: 000024396
DOB
I

NEEDS ASSESSMENT

PART 1 PAGE 2 of 6

ATION

4. EATING	ADMITS	DENIES	D.N.A.*	AS EVIDENCED BY FREQUENCY, INTENSITY, DURATION
BINGING		/		
PURGING		/		
EXCESSIVE EXERCISING		/		
LAXATIVE USE		/		
ABSENCE OF MENSES		/		
COMPULSIVE OVEREATING		/		
OTHER:		/		
CHANGES IN EATING HABITS (DESCRIBE) <i>Patient says used to fluctuate but no changes was on diet lately</i>				
WEIGHT: <u>LOSS</u> <u>GAIN</u> NUMBER OF POUNDS: <u> </u> WITHIN: (Check one) <u> </u> Days <u> </u> Weeks <u> </u> Months				
FREQUENCY OF WEIGHING SELF: <u> </u>				

5. ANXIETY	ADMITS	DENIES	D.N.A.*	AS EVIDENCED BY FREQUENCY, INTENSITY, DURATION
PANIC ATTACKS		/		
OBSESSIVE / COMPULSIVE THOUGHTS		/		
OBSESSIVE / COMPULSIVE BEHAVIORS		/		
OTHER:		/		

6. PSYCHOSIS	ADMITS	DENIES	D.N.A.*	AS EVIDENCED BY FREQUENCY, INTENSITY, DURATION
HALLUCINATIONS		/		
Visual, Tactile, Olfactory, Auditory		/		
Command		/		
DELUSIONS		/		
Bizarre		/		
PARANOID IDEATIONS		/		
ORIENTATION: Time, Place, Person		/		
OTHER		/		

why is that paranoid
locking in door is paranoid
referred source states patient does not know and works so did ms Argo?
carries gun, back fears husband he is plotting against me, looks like villain boss.

7. RISK ASSESSMENT - DUE TO THE IMPORTANCE OF RISK ASSESSMENT, THE SEPARATE "RISK EVALUATION FORM" (FORM #) IS COMPLETED AND ATTACHED.

8. CHILD / ADOLESCENT ASSESSMENT	ADMITS	DENIES	D.N.A.*	AS EVIDENCED BY FREQUENCY, INTENSITY, DURATION
RUNNING AWAY RISK				
BEDWETTING				
DESTRUCTION OF PROPERTY				
CRUELTY TO ANIMALS				
STEALING				
REBELLIOUS / DEFIES FAMILY / AUTHORITY				
SATANIC INVOLVEMENT				
FIRE SETTING				
PROBLEMS AT SCHOOL				
GANG INVOLVEMENT				
OTHER				

9. HISTORY OF PHYSICAL / SEXUAL ABUSE	ADMITS	DENIES	D.N.A.*	AS EVIDENCED BY FREQUENCY, INTENSITY, DURATION
		/		

10. CULTURAL / ETHNIC / COMMUNICATION ISSUES AFFECTING ASSESSMENT / TREATMENT	Yes	No	D.N.A.*	AS EVIDENCED BY FREQUENCY, INTENSITY, DURATION
		/		

PLAINTIFF-00035

ICOR54
User: CWRIGHT
Hospital: 1

THREE RIVERS BEHAVIORAL HEALTH
MONITOR Patient Chart
ARGOE MARTHA L

Page: 3
Date: 7/21/05
Time: 10:57

Demographics

Patient Name: ARGOE MARTHA L
Patient Num: 1018795
Admission Date: 6/09/05
Ht: Sex: F Discharge Date: 7/20/05
Med Rec Num: 24396 Wt: Age: 62 Birth Date:
Adm Dx: MENTAL DISOR NOS OTH DIS

Assessments

Treatment acceptance/ resistance:
Not aware of problem
Accepts Continuing Care
Motivated to learn
Patient strengths:
Average or Above Intelligence
Supportive Family
Active Sense of Humor
Patient deficits:
Marital Conflict
Traumatic Event
Other:(Explain)
ABUSIVE HUSBAND
Will emotional/family/or home concerns affect learning?
No
Does patient have a sensory impairment or physical limitation that may
limit learning ability?
No
Patient Educational Goals:
Orientation to Unit
Medication
Discharge Planning
Anger Management
Depression
Stress Management
Patient Educational Needs:
Current illness
Medication
Community Resources
Family Educational Needs:
Current illness
Medications
Community Resources
Goals for treatment:(as identified by patient)
"TO GET OUT"
Goals for treatment: (as identified by significant other)
N/A
High risk psychosocial issues requiring early treatment planning and
interventions:
None identified
Integrated summary and recommendations:
Include suggested problems to be addressed this episode of treatment:
Anticipated outcomes, treatment and interventions:
PATIENT WILL BE SAFELY STABILIZED ON MEDICATION. ATTEND GROUPS AND GAIN
INSIGHT INTO ISSUES AND COPING SKILLS FOR STRESS. UPON DISCHARGE PATIENT
WILL DENY SUICIDAL AND HOMICIDAL IDEATION AND BE SAFELY DISCHARGED
HOME.

Comprehensive Assessment Tool Nursing 6/09/05 20:39 VLG

Allergies:
None
Medical/Surgical Hospitalizations:
Yes (Name/Year)
gall bladder, hysterectomy, appendectomy
Recent diagnostic testing:
Yes: (Name/date)
CT SCAN Orangeburg Regional Hospital
Communicable disease (s):
No Exposure
Cardiovascular Problems
None
Respiratory Problems

Should ask about
this - wasn't in
records that husband
abused her?

None
Neurological Problems
None
Gastrointestinal Problems
None
Genitourinary Problems
None
Gynecological/Female
Other: Explain
complete hysterectomy
Endocrine disorders
Patient with uncontrolled diabetes indicates need for nutritional
assessment
None
Skin Disorders
No
Visual Problems
Glasses
Hearing Problems
None
Nutrition Screening: Unintentional weight loss or weight gain
How to calculate % weight loss:
a. Determine maximum weight within the past 3 months
b. Subtract current weight from maximum weight to get pounds lost
c. Divide number of pounds lost by maximum weight to get % weight loss
Weight loss or gain of 10% or more in past 3 months indicates need for
nutritional assessment.
Normal weight
Diagnosed eating disorder
Newly diagnosed eating disorder indicates need for nutritional
assessment
No
Special Diet
No
Chewing/swallowing difficulties
No
Identified food allergy
None
Religious, Cultural, or Ethnic food preferences/restrictions
No
Fall Potential: Gait
0=Gait Steady
2=Unsteady when getting up out of chair, changing direction
3=Needs to balance/re-balance self: uses ambulatory assist device
(holds onto rails/chairs to balance)
Fall Risk Potential: Age
0=Less than 70 years of age
1=70 to 79 years of age
2=Greater than 80 years of age
Fall Risk Potential: Mobility
0=Ambulatory
1=Assist needed
2=Use of assistive device
Fall Risk Potential: Mental Status
0=Oriented times 3
1=Confused at all times
2=Intermittent confusion
Fall Risk Assessment: Score Total
Patient scoring 2 or 3 on Gait and/or total score of 5, indicates need
to complete Fall potential assessment.
000
Self Care
Independent
Pain Assessment:
If answer yes to Chronic Pain; initiate pain assessment
None
Body identification marks: Note location of marks

PLAINTIFF-00093

01375

NCOR54
User: CWRIGHT
Hospital: 1

THREE RIVERS BEHAVIORAL HEALTH
MONITOR Patient Chart
ARGOE MARTHA L

Page: 4
Date: 7/21/05
Time: 10:57

Demographics			
Patient Name: ARGOE MARTHA L	Ht:	Sex: F	Admission Date: 6/09/05
Patient Num: 1018795	Wt:	Age: 62	Discharge Date: 7/20/05
Med Rec Num: 24396			Birth Date:
Adm Dx: MENTAL DISOR NOS OTH DIS			

Assessments	
Scars	
surgical, bikini line	
Assessment for Special Precautions:	
Other: Explain	
denies problems, states husband is abusive and is making all this up	
Precautions to be taken:	
15 Minute Observation	
RN Admission Summary:	
Patient denies any problems, states her husband is very abusive and has hit her. She says she moved out of the bedroom into another room and locked the door. Also states that she quit cleaning the house because he quit paying the cleaning service and ordered her to do it and she refused. She admits to spending a lot of money on clothes recently and states she has not had anything new for 20 years and she is taking a stand against her husbands abuse. Calm and cooperative upon admission.	
Patient Contraband Search	6/09/05 20:27 VLG
Addendum: LARGE PINK AND BLACK TOTE CONTAINING ONE PAIR OF WHITE PANTS AND A WIRE HANGER.	
CAD	06/13/05 15:56
Reason for Search:	
New Admission	
Scope of Search	
Belongings Search	
Non-invasive Body Search	
Belongings/ Contraband Removed	
List description of belongings/ contraband:	
Black leather type belt	
Bottle of Scope mouthwash	
Disposition of Contraband/Belongings:	
(Where items are stored)	
IA Closet	
Dietary Order Form	6/09/05 20:25 VLG
Dietary order is for:	
New Admission	
Diet ordered:	
Regular	
Identified food allergy	
None	
Religious, Cultural, or Ethnic food preferences or restrictions:	
No	

Care Plans	
Problem	
SENSORY/PERCEPTUAL ALTERATION: VISUAL/ AUDITORY- AS EVIDENCED BY HALLUCINATIONS/DISORIENTATION, INAPPROPRIATE RESPONSES RAPID MOOD SWINGS, VISUAL AND AUDITORY DISTORTIONS, TALKING/LAUGHING TO SELF, SUSPICIOUSNESS, INABILITY TO CONCENTRATE/LOSS OF ONE'S OWN SENSE OF REALITY OR OF THE EXTERNAL WORLD. (ACTIVE) Assigned: 06/10/05	
Outcome	
SHORT TERM GOAL: DELUSIONS WILL NOT INTERFERE WITH DAILY FUNCTIONING OF MARTHA. (EXP ACH DT 07/26/05) (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05	
Intervention	
* AT- POSITIVE COPING SKILLS. (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/14/05	
* RN ASSESSMENT DAILY FOR MARTHA TO DETERMINE MOOD, MENTAL STATUS, AND PERCEPTION OF EFFECTIVENESS OF MEDICATION. (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05	
* GIVE REINFORCEMENT TO MARTHA TO DIFFERENTIATE BETWEEN REALITY AND NONREALITY	

BASED THINKING. (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05

* ENCOURAGE INDEPENDENCE BUT INTERVENE WHEN MARTHA IS UNABLE TO PERFORM ADL'S (AMBULATION, EATING, HYGIENE). (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05

* IDENTIFY SELF-CARE DEFICITS AND PROVIDE ASSISTANCE AS REQUIRED. ALLOW PLENTY OF TIME FOR MARTHA TO PERFORM TASKS PROVIDE GUIDANCE AND SUPPORT FOR INDEPENDENT ACTIONS. (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05

* MAINTAIN ADEQUATE NUTRITION AND HYDRATION. (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05

* SW GROUP- REALITY ORIENTED CONTACTS WITH OTHERS AND TO GIVE FEEDBACK ABOUT BEHAVIORS TO MARTHA. (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05

Outcome

LONG TERM GOAL: MARTHA VERBALIZES IMPORTANCE OF MEDICATION COMPLIANCE AFTER DISCHARGE (EXP ACH DT 07/26/05) (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05

Intervention

* MEDICATION EDUCATION FOR MARTHA RELATED TO EFFECTS AND SIDE EFFECTS OF CURRENT MEDICATION. (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05

Outcome

LONG TERM GOAL: MARTHA'S THOUGHT PROCESSES REFLECT ACCURATE INTERPRETATION OF ENVIRONMENT. (EXP ACH DT 07/26/05) (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05

Intervention

* CURRENT MEDICATIONS FOR MARTHA AT DOSAGE AND SCHEDULE PRESCRIBED TO ASSIST IN ORGANIZING THOUGHTS. (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05

* HELP MARTHA TO RECOGNIZE TIMES WHEN POOR JUDGEMENT IS BEING USED. WAYS TO HANDLE THE SITUATION BETTER AND RESULTS OF USING POOR JUDGEMENT. (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05

Outcome

SHORT TERM GOAL: MARTHA WILL NOT ATTEMPT TO HARM SELF OR OTHERS DUE TO ALTERED THOUGHT PROCESSES. (EXP ACH DT 07/26/05) (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05

Intervention

* OBSERVATION AT LEVEL ORDERED BY PHYSICIAN TO PREVENT HARM TO SELF AND/OR OTHERS. (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05

Outcome

SHORT TERM GOAL: MARTHA WILL BE ABLE TO FOLLOW TOPIC OF CONVERSATION FOR 3-5 MINUTES. (EXP ACH DT 07/26/05) (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05

Intervention

* IDENTIFY BARRIERS OF COMMUNICATION RELATED TO COGNITIVE DEFECITS AND DISORGANIZED THOUGHT PROCESSES. (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05

* PROMOTE GOOD EYE CONTACT TO CONVEY CORRECT NONVERBAL EXPRESSIONS BY EXAMPLE. (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05

Outcome

LONG TERM GOAL: MARTHA WILL RETURN TO BASELINE LEVEL OF ACTIVITY AND JUDGEMENT. (EXP ACH DT 07/26/05) (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05

Intervention

* SET BEHAVIOR LIMITS, PROVIDE FEEDBACK, AND ENCOURAGE MARTHA TO ASSUME RESPONSIBILITY FOR OWN ACTIONS. (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05

Outcome

SHORT TERM GOAL: MARTHA WILL MAKE SIMPLE DECISIONS REGARDING TREATMENT AND LIVING SKILLS. (EXP ACH DT 07/26/05) (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05

Intervention

* PATIENT EDUCATION FOR MARTHA REGARDING ILLNESS TO PROMOTE SELF CARE AND RELAPSE PREVENTION. (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05

* STAFF WILL ASSIST MARTHA DEVELOP LIST OF PERSONAL STRENGTHS AND WEAKNESSES IN AN EFFORT TO ACHIEVE TREATMENT GOALS. (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05

Outcome

SHORT TERM GOAL: MARTHA WILL DEMONSTRATE DECREASED SUSPICIOUSNESS AS EVIDENCED BY MEDICATION COMPLIANCE, APPROPRIATE EYE CONTACT, AND INTERACTION WITH STAFF AND PEERS. (EXP ACH DT 07/26/05) (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00)

PLAINTIFF-00094

ICOR54
User: CWRIGHT
Hospital: 1

THREE RIVERS BEHAVIORAL HEALTH
MONITOR Patient Chart
ARGOE MARTHA L

Page: 5
Date: 7/21/05
Time: 10:57

Demographics			
Patient Name: ARGOE MARTHA L			
Patient Num: 1018795	Ht:	Sex: F	Admission Date: 6/09/05
Med Rec Num: 24396	Wt:	Age: 62	Discharge Date: 7/20/05
Adm Dx: MENTAL DISOR NOS OTH DIS			Birth Date:

Care Plans	
Assigned: 06/10/05	
<u>Intervention</u>	
* DEVELOP TRUSTING RELATIONSHIP WITH MARTHA. (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05	
* ENCOURAGE MARTHA TO BE OUT OF THEIR ROOM FOR INTERACTION AND TO DECREASE SOCIAL ISOLATION. (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05	
* PROVIDE QUIET ENVIRONMENT. (ACHIEVED-Bobbie Norris, RN 07/20/05 00:00) Assigned: 06/10/05	

Outcome
SHORT-TERM GOAL: MARTHA WILL SEEK OUT STAFF AT ANY TIME THOUGHTS OF HARMING SELF OR OTHERS SHOULD OCCUR. (REMOVED-Vicki Elliott, RN 06/21/05 14:57) Assigned: 06/10/05

Outcome
SHORT-TERM GOAL: MARTHA WILL BE ABLE TO DEFINE REALITY FROM PSYCHOTIC THOUGHTS PRIOR TO DISCHARGE. (REMOVED-Vicki Elliott, RN 06/21/05 14:57) Assigned: 06/10/05

Outcome
SHORT-TERM GOAL: MARTHA WILL PERFORM ADL'S WITHOUT SUPERVISION OR MINIMAL STAFF SUPERVISION. (REMOVED-Vicki Elliott, RN 06/21/05 14:56) Assigned: 06/10/05

Patient Care Activities	
7/20/05 12:00	BON Note GENERAL NOTE PATIENT WAS DISCHARGED TO THE CARE OF HER HUSBAND AND SON. PATIENT RECEIVED DISCHARGE INSTRUCTIONS AND PRESCRIPTIONS. SHE LEFT WITH ALL PERSONAL BELONGINGS.
7/20/05 12:00	BON Achieved OUT OF CONTACT WITH REALITY: SENSORY/PERCEPTUAL ALTERATION MARTHA DEMONSTRATES LESS SUSPICIOUSNESS THRU INTERACTION...
7/20/05 12:00	BON Achieved OUT OF CONTACT WITH REALITY: SENSORY/PERCEPTUAL ALTERATION MARTHA WILL MAKE SIMPLE DECISIONS REGARDING TREATMENT...
7/20/05 12:00	BON Achieved OUT OF CONTACT WITH REALITY: SENSORY/PERCEPTUAL ALTERATION MARTHA WILL RETURN TO BASELINE OF ACTIVITY AND JUDGEMENT.
7/20/05 12:00	BON Achieved OUT OF CONTACT WITH REALITY: SENSORY/PERCEPTUAL ALTERATION MARTHA WILL BE ABLE TO FOLLOW TOPIC OF CONVERSATION.
7/20/05 12:00	BON Achieved OUT OF CONTACT WITH REALITY: SENSORY/PERCEPTUAL ALTERATION MARTHA WILL NOT ATTEMPT TO HARM SELF OR OTHERS.
7/20/05 12:00	BON Achieved OUT OF CONTACT WITH REALITY: SENSORY/PERCEPTUAL ALTERATION MARTHA'S THOUGHT PROCESSES REFLECT ACCURATE INTERPRETATION.
7/20/05 12:00	BON Achieved OUT OF CONTACT WITH REALITY: SENSORY/PERCEPTUAL ALTERATION MARTHA WILL VERBALIZE NEED FOR MEDICATION COMPLIANCE AFTER...
7/20/05 12:00	BON Achieved OUT OF CONTACT WITH REALITY: SENSORY/PERCEPTUAL ALTERATION DELUSIONS WILL NOT INTERFERE WITH MARTHA DAILY FUNCTIONING.
7/20/05 10:10	BON Performed DEVELOP TRUST RELATIONSHIP WITH MARTHA
7/20/05 10:10	BON Performed ENCOURAGE MARTHA TO BE OUT OF ROOM FOR INTERACTION AND TO...
7/20/05 10:10	BON Performed PROVIDE QUIET ENVIRONMENT.
7/20/05 10:10	BON Performed PROMOTE GOOD EYE CONTACT TO CONVEY CORRECT NONVERBAL

7/20/05 10:10	BON	Performed	SET BEHAVIOR LIMITS, PROVIDE FEEDBACK, AND ENCOURAGE MARTHA
7/20/05 10:10	BON	Performed	EDUCATION FOR MARTHA REGARDING ILLNESS TO PROMOTE SELF-CARE
7/20/05 10:09	BON	Performed	EDUCATE MARTHA ABOUT EFFECTS AND SIDE EFFECTS OF MEDICATION
7/20/05 10:09	BON	Performed	MEDICATION FOR MARTHA TO ASSIST IN ORGANIZING THOUGHTS...
7/20/05 10:09	BON	Performed	HELP MARTHA TO RECOGNIZE TIMES WHEN POOR JUDGEMENT
7/20/05 10:09	BON	Performed	OBSERVATION FOR MARTHA TO PREVENT HARM TO SELF/OTHERS
7/20/05 10:09	BON	Performed	REINFORCE MARTHA'S ABILITY TO DIFFERENTIATE BETWEEN REALITY:
7/20/05 10:09	BON	Performed	MARTHA WILL ACCOMPLISH SELF CARE TO BEST OF SHE ABILITY...
7/20/05 10:09	BON	Performed	MAINTAIN ADEQUATE NUTRITION AND HYDRATION.
7/20/05 4:34	FLT	Note	GENERAL NOTE

PATIENT SLEPT THROUGHOUT THE COURSE OF THE NIGHT SHIFT WITHOUT ANY PROBLEMS. RESPIRATIONS WERE EVEN. PATIENT IS ON LEVEL III CONTINUE TO MONITOR.

7/19/05 19:00	RFB	Performed	DEVELOP TRUST RELATIONSHIP WITH MARTHA
7/19/05 19:00	RFB	Performed	ENCOURAGE MARTHA TO BE OUT OF ROOM FOR INTERACTION AND TO...

7/19/05 19:00	RFB	Performed	PROVIDE QUIET ENVIRONMENT.
7/19/05 18:59	RFB	Performed	IDENTIFY BARRIERS OF COMMUNICATION.
7/19/05 18:59	RFB	Performed	PROMOTE GOOD EYE CONTACT TO CONVEY CORRECT NONVERBAL

7/19/05 18:59	RFB	Performed	SET BEHAVIOR LIMITS, PROVIDE FEEDBACK, AND ENCOURAGE MARTHA
7/19/05 18:59	RFB	Performed	EDUCATION FOR MARTHA REGARDING ILLNESS TO PROMOTE SELF-CARE
7/19/05 18:59	RFB	Performed	EDUCATE MARTHA ABOUT EFFECTS AND SIDE EFFECTS OF MEDICATION
7/19/05 18:59	RFB	Performed	MEDICATION FOR MARTHA TO ASSIST IN ORGANIZING THOUGHTS...
7/19/05 18:59	RFB	Performed	HELP MARTHA TO RECOGNIZE TIMES WHEN POOR JUDGEMENT
7/19/05 18:59	RFB	Performed	OBSERVATION FOR MARTHA TO PREVENT HARM TO SELF/OTHERS
7/19/05 18:59	RFB	Performed	REINFORCE MARTHA'S ABILITY TO DIFFERENTIATE BETWEEN REALITY:
7/19/05 18:59	RFB	Performed	ENCOURAGE INDEPENDENCE BUT INTERVENE WHEN MARTHA IS UNABLE
7/19/05 18:59	RFB	Performed	MARTHA WILL ACCOMPLISH SELF CARE TO BEST OF SHE ABILITY...
7/19/05 18:59	RFB	Performed	MAINTAIN ADEQUATE NUTRITION AND HYDRATION.
7/19/05 18:57	RFB	Performed	RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND MEDICATION EFFECT

B: PATIENT IS PLEASANT, FRIENDLY, AND INTERACTS WELL WITH STAFF AND PEERS. IS MEDICATION COMPLIANT, TAKES ADEQUATE FOOD/FLUIDS, AND ATTENDS GROUP. I: ENCOURAGED TO MAINTAIN ADEQUATE FOOD/FLUIDS, TO BE MEDICATION COMPLIANT, AND TO CONTINUE WITH GROUP PARTICIPATION. R: ACKNOWLEDGES UNDERSTANDING. P: CONTINUE WITH PLAN OF CARE

7/19/05 9:27	JIP	Note	OUT OF CONTACT WITH REALITY: SENSORY/PERCEPTUAL ALTERATION

TREATMENT TEAM SW WAITING FOR CALL BACK TO ARRANGE FAMILY SESSION. POSSIBLE PLACEMENT IN AN ASSISTED LIVING FACILITY. FAMILY NEEDS TO GET POA IN PLACE. WILL DISCHARGE AFTER EVERYTHING IS ORDER.

7/19/05 4:48	GS	Note	GENERAL NOTE

PATIENT IS LYING QUIETLY ON BED IN HER ROOM, RESPIRATIONS ARE EVEN AND UNLABORED, WILL CONTINUE TO MONITOR HER ON LEVEL 3.

7/18/05 6:21	SAS	Note	GENERAL NOTE

PT OBSERVED TO BE RESTING IN BED WITH EYES CLOSED THROUGHOUT THE NIGHT. RESPIRATIONS EVEN, NONLABORED. NO DISTRESS NOTED. WILL CONTINUE TO MONITOR PER LEVEL 3.

7/17/05 20:06	SJH	Note	GENERAL NOTE

B)PATIENT WAS SITTING IN THE DAY AREA WATCHING TV WITH

PLAINTIFF-00095

01377

Demographics			
Patient Name: ARGOE MARTHA L	Ht:	Sex: F	Admission Date: 6/09/05
Patient Num: 1018795	Wt:	Age: 62	Discharge Date: 7/20/05
Med Rec Num: 24396			Birth Date:
Adm Dx: MENTAL DISOR NOS OTH OIS			
Patient Care Activities			
			PEERS. DONE ON ONE ASSESSMENT. PATIENT SAID SHE WAS VERY HAPPY ABOUT GETTING A BIRTHDAY PRESENT FROM HER FAMILY. PATIENT WAS COMPLIANT WITH MEDICATIONS AND ATTENDED GROUPS. P. WILL CONTINUE TO MONITOR.
7/17/05 19:40	DAW	Performed	ASSIST MARTHA WITH LIST OF PERSONAL STRENGTHS/WEAKNESSES
7/17/05 19:40	DAW	Performed	DEVELOP TRUST RELATIONSHIP WITH MARTHA
7/17/05 19:40	DAW	Performed	ENCOURAGE MARTHA TO BE OUT OF ROOM FOR INTERACTION AND TO...
7/17/05 19:40	DAW	Performed	PROVIDE QUIET ENVIRONMENT.
7/17/05 19:40	DAW	Performed	HELP MARTHA TO RECOGNIZE TIMES WHEN POOR JUDGEMENT
7/17/05 19:40	DAW	Performed	OBSERVATION FOR MARTHA TO PREVENT HARM TO SELF/OTHERS
7/17/05 19:40	DAW	Performed	IDENTIFY BARRIERS OF COMMUNICATION.
7/17/05 19:40	DAW	Performed	PROMOTE GOOD EYE CONTACT TO CONVEY CORRECT NONVERBAL
7/17/05 19:40	DAW	Performed	SET BEHAVIOR LIMITS, PROVIDE FEEDBACK, AND ENCOURAGE MARTHA
7/17/05 19:40	DAW	Performed	EDUCATION FOR MARTHA REGARDING ILLNESS TO PROMOTE SELF-CARE
7/17/05 19:40	DAW	Performed	EDUCATE MARTHA ABOUT EFFECTS AND SIDE EFFECTS OF MEDICATION
7/17/05 19:40	DAW	Performed	MEDICATION FOR MARTHA TO ASSIST IN ORGANIZING THOUGHTS
7/17/05 19:40	DAW	Performed	REINFORCE MARTHA'S ABILITY TO DIFFERENTIATE BETWEEN REALITY
7/17/05 19:40	DAW	Performed	ENCOURAGE INDEPENDENCE BUT INTERVENE WHEN MARTHA IS UNABLE
7/17/05 19:40	DAW	Performed	MARTHA WILL ACCOMPLISH SELF CARE TO BEST OF SHE ABILITY.
7/17/05 19:40	DAW	Performed	MAINTAIN ADEQUATE NUTRITION AND HYDRATION.
7/17/05 19:34	DAW	Performed	RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND MEDICATION EFFECT
			B: OBSERVED IN DAYAREA INTERACTING WITH PEERS. I: ONE TO ONE ASSESSMENT. R: PLEASANT AND COOPERATIVE. JOVIAL WHEN APPROACHED. VISITED WITH SPOUSE AND SON AND DAUGHTER IN LAW TODAY. VOICED SHE WAS GLAD TO SEE THEM. DOES STATE THAT SHE IS PLANNING TO GO HOME AT DISCHARGE BUT THAT IS STILL PLANNING TO DIVORCE HER SPOUSE AND THAT HE IS AWARE OF THIS. VOICE HER SON WILL "ALWAYS BE MY SON" BUT THAT SHE HOPES HE HAS NOT GIVEN HER SPOUSE THINGS HE SHOULD'NT HAVE. STATES SHE HAS EXPOSED WHO HE IS AND THAT HE CAN'T DENY IT. VOICED SHE HAS BEEN READING HER BIBLE AND FEELS GOD IS OK WITH HER DECISION. STATES SHE HOPEFUL TO HAVE A GOOD LIFE AND TO START OVER. ATTENDS GROUPS AND MEALS AND IS MEDICATION COMPLIANT ALTHOUGH REQUEST STAFF TO DOCUMENT THAT SHE DOES NOT WANT TO TAKE MEDICATION. P: FOLLOW TREATMENT PLAN.
7/17/05 4:34	SAS	Note	GENERAL NOTE
			PT RESTING IN BED WITH EYES CLOSED. RESPIRATIONS EVEN, UNLABORED. NO DISTRESS NOTED. WILL CONTINUE TO MONITOR PER LEVEL 3.
7/16/05 9:43	LHJ	Performed	RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND MEDICATION EFFECT
			B: APPROPRIATE AFFECT. OBSERVED SOCIALIZING WITH HER PEERS. GOOD EYE CONTACT DURING GROUP SESSION. I: L: NURSING CONSULTATION AND GROUP SUPPORT AND ENCOURAGEMENT. R: REPORTS HER GOAL WAS TO PRAISE GOD ALL DAY AND TO CONTINUE WORKING ON HER GOALS AND ATTEND GROUPS, ALSO REPORTS FEELING SLUGGISH WHEN TAKING HER MEDICATIONS. P: CONTINUE TO ENCOURAGE PATIENT TO CONTINUE WORKING ON HER CARE PLAN

			GOALS AND GOALS SHE SETS IN GROUPS DAILY, AND MONITOR ACTIVITIES ON THE UNIT.
7/16/05 9:40	LHJ	Performed	RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND MEDICATION EFFECT
			B: GOOD EYE CONTACT, APPROPRIATE AFFECT, AND OBSERVED SOCIALIZING WITH HER PEERS.
7/16/05 6:02	SAS	Note	GENERAL NOTE
			PT RESTING IN BED WITH EYES CLOSED. RESPIRATIONS EVEN, UNLABORED. NO DISTRESS NOTED. WILL CONTINUE TO MONITOR PER LEVEL 3.
7/15/05 21:48	VLG	Performed	RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND MEDICATION EFFECT
			B: PATIENT UP ON UNIT WITH PLEASANT AFFECT. QUIET MOOD. INTERACTS WITH SELECT PEERS. I: ONE TO ONE TO ASSESS. R: PATIENT STATES SHE DOES NOT KNOW HOW LONG SHE WILL BE HERE, BUT DOES NOT EXPECT FAMILY SESSION NEXT WEEK TO GO WELL. WE'LL SEE. COOPERATIVE WITH STAFF AND ATTENDS UNIT ACTIVITIES. COMPLIANT WITH MEDS. P: CONTINUE TO MONITOR PER LEVEL 3.
7/15/05 4:11	RLL	Note	GENERAL NOTE
			PATIENT RESTING WITH EYES CLOSED, RESPIRATIONS EVEN AND UNLABORED. NO DISTRESS OR DISCOMFORT NOTED, WILL CONTINUE TO MONITOR AT LEVEL 3
7/14/05 22:26	VLG	Performed	RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND MEDICATION EFFECT
			B: UP ON UNIT WITH PLEASANT MOOD AND AFFECT. INTERACTING WELL WITH PEERS. I: ONE TO ONE TO ASSESS. R: SLIGHTLY DROWSY, BUT PLEASANT AND COOPERATIVE. STILL MINIMIZING HER PROBLEMS. ATTENDS ALL GROUPS AND ACTIVITIES. COMPLIANT WITH MEDS. P: CONTINUE LEVEL 3 OBSERVATION.
7/14/05 3:56	RLL	Note	GENERAL NOTE
			PATIENT RESTING WITH EYES CLOSED, RESPIRATIONS EVEN AND UNLABORED. NO DISTRESS OR DISCOMFORT NOTED, WILL CONTINUE TO MONITOR AT LEVEL 3
7/13/05 21:01	VLG	Performed	RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND MEDICATION EFFECT
			B: PATIENT UP ON UNIT WITH BRIGHT, FRIENDLY AFFECT. INTERACTING WITH PEERS. I: ONE TO ONE TO ASSESS. R: LAUGHING AND JOKING. RESPONSES REMAIN THE SAME. BLAMING HUSBAND FOR HER ADMISSION HERE. APPEARS DROWSY. ATTENDS GROUPS AND ACTIVITIES AND IS COMPLIANT WITH MEDICATIONS. P: WILL CONTINUE LEVEL 3 OBSERVATION.
7/13/05 4:03	CSM	Note	GENERAL NOTE
			RESTING QUIETLY IN BED WITH EYES CLOSED, RESPIRATIONS EVEN AND UNLABORED. WILL CONTINUE TO MONITOR PER TREATMENT PLAN.
7/12/05 20:08	RSE	Note	GENERAL NOTE
			ALERT, QUIET, PLEASANT, COOPERATIVE. NORMAL AFFECT. ATTENDING GROUPS. INTERACTING WELL WITH OTHER PATIENTS. DENIES ANY SI OR HALLUCINATIONS. NO RELIGIOUS FIXATIONS TODAY. STATES SHE IS DOING FINE.
7/12/05 9:26	MAM	Note	OUT OF CONTACT WITH REALITY: SENSORY/PERCEPTUAL ALTERATION
			TREATMENT TEAM: PATIENT CONTINUES TO HAVE DELUSIONS ABOUT HER HUSBAND. FOR EXAMPLE, SHE THINKS HER HUSBAND ALLOWED HIS 80 YEAR OLD MOTHER DIE OF STARVATION. NOTE MOTHER WAS IN THE LATER STAGES OF ALZHEIMERS. SHE DOES FEEL LIKE HER HUSBAND WILL NOT HIT HER AGAIN. SHE FEELS THAT SHE CAN LIVE WITH HIM.
7/12/05 4:20	TMP	Note	GENERAL NOTE
			PATIENT SLEEPING EYES CLOSED RESPIRATION EVEN NO COMPLAINTS. CONTINUE TO MONITOR THROUGHOUT SHIFT LEVEL III OBSERVATION.
7/11/05 23:32	MSH	Performed	RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND MEDICATION EFFECT
7/11/05 4:52	TMP	Note	GENERAL NOTE
			PATIENT SLEEPING EYES CLOSED RESPIRATION EVEN NO COMPLAINTS. CONTINUE TO MONITOR LEVEL III OBSERVATION THROUGHOUT SHIFT.
7/10/05 13:26	JRF	Note	GENERAL NOTE
			B: MARTHA OBSERVED ON SHIFT INTERACTING WITH PEERS AND

ICOR54
User: CWRIGHT
Hospital: 1

THREE RIVERS BEHAVIORAL HEALTH
MONITOR Patient Chart
ARGOE MARTHA L

Page: 7
Date: 7/21/05
Time: 10:57

Demographics

Patient Name: ARGOE MARTHA L
Patient Num: 1018795
Adm Rec Num: 24396
Adm Dx: MENTAL DISOR NOS OTH DIS

Sex: F
Age: 62

Admission Date: 6/09/05
Discharge Date: 7/20/05
Birth Date:

Patient Care Activities

ATTENDING SCHEDULED ACTIVITIES. DURING GOAL'S GROUP WHEN ASKED ABOUT SWEEPING NEGATIVE THINGS OUT OF HER LIFE SHE STATED AN ABUSIVE HUSBAND. I SPOKE WITH MARTHA L. AND DID A ROLE PLAY WITH HER IN REFERENCE TO BEING ASSERTIVE AND INFORMING HER HUSBAND THAT SHE IS DIVORCING HIM. R-SHE DISCLOSED THAT SHE WAS DEFINITELY GOING TO GET A DIVORCE. SHE WAS ABLE TO ROLE PLAY WITHOUT A PROBLEM, BUT STATED HOW DIFFICULT IT WAS TO TRANSFER HOW SHE FELT ONTO THE PARTICIPANT IN THE ROLE PLAY. P-CONTINUE TO MONITOR AND FOLLOW CURRENT TREATMENT PLAN.

7/10/05 4:23 CSM Note GENERAL NOTE
EYES CLOSED, RESPIRATIONS EVEN AND UNLABORED, RESTING QUIETLY IN BED AT PRESENT. WILL CONTINUE TO MONITOR PER TREATMENT PLAN.

7/09/05 19:52 DEB Performed RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND MEDICATION EFFECT
B- MARTHA HAS BEEN INTERACTING WITH HER PEERS. SHE IS PLEASANT AND COOPERATIVE. STILL IN DENIAL REGARDING HER ILLNESS. STILL BLAMES EVERYTHING ON HER HUSBAND. I- INTERACTION TO ASSESS MOOD, MEDICATIONS AS ORDERED. GROUP R- ATTENDING GROUPS AND ACTIVITIES. P- CONTINUE TO MONITOR MOOD AND BEHAVIOR. DALE E. BEINOR, RN

7/09/05 13:26 JRF Note GENERAL NOTE
R-MARTHA CONTINUED TO FOLLOW THE DAILY SCHEDULE AND SPOKE OF A NEED TO HAVE FINGER NAILS CUT BECAUSE THEY WERE CAUSING HER SOME PAIN. SHE STATED THAT THE NURSE AND DOCTOR KNOWS ABOUT THIS NEED. SHE ALSO WAS COMPLIANT WITH TAKING HER MEDICATIONS. P-CONTINUE TO FOLLOW CURRENT TREATMENT PLAN.

7/09/05 13:19 JRF Note GENERAL NOTE
B-MARTHA OBSERVED ON SHIFT WITH NO MAJOR PROBLEMS. AFFECT BRIGHT. SHE ATTENDED ACTIVITIES AND INTERACTED WITH PEERS. I- ACTIVELY OBSERVED.

7/09/05 4:41 CSM Note GENERAL NOTE
RESTING QUIETLY IN BED WITH EYES CLOSED, RESPIRATIONS EVEN AND UNLABORED. WILL CONTINUE TO MONITOR PER TREATMENT PLAN.

7/08/05 22:54 VLG Performed RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND MEDICATION EFFECT
B. UP ON UNIT WITH QUIET MOOD. MINIMAL INTERACTION WITH PEERS. I. ONE TO ONE TO ASSESS. R. CONTINUES WITH SAME COMPLAINTS ABOUT HUSBAND. ISOLATING MORE. COMPLIANT WITH GROUPS AND MEDS. P. CONTINUE LEVEL 3 OBSERVATION.

7/08/05 4:53 IAM Note GENERAL NOTE
PATIENT RESTING QUIETLY IN ROOM IN BED EYES ARE CLOSED RESPERATIONS ARE EVEN AND UNLABORED WILL CONTINUE TO MONITOR ON A LEVEL III OBSERVATION.

7/07/05 21:42 VLG Performed RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND MEDICATION EFFECT

7/07/05 4:18 ADA Note GENERAL NOTE
PATIENT RESTED WELL DURING THE NIGHT WITH EYES CLOSED. NO DISTRESS NOTED. RESPIRATIONS EQUAL AND UNLABORED. PRESENTLY ON LEVEL 3. WILL CONTINUE TO MONITOR ACCORDING TO HER TREATMENT PLAN.

7/06/05 22:35 VLG Performed RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND MEDICATION EFFECT
B. UP ON UNIT WITH CALM PLEASANT MOOD AND AFFECT. HUSBAND AND SON VISITED. WITH PATIENT REFUSING TO TALK WITH HUSBAND. I. ONE TO ONE TO ASSESS. R. PATIENT STATES HUSBAND HAS EVERYONE FOOLED. THAT HE IS ABUSIVE AND SHE WILL DIVORCE HIM WHEN RELEASED. ALL SAID WITH A CALM SMILE. ATTENDING ALL GROUPS AND ACTIVITIES. GOT UPSET ABOUT HAVING

TO TAKE MORE MEDICINE AFTER GETTING RISPERDAL CONSTA TODAY.
P. CONTINUE LEVEL 3 OBSERVATION.

7/06/05 4:31 BNS Note GENERAL NOTE
PATIENT IS IN BED RESTING QUIETLY WITH EYES CLOSED. RESPIRATIONS ARE EVEN AND UNLABORED. NO DISTRESS NOTED. PATIENT WILL CONTINUE TO BE MONITORED AT LEVEL 3.

7/05/05 13:35 BON Performed RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND MEDICATION EFFECT
B: PATIENT IS AMBULATING IN HER ROOM. I: ONE TO ONE ASSESSMENT R: ALERT AND ORIENTED TIMES THREE. ATTENDS GROUPS AND IS COMPLIANT WITH MEDICATIONS. PARANOID. NO INSIGHT. DENIES A/V HALLUCINATIONS. DENIES SUICIDAL/HOMICIDAL IDEATIONS. INTERACTS MOSTLY WITH SELECT FEMALE PEER. NO PHYSICAL COMPLAINTS VOICED. P: CONTINUE WITH CURRENT TREATMENT PLAN.

7/05/05 9:21 VBE Note OUT OF CONTACT WITH REALITY: SENSORY/PERCEPTUAL ALTERATION.
TREATMENT TEAM: REMAINS VERY PARANOID, THOUGH VERY PLEASANT. MAY NEED ANOTHER RISPERDAL CONSTA INJECTION. SLIGHTLY IMPROVED.

7/05/05 8:03 BON Performed PROVIDE QUIET ENVIRONMENT.
7/05/05 8:03 BON Performed DEVELOP TRUST RELATIONSHIP WITH MARTHA
7/05/05 8:03 BON Performed ENCOURAGE MARTHA TO BE OUT OF ROOM FOR INTERACTION AND TO...
7/05/05 8:03 BON Performed SET BEHAVIOR LIMITS, PROVIDE FEEDBACK, AND ENCOURAGE MARTHA
7/05/05 8:03 BON Performed EDUCATION FOR MARTHA REGARDING ILLNESS TO PROMOTE SELF-CARE
7/05/05 8:03 BON Performed PROMOTE GOOD EYE CONTACT TO CONVEY CORRECT NONVERBAL
7/05/05 8:03 BON Performed OBSERVATION FOR MARTHA TO PREVENT HARM TO SELF/OTHERS
7/05/05 8:03 BON Performed EDUCATE MARTHA ABOUT EFFECTS AND SIDE EFFECTS OF MEDICATION
7/05/05 8:03 BON Performed MEDICATION FOR MARTHA TO ASSIST IN ORGANIZING THOUGHTS.
7/05/05 8:03 BON Performed HELP MARTHA TO RECOGNIZE TIMES WHEN POOR JUDGEMENT
7/05/05 8:02 BON Performed REINFORCE MARTHA'S ABILITY TO DIFFERENTIATE BETWEEN REALITY.
7/05/05 8:02 BON Performed MARTHA WILL ACCOMPLISH SELF CARE TO BEST OF SHE ABILITY.
7/05/05 8:02 BON Performed MAINTAIN ADEQUATE NUTRITION AND HYDRATION.
7/05/05 4:19 FLT Note GENERAL NOTE
PATIENT SLEPT THROUGHTOUT THE COURSE OF THE NIGHT SHIFT WITHOUT ANY PROBLEMS. RESPIRATIONS WERE EVEN. PATIENT IS ON LEVEL III CONTINUE TO MONITOR.

7/04/05 12:40 BFM Performed RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND MEDICATION EFFECT
B: MARTHA HAS ATTENDED GROUPS TODAY AND IS MEDICATION COMPLIANT. I: ONE ON ONE ASSESSMENT. R: ALERT AND ORIENTED TIMES THREE. STATES SHE IS FEELING OKAY TODAY. AFFECT BRIGHT. INTERACTING WELL WITH SELECT PEERS. SPENDING MOST OF HER TIME IN THE DAY AREA. ENCOURAGED TO PARTICIPATE IN GROUPS. P: CONTINUE CURRENT TREATMENT PLAN.

7/04/05 7:58 BFM Performed ASSIST MARTHA WITH LIST OF PERSONAL STRENGTHS/WEAKNESSES
7/04/05 7:58 BFM Performed DEVELOP TRUST RELATIONSHIP WITH MARTHA
7/04/05 7:58 BFM Performed ENCOURAGE MARTHA TO BE OUT OF ROOM FOR INTERACTION AND TO...
7/04/05 7:58 BFM Performed PROVIDE QUIET ENVIRONMENT.
7/04/05 7:58 BFM Performed IDENTIFY BARRIERS OF COMMUNICATION.
7/04/05 7:58 BFM Performed PROMOTE GOOD EYE CONTACT TO CONVEY CORRECT NONVERBAL
7/04/05 7:58 BFM Performed SET BEHAVIOR LIMITS, PROVIDE FEEDBACK, AND ENCOURAGE MARTHA
7/04/05 7:58 BFM Performed EDUCATION FOR MARTHA REGARDING ILLNESS TO PROMOTE SELF-CARE
7/04/05 7:58 BFM Performed EDUCATE MARTHA ABOUT EFFECTS AND SIDE EFFECTS OF MEDICATION
7/04/05 7:58 BFM Performed MEDICATION FOR MARTHA TO ASSIST IN ORGANIZING

What
did
you
believe
that
was
crazy

PLAINTIFF-00097

01379

NCOR54
User: CWRIGHT
Hospital: 1

THREE RIVERS BEHAVIORAL HEALTH
MONITOR Patient Chart
ARGOE MARTHA L

Page: 8
Date: 7/21/05
Time: 10:57

Demographics	
Patient Name: ARGOE MARTHA L	Admission Date: 6/09/05
Patient Num: 1018795	Discharge Date: 7/20/05
Med Rec Num: 24396	Birth Date:
Adm Dx: MENTAL DISOR NOS OTH DIS	

Patient Care Activities	
7/04/05 7:58	BFM Performed THOUGHTS. HELP MARTHA TO RECOGNIZE TIMES WHEN POOR JUDGEMENT
7/04/05 7:58	BFM Performed OBSERVATION FOR MARTHA TO PREVENT HARM TO SELF/OTHERS
7/04/05 7:58	BFM Performed REINFORCE MARTHA'S ABILITY TO DIFFERENTIATE BETWEEN REALITY:
7/04/05 7:58	BFM Performed ENCOURAGE INDEPENDENCE BUT INTERVENE WHEN MARTHA IS UNABLE
7/04/05 7:58	BFM Performed MARTHA WILL ACCOMPLISH SELF CARE TO BEST OF SHE ABILITY.
7/04/05 7:58	BFM Performed MAINTAIN ADEQUATE NUTRITION AND HYDRATION.
7/04/05 4:33	FLT Note GENERAL NOTE
7/03/05 17:59	RSE Note GENERAL NOTE
7/03/05 5:13	IAM Note GENERAL NOTE
7/02/05 13:26	DAA Note GENERAL NOTE
7/02/05 4:00	SAM Note GENERAL NOTE
7/01/05 21:16	VLG Performed RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND MEDICATION EFFECT
7/01/05 17:36	VLG Note GENERAL NOTE
7/01/05 5:17	CSM Note GENERAL NOTE
6/30/05 5:19	ADA Note GENERAL NOTE
6/29/05 20:49	VLG Performed RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND MEDICATION EFFECT
6/29/05 9:38	NAM Note OUT OF CONTACT WITH REALITY: SENSORY/PERCEPTUAL

ALTERATION	
6/29/05 4:21	TMP Note GENERAL NOTE
6/28/05 20:36	VLG Performed RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND MEDICATION EFFECT
6/28/05 16:32	MAM Note GENERAL NOTE
6/28/05 8:28	BON Performed SOCIAL WORKER MET WITH PATIENT TO OBTAIN VERBAL PERMISSION TO TALK WITH HER FAMILY ABOUT PATIENT'S TREATMENT. PATIENT GAVE SOCIAL WORKER PERMISSION TO TALK WITH HER FAMILY, BUT PATIENT SAID SHE DIDN'T WANT TO TALK WITH HER SIBLINGS AND HUSBAND ONLY WITH HER SON. PATIENT DENIES HAVING ANY DISORDER. HOWEVER, HER SIBLINGS HAVE GIVEN A DESCRIPTION OF PATIENT'S HOME AS BEING DISORGANIZED AND FILTHY. IN ADDITION, PATIENT HAS STORED AND HIDDEN MANY OBJECTS AROUND THE TOWN IN VARIOUS SHEDS. PATIENT SHARED HAS PARANOID IDEAS ABOUT HER HUSBAND FOR YEARS, INCLUDING PATIENT'S BELIEFS ABOUT HOUSE BEING POISONED AND BUGGED. PATIENT'S SIBLINGS (ONE IS A DOCTOR) SAID THAT PATIENT'S GRANDMOTHER AND MOTHER HAD SYMPTOMS OF BI-POLAR MANIA. PATIENT DOESN'T BELIEVE THAT HER MOTHER NOR GRANDMOTHER WERE BI-POLAR.
6/28/05 8:28	BON Performed DEVELOP TRUST RELATIONSHIP WITH MARTHA
6/28/05 8:28	BON Performed ENCOURAGE MARTHA TO BE OUT OF ROOM FOR INTERACTION AND TO...
6/28/05 8:28	BON Performed PROVIDE QUIET ENVIRONMENT.
6/28/05 8:28	BON Performed PROMOTE GOOD EYE CONTACT TO CONVEY CORRECT NONVERBAL
6/28/05 8:28	BON Performed SET BEHAVIOR LIMITS, PROVIDE FEEDBACK, AND ENCOURAGE MARTHA
6/28/05 8:28	BON Performed EDUCATION FOR MARTHA REGARDING ILLNESS TO PROMOTE SELF-CARE
6/28/05 8:28	BON Performed EDUCATE MARTHA ABOUT EFFECTS AND SIDE EFFECTS OF MEDICATION
6/28/05 8:28	BON Performed HELP MARTHA TO RECOGNIZE TIMES WHEN POOR JUDGEMENT
6/28/05 8:27	BON Performed OBSERVATION FOR MARTHA TO PREVENT HARM TO SELF/OTHERS
6/28/05 8:27	BON Performed REINFORCE MARTHA'S ABILITY TO DIFFERENTIATE BETWEEN REALITY:
6/28/05 8:27	BON Performed ENCOURAGE INDEPENDENCE BUT INTERVENE WHEN MARTHA IS UNABLE
6/28/05 8:27	BON Performed MARTHA WILL ACCOMPLISH SELF CARE TO BEST OF SHE ABILITY.
6/28/05 8:27	BON Performed MAINTAIN ADEQUATE NUTRITION AND HYDRATION.
6/28/05 4:28	GS Note GENERAL NOTE
6/27/05 14:53	DAW Performed PATIENT IS LYING QUIETLY ON BED IN HER ROOM, RESPIRATIONS ARE EVEN AND UNLABORED, WILL CONTINUE TO MONITOR ON LEVEL 3.
6/27/05 14:53	DAW Performed ENCOURAGE MARTHA TO BE OUT OF ROOM FOR INTERACTION AND TO...
6/27/05 14:53	DAW Performed PROVIDE QUIET ENVIRONMENT.
6/27/05 14:53	DAW Performed SET BEHAVIOR LIMITS, PROVIDE FEEDBACK, AND ENCOURAGE MARTHA
6/27/05 14:53	DAW Performed EDUCATION FOR MARTHA REGARDING ILLNESS TO PROMOTE SELF-CARE
6/27/05 14:53	DAW Performed ASSIST MARTHA WITH LIST OF PERSONAL STRENGTHS/WEAKNESSES
6/27/05 14:53	DAW Performed DEVELOP TRUST RELATIONSHIP WITH MARTHA
6/27/05 14:52	DAW Performed PROMOTE GOOD EYE CONTACT TO CONVEY CORRECT NONVERBAL
6/27/05 14:52	DAW Performed IDENTIFY BARRIERS OF COMMUNICATION.

PLAINTIFF-00098

01380

Demographics

Patient Name: ARGOE MARTHA L
Patient Num: 1018795 Ht: Sex: F Admission Date: 6/09/05
Bed Rec Num: 24396 Wt: Discharge Date: 7/20/05
dm Dx: MENTAL DISOR NOS OTH DIS Birth Date:

Patient Care Activities

6/27/05 14:52 DAW Performed HELP MARTHA TO RECOGNIZE TIMES WHEN POOR JUDGEMENT
6/27/05 14:52 DAW Performed OBSERVATION FOR MARTHA TO PREVENT HARM TO SELF/OTHERS
6/27/05 14:52 DAW Performed EDUCATE MARTHA ABOUT EFFECTS AND SIDE EFFECTS OF MEDICATION
6/27/05 14:52 DAW Performed MEDICATION FOR MARTHA TO ASSIST IN ORGANIZING THOUGHTS
6/27/05 14:52 DAW Performed MARTHA WILL ACCOMPLISH SELF CARE TO BEST OF SHE ABILITY
6/27/05 14:52 DAW Performed MAINTAIN ADEQUATE NUTRITION AND HYDRATION
6/27/05 14:52 DAW Performed ENCOURAGE INDEPENDENCE BUT INTERVENE WHEN MARTHA IS UNABLE
6/27/05 14:52 DAW Performed REINFORCE MARTHA'S ABILITY TO DIFFERENTIATE BETWEEN REALITY
6/27/05 14:48 DAW Performed RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND MEDICATION EFFECT
B. OBSERVED IN DAY AREA INTERACTING WITH PEERS. I. ONE TO ONE ASSESSMENT. R. PLEASANT AND COOPERATIVE. STATES HER SPOUSE VISITED THIS WEEKEND ON SUNDAY AND SHE RAN HIM OUT OF HERE. ALSO STATES HER SON VISITED AND PATIENT FEELS HE'S ALLOWING THE FATHER TO GET THINGS HE SHOULD'NT AND THAT SHE BECAME AGITATED. SHE ALSO STATES HER MARRIAGE IS OVER AND THAT SHE HAS MADE A DECISION AND THAT GOD GAVE HER PERMISSION FOR A DIVORCE. MARTHA IS VERY PLEASANT AND VERY MATTER OF FACT WHEN TALKING WITH RN. SHE STATES THAT SHE IS PRETTY MUCH STRESS FREE AT PRESENT BECAUSE IS NOT HAVING TO DEAL WITH BILLS ECT. SHE ALSO STATES HER FAMILY PUT HER HERE BECAUSE SHE WAS SHOPPING AND GOING OUT TO EAT A LOT WHICH WAS OUT OF CHARACTER FOR HER BUT THAT SHE HAD JUST BEGUN TO LIVE. SHE ATTENDS GROUPS AND MEALS AND IS MEDICATION COMPLIANT. SHE IS AWARE OF ALL MEDICATIONS TAKEN AND ASK PERTINENT QUESTIONS. DENIES SI/HI. P. FOLLOW TREATMENT PLAN.
6/27/05 4:13 GS Note GENERAL NOTE
PATIENT IS LYING QUIETLY ON BED IN HER ROOM, RESPIRATIONS ARE EVEN AND UNLABORED, WILL CONTINUE TO MONITOR HER IN ACCORDANCE WITH HER TREATMENT PLAN.
6/26/05 19:27 SJH Note GENERAL NOTE
B) PATIENT WAS SITTING IN THE DAY AREA WATCHING TV WITH PEERS. I) ONE ON ONE ASSESSMENT. R) PATIENT SAID THAT SHE WAS VERY EXCITED AND SUPRISED TO SEE HER SON TODAY. PATIENT WAS COMPLIANT WITH MEDICATIONS AND ATTENDED GROUPS WITH PEERS. P) WILL CONTINUE TO MONITOR.
6/26/05 11:10 DAA Note GENERAL NOTE
B. SITTING IN DAY ROOM, LOOKING AT NEWSPAPER. PLEASANT. RAPID SPEECH AND CONSTANT LOOKING AROUND. INTERACT WITH OTHERS AND FOLLOWS UNIT DIRECTIONS. MED: COMPLIANT. I. ENOURAGE HER TO CONTINUE WITH TX. AFTER D/C. R. STATES SHE DOESN'T KNOW WHEN SHE WILL BE D/C, BUT HOPES IT WILL BE SOON. WHEN ASKED ABOUT TAKING MEDS, "IF THEY COURTS SAY I HAVE TOO", DENIES THE NEED FOR THEM. CLAIMS SHE DOESN'T DRINK, SMOKE, OR TAKE DRUGS AND DOESN'T LIKE THE FEELING FROM THE MEDS. NO INSIGHT. P. CONTINUE WITH TX. PLAN.
6/26/05 4:03 KJK Note GENERAL NOTE
PATIENT SLEPT THROUGHOUT THE NIGHT WITH EYES CLOSED. RESPIRATION WAS EVEN AND UNLABORED. NO DISTRESS NOTED. STAFF WILL CONTINUE TO MONITOR LEVEL 3.
6/25/05 20:33 VLG Performed RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND MEDICATION EFFECT
6/25/05 13:27 KMB Note GENERAL NOTE
B) IN SW GROUP. I) 1:1 ASSESSEMENT AND OBSERVATION. R)

INTERACTS WELL WITH PEERS. IN DAY AREA WATCHING TELEVISION DURING FREE TIME. ATTENDED ALL SCHEDULED GROUPS. GOAL IS TO SERVE THE LORD. PT IS PLEASANT AND COOPERATIVE WITH STAFF. REMAINS ON PHONE RESTRICTION. NO BEHAVIOR PROBLEMS OBSERVED. P) WILL CONTINUE TO MONITOR AND ASSESS.

6/25/05 5:44 SAS Note GENERAL NOTE
PT RESTING IN BED WITH EYES CLOSED. RESPIRATIONS EVEN, NONLABORED. NO DISTRESS NOTED. WILL CONTINUE TO MONITOR PER LEVEL 3.
6/24/05 20:26 SJH Note GENERAL NOTE
B) PATIENT WAS SITTING IN THE DAY AREA WATCHING TV WITH PEERS. I) ONE ON ONE ASSESSMENT. R) PATIENT WAS COMPLIANT WITH MEDICATIONS AND ATTENDED GROUPS. PATIENT SAID SHE WAS LOOKING FORWARD TO THE WEEKEND BECAUSE OF VISITATIONS THIS WEEKEND. P) WILL CONTINUE TO MONITOR.
6/24/05 13:24 BFM Performed RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND MEDICATION EFFECT
6/24/05 8:41 BFM Performed ASSIST MARTHA WITH LIST OF PERSONAL STRENGTHS/WEAKNESSES
6/24/05 8:41 BFM Performed DEVELOP TRUST RELATIONSHIP WITH MARTHA
6/24/05 8:41 BFM Performed ENCOURAGE MARTHA TO BE OUT OF ROOM FOR INTERACTION AND TO...
6/24/05 8:41 BFM Performed PROVIDE QUIET ENVIRONMENT.
6/24/05 8:41 BFM Performed IDENTIFY BARRIERS OF COMMUNICATION.
6/24/05 8:41 BFM Performed PROMOTE GOOD EYE CONTACT TO CONVEY CORRECT NONVERBAL
6/24/05 8:41 BFM Performed SET BEHAVIOR LIMITS, PROVIDE FEEDBACK, AND ENCOURAGE MARTHA
6/24/05 8:41 BFM Performed EDUCATION FOR MARTHA REGARDING ILLNESS TO PROMOTE SELF-CARE
6/24/05 8:40 BFM Performed EDUCATE MARTHA ABOUT EFFECTS AND SIDE EFFECTS OF MEDICATION
6/24/05 8:40 BFM Performed MEDICATION FOR MARTHA TO ASSIST IN ORGANIZING THOUGHTS
6/24/05 8:40 BFM Performed HELP MARTHA TO RECOGNIZE TIMES WHEN POOR JUDGEMENT
6/24/05 8:40 BFM Performed OBSERVATION FOR MARTHA TO PREVENT HARM TO SELF/OTHERS
6/24/05 8:40 BFM Performed REINFORCE MARTHA'S ABILITY TO DIFFERENTIATE BETWEEN REALITY
6/24/05 8:40 BFM Performed ENCOURAGE INDEPENDENCE BUT INTERVENE WHEN MARTHA IS UNABLE
6/24/05 8:40 BFM Performed MARTHA WILL ACCOMPLISH SELF CARE TO BEST OF SHE ABILITY
6/24/05 8:40 BFM Performed MAINTAIN ADEQUATE NUTRITION AND HYDRATION.
6/24/05 4:47 IAM Note GENERAL NOTE
PATIENT RESTING QUIETLY IN ROOM. IN BED EYES ARE CLOSED RESPERATIONS ARE EVEN AND UNLABORED WILL CONTINUE TO MONITOR ON A LEVEL III OBSERVATION.
6/23/05 9:13 LBJ Performed RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND MEDICATION EFFECT
B-SITTING IN THE DAY AREA. I-ASSESSMENT BY THE REGISTERED NURSE. R-ALERT AND ORIENTATED X4. REQUESTING TO TALK TO MARIA THIS MORNING. SAID SHE IS HERE BECAUSE HER HUSBAND HAD HER ADMITTED. SHE BELIEVES HER HUSBAND IS UNHAPPY BECAUSE SHE HAS GIVEN HER THE POWER OF ATTORNEY OVER HER AFFAIRS. P-WILL CONTINUE TO MONITOR AND ASSIST AS NEEDED.
6/23/05 4:59 ADA Note GENERAL NOTE
PATIENT RESTED WELL THROUGHOUT THE NIGHT WITH EYES CLOSED. RESPIRATIONS EQUAL AND UNLABORED. NO DISTRESS NOTED. PRESENTLY ON LEVEL 3. WILL CONTINUE TO MONITOR ACCORDING TO HER TREATMENT PLAN.
6/22/05-17:02 HAM Note GENERAL NOTE
SOCIAL WORKER MET WITH PATIENT AND HER HUSBAND WHO BROUGHT PATIENT THINGS SHE REQUESTED. PATIENT WAS WILLING TO ENGAGE IN DISCUSSION WITH HUSBAND ABOUT THINGS HE COULD CHANGE, IN ORDER TO MAKE LIFE BETTER FOR BOTH OF THEM SINCE SHE IS PLANNING ON LIVING WITH HIM IN ORANGEBURG. PATIENT SAID THAT SHE WOULD LIKE HER HUSBAND TO STOP DRINKING AND TO ATTEND HER CHURCH. ASKED PATIENT IF SHE WOULD BE PLEASED IF HER HUSBAND WENT TO HER CHURCH THIS SUNDAY, PATIENT SAID

Demographics			
Patient Name: ARGOE MARTHA L	Ht:	Sex: F	Admission Date: 6/09/05
Patient Num: 1018795	Wt:	Age: 62	Discharge Date: 7/20/05
Med Rec Num: 24396			Birth Date:
Adm Dx: MENTAL DISOR NOS OTH DIS			

Patient Care Activities	
6/22/05 15:36	MSH Performed RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND MEDICATION EFFECT B: PATIENT WITH BLUNTED AFFECT, MOOD FLAT. INTERACTION WITH PEERS LIMITED. 1: 1 TO 1 TO ASSESS MOOD, MEDS AS ORDERED, GROUPS. R: PATIENT PLEASANT UPON APPROACH, STILL UPSET ABOUT PSYCHIATRIC DIAGNOSIS, AND WITH TAKING MEDICATIONS. COMPLIANT WITH MEDICATIONS AND GROUPS. P: CONTINUE TO MONITOR
6/22/05 11:21	JIP Note OUT OF CONTACT WITH REALITY: SENSORY/PERCEPTUAL ALTERATION TREATMENT TEAM: REMAINS DELUSIONAL. WAS UPSET AFTER COURT. FELT MD WAS GOING TO TELL JUDGE SHE WAS A MODEL PATIENT AND ABLE TO DISCHARGE. FAMILY AND MD ALL RECOMMENDED SHE BE RETAINED. HAS A PERMIT TO CARRY WEAPON. FAMILY WANTS TO CONTACT SLED TO HAVE PERMIT WITHDRAWN. SWITCHED FROM GEODON TO RISPERDAL.
6/22/05 4:16	ADA Note GENERAL NOTE PATIENT RESTED WELL DURING THE NIGHT WITH EYES CLOSED. RESPIRATIONS EQUAL AND UNLABORED. NO DISTRESS NOTED. PRESENTLY ON LEVEL 3. WILL CONTINUE TO MONITOR ACCORDING TO HER TREATMENT PLAN.
6/21/05 17:51	DAW Performed PROVIDE QUIET ENVIRONMENT.
6/21/05 17:51	DAW Performed EDUCATION FOR MARTHA REGARDING ILLNESS TO PROMOTE SELF-CARE
6/21/05 17:51	DAW Performed ASSIST MARTHA WITH LIST OF PERSONAL STRENGTHS/WEAKNESSES
6/21/05 17:51	DAW Performed DEVELOP TRUST RELATIONSHIP WITH MARTHA
6/21/05 17:51	DAW Performed ENCOURAGE MARTHA TO BE OUT OF ROOM FOR INTERACTION AND TO...
6/21/05 17:51	DAW Performed SET BEHAVIOR LIMITS, PROVIDE FEEDBACK, AND ENCOURAGE MARTHA
6/21/05 17:51	DAW Performed IDENTIFY BARRIERS OF COMMUNICATION.
6/21/05 17:51	DAW Performed PROMOTE GOOD EYE CONTACT TO CONVEY CORRECT NONVERBAL
6/21/05 17:51	DAW Performed HELP MARTHA TO RECOGNIZE TIMES WHEN POOR JUDGEMENT
6/21/05 17:51	DAW Performed OBSERVATION FOR MARTHA TO PREVENT HARM TO SELF/OTHERS
6/21/05 17:51	DAW Performed EDUCATE MARTHA ABOUT EFFECTS AND SIDE EFFECTS OF MEDICATION
6/21/05 17:51	DAW Performed MEDICATION FOR MARTHA TO ASSIST IN ORGANIZING THOUGHTS
6/21/05 17:51	DAW Performed MARTHA WILL ACCOMPLISH SELF CARE TO BEST OF SHE ABILITY.
6/21/05 17:51	DAW Performed MAINTAIN ADEQUATE NUTRITION AND HYDRATION.
6/21/05 17:51	DAW Performed ENCOURAGE INDEPENDENCE BUT INTERVENE WHEN MARTHA IS UNABLE
6/21/05 17:51	DAW Performed REINFORCE MARTHA'S ABILITY TO DIFFERENTIATE BETWEEN REALITY
6/21/05 17:47	DAW Performed RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND

6/21/05 12:30	JJH Note MEDICATION EFFECT GENERAL NOTE PROBATE HEARING HELD, JUDGE LAWSON ORDERED FOR PATIENT TO BE RETAINED FOR FURTHER INPATIENT TREATMENT AND INVOLUNTARY OUTPATIENT AT LOCAL MENTAL HEALTH UPON DISCHARGE. PATIENT DID NOT AGREE WITH ORDER, ALTHOUGH HER FAMILY (HUSBAND, SON, SISTER AND BROTHER-IN-LAW) ALL AGREED WITH ORDER.
6/21/05 4:29	ADA Note GENERAL NOTE PATIENT RESTED WELL DURING THE NIGHT WITH EYES CLOSED. RESPIRATIONS EQUAL AND UNLABORED. NO DISTRESS NOTED. PRESENTLY ON LEVEL 3. WILL CONTINUE TO MONITOR ACCORDING TO THE TREATMENT PLAN.
6/20/05 18:11	VLG Performed RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND MEDICATION EFFECT B. UP ON UNIT WITH CALM MOOD, SMILING. INTERACTS EASILY WITH PEERS. 1. ONE TO ONE TO ASSESS. R. PATIENT STILL INSISTS THERE IS NOTHING WRONG WITH HER AND THAT HER HUSBAND WAS TRYING TO GET CONTROL OF HER ASSETS. STATES, "IT'S LIKE THAT MOVIE, 'WAR OF THE ROSES, AT OUR HOUSE, AND HAS BEEN FOR THE LAST YEAR." STATES SHE WILL NOT RIDE IN THE CAR WITH HER HUSBAND BECAUSE HE DRINKS ALL THE TIME. CONTINUES TO SAY HUSBAND ABUSES HER. ATTENDING UNIT ACTIVITIES AND COMPLIANT WITH MEDS. P. CONTINUE LEVEL 3 OBSERVATION.
6/20/05 15:27	MAM Note GENERAL NOTE SOCIAL WORKER MET PATIENT TO DISCUSS HER PARANOID IDEATIONS AND DELUSIONS. PATIENT CONTINUES TO BELIEVE THAT HER HOUSE IS BUGGED. SHE SAID ABOUT HER HUSBAND, "EITHER HE IS LYING TO TELLING THE TRUTH, WHICH ONE IS IT!" PATIENT IS HOSTILE ABOUT HER HUSBAND. HER DEEMANOR AND FACADE IS CALM. AFTER SCRATCHING THE SURFACE AND ASKING HER QUESTIONS ABOUT HER HOME LIFE, SHE REVEALS THAT SHE BELIEVES THAT HER HUSBAND DOES HAVE A SECOND FAMILY, BUT SHE "DOESN'T WANT TO REVEAL HER RESOURCES" BECAUSE SHE BELIEVES THAT HER HUSBAND IS ABLE TO BE "BRUTAL." ON THE SURFACE PATIENT IS CALMER WITHOUT RAPID SPEECH. PATIENT DOES NOT APPEAR TO APPRECIATE THAT HER EXTREME HOARDING BEHAVIORS, HER DELUSIONS AND PARANOIDAS ARE NOT MENTALLY HYGIENIC. PATIENT HAS AN APPOINTMENT ON FRIDAY JUNE 24, 2005 AT 10:00 MORNING. PATIENT'S HUSBAND, ADULT SON (POA), PATIENT'S BROTHER AND SISTER WILL ATTEND THE COURT HEARING TO SUPPORT PATIENT BEING RETAINED. THEY ARE OF THE OPINION THAT PATIENT WILL NEED TO BE RETAINED.
6/20/05 5:20	FLT Note GENERAL NOTE PATIENT SLEPT THROUGHOUT THE COURSE OF THE NIGHT SHIFT WITHOUT ANY PROBLEMS. RESPIRATIONS WERE EVEN. PATIENT IS ON LEVEL III CONTINUE TO MONITOR.
6/19/05 19:22	RSE Note GENERAL NOTE ALERT, PLEASANT, COOPERATIVE. INTERACTING WITH A SELECT FEW PEERS. FLAT AFFECT. ATTENDING GROUPS. STATES SHE IS DOING OKAY.
6/19/05 10:41	SJH Note GENERAL NOTE B)PATIENT WAS SITTING IN THE DAY AREA WATCHING TV WITH PEERS. 1)ONE ON ONE ASSESSMENT. R)PATIENT SAID SHE ENJOYED THE CHURCH SERVICE TODAY. PATIENT WAS COMPLIANT WITH MEDICATIONS AND ATTENDED GROUPS WITH PEERS. P)WILL CONTINUE TO MONITOR.
6/19/05 4:43	SAS Note GENERAL NOTE PT RESTING IN BED WITH EYES CLOSED. RESPIRATIONS EVEN, NONLABORED. NO DISTRESS NOTED. WILL CONTINUE TO MONITOR PER LEVEL 3.
6/18/05 13:22	DAA Note GENERAL NOTE B. UP THIS MORNING, HAS BEEN IN AND OUT OF ROOM. PLEASANT AND POLITE. COMPLIANT WITH MEDS, BUT DENIES NEED FOR THEM. ATTENDS GROUPS AND ACTIVITIES. 1. MONITOR AND ENCOURAGE HER TO CONTINUE WITH TX. AFTER D/C AND TO COMPLY WITH MEDS. R. WAS UPSET ABOUT MED DOSE, BUT HAPPY ABOUT IT BEING DECREASED. ABLE TO BETTER FOCUS. P. CONTINUE WITH TX. PLAN.
6/18/05 4:13	SAM Note GENERAL NOTE HAS RESTED WITHOUT PROBLEMS NOTED; WILL CONTINUE TO MONITOR PER TREATMENT PLAN; REMAINS IN BED WITH EYES CLOSED;

ICORS4
User: CWRIGHT
Hospital: 1

multiple reports of THREE RIVERS BEHAVIORAL HEALTH
MONITOR Patient Chart
ARGOE MARTHA L

APS NANA pulled

spousal abuse - did anyone ever intervene?

Page: 11
Date: 7/21/05

Patient Name: ARGOE, MARTHA L
Patient Num: 1018795 Ht:
Med Rec Num: 24396 Wt:
Adm Dx: MENTAL DISOR NOS OTH DIS Sex: F
Age: 62 Admission Date: 6/09/05
Discharge Date: 7/20/05
Birth Date:

Patient Care Activities

6/17/05 4:53 RESPIRATIONS NOTED WITHOUT DISTRESS.
FLT Note GENERAL NOTE
PATIENT SLEPT THROUGHOUT THE COURSE OF THE NIGHT SHIFT
WITHOUT ANY PROBLEMS. RESPIRATIONS WERE EVEN. PATIENT IS ON
LEVEL III CONTINUE TO MONITOR.
6/16/05 20:02 VLG Performed RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND
MEDICATION EFFECT
B. PATIENT UP ON UNIT SMILING, TALKING WITH PEERS. MORE
GUARDED TODAY, GLANCING FREQUENTLY TOWARD STAFF.
INTERACTING MOSTLY WITH NEW ADMITTED MALE PEER. I. ONE TO
ONE TO ASSESS. R. WHEN ASKED IF SHE WANTED TO TALK PATIENT
REFUSED AND SHOOK HER HEAD LAUGHING. CONTINUED HER PREVIOUS
ACTIVITY. ATTENDING UNIT ACTIVITIES. P. CONTINUE LEVEL 3
OBSERVATION.
6/16/05 4:43 FLT Note GENERAL NOTE
PATIENT SLEPT THROUGHOUT THE COURSE OF THE NIGHT SHIFT
WITHOUT ANY PROBLEMS. RESPIRATIONS WERE EVEN. PATIENT IS ON
LEVEL II CONTINUE TO MONITOR.
6/15/05 18:24 VLG Performed RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND
MEDICATION EFFECT
6/15/05 11:26 JIP Note OUT OF CONTACT WITH REALITY: SENSORY/PERCEPTUAL
ALTERATION
TREATMENT TEAM: IS STILL PARANOID, TALKING ABOUT HOUSE
BEING DONE. IS MANIC. REFUSES MEDICATIONS IN A POLITE
MANNER. HUSBAND AND SON REPORT SPENDING 60,000 DOLLARS IN
PAST 8 MONTHS. PSYCH TESTING DONE. SHE WAS TOO CLOSED OFF
WITH PROVIDED INFORMATION THAT NO RESULTS COULD BE
DETERMINED. SHE APPEARS TO BE VERY INTELLIGENT AND ABLE TO
TAKE CARE OF EVERYTHING HERSELF. SHE REFUSES MEDICATION
BECAUSE "IF I TAKE VOLUNTARILY IT MEANS I ACCEPT MY
DIAGNOSIS AND THERE IS NOTHING WRONG WITH ME." BELIEVES HER
HUSBAND HAS BEEN "WORKING THE SYSTEM" AND HE IS THE ONE WHO
SHOULD BE LOCKED UP. WILL RETAIN FOR COURT.
6/15/05 4:11 TMP Note GENERAL NOTE
PATIENT SLEEPING EYES CLOSED RESPIRATION EVEN. PATIENT WAS
COMPLAINING AT 0030 OF BEING DIZZY. NO OTHER COMPLAINTS.
CONTINUE TO MONITOR LEVEL II OBSERVATION THROUGHOUT SHIFT.
6/14/05 23:51 VLG Performed RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND
MEDICATION EFFECT
B. UP ON UNIT WITH GUARDED AFFECT AND IRRITABLE MOOD. NOT
AS SOCIABLE TODAY. I. ONE TO ONE TO ASSESS. R. PATIENT VERY
ADAMANT ABOUT NOT TAKING MEDICATIONS AS ORDERED TONIGHT.
VERY ARGUMENTATIVE AND INSISTING THERE IS NOTHING WRONG
WITH HER. ITS JUST HER HUSBAND MANIPULATING THE SYSTEM.
REQUESTED TO RECEIVE "FORCED MEDICATION" STATING THAT
TAKING MEDICATION VOLUNTARILY WOULD MEAN SHE ACCEPTS HER
DIAGNOSIS. RECEIVED GEODON 20 MILLIGRAMS INTRAMUSCULARLY
AFTER REFUSING TO TAKE MEDICATION BY MOUTH. P. WILL
CONTINUE LEVEL 2 OBSERVATION.
6/14/05 9:58 JJH Note GENERAL NOTE
PATIENT REQUESTED TO SEE PATIENT ADVOCATE (WRITER) BEFORE
BEING MEDICATED AGAINST HER WILL. I CAME AND TALKED WITH
PATIENT, SHE INFORMED ME THAT SHE DID NOT NEED TO BE HERE,
THAT SHE DID NOT NEED MEDICATION AND WOULD REFUSE ANY
MEDICATION OFFERED. IT WAS EXPLAINED THAT IF SHE REFUSED
THE MD WOULD EVALUATE THE NEED TO FORCE MEDICATE. THE
PATIENT STATED THAT WE WOULD HAVE TO FORCE MEDICATE BECAUSE
SHE WOULD CONTINUE TO REFUSE. PATIENT STATED THAT HER
HUSBAND HAS THREATENED TO KILL HER AND THAT SHE DOES NOT
FEEL SAFE WITH HIM. SHE STATED THAT HE WAS THE ONE WITH
THE PROBLEM (STATING HE WAS A BAD ALCOHOLIC). SHE EXPRESSED
THAT SHE WOULD NOT GET INTO A VEHICLE OR ON THEIR BOAT

WHILE HE WAS DRIVING BECAUSE SHE DIDN'T KNOW WHERE HE WOULD
TAKE HER. SHE STATED THAT SHE DOES CARRY A WEAPON WITH A
PERMIT FOR CONCEALED WEAPONS BECAUSE SHE DOES NOT FEEL THAT
ORANGEBURG IS A SAFE TOWN FOR A FEMALE. SHE EXPLAINED TO
ME THAT SHE SPENDS MOST OF HER TIME ALONE FOCUSING ON "THE
WORD" SHE STATES SHE HAS 2 TV'S IN HER ROOM THAT SHE KEEPS
ON CHRISTIAN TV. SHE TOLD ME THAT SHE HAS REMOVED FAMILY
DEVELOP TRUST RELATIONSHIP WITH MARTHA
6/14/05 8:03 BON Performed ENCOURAGE MARTHA TO BE OUT OF ROOM FOR
6/14/05 8:03 BON Performed INTERACTION AND TO...
6/14/05 8:03 BON Performed PROVIDE QUIET ENVIRONMENT.
6/14/05 8:03 BON Performed PROMOTE GOOD EYE CONTACT TO CONVEY CORRECT
NONVERBAL
6/14/05 8:03 BON Performed SET BEHAVIOR LIMITS. PROVIDE FEEDBACK, AND
ENCOURAGE MARTHA
6/14/05 8:03 BON Performed EDUCATION FOR MARTHA REGARDING ILLNESS TO PROMOTE
SELF-CARE
6/14/05 8:02 BON Performed EDUCATE MARTHA ABOUT EFFECTS AND SIDE EFFECTS OF
MEDICATION
6/14/05 8:02 BON Performed MEDICATION FOR MARTHA TO ASSIST IN ORGANIZING
THOUGHTS.
6/14/05 8:02 BON Performed HELP MARTHA TO RECOGNIZE TIMES WHEN POOR
JUDGEMENT
6/14/05 8:02 BON Performed OBSERVATION FOR MARTHA TO PREVENT HARM TO
SELF/OTHERS
6/14/05 8:02 BON Performed REINFORCE MARTHA'S ABILITY TO DIFFERENTIATE
BETWEEN REALITY:
6/14/05 8:02 BON Performed ENCOURAGE INDEPENDENCE BUT INTERVENE WHEN MARTHA
IS UNABLE
6/14/05 8:02 BON Performed MARTHA WILL ACCOMPLISH SELF CARE TO BEST OF SHE
ABILITY.
6/14/05 8:02 BON Performed MAINTAIN ADEQUATE NUTRITION AND HYDRATION.
6/14/05 4:50 FLT Note GENERAL NOTE
PATIENT SLEPT THROUGHOUT THE COURSE OF THE NIGHT SHIFT
WITHOUT ANY PROBLEMS. RESPIRATIONS WERE EVEN. PATIENT IS ON
LEVEL II CONTINUE TO MONITOR.
6/13/05 19:06 RSE Note GENERAL NOTE
ALERT, PLEASANT, COOPERATIVE. INTERACTING SOME WITH OTHER
PATIENTS. ATTENDING GROUPS. NORMAL AFFECT. NO EVIDENCE
OF ANY MANIC BEHAVIOR TODAY. STATES SHE IS DOING OKAY.
6/13/05 4:37 FLT Note GENERAL NOTE
PATIENT SLEPT THROUGHOUT THE COURSE OF THE NIGHT SHIFT
WITHOUT ANY PROBLEMS. RESPIRATIONS WERE EVEN. PATIENT IS ON
LEVEL II CONTINUE TO MONITOR.
6/12/05 23:17 PAE Performed RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND
MEDICATION EFFECT
B- PATIENT AFFECT PLEASANT I ONE TO ONE TO ASSESS BEHAVIOR
R- DENIES SI AND HI. R- CONTINUE WITH CURRENT TREATMENT
PLAN.
6/12/05 10:23 SJH Note GENERAL NOTE
B)PATIENT WAS SITTING IN THE DAY AREA WATCHING TV WITH
PEERS. I)ONE ON ONE ASSESSMENT. R)PATIENT SAID THAT HE
HUSBAND BEAT UP ON HER AND SHE IS THE ONE "LOCKED UP" THE
HOSPITAL. P)WILL CONTINUE TO MONITOR.
6/12/05 4:43 FLT Note GENERAL NOTE
PATIENT SLEPT THROUGHOUT THE COURSE OF THE NIGHT SHIFT
WITHOUT ANY PROBLEMS. RESPIRATIONS WERE EVEN. PATIENT IS ON
LEVEL II CONTINUE TO MONITOR.
6/11/05 22:40 VLG Performed RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND
MEDICATION EFFECT
B. CALM, PLEASANT MOOD, SMILING MOST OF THE TIME. INTERACTS
WELL WITH PEERS. TALKS MOSTLY WITH SELECT MALE PEERS. I.
ONE TO ONE TO ASSESS. R. CONTINUES TO DENY REASONS FOR
ADMISSION AND COMPARE NOTES ABOUT UNFAIR COMMITMENT WITH
OTHER PATIENTS. PARTICIPATES IN ALL UNIT ACTIVITIES.
COMPLIANT WITH MEDS. P. CONTINUE LEVEL 2 OBSERVATION.
6/11/05 10:47 RLM Note GENERAL NOTE
B-PATIENT CURRENTLY HAS A PLEASANT ATTITUDE AND AFFECT.
PATIENT MAYBE A LITTLE MANIC. I-GROUP INTERVENTION AND
INTERACTION. R-PATIENT CURRENTLY HAS CONCERNS ABOUT THINGS
THAT HAPPENED ON YESTERDAY.

NCOR54
User: CHR1GHT
Hospital: 1

THREE RIVERS BEHAVIORAL HEALTH
MONITOR Patient Chart
ARGOE MARTHA L

Page: 12
Date: 7/21/05
Time: 10:57

Demographics

Patient Name: ARGOE MARTHA L
Patient Num: 1018795 Ht: Sex: F Admission Date: 6/09/05
Med Rec Num: 24396 Wt: Discharge Date: 7/20/05
Adm Dx: MENTAL DISOR NOS OTH DIS Age: 62 Birth Date:

Patient Care Activities

6/11/05 5:29 JAM Note GENERAL NOTE
PATIENT RESTED QUIETLY IN ROOM IN BED EYES ARE CLOSED
RESPERATIONS ARE EVEN AND UNLABORED WILL CONTINUE TO
MONITOR ON A LEVEL II OBSERVATION.

6/10/05 22:59 VLG Performed RN ASSESSMENT FOR MOOD, MENTAL STATUS, AND
MEDICATION EFFECT

6/10/05 17:00 NAM Note GENERAL NOTE
[CONTINUATION] PATIENT HAS A PERMIT TO CARRY A CONCEALED
WEAPON, WHICH IS LEGAL, BUT MISSING. PATIENT LEAVES THE
HOUSE LATE AT NIGHT WITH \$100,000 IN JEWELRY. HUSBAND SAID
HE "STANDS BY THE COMMITMENT PAPERS" THAT HE SIGNED.
PATIENT HAS NO INSIGHT THAT HER BEHAVIORS ARE BIZARRE AND
THAT HER MOOD IS A PROBLEM. HER FOCUS IS THAT HER HUSBAND
IS ABUSIVE. HUSBAND AND GEORGE HAVE NOT CONFIRMED THE
ABUSE. PATIENT IS PARANOID AND DELUSIONAL ABOUT HUSBAND TO
THE POINT THAT SHE DOES NOT TRUST HIM AND HAS MADE HER SON
POWER OF ATTORNEY. HUSBAND AND GEORGE, BOTH HAVE SAID THAT
OVER A YEAR AGO PATIENT WAS TOLD BY GOD THAT HUSBAND WOULD
COMMIT HER. MOTHER AND TWO SIBLINGS WERE DESCRIBED AS BEING
UNSTABLE WITH THE PATIENT BEING THE MOST STABLE. PATIENT
IS EXCESSIVELY RELIGIOUS AND HAS THREE TV'S ON 24 HOURS A
DAY ON 3 DIFFERENT RELIGIOUS CHANNELS. PATIENT APPEARS TO
HAVE A STREAM OF NEGATIVE THOUGHTS ABOUT HER HUSBAND; SHE
IS IRRITABLE WITH STAFF WITHOUT INSIGHT AS TO HER
BEHAVIORS. PATIENT HAS NEVER HAD TREATMENT; ALTHOUGH FAMILY
HAS SAID PATIENT HAS BEEN ILL ALL OF HER LIFE.

6/10/05 16:23 NAM Note GENERAL NOTE
SOCIAL WORKER AND DOCTOR MET WITH PATIENT AND HER FAMILY
(ADULT SON, GEORGE; AND HUSBAND OF PATIENT) TO DISCUSS
DISCHARGE PLANS, HISTORY OF PATIENT AND TREATMENT. PATIENT
REFUSES TO TAKE MEDICATIONS EVEN AFTER MEETING WITH GEORGE.
GEORGE INITIALLY ASKED IF WE WOULD WAIT UNTIL HE CONTACTED
A LAWYER, THEN LATER GEORGE (HUSBAND WAS PRESENT) GAVE
SOCIAL WORKER AND DOCTOR CONSENT FOR MEDICATIONS. PATIENT
ASKED TO SPEAK WITH A PATIENT'S RIGHTS PERSON. STAFF CALLED
THAT PERSON TO SEEK INFORMATION. STAFF WILL DIRECT PATIENT
ACCORDING TO THAT INFORMATION. BOTH GEORGE AND PATIENT'S
HUSBAND GAVE DESCRIPTIVE INFORMATION ABOUT PATIENT'S
BIZARRE BEHAVIORS. FOR 40 YEARS, PATIENT'S HUSBAND HAS
"COVERED FOR HER" AS IN PROTECTING HER FROM HER MANIC AND
DEPRESSIVE BEHAVIORS, SUCH AS SPENDING MONEY IN EXCESS,
E.G., IN THE LAST 8-10 MONTHS SHE SPENT \$50,000 AND EACH
MONTH HAS MAXED-OUT HER CREDIT CARDS. IT IS CONFIRMED THAT
SHE BELIEVES HE HAS ANOTHER FAMILY. SHE HAS STORED
EXPENSIVE ITEMS IN STORAGE SHEDS, E.G., \$100,000 CAR,
CHINA, ETC. SHE BELIEVES THAT THERE IS POISON IN THE HOUSE.
[CONTINUES]

6/10/05 9:56 NAM Note GENERAL NOTE
SOCIAL WORKER MET WITH PATIENT AND TALKED WITH PATIENT'S
POWER OF ATTORNEY SON GEORGE TO DISCUSS DISCHARGE PLANS AND
PATIENT'S HISTORY. PATIENT'S SON PLANS TO COME IN FOR A
FAMILY SESSION TODAY AT 2:00 AFTERNOON TODAY. PATIENT HAS
BEEN ILL SINCE 2004 WITHOUT ACCEPTING TREATMENT. PATIENT
HAS BEEN PARANOID ABOUT HUSBAND, DELUSIONAL ABOUT PEOPLE
BUGGING HER HOME, HOARDING EXPENSIVE MATERIAL ITEMS FROM
HOME, PATIENT IS AFRAID OF DIRT, ETC.

6/10/05 5:10 SAS Note GENERAL NOTE
PT PRESENTLY RESTING IN BED. PT UP TO NURSES STATION AT
0500 REQUESTING A SODA FROM THE CANTEEN. PT NOTIFIED THAT
SHE COULD OBTAIN A SODA FROM THE CANTEEN DURING BREAKFAST.
PT VERBALIZED UNDERSTANDING. PT WITHOUT C/O. NO DISTRESS
NOTED. WILL CONTINUE TO MONITOR PER LEVEL 2.

Flow Sheet

PATIENT/FAMILY EDUCATION RECORD

Date	Time	LLM	TCHING METHOD	TOPIC	GOALS GROUP
7/20/05	8:30	LLM	TCHING METHOD	METHOD	GROUP
7/20/05	8:30	LLM	TCHING METHOD	OUTCOME	FULL KNOWLEDGE
7/20/05	8:30	LLM	TCHING METHOD	OUTCOME	SOME SKILL
7/20/05	8:30	JRC	TCHING METHOD	TOPIC	GOALS GROUP
7/19/05	8:30	JRC	TCHING METHOD	TOPIC	UNIT ORIENT
7/19/05	8:30	JRC	TCHING METHOD	METHOD	GROUP
7/19/05	8:30	JRC	TCHING METHOD	OUTCOME	SOME KNOWLEDGE

B: SITTING IN DAY AREA AND OUT ON THE PATIO. I: GOALS G
ROUP AND OBSERVATION. R: PATIENT IS ATTENDING GROUPS AN
D INTERACTING WELL WITH HER PEERS. PATIENT STATED THAT
SHE FEELS LIKE SHE IS JUST STUCK. PATIENT STILL HAS A H
APPY AFFECT. PATIENT IS COOPERATIVE AND PLEASANT. PATIE
NT GOAL FOR TODAY IS TO STAY FOCUS ON GOD. P: WILL CONT
INUE TO MONITOR ON LEVEL III PRECAUTION.

Date	Time	LLM	TCHING METHOD	TOPIC	GOALS GROUP
7/18/05	8:30	LLM	TCHING METHOD	METHOD	GROUP
7/18/05	8:30	LLM	TCHING METHOD	OUTCOME	SOME KNOWLEDGE
7/18/05	8:30	LLM	TCHING METHOD	OUTCOME	SOME SKILL
7/16/05	22:15	WLW	TCHING METHOD	TOPIC	WRAP UP GROUP
7/16/05	22:15	WLW	TCHING METHOD	METHOD	INDIVIDUAL
7/16/05	22:15	WLW	TCHING METHOD	OUTCOME	SEE NOTES

B) IN DAY AREA MOST OF THE SHIFT
I) 1:1 ASSESSMENT & OBSERVATION
R) VERY QUIET/ FLAT AFFECT/ MINIMAL INTERACTION WITH
PEERS/ GOOD VISIT WITH FAMILY
P) WILL CONTINUE TO MONITOR EVERY 30 MINUTES

7/15/05 8:30 GAR TCHING METHOD TOPIC GOALS GROUP
B-PATIENT WILL BE ABLE TO UNDERSTAND HOW THINKING IMPAC
TS OF THINKING ON BEHAVIOR. I-GOALS GROUP, INTERACTED W
TH PATIENT. R-ALERT AND APPROPRIATE. P-FOLLOW CURRENT C
ARE PLAN.

Date	Time	GAR	TCHING METHOD	METHOD	GROUP
7/15/05	8:30	GAR	TCHING METHOD	OUTCOME	SEE NOTES
7/15/05	8:30	GAR	TCHING METHOD	TOPIC	GOALS GROUP

B-PATIENT WILL BE ABLE TO FOCUS ON GRIEF AND LOSS ISSUE
S. I-GOALS GROUP, INTERACTED WITH PATIENT. R-ABLE TO FO
CUS ON ISSUES. COOPERATIVE AND SHOWS INTEREST IN GROUP.
P-FOLLOW CURRENT CARE PLAN.

Date	Time	GAR	TCHING METHOD	METHOD	GROUP
7/14/05	8:30	GAR	TCHING METHOD	OUTCOME	SEE NOTES
7/14/05	8:30	GAR	TCHING METHOD	TOPIC	GOALS GROUP

B-PATIENT WILL BE ABLE TO VOICE HURT ISSUES. I-GOALS GR
OUP, INTERACTED WITH PATIENT. R-ABLE TO VOICE HURT ISSUE
S. P-FOLLOW CURRENT CARE PLAN. CONTINUE SUPPORTIVE APPRO
ACH.

Date	Time	GAR	TCHING METHOD	METHOD	GROUP
7/13/05	8:30	GAR	TCHING METHOD	OUTCOME	SEE NOTES
7/13/05	8:30	LLM	TCHING METHOD	TOPIC	UNIT ORIENT
7/11/05	8:30	LLM	TCHING METHOD	METHOD	GROUP
7/11/05	8:30	LLM	TCHING METHOD	OUTCOME	SOME KNOWLEDGE
7/11/05	8:30	LLM	TCHING METHOD	OUTCOME	SOME SKILL
7/08/05	8:30	LLM	TCHING METHOD	TOPIC	GOALS GROUP
7/08/05	8:30	LLM	TCHING METHOD	METHOD	GROUP
7/08/05	8:30	LLM	TCHING METHOD	OUTCOME	SOME KNOWLEDGE
7/08/05	8:30	LLM	TCHING METHOD	OUTCOME	SOME SKILL
7/07/05	8:30	GAR	TCHING METHOD	TOPIC	GOALS GROUP

B-PATIENT WILL BE ABLE TO RESPOND TO STORY AS IT RELATE
S TO HER CARE. I-GOALS GROUP, INTERACTED WITH PATIENT.
R-ALERT, COOPERATIVE AND RESPONSIVE. PLEASANT AND FOCU
SED ON TREATMENT. P-FOLLOW CURRENT CARE PLAN.

Date	Time	GAR	TCHING METHOD	METHOD	GROUP
7/07/05	8:30	GAR	TCHING METHOD	OUTCOME	SEE NOTES
7/06/05	8:30	GAR	TCHING METHOD	TOPIC	GOALS GROUP

B-PATIENT WILL BE ABLE TO INCREASE SELF AWARENESS THROU
GH KNOWLEDGE OF THE THREE EGO STATES. I-GOALS GROUP, IN
TERACTED WITH PATIENT. R-RESPONSIVE AND INTERESTED. P-

PLAINTIFF-00102



REV. 05/01/2007

01385



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Transcript of the
Deposition of

Frank Quinn, Ph.D.

5/17/2013

Argoe vs. Three Rivers Behavioral Health, LLC,
et al.

2007-CP-32-1981

COPY

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State of South Carolina	)	
	)	
County of Lexington	)	
Martha Lewin Argoe,	)	2007-CP-32-1981
	)	
Plaintiff,	)	
	)	
vs.	)	Deposition
	)	
Three Rivers Behavioral	)	of
Health, LLC, and	)	
Psychiatric Solutions,	)	Frank Quinn, Ph.D.
Inc., Its Successor;	)	
Phyllis Bryant-Mobley,	)	
M.D.; Aiken Regional	)	
Medical Center; Aurora	)	
Pavilion; David A. Steiner,	)	
M.D.; Cheryl C. Dodds,	)	
M.D., Doris Ann Burrell,	)	
R.N.; and Carolina Care	)	
Plan,	)	
	)	
Defendants.	)	

Deposition of Frank Quinn, Ph.D., taken before Sandra J. Ayers, a notary public in and for the State of South Carolina, commencing at the hour of 10:20 a.m., Friday, May 17, 2103, at the office of Davidson & Lindemann, PA, 1611 Devonshire Drive, Second Floor, Columbia, South Carolina.

Reported by
Sandra J. Ayers

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Martha Argoe

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EXHIBITS

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1

STIPULATIONS

2

It is stipulated by and between counsel for

3

the respective parties that all objections are

4

reserved until the time of trial, except as to

5

the form of the questions.

6

This deposition is being taken pursuant to the

7

South Carolina Rules of Civil Procedure.

8

- - - -

9

The reading and signing of this deposition is

10

reserved by the deponent and counsel for the

11

respective parties.

12

Whereupon,

13

Frank Quinn, Ph.D., being duly sworn and

14

cautioned to speak the truth, the whole truth,

15

and nothing but the truth, testified as

16

follows:

17

EXAMINATION

18

BY MR. PARHAM:

19

Q State your full name, please.

20

A Frank Lawrence Quinn, Jr.

21

Q And your business address?

22

A One -- Carolina Psychiatric Services, 160 Medical

23

Circle, West Columbia. That's Suite A and B, but

24

you don't need that.

25

Q And what do you do at Carolina Psychiatric

1 Services?

2 A I'm the managing partner, and I see patients.

3 Q Okay. And what do you do for a living?

4 A Well, for a living, I see patients at --

5 Q I mean, what -- well, how -- oh, I see patients,
6 too. But, I mean, what do you do when you see
7 patients?

8 A Oh, I -- I do assessments. I provide therapy. I
9 do consultations. I do evaluations.

10 Q And you are a psychiatrist?

11 A No. No, no, no. I am a licensed professional
12 counselor.

13 Q Okay. And when did you receive that license?

14 A Oh, gosh. Back in '80 -- somewhere around 1986, or
15 something like that. Eighty-five. I could be
16 specific, I guess, but, roughly, 1985/'86.

17 Q Okay. Is -- is a licensed professional counselor
18 different than a psychologist?

19 A It -- it is in this state, yes.

20 Q Okay. And what's the difference?

21 A Well, when I started the program I was in, I could
22 be licensed as a psychologist, but they changed the
23 licensing requirements. So in South Carolina
24 currently to be licensed as a psychologist, you
25 have to graduate from a program in clinical

1 psychology that's been approved by the APA. And
2 the program I was in was counseling psychology, at
3 the time. So the primary difference is we do a lot
4 of the same things. Psychologists do a whole lot
5 more evaluation, testing and that kind of stuff.

6 Q But in -- in '86, could you have gotten a license
7 as a psychologist?

8 A No. Because that's when I was finishing my degree.

9 Q Okay. And they already had the new criteria --

10 A Right.

11 Q -- in place?

12 A They had already started -- there was a lawsuit
13 going on at the time, but it -- it didn't end
14 favorably for those of us under . . . People with
15 my same degree had been licensed as psychologists
16 prior to that, but they had changed the -- they had
17 changed the criteria, so I -- I was not eligible.

18 Q Did they get grandfathered in? The ones who were
19 already licensed?

20 A Oh, well --

21 Q Or was that --

22 A -- that -- that --

23 Q -- the lawsuit?

24 A -- that was what the lawsuit was about.

25 Q And, again, the psychologist does a -- more of an

1 evaluation of the --

2 A They --

3 Q -- patient?

4 A -- they -- they -- they are much more involved in
5 doing different types of psychological testing,
6 neuropsychological evaluation, intelligence
7 assessments, things like that. Now, they -- they
8 also are capable/competent at doing therapy,
9 counseling, and they do those things, also. But
10 the primary difference is that they're much more
11 oriented towards that than we are.

12 Q And then --

13 A We're more into therapy and . . .

14 Q And then the psychiatrist -- I guess, the main
15 demarcation is they can prescribe medication?

16 A In South Carolina, the primary demarcation is they
17 can prescribe medication. In some other states,
18 psychologists actually have prescriptive authority,
19 also. But, yes. And -- and -- and they can do
20 therapy. They don't typically do psychological
21 assessment testing and things like that. They're -
22 - they -- a little bit, but not much.

23 Q Who are the other members of the Carolina
24 Psychiatric Services Group today?

25 A Currently, it would be: Dr. Larry Nelson,

1 psychiatrist; Dr. Robert Ornelas, who is also a
2 psychiatrist; myself; Ashton Carrigan, who is a
3 social worker; Susan Taylor, who is a clinical
4 nurse specialist; and Shannon Wilson, who is a
5 clinical nurse specialist.

6 Q Now, I was looking at your CV.

7 A Uh-huh.

8 Q I think everybody's got a copy now.

9 A All right.

10 Q At the bottom, under the "Clinical Director of
11 Outpatient Services for Carolina Psychiatric
12 Services," one of the responsibilities states,
13 "Provide consultation and assessment and
14 psychometric evaluation to members of the
15 practice."

16 What is psychometric --

17 A Well --

18 Q -- evaluation?

19 A -- that -- that would involve any -- any form of
20 testing. Like, we do MMPIs. We do some low-level
21 screening, essentially, for dementia. If you -- if
22 -- if you came in with your mother and were
23 concerned about her cognitive abilities, we would
24 do some screening to see what her cognitive
25 abilities were. And then, if we felt like it was -

1 - there were some significant deficits, we might
2 refer you to a neuropsychologist to do further
3 evaluation and testing. Or, if you came in, and
4 you had a child that you thought was ADD, we might
5 do some screening with that. And, once more, if we
6 felt like further evaluation was needed, we would
7 refer you to someone that specializes in that.

8 Q All right. In your -- in your education, I've --
9 I've got to ask --

10 A Yeah.

11 Q -- you concentrated in Renaissance drama?

12 A Absolutely. Absolutely. Shakespeare was my man.

13 Q Okay. Well, I -- yeah. Actually, in my younger
14 days, I was actually a English lit major, and I did
15 emphasize in that. But the Renaissance drama, does
16 that include the things like the morality plays and
17 stuff, or was that before? It's been a long time
18 for me.

19 A Morality plays are, actually, a little bit before,
20 but this would be people like Shakespeare,
21 Middleton and Rowley, Ben Johnson. You know,
22 that's when I thought I was going to save the world
23 with poetry. But, as it -- as it turns out,
24 literature, and particularly drama, are actually
25 excellent training for learning about individuals'

1 personalities and things like that.

2 Q Did you act?

3 A I did. And one of -- it's not listed on here, but
4 one of my early jobs is I was the assistant
5 supervisor for cultural and fine arts for the City
6 of Durham, which meant they paid me a \$1.60 an hour
7 to run a children's theater.

8 Q Cool. Anything to make a living, right?

9 A Well, I was -- I was a starving hippie. You know,
10 I had --

11 Q Yeah.

12 A -- to do something.

13 Q What did you do between '73 and '77?

14 A Seventy --

15 Q I don't --

16 A -- three . . .

17 Q -- see anything on the -- on your CV that actually
18 talks about that period. Maybe I missed it?

19 A Seventy-three and '77? Well, let's see. I was in
20 -- okay. Yeah. All right. I was -- I was living
21 in Chapel Hill most of that time and either in
22 school. I worked at a bookstore for a while. I
23 worked for -- it -- well, that's part of when I was
24 working for the City of Durham. Also, for roughly
25 a year there, I lived in Greensboro. I was in

1 school there pursuing a master's in English and
2 worked in -- with the visually impaired there,
3 briefly. But from '74 through '77, I was primarily
4 back in Chapel Hill eking out a meager existence as
5 a graduate student and working at a bookstore.

6 Q And this "Master in Science and Recreation" --

7 A Uh-huh.

8 Q -- "Therapy with Special Populations and Leisure
9 Counseling," what is that?

10 A Well, besides being interested in Renaissance
11 drama, I'm an old jock And, as a starving hippie,
12 I was trying to figure out what I wanted to do.
13 And the University of North Carolina, in their
14 sociology department -- you see, I had a minor in
15 sociology -- offered a program called "Leisure
16 Studies," and it was a fairly philosophical program
17 about leisure.

18 But they had a track for people who wanted to
19 become recreational therapists, and one of my old
20 fraternity brothers had done that. And he said,
21 "Look. You can get a job doing this, and these
22 people will pay for you to go to school. Why don't
23 you come over here and do this?"

24 And I said, "Yeah." It --

25 Q So --

1 A -- was a good program.

2 Q -- leisure counseling? How could you counsel me in
3 the leisure?

4 A Well, one of the things we would do is assess you
5 for leisure dysfunction, and we would take a look
6 at how you spend your unobligated time. We'd take
7 a look at what assets you have, in terms of
8 choosing leisure. We'd look at your -- your own
9 concepts and theories of leisure.

10 The Greeks thought that -- that leisure was
11 the highest state for a man. It wasn't just
12 setting around under the tree, but it was
13 contemplating what's good in life, and it was what
14 brought them health, actually. So we'd -- my wife
15 actually devised a leisure counseling assessment
16 and treatment program that was widely used, so we
17 would probably use her program.

18 Q So you could find me some leisure time if I -- if I
19 consulted --

20 A There --

21 Q -- you?

22 A There's no such thing as leisure time. Leisure's a
23 state of mind. But what we could do is we could
24 help you maximize your leisure potential, if you
25 will.

Frank Quinn, Ph.D.

1 Q So my favorite line from the movie "Office Space" -
2 - you ever seen it?

3 A I have seen it.

4 Q My favorite line is, "What'd you do this weekend?"
5 And he says, "I did absolutely nothing, and
6 it's everything I thought it would be."

7 Is that, pretty much, sum up leisure
8 counseling?

9 A Not really.

10 Q No?

11 A But I think for a lot of people, that's exactly
12 what it would symbolize.

13 Q Now, I'm going to back -- ask about this, too.

14 A Absolutely.

15 Q This is a book you wrote. It -- called "Fat Dog
16 Don't Run No Rabbit: Promoting" --

17 A Absolutely.

18 Q -- "Change In Overprivileged Children and Their
19 Families."

20 A Absolutely.

21 Q What does that mean?

22 A Well, I, for years, had been giving a lecture
23 because in -- in my private practice, I kept
24 running into children of relatively wealthy people
25 who were over-privileging and over-indulging their

1 children.

2 "Fat dog don't run no rabbit" is an old
3 hunting term. I grew up in eastern North Carolina.
4 In the coastal plains, people hunt rabbits with
5 beagles. And, essentially, if you over-feed your
6 hunting dogs, and you take them out to chase
7 rabbits, they just -- they won't go.

8 Those are -- several corollaries to that:
9 "Fat dog don't run no rabbit; hungry dog do." But
10 I stole that term, even though I was familiar with
11 it, with a friend of mine who's a psychiatrist in
12 Greenville -- Dr. Jimmy Page, when we were . . .

13 We were talking about a client one day, and I
14 was seeing a young man who had been in college for
15 six years, who was in his fifth different school.
16 He was a sophomore. He had a brand-new Mustang
17 convertible, a DeLorean as his second car. He was
18 getting, roughly, \$50,000 a -- a year in spending
19 money, with his parents paying all of his other
20 expenses. And his daddy came to me and said, "I
21 just don't understand why he doesn't want to get
22 out of college?"

23 And so Jimmy and I were talking about this
24 client, and Jimmy just looked at me across the
25 tennis net, and he said, "You know, fat dog don't

1 run no rabbit."

2 So it's a great book. It's suitable for
3 Christmas presents. I live large off of the
4 royalties. I get, sometimes, a \$1.59 a quarter.
5 You can order it online from Barnes & Noble's or
6 Amazon.com, and I'll be glad to sign it for you.

7 Q Well, the problem with my children is they're
8 having such fun being leisurely that they probably
9 wouldn't want to read it, so . . .

10 A It's actually not for them. It's for you.

11 Q And -- and I -- and the last thing is talking about
12 this gambling --

13 A Yeah.

14 Q -- emphasis.

15 A Absolutely.

16 Q Especially, you have -- in the "Current Research,"
17 at the end, you talk about, "More importantly, I'm
18 testing the transferability of addiction proposed"
19 --

20 A Yeah.

21 Q -- "by Jacobs' General Theory of Addiction, and the
22 possibility that electronic gambling may prove to
23 be an exception."

24 A Yeah. Jacob -- Jacobs' General Theory states that
25 -- it -- it -- and it -- it makes sense to most

1 people for most forms of addiction -- that if
2 you're, say, addicted to alcohol, it doesn't matter
3 whether you drink beer or wine or Johnny Walker.
4 If you can't get one, you'll drink the other. And
5 so he -- he hypothesized that that was true of all
6 forms of addiction. But what -- what my initial
7 research was showing, and -- and what -- I think
8 someone in Norway did some follow-up on it and it
9 showed the exact same thing. With electronic
10 gambling, that didn't seem to be the case.

11 And, in fact, in South Carolina when the video
12 poker machines disappeared, within a six-month
13 period, we went from having 32 active Gamblers
14 Anonymous groups in the state to something like
15 six, within a six-month period. The call center in
16 Myrtle Beach alone was getting 200 calls a month.
17 They went to zero.

18 And so part of what we were looking at is the
19 idea that this particular type of addiction to
20 gambling was non-transferrable; that these people
21 would not turn to some other form of gambling, such
22 as bingo, the lottery, high-stakes poker, flitting
23 out to Vegas, or whatever. And I -- I hate to tell
24 you but, unfortunately, even though the results
25 look very promising, I haven't done much with that

1 in the last couple of years because I've been too
2 busy. But --

3 Q So, I mean -- so you think that without, like, the
4 -- the video poker, that they just don't do any
5 gambling?

6 A Well, it -- here -- here's what the initial
7 research showed, is that, particularly for women,
8 they typically did not gamble at the same rate as
9 men, period, until the advent of electronic forms
10 of gambling. And with that, they not only caught
11 up, but in some areas surpassed it. But when you
12 took those forms of gambling away, they just quit.
13 They -- they did not seek other forms of gambling.
14 They did not seek Bingo. They did not seek out the
15 lottery. They didn't seek out even friendly poker
16 games. But there was something about electronic
17 gambling that was not only attractive to them but
18 very, very addictive. So just be thankful that
19 your state chose to do away with it.

20 Q Well, it's still a little reverberating; I'm sure
21 you've read about the recent --

22 A Absolutely.

23 Q -- lawsuit.

24 A It never went away, but at -- at one point, we had
25 more licensed gambling locations than the state of

1 Nevada did. And Columbia had more than Las Vegas
2 did.

3 Q All right. So in your practice today, what's the
4 number of patients you see per week? Or clients.
5 Whatever you call --

6 A Yeah.

7 Q -- them.

8 A Well, typically speaking, I see patients Monday,
9 Tuesday, Wednesday, and Thursday from nine o'clock
10 in the morning till six o'clock at night, which
11 means I potentially could see eight patients a day;
12 32 a week. More often, it's between probably 25 to
13 30; I'll have some openings here and there.

14 Q Okay. And other than the counseling between nine
15 and six, four days a week, and -- and what we
16 talked about with your other interests, is there
17 any other type of counseling you do in any other
18 venue?

19 A No other form of counseling. I -- I teach.

20 Q Okay. And your sessions in counseling, are there -
21 - it's an hour?

22 A It -- yes. Some people quibble it's a therapeutic
23 hour, which is 50 minutes, but mine are usually an
24 hour, if not more..

25 Q Okay. And you -- you understand you're here today

1 as an expert witness, correct?

2 A Absolutely.

3 Q Okay. What -- how much expert witness testifying
4 do you do?

5 A Actually, very little. If you -- if you look at --
6 at the vita, you'll see that I've -- I've testified
7 as an expert, predominately regarding gambling.
8 Have testified some in some, really kind of family
9 disputes, where I was expert as a -- a -- for --
10 for family, marriage and -- and psychology. And
11 the -- the Joy Baker case, I guess, which was
12 really related to gambling, too, but it was -- it
13 had more to do with the death of a -- of a small
14 child.

15 Q And as far as testifying as you are today, in a
16 medical negligence case, how often have you done
17 that?

18 A Never in a medical negligence case. I've -- I've
19 testified to the Board of Medical Examiners before.
20 That's a little bit different.

21 Q All right. Now, as a licensed -- is it --

22 A -- professional.

23 Q -- professional counselor --

24 A Uh-huh.

25 Q -- do you make mental health diagnoses?

1 A Well, I do the -- in our practice, I do the vast
2 majority of all the intakes, which is -- we have a
3 two-step process. If you came in to our practice,
4 I would see you for an hour, do a basic assessment,
5 and make a determination as to whether or not you
6 were -- you needed to be seen by a psychiatrist,
7 whether you needed therapy, whether you needed to
8 be hospitalized. I make a diagnostic impression.
9 We leave the diagnoses specifically to the
10 psychiatrist.

11 Q Now, if -- if one of your patients does not go
12 beyond just the therapy that you can provide as a
13 licensed professional counselor, then there's never
14 a -- other than your diagnostic impression, there's
15 never a definitive diagnosis made for that patient?

16 A Well, there -- there is. And I would make, you
17 know -- for example, if you came to see me, and you
18 presented as -- you had the symptoms of depression,
19 after the -- on the assessment and beyond that, I
20 would be assessing you on the five axis of the DSM-
21 IV-TR that we've got limited there as, you know,
22 major depression, recurrent -- whatever, like that.
23 Yes.

24 Q All right. Now, we -- or Mr. Cole, I think,
25 subpoenaed your file -- or asked for your file to

1 be produced --

2 A Uh-huh.

3 Q -- which I have a copy of, and -- and I have a few
4 questions before we get into the --

5 A Absolutely.

6 Q -- the substance of stuff. In -- in the file that
7 I received, it looked like there was a -- a
8 transaction printout of -- of --

9 A Yeah.

10 Q -- of -- of -- I guess -- you may not have your
11 file with you, but here's a copy.

12 There was a transaction printout and I -- and
13 it -- it looked as if there were other transactions
14 or -- or other visits that did not coincide with
15 your counseling notes. For instance --

16 A Okay.

17 Q -- for instance --

18 A Where is it?

19 Q -- the first the first thing I see is a -- a -- a
20 history was taken by you; it's dated August 4th --

21 A Right.

22 Q -- 2006, but your first visit, where there's any
23 dictation or typing, is September --

24 A Right. The first --

25 Q -- 27th, 2006.

1 A The -- the first visit would have been on that
2 handwritten assessment sheet. It would say -- I
3 think that says August 4th or something --

4 Q Yes, sir.

5 A -- like that.

6 Q August 4th. So this --

7 A Right. That would be the first time that I saw Ms.
8 Argoe.

9 Q All right.

10 A And if you can see, it would be --

11 Q It's --

12 A -- the date's right up at the --

13 Q Right.

14 A -- top. Okay.

15 Q Yes, sir. August 4th, 2006.

16 A Right.

17 Q So after this initial visit of -- this is six pages
18 --

19 A Right.

20 Q -- three back and front, then your next visit would
21 be the September 27th --

22 A Yes.

23 Q -- 2006? Okay.

24 A Yeah.

25 Q And it looked like, once you started on September

1 27th, 2006, you saw her once a week.

2 A Pretty much weekly.

3 Q Okay.

4 A Absolutely. I can't really tell you why there's a
5 gap there other than that's normally the time that
6 I go to Maine for vacation, and I think that's what
7 happened.

8 Q That's fine. Now, do you -- if you need to see
9 this initial assessment --

10 A Yeah.

11 Q -- do you -- do you know how you first came to see
12 Ms. Argoe?

13 A She was referred by, I believe, her attorney, Jan
14 Warner.

15 Q For what purpose?

16 A Basically, wanted to be sure that she was seeing
17 that she was okay. You know, supportive therapy,
18 basically, is all I was doing.

19 Q Well, I -- I know that in -- in -- in some of the
20 records we have, during this time, she was going --
21 I think she was going through a divorce, and I --
22 and --

23 A Uh-huh.

24 Q -- it apparently -- it appeared you gave an
25 affidavit with --

1 A Right.

2 Q -- the divorce caption --

3 A Absolutely.

4 Q -- heading. I mean, was that the purpose that Jan
5 had you involved?

6 A I -- I don't --

7 MR. DODSON: Object to the form. (To the
8 deponent) You -- you can still answer. If
9 you hear me make an objection, that's just for
10 the record, but you still answer.

11 A I -- I -- I can't say what Jan's purposes were.
12 What -- what he communicated to me was he had this
13 lady who'd been through an awful lot of stuff, and
14 he wanted to be sure she was seeing someone so that
15 she was okay. In the process of that, as she was
16 going through a divorce, he asked me for an
17 affidavit. I'd hate to even guess what Jan's
18 purposes were.

19 Q Well, the typicality was he was kind of missed.

20 A He was a great guy. He was crazy but great.

21 Q Yeah. Away from -- away from the business, he was
22 actually a pretty cool guy.

23 MR. PARHAM: (To all counsel) I -- I did not
24 make a copy of this. I don't know if
25 everybody has one. Maybe -- if -- if we need

1 to take a break, I will.

2 MR. COLE: (To Mr. Parham) He's got a copy of
3 it.

4 MR. DODSON: (To Mr. Parham) He -- he's got
5 his own.

6 THE DEPONENT: I -- I've got a copy, so --

7 MR. DODSON: He brought --

8 THE DEPONENT: -- so we could have these.

9 MR. DODSON: -- he brought his own.

10 MR. PARHAM: Does everybody have a copy?

11 MR. HAILE: Uh-huh.

12 MR. DODSON: These are just part of his
13 records, Jim? What -- what -- what you have
14 there, is that a part of his --

15 THE DEPONENT: Yeah. That's part of mine.

16 MS. GANES: Yeah.

17 MR. COLE: Yeah. I've got a copy, then.

18 Q All right. Doctor, if you -- if you go to that
19 first --

20 A Uh-huh.

21 Q -- that August 4th --

22 A Uh-huh.

23 Q -- visit --

24 A Yep.

25 Q -- the presenting problem -- now, is this your

1 handwriting?

2 A Absolutely.

3 Q Okay. So you're taking a history talking to her --

4 A Absolutely.

5 Q -- individually? And it looks like the presenting
6 problem is, quote, My husband had me committed,
7 unquote, and also marital problems. Is that right?

8 A Right. As -- as part of what I would normally do
9 if you came in, I would say, "Look, I want you to
10 take a few minutes, and just sort of briefly tell
11 me why you're here today." And that's what she
12 said. And then as we went on, I wrote in my own
13 little note that marital problems seemed to be the
14 primary issue.

15 Q And then when you went to the symptoms, you're
16 asking her to tell you whether it's -- or is she
17 checking those blocks?

18 A No. I'm asking if -- some -- some of these I'm --
19 like affect is something that I would pick up just
20 by watching you, but, for example, under "sleep," I
21 would say, you know, "Tell me a little bit about
22 how you sleep, and are you having any difficulty
23 going to sleep? Do you wake up in the middle of
24 the night? Do you sleep too much?" And we sort of
25 go through all of those. So some of those are --

1 are part of my experience of you, but all of that
2 is self-report and then me digging a little bit
3 deeper one way or the other.

4 Q Okay. Now, at -- in one of the pages, it looks
5 under -- under "addictions."

6 A Yes.

7 Q Now, you wrote, "No alcohol or smoking. Possible
8 compulsive shopping."

9 A Yep.

10 Q How did you reach that --

11 A I put that as a note to myself because, in talking
12 with her, she said that her husband thought that
13 she spent too much money and that, indeed, she had,
14 you know, bought a lot of clothes. So I put that
15 down as something I could refer back to later to
16 see if that was an issue.

17 Q But when you asked her the question about if she
18 had any obsessions, compulsions, she denied, right?

19 A Yeah. And compulsions there -- compulsive shopping
20 certainly is a compulsion, but, typically, when
21 you're talking about compulsions like that, we're
22 asking people any checking, counting,
23 straightening, cleaning. Things like that. Any
24 obsessional thoughts, things that you can't not
25 think about, and that -- there didn't appear to be

1 any -- or she denied it.

2 Q And on the last page of this six-page form -- well,
3 hold on.

4 A Yeah.

5 Q At the top, the MM -- MMSE --

6 A Uh-huh.

7 Q -- is 28. What's the MMSE?

8 A It's a "mini-mental status exam," possible 30
9 points out of a -- a total of 30 points, and I
10 think the two she missed on that -- on that one was
11 the two -- she -- she had difficulty recalling two
12 items in the short-term memory, and I don't -- I do
13 not use the flag, tree, ball on there because,
14 unfortunately, lots of people who've had mini-
15 mental status exams -- if people use the same form,
16 they use the same ones on there, so I -- I usually
17 come up with my own. And she was unable to recall
18 two of them, which I found sort of surprising, but
19 I -- I don't know that -- whether she was just
20 inattentive that day or not because after that, she
21 always got them a hundred percent. But that was
22 fairly insignificant. A 28 out of 30 is still well
23 within the normal range.

24 Q Did -- did you get the prior records where she had
25 been ordered treatment for one year from Coastal?

1 A Well, I did not have them when I did this
2 assessment, but do you mean did I get them later --

3 Q At some point during the treatment.

4 A Yes. Yes. Yeah.

5 Q Okay. And you reviewed those?

6 A Yes.

7 Q All right. And then under -- the last page, the
8 diagnostic impression that you told me you would --

9 A Uh-huh.

10 Q -- you would make as a -- as a counselor -- under
11 Axis I, you've got "bipolar with psychosis by
12 history," parentheses, "no" --

13 A -- "present symptoms."

14 Q -- "present symptoms," parentheses. You deferred
15 Axis II. N/A on Axis III. Axis IV, marital
16 problems. End of the treatment plan: further
17 evaluation and treatment --

18 A -- planning.

19 Q -- planning. Which meant counseling?

20 A And -- and/or possibly some further psychological
21 evaluation, if needed, by, I think, maybe Dr.
22 Washington, was someone they were talking about.
23 Yeah. I put the bipolar with psychosis by history
24 because, you know, that's what she was telling me
25 she'd been diagnosed as, but didn't present that

1 currently.

2 Q Okay. And when you say "present -- present
3 symptoms," what -- what would you be looking for
4 under that diagnosis?

5 A Well, in this particular case, there are a whole
6 array of symptoms I could read you out of DSM-IV,
7 but, essentially, if she was having sleep
8 disturbance, for example, to the point that she was
9 unable to sleep for three or four days in a row; if
10 she had rapid pressured speech; if she was engaging
11 in risky, dangerous behavior; if she felt like her
12 thoughts were racing; if she was unable to stay on
13 task; those would all be -- or if she had any
14 grandiose kind of ideas -- those would manicky
15 symptoms. If -- if there was psychotic symptoms
16 interspersed with that, we would be -- you know,
17 things with the delusional ideas and contents or
18 the expression of -- of any kind of hallucinatory
19 response, and then for it to -- to meet the full
20 bipolar kind of diagnosis, there would have had to
21 been some -- at least some episodes of depression.
22 You can get a bipolar diagnosis without having had
23 a depressive episode because it's assumed that you
24 are eventually going to have one, but, typically,
25 you would -- to confirm the diagnosis you would

1 also see that there had been some depressive
2 episodes.

3 Q Okay. I'm going to mark -- these are your --

4 A Yeah.

5 Q -- counseling notes.

6 A Right.

7 MR. PARHAM: (To the court reporter.) Mark
8 that as 1.

9 Defendants' Exhibit Number 1, Chart notes
10 for Martha L. Argoe.

11 Q And -- and -- and, Doctor, I'm not going to go
12 through all of them. I'm -- somebody else might,
13 but I'm not.

14 A Sure.

15 Q I'm just going to, kind of, hit things I'm --

16 A Absolutely.

17 Q -- interested in.

18 A Absolutely.

19 Q In the October 4, 2006, visit, you talked about
20 she's working at Cracker Barrel?

21 A Uh-huh.

22 Q But then, down on October 18, it talks about Taco
23 Bell, and that's the only time I -- I see a
24 reference to Taco Bell. Do you -- do you know if
25 she actually worked there, or is that just a typo?

1 A I would have to say that must be a typo; I can't --

2 Q I don't see it any other notes.

3 A As far as I know, she never worked at a Taco Bell.

4 I think, either myself or the transcriptionist was,
5 you know, having a brain fart, but --

6 Q That's fine. I -- I don't recall --

7 A No, I --

8 Q -- her working at Taco Bell.

9 A No.

10 Q That's why I'm asking.

11 A Yeah.

12 Q Then on the November 1st, 2006, visit, there at the
13 bottom of the first page: "She's still working at
14 Cracker Barrel part time and does remain somewhat
15 self-sustaining." What do you mean by "somewhat
16 self-sustaining"?

17 A Can't specifically say all the way back to that. I
18 know at -- during that -- that time, you know,
19 money was an issue for her in terms of where --
20 where she was going to get income from because she
21 was in the middle of this thing with her husband,
22 and I don't know if that was in reference to the
23 fact that he was paying her any, you know, support
24 or anything like that, but, I mean, she was living
25 on her own.

1 Q And then the next one is November 8, 2006.

2 A Yep.

3 Q About three lines down, it says, "By all reports,
4 she appears to being doing quite well."

5 A Reports --

6 Q What reports are you referring to?

7 A By -- by her.

8 Q Okay.

9 A Yeah.

10 Q I mean, and in -- in all these notes, can you --
11 and maybe I need to go through all of them -- but
12 are these pretty much what you can remember, or do
13 you have an independent recollection outside of
14 these notes about these visits?

15 A Well, if -- if you look at the notes, they're --
16 they're all basically pretty white bread, and,
17 basically, it's just to help me recall where we
18 were, what was happening. And it is a reflection
19 of, you know, not only of what she shared with me,
20 but the interaction we're having during that day.
21 Typically, we'd have a full hour. I might would
22 start by asking her, you know, kind of, what's
23 going on; how things are doing, and I'm reflecting
24 that notes, but at the same time, I'm just, kind
25 of, assessing: whether or not the story sticks,

1 whether or not things are the same, whether or not
2 she can stay on track, whether or not she's
3 presented any other kind of symptoms, and how she's
4 dealing with specific levels of stress in her life.
5 Throughout the entire time, she appeared really,
6 fairly stable.

7 Q And I -- I understand that --

8 A Yeah.

9 Q -- statement, but is there -- are there things you
10 can tell me in each of these visits that's not
11 reflected in the note, or is that -- is this just a
12 synopsis -- conclusion --

13 A Yeah. This would pretty much be it.

14 Q When you were taking -- when you -- when you are
15 talking to a patient for that hour, do you take
16 handwritten notes?

17 A No.

18 Q Okay. So all -- so, you finish the -- the session,
19 do you dictate or type yourself --

20 A Not --

21 Q -- at the end of the session or you wait until the
22 end of the day?

23 A Well, in -- in those days, what we did, is we would
24 dictate them either at the end of the session or at
25 some point later in the day. Couple of years ago,

1 we changed and I do all handwritten notes now. But
2 so -- but in those days, yes, I would just pick up
3 a little Dictaphone and blah blah blah blah.

4 Q So no handwritten notes?

5 A No.

6 Q This is what we have --

7 A That's right

8 Q -- for the visit?

9 A That's right.

10 Q Go down to November 29, 2006.

11 A Yes.

12 Q And starting with the end of the first line: "This
13 lady continues to make improvement."

14 A Right.

15 Q What -- what is she improving from?

16 A Well, because, you know, she had been through a
17 tremendous amount of stress. She was trying to get
18 settled. Her affect in mood of -- certainly seemed
19 appropriate when she started, but you could tell
20 she was just gaining in strength. She -- I think I
21 reflect later on that she's become more assertive,
22 willing stand up for herself, and seemed to be a
23 lot more outgoing. She's -- this isn't reflected
24 in the notes, so I probably shouldn't mention this,
25 but just as a casual observation, she was very

1 friendly, very outgoing, very talkative to people
2 in our -- our waiting room and the other therapists
3 walking through, and they would all comment on
4 that, but, as I said, that's not there, so I won't
5

6 Q And then December 13, 2006, the third line down:
7 "Seems much more upbeat than when she first was
8 seen in this office --

9 A Yeah.

10 Q -- so, that's you're --

11 A Yeah.

12 Q -- talking about the improvement from the stressors
13 and things?

14 A Yeah. She -- she -- you know, she was -- seemed,
15 kind of, beat down by the whole thing of, you know,
16 she felt like she was being over-controlled by her
17 husband. She felt like the whole experience in the
18 hospital had robbed her of -- of, you know, dignity
19 and that kind of stuff, but she was -- she was
20 pretty upbeat by now.

21 Q And then January 10, 2006, which may be on the
22 third page.

23 A Yes.

24 Q Three lines down: "She reported that she has had a
25 hearing involving her commitment several months ago

1 and after reviewing the information, it appears the
2 judge is ruling in her favor." Do you remember any
3 details about that?

4 A No. Other than that's, maybe, something she just
5 told me, but, no, I don't.

6 Q Okay.

7 MR. COLE: (To the deponent) Should that be
8 2007?

9 THE DEPONENT: Should be.

10 MR. PARHAM: Yeah.

11 THE DEPONENT: Yeah. Absolutely.

12 Q All right. Go down to the bottom of page, January
13 24, 2007, second line: "Even though she still has
14 periods of depression, she's not exhibited any
15 symptoms of mania, lately." Does that imply she'd
16 had mania before?

17 A No. It -- what I'm referring to there is, you
18 know, what had been ascribed to her earlier before
19 I saw her. I never saw any symptoms of mania, and
20 probably, quite frankly, I use that term
21 "depression" probably too loosely. I should've
22 said "dysphoria" because I never saw even any real
23 depression with Ms. Argoe.

24 Q What's "dysphoria"?

25 A It's sad mood, or, you know, if you and your wife

1 had a fight and you might out of sorts for a day or
2 two. Or if your boss had called you in and chewed
3 you out, you -- you might be down, but it's -- it
4 doesn't involve any diminishment in any
5 functioning. It's not clinical depression. I -- I
6 really never saw any clinical depression with her
7 at all.

8 Q And then you mentioned, "She's back in a
9 relationship." Is that a relationship with another
10 man?

11 A Yeah, I've read this and there's another note here
12 I've read. And I'm trying to remember what in the
13 world was that about? I really have no memory of
14 that one way or the other.

15 Q March 21st, 2007, I think it's Page 5.

16 A March -- which one?

17 Q Twenty-first.

18 A Twenty-first. Yes.

19 Q Down at the bottom: "At this point she does not
20 appear stressed out as she has been in the past.
21 She says primarily because she is free of the
22 domination of her husband." That was the
23 controlling aspect you'd discussed --

24 A Yes.

25 Q -- earlier?

1 A Yes. Uh-huh.

2 Q And then go to Page 6, at the top, the next page.

3 A Uh-huh.

4 Q April 18, 2007. Do you have that?

5 A April 18th?

6 Q Yes, sir.

7 A Oh, yes, okay.

8 Q Okay. Second line: "She functions at extremely
9 high level for someone who's supposedly is
10 incapable of managing her own affairs." Who are
11 you referencing about "supposedly incapable of
12 managing her own affairs"?

13 A Oh, going back to the -- the whole idea, during the
14 divorce, there's a question about whether or not
15 she is able to manage her own affairs.

16 Q And then the next visit, April 25, 2007, this is
17 the first note I see, and you're about eight or
18 nine months into your treatment, where you mention
19 for the first time the psychiatric hospital
20 episode.

21 A I think I'd mentioned it tangentially before that,
22 but, yeah, basically, we'd mentioned something
23 before where she talked about her treatment in the
24 hospital, but I think that was -- this may be the
25 first time I've mentioned that directly, yes.

1 Q Because it -- it says, "We spoke at length about
2 some of her treatment in the" --

3 A Yeah.

4 Q -- "psychiatric" --

5 A Yeah.

6 Q -- "hospital."

7 A Right.

8 Q At this point had you gotten any record from Three
9 Rivers?

10 A I'd have to look at the dates in the chart to see
11 when I did get some of that. I'm really not sure
12 whether I -- I -- I don't think so, but I'm not
13 sure. I think this was just going off what she was
14 telling me.

15 Q I mean, was it -- at -- during this time you were
16 actually treating her as a patient, would that have
17 been important to you or really not?

18 A Would which have been --

19 Q Three Rivers.

20 A What would've been important to me about her
21 treatment at Three Rivers, at that point, would've
22 been the impact that it was having on her
23 currently, and, possibly, the impact it had on her
24 previously if -- if indeed she were traumatized by
25 that.

1 Q Well, I mean, do you remember anything about this -
2 - this lengthy discussion you had during this
3 session on April 25, 2007?

4 A Yeah. Basically, what we went through is -- is her
5 discussion of them telling her that she was
6 psychotic; she didn't think she was psychotic.
7 Them telling her she had to take medication and her
8 saying she didn't want to take medication. But
9 then when they said she was going to have to take
10 it, she went ahead and took it. And, you know,
11 basically, the sense that she felt like she had
12 been committed unlawfully and held against her will
13 unlawfully, but, you know, she really didn't have
14 much choice at that point.

15 Q Do you commit people?

16 A Do I personally commit people?

17 Q Yes, sir.

18 A In the state of South Carolina, I can be party to a
19 commitment, but it would require a physician to do
20 that. I have served as a designated examiner for
21 the same hospital, and I have filled out the papers
22 and I have served as -- as one of the people
23 signing that off with one of our psychiatrists,
24 yes.

25 Q Okay. But you -- you can't without -- I mean,

1 there has to be a physician's signature to make the
2 commitment, correct?

3 A Well, you can go to a probate judge and have a
4 order of detainment issued where they would send
5 two deputy sheriffs out to pick up someone and take
6 them for an evaluation. But to actually have them
7 committed, that has to be signed by a physician.

8 Q Right. That's what I'm saying.

9 A Right.

10 Q So --

11 A Yeah, yes.

12 Q -- to get--

13 A I'm sorry.

14 Q -- to get them committed --

15 A I'm sorry, yeah. I -- I -- I can be involved in
16 the process, but that's right, a physician would
17 have to sign --

18 Q Right.

19 A -- that.

20 Q And one of my favorite cases I defended, when I had
21 to defend an ER physician for an involuntary
22 commitment, was that the woman had her boyfriend
23 committed for the 72 hours so she could off with
24 another man. That's one of my favorite cases.

25 A Yeah. Yeah. Yeah. Unfortunate.

1 Q So I learned then I could pretty much put whoever I
2 wanted into the hospital for a couple --

3 A You -- you can -- you could start the process.
4 Anybody can. And that's -- that's why -- that's
5 why, for a commitment to be upheld, it should be
6 taken very seriously.

7 Q And you understand her commitments have been
8 legally upheld. You understand that, right?

9 MR. DODSON: Object to the form.

10 A When you say they've been legally upheld?

11 Q Well, they've been adjudicated, and they've
12 actually gone to our Supreme Court -- our State
13 Supreme Court and been affirmed. Do you understand
14 that?

15 MR. DODSON: Same objection.

16 A I'm not sure I understand all of that.

17 Q Okay.

18 A And -- and look -- what I understood is that
19 certain aspects of that were upheld by the Supreme
20 Court in terms of the procedure, not necessarily
21 whether it was right or wrong.

22 Q Well, there's a distinction there, right? I mean,
23 you can --

24 A Yeah. Yeah.

25 Q -- you can --

1 A Right.

2 Q You can procedurally --

3 A Right.

4 Q -- meet the requirements --

5 A That's right.

6 Q -- to -- you can voluntarily commit somebody.

7 A That's right.

8 Q Now, whether it's right or wrong is a different

9 aspect.

10 A Right. That -- and that -- that was my

11 understanding.

12 Q But as long as it's procedurally and legally

13 correct, then you're in the place?

14 A You're in the place.

15 Q Okay.

16 A You've got that right.

17 Q Okay. I'm not trying to --

18 A No. I know, I just wanted to be --

19 Q -- I'm not trying to get -- yes, sir --

20 A I wanted to be sure you understand where I was.

21 Q Right. And I'm not trying to say anything about --

22 A Yeah.

23 Q -- the lawsuit --

24 A Right.

25 Q -- she's brought.

1 A Right.

2 Q I -- I think there's different issues --

3 A Yes.

4 Q -- than what I'm talking about, but --

5 A Yeah.

6 Q -- that's not what I'm trying to --

7 A Yes. I just . . .

8 Q All right. And -- and back when -- back when you
9 mentioned on April 25th, 2007, that she'd spoken at
10 length about treatment in the psychiatric hospital,
11 were you aware that, within about 30 days, she was
12 getting ready to file the lawsuit against all the
13 providers that had put her in the hospital,
14 including her family?

15 A I knew that she was going to at some point. I
16 didn't know --

17 Q Okay. So you weren't aware that, about five weeks
18 later, on June 6th, 2007, she actually filed the
19 complaint?

20 A Probably not at that date. I mean, I knew that
21 that was something that she was going to do, and I
22 knew that it occurred at some point. I don't -- I
23 don't know exactly what the timeline was.

24 Q In fact, on the same day the complaint was filed on
25 June 6th, 2007, you saw her and she tells you that

1 "She's very excited that the attorneys filed the
2 motion against the hospital that she was held
3 against her will for almost a month." You remember
4 that?

5 A Yeah. I mean, it's -- it's certainly right there.

6 Q And then the June 20th, 2007, which is the top of
7 the last page, I believe. There, towards the
8 bottom: "Part of this session was spent discussing
9 a recent court hearing during which she was able to
10 conduct herself with grace and dignity." Is -- is
11 there an implication there at times she hadn't
12 conducted herself with grace and dignity?

13 A No. The implication there is that she was very
14 happy that she didn't break down or didn't --
15 didn't feel bullied by her husband or attorneys or
16 anyone like that. That she was able to say exactly
17 what she thought, and she felt good about that.

18 Q And it looked like, starting in August, you started
19 seeing her about once a month. You went from
20 August to September to October?

21 A What's more, that probably coincided with my annual
22 trip to Maine, but -- but yes, we'd already begun.
23 She was -- there wasn't a whole lot of reason for
24 me to continue seeing Ms. Argoe. She was
25 functioning fine, and it -- it was beginning to

1 fall under the category of what pediatricians used
2 to refer to as "well baby visits." She was doing -
3 - she was doing just fine, as you can see, shortly
4 after that.

5 Q I mean, was there -- was there much change from --
6 from the time you first saw her in September of
7 2006 to, the last visit apparently was, October
8 3rd, 2007?

9 A The -- the -- the change qualitatively would be
10 just in a -- a person who now seemed much more sure
11 of herself and more willing to -- to -- to assert
12 herself. But in terms of -- you know, I never saw
13 her as being depressed, manicky, psychotic, or
14 anything like that from day one till the end of the
15 sessions. Never exhibited any symptoms that would
16 suggest that.

17 Q Well, I mean, I'm sure you've handled plenty of
18 people that've been going through divorce. I mean,
19 people do actually get happier when they away from
20 somebody they don't like that they'd been married
21 to, right?

22 A Well, I've -- I've heard that that happens, yes.
23 Yes, of course. I mean, she had felt like she had
24 been dominated for a long time, and she -- she felt
25 much better.

1 Q All right. Anywhere else in your records that you
2 made your own diagnostic impression, absent the one
3 she gave you by history, where you've actually
4 written out another --

5 A No.

6 Q -- diagnostic -- nothing at all?

7 A No.

8 Q All right.

9 A And the -- you know, quite frankly, the only -- the
10 only things that if you were to ask me today
11 reviewing that, I would say, "Look, she might would
12 meet some of the V-codes, like for marital
13 problems, but she didn't meet any of the criteria
14 for depression or anxiety, or even, well, certainly
15 not bipolar disorder or psychosis."

16 Q Did you ever talk to anybody directly at the
17 Coastal Center about what they had done for the
18 year after she was released from the hospital?

19 A I'm pretty sure not, no.

20 Q Has your group ever been a part of a court order,
21 where they had -- they instructed to treat someone
22 for a year? For any period of time?

23 A Yes. Yes.

24 Q And you have to, right?

25 A Yeah.

1 Q Okay.

2 A I've -- I've had that. Usually, it's more through,
3 like, PTI or something like that, though.

4 Q And -- and if you -- if there's court order for a
5 -- for a patient of yours to be treated for a
6 certain length of time and -- and prescribed
7 medication, your group would do that, even though
8 you may not feel like it was necessary?

9 MR. DODSON: Object to the --

10 Q Or would you go against the order?

11 MR. DODSON: Object to the form.

12 A If -- if we felt like they did not need the
13 medication, we certainly would communicate that to
14 the Court. I mean, I don't think the Court can --
15 can force the physician to -- to malpractice.

16 Q Well, that's -- that's what I'm saying, so if you
17 felt like you couldn't treat a patient of yours
18 under the court order about treatment and drugs,
19 then you would make petition back to the Court?

20 A I -- I would -- I would --

21 Q Oh, you agree?

22 A -- hope our group would, yes.

23 Q Okay. All right. I mean, you just wouldn't stop
24 it summarily. You would seek the Court, right?

25 A I would hope so, yes.

1 Q Okay. So if Coastal didn't seek any petition, they
2 must've felt it was necessary to treat her for that
3 year, correct?

4 MR. DODSON: Object to the form.

5 A You'd certainly have to ask Coastal about that, but
6 --

7 Q Well, you reviewed the records.

8 A Yeah. I think --

9 MR. DODSON: Same objection. (To the
10 deponent) Go ahead.

11 THE DEPONENT: Yeah.

12 A I -- I think there may have been some hesitancy
13 there, but they continued treatment.

14 Q Okay. Now, in your sessions with someone -- a
15 patient of yours, are you asking specific questions
16 about depression, mania, psychosis, or are you just
17 evaluating from your interaction with that patient?

18 A Both. Because, quite often, what -- what I might
19 do, is very briefly at some point, say, "Well,
20 let's do a quick symptom checklist: How're you
21 sleeping? How's your appetite? Any irritability?
22 Moodiness? Any difficulty concentrating?"

23 That kind of stuff. But -- but typically
24 speaking, I'll save that really towards the end
25 because what I want to see is, as they're telling

1 me things, whether or not I can pick up any cues
2 that might say -- you know, because if they're
3 going to say, "Well, you know, I'm really -- I'm
4 really tired today. I'm not sleeping well."

5 Then I'm going to say, "Well, you know, tell
6 me a little bit more about that. How long has that
7 been going on?" Blah blah blah.

8 But if, throughout the course of the session,
9 I'm getting information. I'm trying to make some
10 sense of -- of -- of what's going on in their life,
11 it's -- it's not unusual that I'd, also, at the end
12 say, "Well, let's -- let's just do a quick symptom
13 checklist of some of the things that have been a
14 problem in the past." And one of the things I
15 might would do is turn back to this initial intake
16 thing and go over the symptom checklist. And say,
17 "Well, let's -- let's just see how you're doing
18 compared to that."

19 And, typically speaking, if -- if someone is
20 making progress, they're -- they're showing
21 improvements over where they were. You know, if
22 you look at the initial intake with Ms. Argoe, she
23 actually seemed to be doing pretty well the day she
24 got there, so.

25 Q And -- and you -- you -- you did two additional --

1 A -- mini-mental status exams, yeah.

2 Q -- mini-mental status -- is that just to update
3 you? Just to see if everything's fine?

4 A Well, one of the concerns, of course, because, you
5 know, I'm -- I'm thinking, Listen, I've been seeing
6 this lady. She appears to be fine to me. Got
7 these other people saying things were not so good
8 at some point. I want to continually just kind of
9 check on her -- her cognitive abilities.

10 If -- if I were to ask you, "How's your
11 concentration?"

12 You might say, "Well, it's fine."

13 And I'd say, "Well, good. I'd like you to
14 start with the number 100, and I'd like you to
15 count backwards by 7's until I tell you to stop,
16 and if you have difficulty doing that, then I'd
17 say, "Well, you may think you're concentration is
18 pretty good, but not so good." And I might say,
19 "How's your memory?"

20 You might say, "My memory's very good."

21 And I'd say, "Okay. Well, I'm going to name a
22 couple of items. I want you to repeat them. In a
23 few minutes, I'll ask you to tell me what those
24 items are. And if you can't do that, then it would
25 indicate you're having some difficulty."

1 So sometimes, obviously, just because I think
2 I'm doing fine, there may be some issues. So
3 that's why we would do periodic mini-mental-status
4 exams, just to see what's happening.

5 Q And then the last visit on October 3rd, 2007, you
6 say, "Continue to work with her in a supportive
7 fashion. See her in several weeks." But she just
8 didn't come back, right?

9 A She didn't come back in -- I -- I can't remember
10 exactly what happened then. I think, at about that
11 time, I may have talked to Jan or -- about this,
12 but she was doing perfectly fine, and I -- there
13 really wasn't much need to see her anyway. You
14 know, well, yeah, I'm not -- I'm not sure what
15 happen there.

16 Q And -- and was she on any medication when she first
17 saw you on August 4, 2006?

18 A No.

19 Q Okay.

20 A She'd -- she'd been on Risperdal. I think at some
21 point, Ativan. They'd tried her on Geodon and
22 they'd had her on Haldol, at one point, but I think
23 Dr. Dodds had eventually removed her from that,
24 also.

25 Q And the Risperdal, she at least told you and you

1 reported in your initial assessment, that wasn't
2 the stuff she was ordered by the Court to take for
3 one year, at least by her quote?

4 A Yeah. But she -- she had been on that in the
5 hospital, also.

6 Q Right.

7 A Yeah.

8 Q I mean, but she --

9 A Right. Right. That --

10 Q -- was still not on that.

11 A Right.

12 Q She wasn't on that when she -- you saw her,
13 according to your notes?

14 A According to my notes.

15 Q Okay. And -- and -- and what -- what does
16 Risperdal treat?

17 A It's a -- it's an atypical antipsychotic. And it's
18 used, predominately, to treat people with
19 psychosis, hallucinations, delusions. It does have
20 some efficacy in treating the psychosis associated
21 with bipolar disorder. I'm not sure they have an
22 indication for that, but it is used for that. And
23 it does have, well, somewhat of a sedative effect,
24 too.

25 MR. PARHAM: All right. Let's take a little

1 break, and then I'm going into --

2 THE DEPONENT: Sure.

3 MR. PARHAM: -- the lawsuit.

4 THE DEPONENT: Absolutely.

5 (Off the record from 11:16 a.m.

6 until 11:28 a.m.)

7 THE EXAMINATION BY MR. PARHAM CONTINUES.

8 Q Doctor, now we're going to turn to the -- to the
9 lawsuit.

10 A Sure.

11 Q But before the deposition started, you handed me a
12 notebook of -- of -- and that is everything you
13 have reviewed in the case; is that correct?

14 A Absolutely.

15 Q All right. And in there, it looked like you had
16 two medical records. One was the -- from Aiken
17 Regional --

18 A Aiken.

19 Q -- and then the other one was from Three Rivers,
20 correct?

21 A Yes, yes.

22 Q And then the rest of them, numbered 3 through 15,
23 are the depositions taken in the case?

24 A Yes. Uh-huh.

25 Q And did you read all that?

1 A As a matter of fact, I -- I did.

2 Q Okay. All right.

3 A And that is mind-numbing.

4 Q Yes. And --

5 A And this --

6 Q -- the affidavit of Dr. -- or two affidavits of Dr.
7 Davis, correct? I think there were two, or is
8 there just one?

9 A I think there's just one in here. And then the
10 rest of it is like his vita and stuff. I -- I
11 think there's just one. Yeah.

12 Q And that -- this affidavit is dated -- well, it's
13 notarized May 6th, 2008. Looks like it's dated, at
14 least in the top corner of two of the three pages,
15 April 30th, 2008. All right. And that's -- that's
16 it for your review of everything, correct?

17 A Yep.

18 Q And what are you -- what are you charging to review
19 the records in this case?

20 A Two hundred fifty dollars an hour.

21 Q And what are you charging to give your deposition?

22 A I have to look. I think it's about \$300 an hour.
23 Three hundred fifty dollars an hour. This is
24 great.

25 Q I'll take my time.

1 MS. GANES: Hurry up, Jim.

2 THE DEPONENT: Well, I thought I was doing
3 real well with a -- in a case with video poker
4 until I realized the -- the person that was
5 deposing me had six attorneys who were all
6 getting \$600 an hour apiece, and I thought,
7 Well, hell, I'm on the wrong side of this
8 table.

9 MR. PARHAM: I will beg to differ about that.

10 Q And what are you going to charge if you have to
11 come and testify at trial in Lexington in October?

12 A I think it's about the same, but I can tell you.
13 I've got a little price list here. Three hundred
14 fifty -- the same, three-fifty.

15 Q Let me see that, please.

16 A Yeah.

17 Q Just give me -- give me the whole thing. Give me
18 the whole --

19 A Oh, sure.

20 Q -- thing.

21 Q Is this a -- is this a fee sheet from your --

22 A -- practice.

23 Q -- practice?

24 A Yeah. Yes.

25 Q So that's what everybody would charge?

1 A No. The psychiatrists charge much more; the social
2 workers charge a little less.

3 Q Okay.

4 A We actually don't do a whole lot of this anymore.
5 We used to have a partner who was a forensic
6 psychiatrist.

7 Q Who was that?

8 A Dr. John DeWitt.

9 Q He's -- he's in Aiken now, right?

10 A Yes. Those are all just blank.

11 Q And this forensic flow chart -- were you just using
12 it as a billing sheet?

13 A It's just a way to keep track of it. It's -- it's
14 not even complete right now.

15 Q How many hours have you spent working on this case
16 since you were first retained?

17 A I'd have to take a look at that, but it'd be
18 somewhere -- probably 10 or 15. I don't know.

19 Q Is that this sheet you're --

20 A Yeah, yeah. There's some -- couple of things I
21 haven't added there yet. Let's see. One, two,
22 four, twelve -- there're about three other hours
23 before this. So somewhere in the neighborhood of
24 15 or 16.

25 Q And that's before you walked in here today?

1 A Yeah, uh-huh.

2 Q And when you -- when were you first contacted about
3 being an expert in this case?

4 A In --

5 Q In general, if you don't have a specific date.

6 A Early this year.

7 Q Okay. And when you were contacted by Mr. Dodson or
8 his office, what were you told that they wanted you
9 to do?

10 A They said they would like for me to -- to serve as
11 an expert in the case, and to, you know, just
12 testify to my treatment and to -- to review the
13 records and to give my thoughts on that.

14 Q Yeah.

15 MR. PARHAM: I'll need a copy of this letter,
16 Robert.

17 Q Now, since October of 2000 -- October 3rd, 2007,
18 when you last saw Ms. Argoe, have you assessed her
19 again in any way?

20 A Absolutely not.

21 Q Okay. If you were going to come to trial and
22 testify -- I think we've got an October 14 two-week
23 trial date this year of 2013 -- would you assess
24 her again, or is that not what you're here for?

25 A I guess the answer would -- to that would be: If -

1 - if that were allowed under the protocol, perhaps.
2 I don't -- I don't know whether my testimony would
3 allow me to do that at this point. That -- that's
4 --

5 Q I mean, if -- is it --

6 A -- that's a legal issue. I -- I'd love to do that,
7 yeah, but I don't --

8 Q Is that important to your opinions?

9 A No. Not at this point.

10 Q Okay.

11 A Because I'm predominantly testifying about what
12 I've observed and seen in the past.

13 Q Are you aware if Ms. Argoe's been treated by anyone
14 else on any level of mental health care since you
15 saw her in October 2007?

16 A I -- I'm not. I've had no contact with her since
17 then.

18 Q And how many discussions, either in person or by
19 phone, have you had with Mr. Dodson about -- about
20 this case?

21 A Today, I talked to him before we came here and
22 maybe twice on the phone for five minutes.

23 Q Did you create any reports?

24 A No. I mean -- no.

25 Q I mean, absent -- since your care, have you created

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1 any reports from your review of the records or
2 depositions?

3 A Oh, no, no. Not at this point.

4 Q Do you have any handwritten notes --

5 A No.

6 Q -- or anything generated on a computer --

7 A Nope.

8 Q -- or --

9 A Nope.

10 Q -- iPad or anything --

11 A Nope.

12 Q -- from the case? Now, you don't have hospital
13 privileges, do you?

14 A No.

15 Q And once -- once a patient goes into a hospital
16 inpatient setting, either voluntarily or
17 involuntarily, do you ever go in and provide
18 treatment?

19 A I have in the past but not in 20-something years,
20 and for years I worked in the hospital, so that was
21 kind of a moot point, but -- yeah. Now, we waited
22 -- I've -- I've gone in to do consults and things
23 like that in the past, but the -- the real answer
24 would be probably "no."

25 Q Okay. It's -- so if you have, it's been 20-plus

1 years since; is that correct?

2 A (Nods head up and down.) Yes.

3 Q Did you say yes?

4 A Yes, yes. I'm -- I'm sorry. I'm sorry, yes.

5 MR. DODSON: Yeah. I -- I probably should
6 have told you earlier. Just try to give
7 verbal or --

8 THE DEPONENT: I -- I'm sorry.

9 MR. DODSON: -- oral answers. It's just --
10 you know, it's every -- we all do that.

11 MR. PARHAM: You did good until that point.

12 THE DEPONENT: Right. We were doing good.

13 Q Have you ever been sued personally for any of your
14 treatment?

15 A I have.

16 Q Okay. How many times?

17 A Once.

18 Q And when was that?

19 A It was roughly 1992 or '3. It drug on for a couple
20 of years, and then it was dropped, dismissed,
21 whatever.

22 Q Was it here in Richland County?

23 A Well, our office was in -- it's hard for me to
24 remember. It was either in Richland or Lexington
25 County. I'm --

1 Q Who represented you?

2 A Whoever was appointed by the JUA.

3 Q You don't remember his name or her name?

4 A Maybe it was Ernie Naufel. I know Ernie had
5 represented us in the past.

6 Q And what were the allegations?

7 A We had a patient in our practice who got -- had
8 been prescribed a medication by the name of
9 Klonopin, which is an anti-anxiety medication.
10 Somewhere along the line, she started receiving
11 clonidine, which is a blood pressure medication,
12 but it's -- actually, it's also used to treat
13 anxiety. And when that came to her attention, she
14 had, kind of, a meltdown at a pharmacy. And I
15 think it was Asheville at the time, and she sued
16 the pharmacist; she sued the doctor who was
17 prescribing the medicine, our practice. She sued
18 me because I was treating her, but I had not seen
19 her for six months before this incident. And so
20 she said I should have known that she was on the
21 wrong medication, but I had nothing to do with
22 that, so -- it drug on for a couple of years, and
23 then the whole case just disappeared. She dropped
24 it.

25 Q She dropped it against everybody?

1 A As far as I know. Now, I'm not sure whether or not
2 the pharmacist, which was distributing the
3 medication, didn't settle with her at some point,
4 but every -- everything else was dropped.

5 Q Now, as a retained expert in this case, are -- are
6 -- is it your intent and are you going to render
7 opinions about standard of care for any of the
8 defendants in this case?

9 A What my intent is: To comment on whether or not
10 there was enough information to uphold a
11 commitment. In terms of standard of care, assuming
12 the diagnosis and the commitment was valid is a
13 totally different issue, but to answer the question
14 the way I think you intended, the answer would be
15 "yes."

16 Q Okay. And you've broken it down in two separate
17 areas. One is the -- the -- the commitment itself.
18 And then the second one, as I understand it, would
19 be what happened after the commitment in the -- in
20 the hospital; is that correct?

21 A That -- that -- that would -- that would be
22 correct.

23 Q All right. And your intent is to testify about
24 both?

25 A Yes.

1 Q All right. And, again, do you understand that the
2 commitments -- the commitment -- the initial and
3 voluntary commitment, and then the subsequent full
4 hearing on June 21st, 2005, have been upheld as
5 legal by our South Carolina Supreme Court?

6 MR. DODSON: Object to the form. (To the
7 deponent) You can still answer it, Doctor.

8 A You informed me of that earlier, yes, sir.

9 Q You didn't know that?

10 A No.

11 MR. DODSON: Same objection.

12 Q Okay.

13 A But wouldn't change what I'm going to say.

14 Q Well, I understand. I've got lots of opinions, but
15 whether they need to be said or not --

16 A Right.

17 Q -- is a different story.

18 A That's right. That's right.

19 Q And then I guess a -- a third area that you would
20 testify about, would be what we've gone over
21 earlier in the deposition, is where you picked her
22 up --

23 A Absolutely.

24 Q -- and treated her through --

25 A Absolutely.

1 Q -- from December 2006 to 2007?

2 A Absolutely.

3 Q Okay. And we've already covered that, correct?

4 A Absolutely.

5 Q All right. Well, I think if -- if we're going to
6 go back to the beginning, I think it might be best
7 to start at the beginning. And I don't -- I don't
8 want to -- it may be best to go chronologically
9 because I'm not --

10 A That's okay.

11 Q -- sure we were thinking we would be going all the
12 way -- way back, but --

13 MS. GANES: Sure.

14 MR. PARHAM: Is that -- is that fair, Ellore?

15 MS. GANES: Yeah.

16 MR. PARHAM: You want to come up here?

17 MS. GANES: No. I'll go -- I'll go from here,
18 if that's all right.

19 MR. PARHAM: Okay.

20 EXAMINATION

21 BY MS. GANES:

22 Q Dr. Quinn, my name's Ellore Ganes, and we've met
23 off the record. I represent Dr. David Steiner who
24 was, after the court-appointed examiners, the first
25 physician to see Ms. Argoe back in 2005 in

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1 reference to the events that this case pertains to.
2 Have you reviewed Dr. Steiner's records in this
3 case?

4 A I did.

5 Q Okay. And do you have opinions related to the
6 standard of care of a psychiatrist in this case?

7 A Do I have opinions related to the standard of care
8 by a -- yes.

9 Q Particularly Dr. Steiner?

10 A Yes.

11 Q All right. What are your opinions related to Dr.
12 Steiner's treatment of Ms. Argoe in this case?

13 A Let me -- can we go back to -- can I pull out the -
14 -

15 Q Sure.

16 A -- sheet over here?

17 Q You just tell me what you're referencing as you
18 testify, please.

19 A Okay. Let me get back --

20 MR. DODSON: (To Ms. Ganes) He's looking at
21 his --

22 A Yeah.

23 MR. DODSON: -- Steiner's deposition.

24 MS. GANES: Uh-huh.

25 A Yeah. Let me get back to where I . . . Well, I

1 guess I can probably just say: The -- the basic
2 opinion I have is that this lady was found to be
3 psychotic, when I'm not sure that that was
4 justified.

5 Q Okay. Anything else?

6 A That's basically it.

7 Q All right. And you did not examine Ms. Argoe at
8 any time prior to 2006, correct?

9 A That's correct.

10 Q Never seen her before in your life --

11 A That's --

12 Q -- prior to --

13 A That's correct.

14 Q -- 2006?

15 A That's correct.

16 Q All right. What is the basis, or the bases, of
17 your opinion that she was, quote, found to be
18 psychotic when you're not sure that was justified?

19 A That -- and this holds true with -- with most of
20 the physicians and the evaluators that see her said
21 after that also -- that basically they're relying
22 on information provided by the husband, but that no
23 one really presents any very specific symptomology
24 that would suggest psychosis. They reference
25 things like "sees witches and warlocks," which she

1 denies. They say, you know, she carries a handgun
2 on her hip. She's got a CWP. I think -- I can't
3 remember if it's Dr. Steiner. I know Dr. Mobley
4 and Dr. Dodds reference "pressured speech," which
5 may or may not be subjective, and "flight of
6 ideas," but almost everything else is related
7 directly to information provided by the husband and
8 not directly from the interview that they have with
9 this lady.

10 Q Okay. Do you have an opinion as to -- or do you
11 know whether Dr. Steiner had the authority to
12 discharge Ms. Argoe when he saw her upon
13 presentation to Aiken Regional?

14 MR. DODSON: Object to the form.

15 A I do not know whether he had the authority --

16 Q Okay.

17 A -- to do that, yes.

18 Q And did you ever interview Ms. Argoe's husband?
19 Did you ever meet him?

20 A Absolutely not, no.

21 Q Okay. Would you agree with me that you can't
22 testify to the jury whether the husband was a
23 reliable historian?

24 A Can I agree with you that the husband was not --
25 whether or not he was a reliable historian? I -- I

1 can't say one way or another whether he was a
2 reliable historian. Correct.

3 Q Okay. And do you -- is it your testimony that
4 anything that Dr. Steiner -- well, first of all,
5 let me ask you this: Do you have any specific
6 opinions as to anything that Dr. Steiner --
7 specific opinions as to anything that Dr. Steiner
8 should have done differently in his evaluation of
9 Ms. Argoe?

10 A Well, opinion may, as you say, be a little bit
11 different. It -- it's my opinion that there
12 probably was not enough information consistent with
13 the diagnosis that would mandate a commitment of
14 this lady.

15 Q Okay. But you understand that Dr. Steiner --

16 A Right.

17 Q -- did not commit Ms. Argoe, correct?

18 A No, no -- yes, yes.

19 Q Okay. Now, you understand the legal process
20 related to involuntary commitment --

21 A Yeah.

22 Q -- in South Carolina --

23 A Yes.

24 Q -- presumably? And do you agree with me that Dr.
25 Steiner, in the short time period that he saw Ms.

1 Argoe, could not release her legally? He couldn't
2 say, "You're here. I'm sorry that you're here.
3 It's been a misunderstanding. Go ahead home"?
4 A Actually, yes. We -- you and I just said that,
5 yes.

6 MR. DODSON: Object to the form.

7 Q You agree with that?

8 A Yes.

9 MR. DODSON: Same objection.

10 Q All right. What was Dr. Steiner free to do for Ms.
11 Argoe at the time that he saw her, as you
12 understand his role?

13 A Well, he could not release her, I guess, as you
14 say. I -- I'd have to tell you right now, off the
15 top of my head, I don't know.

16 Q Okay. All right. Well, then --

17 A Because he -- he really was in a caught. You're
18 right.

19 Q Okay. Now, I assume that you take your
20 professional qualifications very seriously.

21 A Yes.

22 Q And you've been sued in a lawsuit that you didn't
23 think you should have been in.

24 A Absolutely.

25 Q All right. So on what grounds can you sit here

1 under oath and testify against Dr. Steiner when you
2 agree with me that he couldn't have done anything
3 differently for Ms. Argoe than he did?

4 A He couldn't do anything differently in terms of
5 perhaps releasing her. He may have could have made
6 a professional statement that he no longer thought
7 that this lady was a -- a danger to herself or
8 anyone else.

9 Q Okay. Is it your opinion -- do you intend to tell
10 the jury in this case that there was a bases for
11 Dr. Steiner to make a professional statement that
12 he didn't think Ms. Argoe was psychotic?

13 A It's -- it's my opinion that he did not have
14 sufficient information to support a diagnosis of
15 that, yes.

16 Q Okay. But having -- not having sufficient
17 information to support that diagnoses --

18 A Right.

19 Q -- is very different than having sufficient
20 information to rule out the diagnoses, is it not?

21 A Well, you would not want to make a diagnoses, in
22 the first place, if you did not have sufficient
23 information.

24 Q Okay. Do you give any deference to the fact that
25 Dr. Steiner sat across the table from Ms. Argoe and

1 actually had an opportunity to clinically evaluate
2 her?

3 A Absolutely.

4 Q Okay. Well, then, would you agree with me that
5 it's not fair for you to substitute your opinion in
6 hindsight for Dr. Steiner's clinical judgment on
7 the day he evaluated her?

8 MR. DODSON: Object to the form.

9 A I don't think I would totally agree with you in
10 that we do have a difference of opinion of what
11 that may have be, but I certainly -- I certainly
12 understand that he saw her in a totally different
13 setting at a totally different time than I did.

14 Q Okay. Well, what -- can you itemize anything that
15 you see in the records related to Dr. Steiner for
16 me that you felt was unreasonable or a breach in
17 the standard of care?

18 A Okay. Well, it'll take me a few minutes --

19 Q Uh-huh.

20 A -- to get back to some of this. Oh, I'm sorry.
21 I'm looking at his deposition. I'm sorry. I
22 wasn't looking at the . . .

23 The -- the -- the only other primary complaint
24 I have is with this final diagnosis on Axis I where
25 he says, "Based on the information given by the

1 family, she's diagnosed with psychosis not
2 otherwise specified." And he wants to rule out
3 bipolar-mania, but he's not really presenting any
4 clear-cut symptoms that would suggest any of those.
5 He does say that he felt like her judgment was
6 impaired and that she was a little bit anxious, but
7 it doesn't explain why he thinks her judgment is
8 impaired.

9 Q Okay. So are you critical of his documentation or
10 of his care?

11 A Well, if the documentation is reflective of his
12 care, then both. Yes.

13 Q Okay. Well, what if it's not? What if his care is
14 different from what he wrote down because what he
15 wrote down was for use in a medical evaluation, not
16 a legal setting?

17 MR. DODSON: Object to the form.

18 A Okay. If his medical care is based on the
19 assumption of a diagnosis based on information from
20 the family as opposed to his evaluation of Ms.
21 Argoe, yes. I'm -- I would have a problem with
22 that.

23 Q Okay. Well, what did the standard of care require
24 that Dr. Steiner did not do related to Ms. Argoe?

25 A That he be able to evaluate and demonstrate

1 symptoms that would directly reflect that
2 diagnosis, and he mentioned -- for example, he says
3 that she's paranoid and that she states that the
4 house is bugged. But, you know, she later says her
5 husband told her the house was bugged. He said she
6 has hallucinations of seeing witches and warlocks,
7 but he doesn't elicit any of those from her. He's
8 -- he's just reporting what other people have told
9 him. And he doesn't say at any point that he has
10 experienced any of those. It's just totally
11 hearsay. There's a whole list of things that he
12 describes that he's using to build the case of a
13 diagnosis of psychosis and/or bipolar with
14 psychotic symptoms that are just regurgitations of
15 what the family have said. These aren't things
16 that he necessarily observed himself or even
17 experienced during his evaluation.

18 Q Okay. You agree with me, Dr. Quinn, that in
19 psychosis, different symptoms present at different
20 times in individual patients, correct?

21 A They certainly could.

22 Q Okay. And you're not always going to be able to
23 demonstrate and evaluate specific symptoms in every
24 psychotic patient, are you?

25 A Not every single time, no.

1 Q Okay. And individuals who have told their family
2 members that they are homicidal or suicidal, that's
3 to be taken seriously by a clinician, correct?

4 A Has to be taken seriously.

5 Q Okay. All right. Well, let me ask you this: Do
6 you have any opinions related to causation against
7 Dr. Steiner that you intend to tell the jury? And
8 what I mean by that is: You've already told me Dr.
9 Steiner couldn't release Ms. Argoe. He wasn't free
10 to do that, correct?

11 MR. DODSON: Object to the form.

12 A Actually, you told me that, but I -- I agree with
13 you. I think that's the case.

14 Q Okay. And you know from your review of the records
15 that Ms. Argoe left Dr. Steiner's care for
16 circumstances that had nothing to do with Dr.
17 Steiner. Her insurance coverage was different, and
18 she went to -- went over to Three Rivers, correct?

19 A Yes.

20 MR. DODSON: Same objection.

21 Q So Dr. Steiner's anticipated care of Ms. Argoe did
22 not continue beyond that first day, correct?

23 A Yes.

24 Q Okay.

25 A Yeah. It was very -- very brief.

1 Q All right. So what did Dr. Steiner do, if
2 anything, that had any ultimate impact on Ms.
3 Argoe's outcome?

4 A Well, I think if Dr. Steiner had said, "Listen,
5 this is a nasty family situation. I see nothing
6 terribly wrong with this woman other than hearsay
7 evidence, that it may not have progressed any
8 further than that. I understand, and I certainly
9 appreciate the difficulty of the situation he was
10 in. And you're exactly right; we have to take
11 seriously whether or not someone's a danger to
12 themself or to others. But at the same time, we
13 have to tread very softly on whether or not to have
14 people committed -- even though as you -- we
15 mentioned, this is not his ballgame -- unjustly.
16 And I think if he had, at the point of evaluating
17 Ms. Argoe, said, you know, "Here's some things that
18 are being reported to me, but in my assessment I
19 don't see this. I mean where -- where is the
20 hallucinations? Where are the delusions? What I
21 see is that we got a -- a nasty family situation
22 going on, and what I see is, when I ask her, "Do
23 you see witches and warlocks?"

24 And she says, "No."

25 And I say, "I hear you have a gun."

1 She says, "Yes. I got a concealed weapons
2 permit."

3 "Have you threatened anybody with that gun?"

4 "No."

5 "You going to hurt yourself?"

6 "Nope."

7 I think he had the potential of helping stop
8 this thing in its tracks; that's all.

9 Q But you don't know.

10 MR. DODSON: Object to the form.

11 A We --

12 Q You don't know what --

13 A -- we -- we --

14 Q -- subsequent treaters would have done, correct?

15 A Absolutely.

16 MR. DODSON: Object.

17 A Yeah. There's -- there's no way to know what the
18 future would hold. You're absolutely correct.

19 Q And, in fact, Ms. Argoe was re-evaluated by the
20 subsequent clinicians that she saw; was she not?

21 A She absolutely was.

22 Q And she was re-evaluated at numerous points where
23 they did have the right and the freedom to
24 discharge her from psychiatric care if they felt
25 that was necessary, correct? And appropriate.

1 A Yes.

2 Q Okay. And that didn't happen.

3 A They did -- they did not, and I will be testifying
4 I think they should have also, so you're --

5 Q Well --

6 A -- exactly right.

7 Q Right. And is it your understanding that any of
8 that was based on anything that Dr. Steiner did or
9 failed to do?

10 A Well, as I said, I do believe if he had taken a
11 more considerate approach here, this whole thing
12 may have stopped in its tracks; that's all.

13 Q Okay. And you agree with me that Dr. Steiner
14 should not have given an opinion that was not his
15 clinical opinion, correct?

16 A That's correct.

17 Q Okay.

18 A He should not have given an opinion if it's not his
19 clinical opinion. Correct.

20 Q So if, in his assessment of Ms. Argoe in 2005, he
21 believed that she needed additional care, then
22 that's the judgment that he should have passed on,
23 correct?

24 A Absolutely.

25 Q Okay.

1 A Absolutely.

2 Q And are -- what -- what -- are you relying on any
3 scientific basis for your opinions against Dr.
4 Steiner?

5 A Scientific basis in terms of what?

6 Q In terms of any qualitative or quantitative studies
7 or analysis.

8 A What I'm relying on are the diagnostic criteria
9 laid out in DSM-IV-TR, which would have been
10 operating at the time --

11 Q Uh-huh.

12 A -- in terms of determining whether or not someone
13 would meet these criteria for either Bipolar I with
14 psychosis or -- or and/or a psychosis not otherwise
15 specified. It -- it's one thing to say that --
16 that someone is paranoid; it's another thing to
17 identify what the paranoia is and what the criteria
18 are. And have you observed those in -- you know,
19 other than, as we say, the -- the hearsay evidence
20 from, it appears, mostly her estranged husband at
21 the time.

22 Q Well, you keep calling it "hearsay," but when you
23 treat psychotic individuals or individuals who are
24 alleged to be having psychiatric --

25 A Right.

1 Q -- problems, isn't the history given by those who
2 are closest to them important to you in your
3 assessment?

4 A Absolutely.

5 Q Now, have you ever had the experience to have an
6 individual referred to you for treatment and said,
7 "Nope. I don't see anything wrong with them,"
8 within 48 hours of seeing them?

9 MR. DODSON: Object to the form.

10 A Could -- could you repeat the question again?
11 because --

12 Q Yeah.

13 A -- quite get what you were saying.

14 Q Well, we know in this case that you actually saw
15 Ms. Argoe almost weekly --

16 A Right.

17 Q -- for a period of more than a year.

18 A Absolutely.

19 Q And you wouldn't have continued to see her if you
20 didn't feel like she needed your services, would
21 you?

22 A Wouldn't have continued to see her? Well, yes.
23 That's right.

24 Q Okay. So have you ever had an individual who was
25 referred to you for psychological or psychiatric

1 treatment that, within taking one look at them, you
2 said, "There's nothing wrong with them. I don't
3 need to see them back"?

4 A Yes.

5 Q Okay. Have those individuals, then, suggested to
6 be suicidal or homicidal?

7 MR. DODSON: I'm going to object to the form.

8 Q Have you ever had an individual referred to you --

9 A Oh, to -- who -- who I didn't feel needed
10 treatment, and so, I said, "I don't need to see
11 you." But someone had said --

12 Q Uh-huh.

13 A -- "We think they're suicidal or homicidal"?

14 Q Right.

15 A I -- I really can't think of a case of -- of that.

16 Q Okay. Because --

17 A Because that is -- you're right. That's serious.

18 Q -- those are matters that have to be --

19 A Absolutely.

20 Q -- taken seriously.

21 A Absolutely.

22 Q Do you advertise -- or does your practice advertise
23 anywhere for services as experts in criminal or
24 civil cases?

25 A No.

1 Q Have you ever had any complaints made against your
2 license?

3 A Not that I know of.

4 Q Okay. Did you charge a retainer for your services
5 as an expert in this case?

6 A No.

7 Q Do you serve on any charitable or civic boards?

8 A No. Not -- not currently. No.

9 Q Okay. Have you ever?

10 A Yeah. I've served on the board of several gambling
11 treatment boards and things like that -- a board
12 for a treatment center in Baltimore; I served on a
13 board of that. And for a -- it was a non-profit,
14 national anti-gambling board that I was on for a
15 year or two, but that's -- that's been some years.

16 Q By your licensing specifications, are you licensed
17 to diagnose?

18 A Yes and no. And, as I said, the -- the license
19 allows it. In our practice, typically, we've
20 chosen to -- to have the people with the bigger
21 stick do that, the psychiatrists.

22 Q Okay. Are you authorized by your license to
23 diagnose?

24 A Yeah, I believe so.

25 Q Okay. Are you licensed to prescribe medication?

1 A Absolutely not.

2 Q Okay. All right. I'll look over my notes. I
3 don't think I have any more questions, but I'll
4 reserve the right if I see something --

5 A Sure.

6 Q -- else and move on to the next treater, I guess.

7 EXAMINATION

8 BY MR. HAILE:

9 Q All right. Dr. Quinn, if we're going to try to go
10 in order, I think that makes me next. I'm Shelton
11 Haile.

12 A Hey.

13 Q I represent Aiken Regional Medical Centers.

14 A Okay.

15 Q Do you understand that none of the individuals who
16 have been named as defendants in this lawsuit --
17 that none of those individuals are Aiken Regional
18 employees?

19 MR. DODSON: Object to the form.

20 A Do I understand that none of the -- the people who
21 are named specifically are --

22 Q Right. The doctors, the nurse.

23 A If you're telling me that, I -- yes.

24 Q Okay. I'll tell you that that's --

25 A Okay.

1 Q -- that's the case; none of them are Aiken Regional
2 employees. Do you understand that, when Ms. Argoe
3 was involuntarily committed, she was initially
4 taken to Aurora Pavilion which is Aiken Regional's
5 inpatient psychiatric center?

6 A I did know that. Yes.

7 Q Do you understand that she was there for less than
8 24 hours before being transferred to Three Rivers?

9 A I knew that it was very brief.

10 Q Okay. Are you going to be offering any opinions in
11 this case that Aiken Regional deviated from the
12 standard of care relating to Ms. Argoe? the
13 hospital itself.

14 A Well, only to the same point that -- that we just
15 had, that I think the process could have gotten
16 stopped earlier. And even though you're saying, I
17 guess, Dr. Steiner, or whoever, is not an employee,
18 he's -- he is working in your hospital, so that
19 would be it.

20 Q So, am I hearing correctly that your opinions as to
21 the hospital are identical to your opinions as to
22 Dr. Steiner?

23 A They -- they are similar in terms of the -- the way
24 that Ms. Argoe was treated in that, even though
25 it's certainly a very serious situation, it does --

1 it's not clear that she presented as a danger to
2 herself or to anyone else.

3 Q Specific to the hospital, which individuals that
4 work for the hospital are you critical of?

5 A Well, in terms of who would be making those
6 decisions, it appears that it was Dr. Steiner.
7 Now, you're saying he doesn't work for you.

8 Q Correct.

9 A Okay. But he's working in your hospital.

10 Q He has privileges at the hospital.

11 A Okay. And so the hospital has no control over the
12 care that he administers; is that what you're
13 telling me?

14 Q I'm just telling you that he's not an employee.

15 A Oh, I'm -- I'm sorry. We reached -- okay. You
16 know. Well, and, specifically, that would be the -
17 - the primary thing that I was talking about there,
18 is that the whole thing could have been stopped
19 right there.

20 Q By who?

21 A Dr. Steiner.

22 Q By anyone else?

23 A I don't remember. Seems like there was a -- is
24 there -- some other person, whose name I saw . . .
25 And there's a -- I can't read that. There's

1 another name, but . . . I would have to say that -
2 - that he would be the primary one that I would --
3 I'd have a problem with. There're other people, it
4 looks like, involved in the care, but his was the
5 one that carries all the weight.

6 Q "He" and "his" refers to Dr. Steiner?

7 A Yes.

8 Q Okay. So when we get to the trial of this case,
9 you're not going to give any opinions that any
10 employees or staff members at Aiken Regional
11 deviated from the standard of care relating to Ms.
12 Argoe, are you?

13 A Other --

14 MR. DODSON: Object to the form. (To the
15 deponent) Go ahead.

16 A Other than, as I said, if it goes to just the
17 repetition of -- of information from the family
18 that does not seem to be justified by the symptoms
19 that they observed.

20 Q I'm not sure I understood how that answered the
21 question.

22 A Oh, okay.

23 Q It may have and I just didn't understand it, but --

24 A Well, it may not, and I may not have understood.

25 The -- the only -- the only thing that I'm -- would

1 say that would impact Aiken Regional, or whatever
2 it is, would go back to the -- the notes here where
3 they're just repeating information given by the
4 family, for example: "Husband explains having
5 history of manic, bizarre behavior." This is
6 information, but nobody's reporting what they're
7 seeing.

8 Q Well, don't you expect hospital staff and nurses to
9 document what they're told by the family?

10 A Absolutely do.

11 Q Sure.

12 A Absolutely.

13 Q Okay. And just like I think you agreed with Ms.
14 Ganes, Dr. Steiner didn't have the authority to
15 discharge Ms. Argoe while she was at Aiken
16 Regional. I assume you agree that the hospital
17 also did not have that authority.

18 A Absolutely.

19 Q Okay.

20 MR. DODSON: Object to the form.

21 Q Is "discharge" a physician decision?

22 A It is something that the physician does, but the --
23 as far as I -- it's been a while since I've worked
24 in a hospital, but the hospital had some
25 culpability in that.

1 Q Okay. That was 20-plus years ago.

2 A Twenty-plus years ago.

3 Q Okay. Now, I noticed in your -- don't recall if it
4 was an initial or assessment, exactly how it was.

5 All right. Dr. Quinn, I'm referring to your
6 initial assessment --

7 A Uh-huh.

8 Q -- in the chart of records that were produced --

9 A Sure.

10 Q -- pursuant to subpoena. I notice that for the
11 Axis II diagnosis, you deferred that. Why did you
12 defer that?

13 A Axis II is a -- predominantly used for personality
14 disorders, things like that. Typically speaking,
15 it would take a while for an Axis II diagnosis to
16 occur. You know, for -- for example: If someone
17 like Ms. Argoe presented a certain set of symptoms
18 and we were trying to determine whether she met the
19 criteria for an Axis I disorder like a primary
20 psychiatric condition, that might be more evident
21 based on the immediate symptoms. But Axis II, you
22 know, a -- for example, borderline personality
23 disorder or obsessive-compulsive personality
24 disorder, typically, takes longer and require,
25 actually, maybe even psychological testing to -- to

1 turn up, so I would defer to that.

2 Q So you weren't able to make an Axis II diagnosis or
3 diagnostic impression immediately. You needed more
4 information to be able to do that. More time.

5 A Yes. I -- and I didn't see anything that would
6 actually even suggest an Axis II diagnosis, period.

7 Q Okay. But you deferred it. You --

8 A Deferred it --

9 Q -- didn't say, "I don't see anything --

10 A Deferred it.

11 Q -- "to suggest she" --

12 A Absolutely.

13 Q -- "doesn't have one." You just said, "Defer."

14 A Absolutely.

15 Q All right. Can you always immediately make an Axis
16 I diagnosis or a diagnostic impression?

17 A Of course not.

18 Q Why not?

19 A You may need more information, just like you said.
20 And your initial -- your initial impression could
21 prove to be wrong, and I think that's part of what
22 I'm saying here.

23 Q Well, just -- just because an initial impression is
24 wrong doesn't mean that the person making that
25 impression was negligent or committed malpractice;

1 would you agree with that?

2 MR. DODSON: Object to the form.

3 A Because an initial impression is wrong would not
4 always mean that an individual had committed
5 malpractice. You're exactly right.

6 Q I also noticed in your initial assessment that
7 under the treatment plan -- I think Mr. Parham
8 asked you about this --

9 A Yes.

10 Q -- you've documented, "Further evaluation and
11 treatment planning"; is that correct?

12 A Yes.

13 Q So, again, you couldn't rely on the initial
14 evaluation that you had done to come up with a
15 final treatment plan for Ms. Argoe, correct?

16 A Absolutely.

17 Q Why not?

18 A You know, just like we're saying, it -- it takes a
19 time -- it takes some time to figure out what may
20 be going on with a person and to determine where
21 the truth actually lies. I've got a lady
22 presenting, saying that she has been unjustly
23 committed by her husband. I don't see any
24 symptoms, but I just can't take that at face value.

25 Q Would you agree that Mr. Argoe made some

1 significant and detailed allegations as far as Ms.
2 Argoe's mental condition?

3 A Absolutely.

4 MR. DODSON: Object to the form.

5 Q And it takes a while to work through those, as
6 you've just said, to determine what may be true,
7 what may be not true, what may need further
8 evaluation.

9 A Absolutely.

10 Q Okay. Do you think it's reasonable that it would
11 take more than 24 hours to work through the
12 allegations that Mr. Argoe and the family levied?

13 A To work through most of those allegations,
14 absolutely correct..

15 Q And while still working through those allegations,
16 how could a hospital or a physician discharge Ms.
17 Argoe when she's there under an involuntary
18 commitment?

19 MR. DODSON: Object --

20 A Well, we had already --

21 MR. DODSON: -- to the form. (To the
22 deponent) Go ahead, Doctor.

23 A You had already told me that she couldn't be
24 discharged. But here's the thing: What I'm saying
25 is, even though she may not have been discharged,

1 assessing her in the here-and-now, regardless of
2 the allegations by Mr. Argoe, they can make some
3 determination whether or not her cognition is
4 whole. They can make some determination or not
5 about whether or not she's hallucinating or
6 delusional. They can make some determination about
7 whether or not she's manicky. And none of those
8 symptoms appear to be evident. No one's listed
9 anything like that. No one's saying she's bouncing
10 off the wall; no one's saying that -- you know,
11 later, someone mentions that there's a -- some
12 flight of ideas and some pressured speech, but they
13 don't really seem to go into that so much. Someone
14 right now might say my speech is pressured, but
15 that wouldn't be clinically significant. It'd only
16 be pressured if I couldn't quit speaking. So I
17 guess you're exactly right. Maybe they could not
18 have made a final determination. But one of the
19 things they could have assessed better in the here-
20 and-now is whether she met any of those criteria,
21 not necessarily whether or not she's carrying a gun
22 on her hip. She doesn't have a gun on her hip in
23 the -- in the hospital. Not necessarily even
24 whether she's -- she's spending a lot of money, but
25 how is she in the here-and-now; can she stay on

1 task? Does she appear to be presenting delusional
2 ideation? Is she having any hallucinatory
3 experience? Is she -- is there any clear sense on
4 her that she is irritated, anxious, or grandiose,
5 other than being pissed off about being held
6 against her will? I -- I just don't see that;
7 that's all.

8 Q What about manic behavior?

9 A Yeah. Those are manic, but those are manic
10 symptoms. That's what I'm talking about.

11 Q So if someone -- go ahead. I didn't mean to
12 interrupt you.

13 A Well, for -- for example, there -- I can read you
14 some out of the DMS-IV, but -- but, basically,
15 you're looking at several different clusters. One
16 of them may just be highly irritated; one of them
17 may be racing thoughts; one of them may be engaging
18 in risky behavior, spending a lot of money, acting
19 out sexually. Typically, there's a great deal of
20 sleep disturbance. Usually, they're preceded by
21 some prodromal symptoms such as increased sleep and
22 increased appetite, although not always. But she's
23 just sitting there, and people are asking her
24 questions. She's saying, "No. I'm -- I'm not
25 going to hurt anybody. I don't see witches; I

1 don't see warlocks. Yeah. I -- I think my husband
2 is out to do me harm. And, yes, I don't sleep with
3 him. And, yes, I lock the door because I don't
4 trust him. And, you asked me if the house was
5 bugged. Yeah. He told me it was bugged." So I'm
6 failing to see where, in the here-and-now, anyone
7 is seeing that this lady is presenting anything
8 near psychosis or presenting anything that would be
9 suggestive of a manic episode. I wholeheartedly
10 agree with you to get a complete and full
11 diagnosis, it takes a long time. And to identify
12 whether or not some of the things Mr. Argoe said
13 were true or not is going to take a lot of time to
14 weed out. But in the here-and-now of that
15 assessment, this lady's presenting, as it appears,
16 you know, pretty normal.

17 Q Can someone acting in what might be described as a
18 hyper-religious manner be considered manic
19 behavior?

20 A Hyper -- hyper-religiosity is -- is and can be one
21 of the symptoms. Once more, we may be talking
22 about a subjective issue about what's hyper-
23 religious. I mean I -- if I told you I go to
24 church; I'm an elder at Shannon Presbyterian; I
25 serve on the Session; I believe in Christ; I pray

1 over my meals; am I hyper-religious?

2 Q But you agree hyper -- a description of someone
3 being hyper-religious is some evidence or
4 indication of potentially manic behavior?

5 A If I say that you are hyper-religious, that may be
6 an -- an indictment of manic behavior. But the
7 real issue is: Are you exhibiting hyper-religious
8 activity? Just because I say it doesn't make it
9 true. And that's -- that's the key here. Most of
10 this information is coming from someone that has an
11 adversarial relationship with Ms. Argoe, yet people
12 are accepting it whole cloth. And when they meet
13 her, person-to-person, they are committing, I
14 think, what we -- we call an affirmation bias. In
15 other words, they have a preconceived idea of where
16 she is, and then they're -- they're looking for
17 ways to confirm that.

18 Q Well, what if someone at Aurora Pavilion, in the
19 less than 24 hours that Ms. Argoe was there,
20 observed her engaging in what they considered to be
21 hyper-religious behavior and documented it? That
22 way, they're not just --

23 A And --

24 Q -- taking it from the family --

25 A And --

1 Q -- that's something they actually observed and
2 documented.

3 MR. DODSON: Object to the form.

4 A Yeah. And -- and I -- and, once more, it goes back
5 to the subjectivity of -- of what is hyper-
6 religious: Is -- is praying several times a day
7 hyper-religious? Is talking about your faith
8 hyper-religious, or is it just religious? And --
9 and that's the issue I had with -- with that
10 comment.

11 Q Isn't everything that we're talking about related
12 to Ms. Argoe subjective? I mean we've got
13 different professionals who can look at the same
14 woman at different times and see different things
15 and have different impressions, can't we?

16 A There certainly are people who -- who ascribe to
17 the belief that -- that everything is relative.
18 All -- all I'm saying here is: If -- if you are
19 saying to me, as I think an individual was in -- in
20 this, that she's hyper-religious because, you know,
21 she wants to listen to religious programs; she
22 wants to pray; and she's proud of her affirmation
23 of faith. I just don't see that as hyper-
24 religiosity.

25 Q What I'm saying to you -- and let me show this

1 document.

2 A Okay.

3 Q It's a therapeutic recreation progress --

4 A Yeah. Ms. --

5 Q -- note, dated --

6 A Is that Ms. Hanner?

7 Q -- June 9th, 2005 -- that's right --

8 A Yeah.

9 Q -- by Heather Hanner.

10 A Yeah.

11 Q And she documents, among other things, "Redirection
12 required: hyper-religious."

13 A Uh-huh.

14 Q I'm happy to give this to you --

15 A No. I --

16 Q -- if you'd like to see it.

17 A I read that.

18 Q Okay.

19 A And, yeah, she said "Redirection required: hyper-
20 religious," but she didn't what it was that she
21 considered hyper-religious.

22 Q So that's a, as Ms. Ganes said, a documentation
23 criticism?

24 A Well, it's only a documentation criticism if it is
25 not necessarily reflective of -- of the young

1 lady's behavior if -- if she is considering Ms.
2 Argoe to be hyper-religious just based on the fact
3 that she wants to pray or she wants some quiet time
4 or she wants to offer a profession of faith. I'm
5 not so sure that's hyper-religious.

6 Q Do you also allow for the possibility that Ms.
7 Hanner observed Ms. Argoe in a legitimate hyper-
8 religious state?

9 A Absolutely. If, indeed, that occurred. Yes.

10 Q And you weren't there, so you have --

11 A Absolutely.

12 Q -- no idea --

13 A Absolutely.

14 Q -- what she saw.

15 A Absolutely not. You're exactly right.

16 Q You would have to defer to Ms. Hanner for what she
17 meant by that and what she observed.

18 A Absolutely.

19 Q Okay. Have we covered all of your opinions
20 relating to Aiken Regional Medical Center in this
21 case?

22 MR. DODSON: Object to the form.

23 A Yes.

24 Q I'm going to say this back to you. This is my
25 understanding kind of in a nutshell of your

1 opinions as to the hospital. Please correct me if
2 I'm wrong, but: The deviation from the standard of
3 care would be as you've discussed with Ms. Ganes
4 relating to Dr. Steiner and however that could be
5 imputed to the hospital. But you've got no direct
6 criticisms of the hospital in this case; is that
7 correct?

8 MR. DODSON: Object to the form. (To the
9 deponent) You can still answer, Doctor.

10 THE DEPONENT: Uh-huh.

11 A The -- the only direct criticism, I guess, that I
12 would -- would have is as it relates to the
13 connection that the hospital would have in
14 providing Dr. Steiner or any of the other
15 therapists, clinicians, nurses that -- that are
16 involved with Ms. Argoe, that does not, from my
17 opinion, appear to be anyone listening to what this
18 lady's saying and observing what she's doing;
19 that's it.

20 Q Okay.

21 REEXAMINATION

22 BY MS. GANES:

23 Q And just real quick, I'm -- just to clean up the
24 record, Doctor: Did you have any additional
25 opinions, other than what you told me and Mr.

1 Haile, related to Dr. Steiner in any way?

2 MR. DODSON: Object to the form.

3 Q You've told me every criticism you have based on
4 your review of the records and documents?

5 MR. DODSON: Same objection.

6 A Pretty much. Yes.

7 Q Well, "pretty much" --

8 A Yes.

9 Q -- doesn't work.

10 A Yes. I'm sorry.

11 MR. DODSON: Same objection.

12 Q Okay. Thank you.

13 A Yes. Yes. I'm sorry.

14 MR. PARHAM: Let's take a break. It's been an
15 hour.

16 (Off the record from 12:23 p.m.
17 until 12:33 p.m.)

18 THE DEPOSITION CONTINUES.

19 MR. DODSON: We're not going to call Dr. Quinn
20 to testify or offer any opinions at trial as
21 to the defendant, Carolina Care Plan.

22 MR. HICKS: And this is Chip Hicks. I
23 represent Carolina Care Plan. We agree to
24 that stipulation. I have no questions for Dr.
25 Quinn.

EXAMINATION

1
2 BY MR. DAVIDSON:

3 Q Dr. Quinn, my name is Will Davidson.

4 A Hi.

5 Q I represent Dr. Mobley -- Phyllis Mobley.

6 A Yes.

7 Q Do you know Dr. Mobley?

8 A I do not know Dr. Mobley personally. I think, over
9 the years, we've -- we've had patients from Three
10 Rivers or from her practice that maybe have come to
11 our practice or vice versa, but I -- I do not know
12 her personally.

13 Q Okay. Are you active in the medical community in
14 Columbia?

15 A Well, I'm not a physician, but I'm active in all
16 kind of things in the city of Columbia I guess,
17 but, yeah.

18 Q In the professional realm --

19 A Yes.

20 Q -- as far as a counselor's concerned?

21 A Sure.

22 Q Okay. Do you know if Dr. Mobley knows you?

23 A My guess is Dr. Mobley maybe knows of me; I -- I do
24 not believe she knows me personally.

25 Q You practice with Dr. Larry Nelson?

1 A Yes, I do.

2 Q Have you asked any of the psychiatrists in your
3 practice to review this case and discuss with you
4 their opinions in regard to the psychiatric care
5 provided by the physicians in this matter?

6 A I have not.

7 Q Now, you've used some terms, and I just want to
8 make sure I understand what you mean when you use
9 them. When you say something is "subjective," what
10 do you mean?

11 A Well, what I -- what I'm saying that it appears to
12 me that someone is reporting their subjective
13 opinion. If you say I'm fat and compared to
14 someone else in this room I may weigh more than
15 they do, but, typically speaking, most people would
16 look at me and not say that I'm fat. Now, we could
17 find a scientific or a professional quantitative
18 measure that would say anyone with a body mass
19 index over X would be considered obese, and anyone
20 with -- who's more than 50 percent -- a body weight
21 50 percent over that would be considered morbidly
22 obese. Those are not subjective issues, but for
23 you to just say I'm fat would be subjective. So
24 when someone says, "Ms. Argoe is experiencing or
25 expressing excessive religiosity," I would say that

1 certainly can be a symptom, but now tell me to what
2 degree is that excessive? If -- if you're saying
3 it's excessive because she says her prayers every
4 evening or she reads her Bible, I don't believe
5 that would meet anybody's criteria of "excessive."

6 Q Well --

7 A And that would be considered "subjective."

8 Q "Subjective" could also mean what someone feels
9 about something. Pain is subjective, correct?

10 MR. DODSON: Object to the form.

11 A Well, there -- there are certain objective measures
12 of pain, but for the most part, we would agree with
13 that. Sure.

14 Q Okay.

15 A Because your experience of pain might be different
16 than mine.

17 Q If someone says that their affect is "flat," is
18 that an objective or subjective determination?

19 MR. DODSON: Object to the form.

20 A It would generally be considered an objective
21 measure because you're examining in the-here-and-
22 now whether or not the individual is expressing
23 affect one way or another: whether they're
24 smiling; whether they're frowning; and whether it's
25 congruent with any -- any mood that they're

1 currently experiencing.

2 Q All right. And when you say "objective findings,"
3 what are those --

4 A Typically -- I'm sorry.

5 Q -- to you in your practice?

6 A Typically speaking, it would be something that you
7 can measure and/or quantify.

8 Q Validate through testing?

9 A That would be one way of doing it. Yes.

10 Q All right. Now, when a professional in -- mental
11 health professional uses the term "provisional
12 diagnoses," what does that mean?

13 A Typically means that would indicate this is their
14 gut, first reaction to this till they sort out all
15 the factors.

16 Q All right. Now, when you say, in a mental health
17 area, that you want "to rule out or rule in
18 something," what do you mean from a mental health
19 perspective?

20 A Well, it would mean -- and, you know, for example,
21 Dr. Mobley said she wanted to rule out OCD. She is
22 saying, "Look. I get a flavor there might be some
23 obsessional thinking or some compulsive behavior
24 going on here, but I don't have anything to totally
25 justify that at this point. I want to investigate

1 that further and see whether or not that plays
2 out."

3 Q Well, now, can you have symptomology of a condition
4 but still want to determine through ruling in or
5 ruling out exactly what the diagnosis might be?

6 A Absolutely you can, because it -- they may not
7 fully meet the criteria specific to a diagnoses.

8 Q Okay. My understanding that DSM-IV, I think, TR
9 was the one, there are multiple symptomology that
10 may apply to a diagnosis; is that correct? In
11 other words, you can have a diagnosis and --

12 A There are criteria.

13 Q -- and there're criteria.

14 A Absolutely.

15 Q And you can have -- some of them say you need four
16 of them; some say you need three of them; some say
17 you may have seven of them. Some may have to last
18 three months; some have to last six months --

19 A Yeah.

20 Q -- correct?

21 A Right. And -- and, typically, they will -- they
22 will not only specify -- must have four of six, but
23 if agitation or anger or whatever is one of them,
24 then you must have five, and they must, as you
25 said, go on for a certain length of time. Exactly.

1 Q In your practice with your physicians -- I think
2 you said your physicians are actually the ones that
3 normally come up with the diagnoses, correct?

4 A Correct.

5 Q In your practice, have there been occasions where
6 your physicians have given a provisional diagnosis
7 but subsequently have changed that diagnosis after
8 obtaining more information?

9 A Absolutely.

10 Q Have there been occasions, from your observation of
11 your practice, that one of your physicians gives a
12 provisional diagnosis and changes it because they
13 got an absolute wrong provisional diagnosis?

14 A Absolute wrong? I would go back to the previous
15 statement. They -- they certainly have changed
16 provisional diagnoses. "Absolute," I'm not so sure
17 about that.

18 Q Doesn't mean that your physician or any physician
19 in saying, "I think it might be X," and after
20 additional information says, "I don't think it's X;
21 it's probably Y."

22 A Right.

23 Q That doesn't mean they're deviating from the
24 standard of care, correct?

25 A Yeah. It can walk like a duck, quack like a duck,

1 but fly like a duck would be a goose, and that's
2 absolutely the case.

3 Q And that's part of the psychiatrist's ability to
4 pull a great deal of information together and try
5 to come up with a diagnoses of someone. They may
6 information from a medical doctor who's done a
7 physical exam; they may get testing results; they
8 may get observation from nursing staff; they may
9 get observations from family; they may get all
10 types of information. And then they have to come
11 up with, first, a provisional -- what sometimes I
12 think physician's refer to as a "working
13 diagnosis."

14 A Working diagnosis. Sure.

15 Q And the more information they get, then they come
16 up with what, hopefully, is a final diagnosis.

17 A That would be the case in any medical setting or,
18 hopefully, in any clinical setting; that's correct.

19 Q And sometimes you've seen where the psychiatrist
20 says, "This is my diagnosis; it's not a
21 provisional; it's not a working," and they say,
22 "This is X," and it turns out, after examining it
23 further on down the line, they've changed that
24 diagnosis.

25 A Absolutely.

1 Q Okay. Now, when we talk about someone having
2 "pressured speech," what does that mean?

3 A Well, "pressured speech" is pretty much what it
4 sounds like, that words are coming out of the
5 person's mouth as though there's pressure behind
6 that, forcing them out. It is not just rapid
7 speech, though; it's almost like they're a volcano
8 that is erupting and words are just spewing forth,
9 sometimes coherently; sometimes, incoherently. But
10 pressured speech -- for those of us that grew up in
11 the South and perhaps we're used to speaking in a -
12 - in a slower, more measured fashion, the first
13 time we run into someone from New York, we may
14 think that's pressured, but it's absolutely not
15 pressured. What's true -- what would truly meet
16 the criteria for being pressured speech is that the
17 individual has a sense of lost control themselves
18 of the ability to -- it's like a runaway train
19 coming out of their mouth.

20 Q All right. Now, is that determination by a
21 physician a subjective or objective finding?

22 A Well, my contention is that, unfortunately, some
23 people may have made it a subjective issue; it
24 should be an objective thing because, as I said,
25 just rapid or continued speech is not necessarily

1 pressured. What makes it pressured is if there is
2 a almost innate inability of the individual to
3 control it and to stop it themselves. But if you
4 were speaking very rapidly, and I said, "Mr.
5 Davidson, could you stop for a moment?" And you
6 did this.

7 And I said, "Now, could you tell me what time
8 it is?"

9 And you said, "Well, it's -- it's 2:30," I
10 would not consider your speech pressured. However,
11 if I made those same requests of you, and you were
12 not only unable to stop that stream of words coming
13 out your mouth, but you're almost incapable of
14 answering the question because you were speaking
15 very rapidly about other things, that would be
16 truly pressured.

17 Q Can someone who has pressured speech stop and then
18 start back again?

19 A Yes. With great difficulty.

20 Q Okay. Would -- when you hear the term "flight of
21 ideas" in conjunction with pressured speech, what
22 does that mean?

23 A That would suggest that not only is the speech
24 pressured, but it is not staying consistently on
25 one topic, that the individual is bouncing around

1 and they may start saying things like, "Well, today
2 is a beautiful day out there, but I had -- let me
3 tell you what I had for supper last night. I don't
4 believe what's going on in Washington, D.C."

5 Q Jumping from subject to subject.

6 A Jumping from subject to subject.

7 Q Now, someone that has pressured speech and flight
8 of ideas, can you tell me from DSM-IV what the
9 various diagnoses those type symptomology would
10 fall under?

11 A Those two specific symptom -- symptoms are
12 typically associated with criteria that are aligned
13 either with mania and, in some cases, with
14 psychosis or -- or both. There, perhaps, would be
15 -- it might be some other diagnoses that they could
16 be sub-criteria under, but those would be the two
17 major ones.

18 Q Now, in regard to Ms. Argoe, who actually -- what -
19 - who was the physician that actually signed off on
20 her being committed to the hospital?

21 A If I --

22 MR. DODSON: Object to the form. (To the
23 deponent) But you can answer; that's fine.

24 A If I read this correctly, I -- I believe it's Dr.
25 Mobley --

1 Q Okay.

2 A -- signed the --

3 Q Do you know --

4 A -- commitment order.

5 Q -- a Dr. Hooker?

6 A I do not know Dr. Hooker.

7 Q Now, as -- I think you said that, obviously, Dr.

8 Steiner could have stopped this whole thing, was

9 your statement, I think to Ms. Elloree -- or,

10 Ganes.

11 MR. DAVIDSON: (To Ms. Ganes) Excuse me.

12 Q Correct?

13 A My -- my -- my opinion is that, even though as we
14 ascertained, perhaps he could not discharge Ms.

15 Argoe -- as the law would prohibit that -- I do
16 believe if he had taken a more assertive stance and
17 listened to Ms. Argoe more directly and weighed the
18 information, he could have derailed the whole
19 process.

20 Q Okay. When was the last time you were a DE?

21 A Off the top of my head, I would have to say 1989 or
22 so.

23 Q Were there times, as a designated examiner, you had
24 questions as to whether or not someone truly needed
25 to be admitted but decided to err on the side of

1 caution?

2 MR. DODSON: Object to the form.

3 A I do not personally have a recollection of that. I
4 could -- I could certainly understand that as a --
5 as a possibility, but I have no personal
6 recollection of myself doing that.

7 Q Now, as a counselor, I think you said you were
8 originally asked to see Mrs. Argoe by Mr. Warner.

9 A Correct.

10 Q Okay. And at that point you were aware that Mrs.
11 Argoe was in -- for lack of a better term -- a
12 fairly nasty domestic matter, were you not?

13 A Essentially, roughly, at the time that I saw her --
14 maybe it preceded it a little or not but, roughly
15 at the same time, yes.

16 Q Now, as a mental health professional, if you do not
17 believe that you can provide any help --
18 therapeutic help for an individual, do your ethical
19 standards say that you should advise the patient
20 and the referring individual that you don't feel it
21 would be appropriate to continue to see someone and
22 charge them for basically useless treatment?

23 A Sure.

24 Q Now, in this instance, would Dr. Mobley -- Mrs.
25 Argoe was sent to her pursuant to an order of

1 commitment, was she not?

2 A Absolutely.

3 Q Now, what opinions do you have in regard to Dr.
4 Mobley and her treatment of Ms. Argoe?

5 A Well, my basic opinion is that Dr. Mobley relied
6 way too much on the other information she had, did
7 not pay any attention to what Ms. Argoe was telling
8 her, and then used her denial of any problems as a
9 symptom of a disorder, which I -- you know, one of
10 the things -- for example, I look on the treatment
11 plan that Dr. Mobley signed, and they list as an
12 asset "supportive family and friends." Well, as it
13 turns out, Ms. Argoe's family was anything but
14 supportive. And so, even though she continually,
15 throughout the entire evaluation and treatment
16 process, tells people, "Listen. Most of this is
17 stuff my husband has trumped up. I'm angry with
18 him. I don't -- I don't need to be here. I don't
19 need the medication." But nobody really listens to
20 that. So the basis of my testimony will be around
21 that.

22 Q Well, now, have there been instances when
23 individuals who have mental illness have denied
24 that they have a mental illness?

25 A Absolutely.

1 Q Have there been instances where individuals who
2 have a mental illness deny symptomology that is
3 presented to the health care professional by the
4 family?

5 A Absolutely.

6 Q One -- and tell me if I'm right about this: One of
7 the tools in trying to get information about an
8 individual who may or may not have a mental illness
9 is to discuss that individual's behavior with third
10 parties, correct?

11 A Certainly could -- that could be one of the things.
12 Absolutely.

13 Q And until you are able to say the patient is
14 delusional and not making appropriate comments as
15 opposed to the family member or a third party
16 trumping something up -- until you can make that
17 determination, do you, as a health care
18 professional, side on the area of treating the
19 patient cautiously so that you don't run into a
20 problem with the patient either hurting themselves
21 or others?

22 A That was a pretty long statement. But what --

23 MR. DODSON: Object to the form.

24 A -- what -- what I would say to you is that it's the
25 role of the health care professional to ascertain

1 the current level functioning of the individual.
2 And one of the things that they might could use
3 would be information from a third party. But,
4 perhaps, the thing that's most important is what
5 they're seeing and hearing in real time. And
6 otherwise, it's like going into a courtroom with
7 the presumption of guilt as opposed to innocence.
8 Certainly, we have to be mindful and careful if we
9 feel like people are a danger to themselves or a
10 danger to others. But the health care
11 professional's role in this is to make a
12 determination in -- in real time about where this
13 person is today.

14 Q Would you agree with me, though, that sometimes
15 that decision can't be made within five minutes or
16 five days?

17 MR. DODSON: Object to the form. (To the
18 deponent) You can --

19 A What -- what I would say is that the diagnostic
20 process sometimes could take much time, sometimes
21 could be very quick.

22 Q Okay. Depends on what you've got.

23 A Depends on a lot of things, including the
24 information you have, ability and skill, and
25 situation.

1 Q Would it be important if the patient indicated that
2 they, in fact -- one third party they trusted, but
3 that third party that said they trusted indicated
4 that they were concerned about the well-being of
5 the patient?

6 MR. DODSON: Object to the form.

7 A If it's the third party that I'm familiar with, it
8 turns out they couldn't trust that person in the
9 first place, but I -- I think it's important that
10 if you have someone that you think is delusional or
11 they're being presented by family as being
12 delusional, and they say, "Well, whether I'm
13 delusional or not, I trust Timmy over here." Then,
14 you know, whether that trust is well-placed or not,
15 I could understand a physician or any clinician
16 paying attention to what that third party would
17 say. Absolutely.

18 Q In Dr. Mobley's position, do you believe it was
19 within the standard of care for her to have a
20 medical exam of Ms. Argoe to assist her in trying
21 to rule out any type of organic issues?

22 A Absolutely. Because Ms. Argoe presents with what
23 appears to have been -- even though the family's
24 saying this is a long-term illness that's gone
25 untreated, she's -- she's -- she's appearing --

1 she's presenting to Dr. Mobley, and it's being said
2 that this woman has developed either psychosis or
3 mania with psychotic features. And one of the
4 things Dr. Mobley would certainly want to rule out
5 was whether or not this had been chemically induced
6 in any way, whether or not there was some brain
7 disorder/dysfunction, or whether or not there was
8 any physical component that could have contributed
9 to behavior or actions that the other people are
10 saying has occurred. And I -- absolutely. She do
11 that first and rule any of that out.

12 Q And she did.

13 A Absolutely.

14 Q And she took that information into consideration.

15 A Absolutely.

16 Q And she ultimately appeared before the probate
17 judge and presented her findings to the probate
18 judge.

19 A Yes.

20 Q And it was the probate judge's decision, at that
21 point, that Mrs. Argoe remained hospitalized for a
22 period of time, correct?

23 A Based on -- based on the information provided by
24 Dr. Mobley and Ms. Burrell, I believe, yes.

25 Q Okay. Well, also, I believe the family was

1 present, were they not?

2 A You know, I can't remember at that one. They could
3 have been present. I just don't remember if they
4 were.

5 Q If the family presented evidence to the probate
6 judge that they were concerned about the well-being
7 of their wife and sister and mother, it would be up
8 to the judge to determine at that point the
9 believability of those individuals, correct?

10 A The judge makes the ultimate determination.
11 There's no question about that.

12 MR. DODSON: Object to the form.

13 Q Okay. Would you agree with me Dr. Mobley could
14 have indicated that he -- she felt that Mrs. Argoe
15 could have been treated on an outpatient basis, but
16 the judge could make the decision to keep her
17 hospitalized?

18 MR. DODSON: Object to the form.

19 A Are you asking me is that within the legal power of
20 the judge?

21 Q Yes.

22 MR. DODSON: Object to the form.

23 A Oh, yeah. Yes. Yes, obviously.

24 Q Okay. If a physician found that a patient had
25 paranoid ideations, bizarre behavior, irritability,

1 insomnia, confusion, flight of ideas, pressured
2 speech, what would those -- what would that
3 symptomology lead you to believe the diagnosis or
4 provisional diagnosis would be?

5 MR. DODSON: Object to the form.

6 THE DEPONENT: (To Mr. Dodson) I can still
7 answer?

8 MR. DODSON: Unless I tell you not to answer -
9 -

10 THE DEPONENT: Oh. Oh, okay.

11 MR. DODSON: -- you can -- I'm just making an
12 objection for the record --

13 THE DEPONENT: Right.

14 MR. DODSON: -- and unless I tell you, you can
15 go ahead and answer.

16 THE DEPONENT: Yeah.

17 A The -- the -- the symptoms you just listed could be
18 used as criteria in several -- several different
19 specific diagnosis. The most common would be some
20 form of psychosis, possibly even schizophrenia.
21 And/or, as I think we looked at psychosis not
22 otherwise specified, but also, commonly, you would
23 see some of those symptoms associated with -- with
24 mania with psychotic features.

25 Q Can stress bring on a psychological event, a break

1 with reality?

2 A Well, certainly, stress can precipitate even a -- a
3 psychotic event. Yes.

4 Q Okay. Would you agree with me the fact that
5 somebody had a -- a concealed weapons permit and
6 had, in fact, a weapon if that individual was
7 having a psychotic event, you would recommend that
8 the pistol be removed from the individual?

9 A Well --

10 MR. DODSON: Object to the form.

11 A An individual who has attained and retained a
12 concealed weapons permit, by law, would be required
13 to surrender that. Yes. And it certainly would be
14 well within the realm of anyone associated with
15 them to -- to make that evident.

16 Q Would it be a concern if you were presented with an
17 individual who had paranoid ideations and delusions
18 and had access to a weapon that that individual
19 could, in fact, be a danger to themselves or
20 others?

21 A If, indeed, I thought that an individual had
22 paranoid ideation, I would be concerned, based on
23 the specificity of the paranoia and the ideations,
24 that they possibly could be a danger to someone
25 else.

1 Q Other than the one opinion you've given in regard
2 to Dr. Mobley, do you have any other opinions
3 regarding her care and treatment of Mrs. Argoe?

4 MR. DODSON: Object to the form.

5 A My general objection to the care provided by Ms. --
6 or provided to Ms. Argoe is that when she denies
7 symptoms, that's considered a lack of insight and a
8 lack of judgment; when she refuses treatment
9 because she doesn't feel that she's sick, that's
10 considered symptomatic; and that no one seems to be
11 listening to her or eliciting some of the behavior
12 that's being claimed by the family, such as the
13 delusions, the hallucinations, placing way much --
14 too much emphasis on things like the fact that she
15 has a concealed weapons permit or that she's
16 wearing some expensive jewelry, or that she doesn't
17 want to sleep in the same room with her husband,
18 and seeing those as clinical issues. Whereas, we
19 have some comments that say she's experiencing
20 flight of ideas and pressured speech. As I've
21 said, no one said -- goes any deeper and explains
22 what that is or -- or give me the example of how is
23 this pressured, so we're just kind of taking that
24 for what it is. Yet, at the same time, if she is
25 saying things like, "Listen. My husband wishes to

1 do me harm," that's being considered being
2 paranoid. If she says, you know, "I feel I am in
3 danger," that's being considered paranoid. If she
4 makes comments like, "I think he may even have
5 another family," that's being considered paranoid,
6 even though he admittedly had had affairs before.
7 So I don't believe the full context is being
8 presented. And it appears to me that,
9 specifically, people are not listening to this
10 woman. And it's like the old joke where the woman
11 comes home and catches her husband in bed with the
12 maid and he claims there's -- there's nobody there.
13 And she says, "Well, I -- I -- I see the maid."
14 And she --

15 And the husband says, "Who are you going to
16 believe? Me or your lying eyes?" You know, people
17 are listening to suppositions from out there, but
18 when it's sitting right in front of them, I don't
19 see any indication that you've got a truly
20 psychotic person here or a person who's presenting
21 a danger to themselves or a danger to anyone else.
22 And that's my full contingent here.

23 Q The judge decided to keep her, correct?

24 A Judge --

25 MR. DODSON: Object to the form.

1 Q The judge ultimately gets to make that decision,
2 based on information provided by the professionals
3 there, and, as you mentioned, the family.

4 Q I don't think I have anything else.

5 REEXAMINATION

6 BY MR. PARHAM:

7 Q All right. Back to me, Doctor. Okay. Tell me how
8 you qualify to be a licensed professional counselor
9 in 1986.

10 A Well, through education, supervision, and years of
11 experience.

12 Q Okay. How do you sit for -- you -- you took an
13 exam, right?

14 A I am so old, I did not have to take the current
15 exam, but I took the national board exam instead.

16 Q Okay. And that was from -- and how did you qualify
17 to sit for the national board exam in 1986?

18 A Through -- through education, experience, and
19 hundreds of hours of supervision.

20 Q Okay. And did you have to have the hundreds of
21 hours of supervision before you could sit for the
22 exam?

23 A Yeah. You have to present a whole packet of
24 information that has your education level, your
25 experience. And I'd -- I'd been working in the

1 field for a while. Plus, the years of supervision
2 that you had had by people who were qualified
3 supervisors.

4 Q And who was -- who was supervising you and in what
5 period of time?

6 A I had several different supervisors. Dr. Margaret
7 Burggraf was one of them. Dr. Russell Haber was
8 one of them. I had further clinical supervision at
9 Morris Village when I worked there. Gosh, that's
10 been so long ago. But those would've been the --
11 those would've been the major ones.

12 Q So you could -- so you were providing -- you were
13 providing counseling at, for instance, the Earle
14 Morris Alcohol and Drug Addiction Treatment Center
15 from '76 to '83 without being certified?

16 A In -- in those days, there was no certification.
17 But, as is the case even today, people working for
18 the state of South Carolina do not often require
19 certification and/or licensure. But, yes. There
20 was -- I was a -- not only a primary therapist, but
21 a -- a Level IV group leader, which meant I -- I
22 trained other people in group psychotherapy in
23 those days.

24 Q But -- but that's -- those are the years you were
25 being supervised for your clinical practice?

1 A That, and I guess I had -- also when I was at
2 Family Service Center. And some of that may be
3 even when I had first -- I -- I -- the dates are
4 not quite clear, but it may've been when I really
5 first came to Charter also.

6 Q And, I guess, I wasn't questioning what you did.

7 A Yeah. Right.

8 Q I'm saying: Those are the years --

9 A Yeah.

10 Q -- that you had --

11 A Oh -- oh, yeah.

12 Q -- those hours that you accumulated --

13 A Oh, yes.

14 Q -- to be able to sit for the exam?

15 A Yes, yes, yes, yeah, yeah.

16 Q Okay. Okay. But you -- you never -- for -- for --
17 to -- to be a licensed professional counselor, you
18 don't have any kind of formal residency program, do
19 you?

20 A Currently, you're required to do internships and
21 practicums. In the days when all the world was
22 young, you were required to do practicums, but not
23 an internship. Now you are required to do an
24 internship.

25 Q But -- but back before 1986, you weren't doing any

1 kind of internship or residency formally?

2 A I did practicums --

3 Q Okay.

4 A -- which --

5 Q Which is --

6 A -- it's supervised -- supervised work in a specific
7 setting.

8 Q Right. So --

9 A Yeah.

10 Q -- you're working a job. You have a supervisor
11 that --

12 A Right.

13 Q -- you can go to?

14 A Right, right.

15 Q And, other than the national test, you did not have
16 to take anything else to get your certification --

17 A Uh-huh.

18 Q -- is that correct?

19 A No. No. Not for that.

20 Q And you may have been asked this, but the -- the
21 times you -- you -- since -- in 1989 or before when
22 you were doing -- being one of the examiners for a
23 probate hearing, did you ever give your opinions
24 that were not recognized by the court?

25 MR. DODSON: I'm going to object to the form.

1 (To the deponent) But you can --

2 A I'm --

3 MR. DODSON: -- answer.

4 A I'm not sure I understand your question.

5 Q Yeah. Okay. Very simply, did -- did -- did you
6 ever submit an opinion that the Court --

7 A Oh.

8 Q -- rejected?

9 A No. Not -- not that I'm aware of.

10 Q Okay.

11 A I've -- I've submitted affidavits and things like
12 that. And -- no. I can't off the -- no.

13 Q Okay. And -- and every time that you submitted an
14 opinion as an examiner in a probate hearing, was
15 your opinion always followed, or did the -- the
16 probate judge reject it and do the opposite?

17 A I believe there was at least one time where I
18 disagreed with the physician and the probate judge
19 went along with the opinion of the physician. But,
20 typically speaking, I -- I -- I don't remember any
21 real disagreements with probate judge, no.

22 Q Are -- are you criticizing the -- the probate court
23 system in this case?

24 A Am I criticizing the probate court system in this
25 case? I -- I had not planned to. I mean, I --

1 Q Well, I mean --

2 A -- I -- I think I could probably come up with a few

3 --

4 Q Well, I --

5 A -- criticisms.

6 Q Well, let me ask --

7 A But --

8 Q -- you this: The -- the -- the -- obviously, the -

9 - the system committed her initially --

10 A Yes.

11 Q -- and then did a formal hearing on June 21st,

12 2005, and --

13 A Yep.

14 Q -- considered her mentally ill --

15 A Right.

16 Q -- to remain in inpatient until stabilized and then

17 required an additional year of treatment and --

18 A Yeah.

19 Q -- medication therapy.

20 A Yeah.

21 Q Do you criticize that?

22 A Yes. I -- I think that was the wrong decision.

23 Q Okay.

24 A But -- I didn't realize they would be part of this,

25 but, yes.

1 Q Well, I -- I didn't say it was. I'm --

2 A Oh, oh, oh.

3 Q I -- I get to --

4 A Oh.

5 Q -- ask you anything I want.

6 A Oh, oh, oh, yeah. Okay. Cool.

7 Q Like, when you were a hippie, did you act? I mean,
8 that's -- I get to ask you questions.

9 A I did act.

10 Q Okay.

11 A Not very well.

12 Q I have two powers as an attorney: I can ask a lot
13 of questions that mean nothing, and I could
14 subpoena you to go anywhere I want. So I take
15 advantage of it.

16 A Hot dog. Can we go to Maine?

17 Q From what you've told me, I'd love to use your
18 house.

19 And we've already determined you -- you -- you
20 do not have hospital privileges, correct?

21 A That's correct.

22 Q And it's been 25 years since you treated anyone in
23 an inpatient setting -- mental health setting,
24 correct?

25 A I've done some hospital consults in less than -- I

1 mean, you know, as -- where sometimes I'm just
2 called in to give an opinion on something. But
3 that's even beyond privileged stuff, so I'm not
4 really treating there.

5 Q All right. And --

6 A Someone's called me in to ask my opinion something.

7 Q So it's --

8 A So, yes.

9 Q It's been over 20-plus --

10 A Yeah.

11 Q -- years that you've actually gone in on rounds and
12 treated a patient in an inpatient mental health
13 setting?

14 A The last time I was -- the last time I saw a
15 patient in inpatient that I had direct care
16 would've been in 1989, I guess.

17 Q And you've never been a primary attending for an
18 inpatient mental health patient?

19 A No. No. That would predominantly be a
20 psychiatrist. Actually, it would always be a --

21 Q When --

22 A -- psychiatrist.

23 Q What -- what is the reason for your -- the setup in
24 your practice at Carolina Psychiatric Services
25 where you defer to the psychiatrist to make the

1 formal diagnosis of your client-patients?

2 A Well, when I joined this practice in 1990, it had
3 been, and always has been, predominantly a medical-
4 model practice. At one point we had ten
5 psychiatrists and probably six or seven non-
6 physicians. And it had been heavily weighted in
7 terms of old-school medical model that doctors were
8 always in charge of every -- or physicians were
9 always in charge of everything. And we began
10 slowly to -- to develop a model that was much more
11 like a treatment team so that we could have almost
12 a private mental health clinic.

13 And, in order to do that, we set up a two-
14 stage intake process whereby everyone -- every new
15 patient that comes into our practice is first seen
16 by a -- one of the non-physicians. And I probably
17 do 75 percent of those. I do an evaluation based
18 on the -- like the one you just saw, make some
19 determinations about how much further this needs to
20 go on, whether or not it needs to be seen --
21 individual actually even needs to be seen by a
22 physician or not, whether or not, perhaps, we're
23 the -- not the place this individual needs to be
24 seeking care.

25 And if that determination is then that they

1 also need medication or need to be seen by a
2 physician, the physician also conducts at least a
3 one-hour diagnostic interview with the patient. So
4 we have -- with people who come in for our full
5 service, they get a two-stage, two-hour diagnostic
6 evaluation, two different sets of eyes and ears
7 listening to them, asking questions. And we just
8 felt better about that.

9 Q Did she get seen by somebody else?

10 A Our determination was Ms. Argoe wasn't on any
11 medication, did not need to be --

12 Q Okay.

13 A -- seen by --

14 Q And have you ever made a -- a preliminary
15 impression or a -- a -- a provisional diagnosis,
16 like you -- like you did with her on that sheet,
17 that did get kicked up to a psychiatrist because
18 you felt it was a mental illness and that
19 psychiatrist in your practice disagreed with your
20 provisional diagnosis?

21 A I have had at least one occasion, I know, in which
22 I have referred them on to see a psychiatrist
23 because I was not certain whether or not medication
24 would be an appropriate issue of that and wasn't a
25 hundred percent sure of my own clinical impression

1 here. And in -- in -- in at least one case where,
2 afterwards, the psychiatrist came and talked to me
3 and said, "You know, I -- I saw Ms. Jones, and, you
4 know, I -- I agree with you. I do not believe this
5 person is in need of -- of, you know, medication.
6 Might could benefit from some -- some counseling,
7 some therapy. But she doesn't need to -- she
8 doesn't need medication, and you were right about
9 that."

10 Q Well, what about -- forget the medication. What
11 about just the mental-illness diagnosis? Have you
12 ever kicked one -- a patient up to the second level
13 for a --

14 A And had a --

15 Q -- psychiatry --

16 A And had a disagreement about the --

17 Q Yes, sir.

18 A Oh, sure.

19 Q Okay.

20 A Sure.

21 Q Is that after just one session with the patient, or
22 did it take that psychiatrist a -- a period of time
23 to assess and decide, "I disagree with -- with
24 Frank Quinn"?

25 A Oh, it would be, more commonly, something like

1 this: If -- if -- if -- if -- if I pass someone
2 and said, "You know, I -- this -- this person's
3 presenting what appears to be major depression with
4 anxiety," and, once they saw them, they said,
5 "Well, you know what? This -- this does look like
6 major depression, but I don't think it's major
7 depression with anxiety. I think they actually
8 have a generalized anxiety disorder also."

9 So it -- it -- it -- not necessarily a total
10 disagreement, but, you know, "I -- I think there's
11 something else there that you maybe didn't see."

12 Q So you've never had a situation, since you've been
13 there since 1990, where a psychiatrist said, "No.
14 This -- this person is not schizophrenic" or, "This
15 person is not bipolar"?

16 A That -- that I had thought they were?

17 Q Yes, sir.

18 A No.

19 Q Okay. Now, if you're diagnosed correctly -- if
20 that's a good word -- as a bipolar --

21 A Yeah.

22 Q -- or a schizophrenic --

23 A Right.

24 Q -- can it ever be determined that you're not?

25 MR. DODSON: Object to the form.

1 A Well, if -- if your question is, "Do either of
2 those disorders ever go into remission?" the answer
3 to that would be yes --

4 Q Okay.

5 A -- obviously. And, even if you met the full
6 criteria, for example, of -- if you met the full
7 criteria for Bipolar I disorder, you -- you
8 certainly are going to have periods where you're
9 not depressed and you may not be manic. Now, in
10 theory, you -- the -- the likelihood of there never
11 being a recurrence of either depression or mania is
12 extremely small. But, certainly, you could have
13 periods of remission.

14 With -- with schizophrenia -- because
15 schizophrenia is not just one disease; it's a
16 spectrum of illnesses -- it should -- it's referred
17 to, really, as the "group of schizophrenias." And
18 I -- I come from a long line of schizophrenics.
19 I've got four schizophrenic aunts. You -- you
20 certainly can see people who, at one point in their
21 life, exhibit psychotic symptoms and they go into
22 remission, typically with continued medication.

23 The -- the biggest mistake most people make
24 with schizophrenia and with bipolar disorder, they
25 start feeling well, they quit taking the

1 medication, and the symptoms come back. In -- in
2 theory, the likelihood of just some sort of
3 spontaneous remission is -- is very small.

4 Q I mean, it's my understanding -- and I could be
5 wrong -- but I've read somewhere there are numerous
6 people -- well-known celebrities, well-known
7 business people -- who are undiagnosed bipolar;
8 isn't that right?

9 MR. DODSON: Object to the form.

10 A They're all attorneys. No. The -- here's the
11 thing: Bipolar disorder -- as we were speaking
12 earlier about the changes in DSM-IV and what's
13 coming in DSM-V and I told you that the epidemic of
14 autism is about to be over because they've changed
15 the criteria and the epidemic in ADHD is about to
16 be over because they've changed the criteria --
17 with the advent of DSM-IV, we -- we saw an
18 explosion of people being diagnosed as being
19 bipolar. It probably is one of the diagnoses out
20 there right now that is over-diagnosed.

21 Now, having said that, are there people
22 amongst us who might meet the criteria for bipolar
23 disorder who've never been diagnosed? Are there
24 people who function? Well, one of the criteria for
25 the diagnosis requires some level of dysfunction.

1 If I'm rich and famous, I can get away with an
2 awful lot of dysfunction before the roof falls in.
3 So, yeah. But in terms of, "Will it -- will it
4 spontaneously remit by itself and stay remitted?"
5 the chances of that are very slim. Once you've had
6 a manic episode -- and once you -- and -- and --
7 and, typically speaking, you don't -- if you've had
8 a manic episode, it's almost assumed you're going
9 to have, at some point, some depressive episodes,
10 even if you haven't had them.

11 But once you've had one, the chance of you
12 having other manic episodes skyrockets. And it
13 doesn't mean that it's a hundred percent. Doesn't
14 mean that you -- you couldn't -- I don't know --
15 Sean Penn or Jack Nicholson or somebody like that -
16 - say, well, yeah, those guys. But, more often
17 than not, when you're looking at people like that,
18 perhaps they're not even really bipolar. They're -
19 - they may be antisocial personality disorder with
20 a substance abuse problem that's making them look
21 manic. So --

22 Q But your -- your mania and your depression doesn't
23 have to be sky high? I mean, you can still be
24 bipolar and have a -- a modest or mild mania and a
25 modest or mild depression, right?

1 A Well, there -- there's a syndrome referred to as
2 "cyclothymia" that would more appropriately
3 probably cover that. If -- if this is the range of
4 normal emotions, high to low, and -- and this is
5 the range with bipolar disorders with highs and
6 lows, cyclothymia's in the middle. In cyclothymia,
7 an individual can bump along. And -- and -- and
8 they have some highs, and they have some lows. But
9 they're not dysfunctional.

10 What you typically see with bipolar disorder
11 is a level of dysfunctional behavior. And,
12 interestingly enough, almost -- almost invariably,
13 the first onset is in late-stage adolescence or
14 early adulthood, although the criteria says it --
15 it just has to be after age 7. If it's -- if -- if
16 those symptoms occur before age 7, they typically
17 are diagnosed as being ADHD. If they occur after
18 age 7, that excludes ADHD, and you're going to see
19 diagnosis of bipolar disorder. Almost invariably,
20 they occur in late-stage adolescence or early
21 adulthood. However, certainly people can develop
22 late-stage depression, and they can develop an
23 episode of mania later in life.

24 It -- going back to his question, often that's
25 more likely related to an organic issue or brain

1 trauma or substance abuse. But it -- it does
2 happen. It's just that that's rare. And that's
3 one of things that was, kind of, confounding with
4 Ms. Argoe. Even though the family says there's a
5 long history of illness with no treatment, there --
6 there does not appear to be any kind of premorbid
7 experience that anyone is discussing. There's --
8 there's no history of treatment. There's no
9 history of any of the dysfunctional aspects of
10 mania or depression. I'm -- I'm sorry, I answered
11 too much.

12 Q It's -- I asked the question.

13 Now, if -- how -- in your opinion from
14 reviewing the records, how quickly should some --
15 should a psychiatrist have realized that Ms. -- in
16 your opinion, Ms. Argoe was not bipolar and did not
17 need to be committed?

18 A Well -- how quickly? Based on what I've read --
19 and -- and I -- and -- and I have great empathy for
20 Dr. Mobley and for Dr. Dodds. When you have a
21 family crying all kind of bad things are happening,
22 you -- you really do have to pay attention to that.
23 But I got to tell you, it's hard for me to believe
24 that they got past the initial evaluation without
25 suggesting either outpatient treatment with some

1 form of follow-up or the possibility of a short
2 voluntary stay for evaluation.

3 I don't -- I -- the -- the damaging -- or the
4 -- the symptoms that most fully meet the criteria
5 for the diagnosis they use are all presented by
6 adversarial relations. In the here and now, when
7 they meet with Ms. Argoe and they're looking for
8 things, there just doesn't appear to be much there
9 to hang your hat on, unless you already have --
10 have a -- what -- what I say is a -- a
11 "confirmation bias," where you're -- you're -- you
12 know, someone tells me, "This is a black cow," so I
13 start looking at ways to prove that it's a black
14 cow.

15 Quite frankly, I -- I'm surprised that they
16 made it through the initial evaluation. And --
17 which, I -- I believe the intake was done, maybe,
18 by Ms. Burrell. But --

19 Q So that -- if -- so if I -- if I -- if I get all
20 the information that the family complained about
21 and I assess Ms. Argoe, that -- within that day I
22 should know that she's not psychotic or -- or meets
23 the requirement for an inpatient admission?

24 A I think a thorough evaluation at that point
25 would've revealed that Ms. Argoe was not presenting

1 any symptoms consistent with either a diagnosis of
2 psychosis and/or bipolar mania with psychotic
3 features. Now, of course, the tricky part, as I
4 said, for -- for Dr. Mobley and Dr. Dodds is you --
5 you've got the family over here rattling the cage.
6 But when you're talking to this lady, what -- what
7 do you see, you know? And when you -- when you try
8 to elicit hallucinations -- when you try to
9 determine whether or not she's delusional, and the
10 only thing you can say that she's delusional is
11 that she doesn't trust her husband -- and she
12 doesn't trust her husband why? Well, he's been
13 unfaithful in the past. He's -- he's got a -- he's
14 got a court order for an evaluation and for
15 commitment.

16 And there doesn't appear -- what -- what we
17 would normally see, by the way, in a case like
18 this, is that the husband, perhaps, would've gone
19 to the -- the primary care physician with Ms. Argoe
20 and said, you know, "Dr. Jones, I think something's
21 going on with Martha. What do you think?" instead
22 of, you know, going straight to the route of
23 getting the detention order and an evaluation
24 order. Those should be real red flags,
25 particularly in the absence of any previous history

1 -- any previous or any alcohol or drug problem or
2 any -- any behavior that suggests she's out of
3 control or really a danger to anyone.

4 You know, when you're saying, "Well, she's got
5 a gun," yeah. She's got a gun, but state of South
6 Carolina says she can carry that gun. Does she
7 spend money? Yeah. She's a middle-aged, upper-
8 middle-class lady living in a small town. What's
9 she going to do? She's going to go shopping.
10 She's wearing expensive jewelry. She has money.
11 What -- what does that prove? She's -- she's
12 hidden a Corvette. Yeah. It's her Corvette. She
13 can do with it whatever she damn well pleases.

14 And, as it turns out, in retrospect, the --
15 the people she didn't trust, she had every reason
16 not to trust them. They were stealing money from
17 her. They were doing some of these things. So I
18 just think there were too many red flags.

19 Q So if -- if a -- if a licensed, reasonably
20 competent, qualified psychologist evaluated Ms.
21 Argoe and did not recommend discharge, do you
22 criticize that?

23 A The psychologist in this case is the only person
24 that raised the red flag and said, "Maybe we need
25 to -- maybe we need to take a look. This lady

1 claims she's being abused by her husband. We need
2 to take a look at this."

3 Q Why -- why didn't she start the -- the discharge
4 process? Do you see where she did?

5 A You -- you have to talk to her about that.

6 Q Okay. Are you critical that she didn't start a
7 discharge process for Ms. Argoe?

8 A I think she brought the information to Dr. Mobley
9 and Dr. Dodds.

10 Q Okay. Again, are you critical that she did not do
11 more to start a discharge process in this case?

12 A To -- to answer your question as broadly as I can,
13 I'm critical of anybody who did not start a process
14 to have Ms. Argoe --

15 Q Okay.

16 A -- discharged.

17 Q Okay. But that psychologist is not a defendant in
18 this case, is she?

19 A As far as I know, she is not.

20 Q Okay. And if there was another psychiatrist that
21 came in and treated Ms. Argoe during her inpatient
22 admission for a minimum of three days and had all
23 the information available to him or her during
24 those three days, you would also be critical of
25 that psychiatrist for not starting a discharge

1 process and getting her out of the hospital,
2 correct?

3 A Well, that's somewhat hypothetical, but I -- I -- I
4 would just state, looking over this information, I
5 would be critical of any trained professional in
6 this chain who did not do anything they could to at
7 least raise the flags about whether or not this was
8 a valid hospitalization.

9 Q Well, it's -- it's -- it's not hypothetical. I'll
10 show you the three notes for a -- a psychiatrist
11 that came in for three days --

12 A Okay. Well, then --

13 Q -- July -- July 2nd --

14 A Sure.

15 Q -- 3rd, and 4th. So you would -- you would be as
16 critical of him as you are of Dr. Mobley, Dr.
17 Dodds, Dr. Steiner for not getting Ms. Argoe out of
18 the hospital?

19 A I would be critical of him.

20 Q Okay. For the same reasons you're critical of the
21 -- of the defendants in this case?

22 A Absolutely.

23 Q And he's not a -- or he or she is not a defendant,
24 is --

25 A As far as I know, not.

1 Q But if you had looked at this case before it was
2 filed, you would recommend that he or she be
3 included in this case, then, right?

4 A Oh, if -- if -- if the question were asked of me,
5 "Would you be critical of -- of anyone -- any
6 professional involved in this case that did not do
7 everything they could to ascertain whether or not
8 this was a valid commitment?" I would say yes.

9 Q Okay. And I just want to point out -- there it is
10 right there. These three notes right are a
11 psychiatrist that's not sued in this case who even
12 says, "Patient seen. Discussed with -- discussed
13 patient's case with staff." And -- and, actually,
14 if you read the notes, it says exactly the same
15 thing as the other doctors. You're critical of
16 that, right?

17 A I'm critical of anyone --

18 Q Okay.

19 A -- involved in this.

20 Q Okay. Including the court system?

21 A Well, including the court system.

22 Q All right. Now, you -- you understand that Dr.
23 Dodds -- Ms. Argoe had been in Three Rivers for --

24 A She took over the case.

25 Q -- took over the case. Been in there quite --

1 A Yeah.

2 Q -- long period of time, in your --

3 A Yeah.

4 Q -- opinion, right?

5 A I got to tell you: It's -- it's -- very few people
6 stay in a psychiatric hospital 41 days these days.

7 So, yes.

8 Q All right.

9 A Yes.

10 Q And that's not because of treatment; that's because
11 of money, right?

12 MR. DODSON: Object to the form.

13 A It's -- it's because of a lot of factors, but
14 insurance is one of them.

15 Q Okay. Yeah. I mean, my -- when my mother had me
16 50-plus years ago, she was in the hospital a long
17 time. Today, we'd have been in and out in a -- in
18 a --

19 A In and out.

20 Q -- day and a half, right?

21 MR. DODSON: Object to the form.

22 A Well, since we're sharing history, I was only in
23 the hospital one night because my father was a
24 mechanic. He overhauled three engines that day.

25 It cost \$99 to get us out of the hospital. He came

1 in and told my mother, "You've got to go home. I
2 can't do this tomorrow." So we were there one day.
3 But you're exactly right.

4 Q Okay.

5 A That's part of it.

6 Q So Dr. Dodds comes on board because Dr. Mobley goes
7 out of town.

8 A Vacation or something, yeah.

9 Q At that point, I think she came -- first saw Ms.
10 Argoe on June 27th. Assume that to be correct.

11 A Yes.

12 Q And the formal hearing that kept Ms. Argoe in the
13 hospital occurred on June 21st. Do you understand
14 that?

15 A Yes.

16 Q Okay. Now, you -- you agree -- you -- you've never
17 had to treat an inpatient -- a patient in -- in a -
18 - a -- commitment in a hospital at any time in your
19 career as a primary physician, right?

20 A No, no. Absolutely not.

21 Q Okay. Okay. Well, having that -- said that, what
22 opinion do you have of what you think Dr. Dodds
23 should've done when she has a court order saying
24 that, "You need to stabilize Ms. Argoe and -- and
25 then discharge her when you feel like she is stable

1 to go to another year of outpatient care and
2 medication" -- the same medication she's getting in
3 the hospital?

4 A All right. And -- and that -- actually, the
5 medication becomes an issue, too, because we're --
6 we're talking about giving someone antipsychotics
7 against their will. And if you do that with
8 certain people, it can produce what's called an
9 "iatrogenic reaction," which means it makes them
10 psychotic. But in this particular case, you know,
11 Dr. Dodds, I think, adjusts the medication. And
12 she's got her on Risperdal. She adds Haldol. And
13 then they go back and forth a little bit.

14 I would have the same general criticism of Dr.
15 Dodds, although I have, as I said, great empathy
16 for both she and Dr. Mobley that this lady is in
17 your hospital; she's not overtly psychotic; there's
18 -- there's nothing to indicate in her records she's
19 been overtly psychotic, other than what the family
20 is saying; she is -- is compliant as she can be,
21 although she at least asserts herself and says, "I
22 do not think I'm crazy. I do not think I need
23 medication," you know. And -- and then when Dr.
24 Dodds wants to place her in a assisted-living home,
25 she says, "I don't want to go to assisted living

1 home. I'd rather go home with the crazy husband
2 that's going to kill me."

3 And Dr. Dodds says, as a result of that, "This
4 demonstrates that her judgment is impaired." I --
5 I -- I don't know. I don't get that. I -- I don't
6 -- I --

7 Q You -- you don't get the fact that a woman sits
8 there and says, "My husband's trying to kill me,"
9 but yet she wants to go home to that husband so
10 that, as she says in the record, "So he won't have
11 an alibi" --

12 A Yeah.

13 Q -- "when I'm dead"?

14 A Absolutely. And -- and part of this is -- to -- to
15 that point, no one else has believed the guy's
16 trying to kill her. So if she says, "Okay. I want
17 to go back and live with him," it -- it would
18 appear to me --

19 Everybody'd say, "Well, okay. That's fine
20 because he's supportive and he's an asset." So I'm
21 -- no matter what she does, it -- it appears it's
22 being used against her. And if -- if you're
23 delusional -- if you're psychotic, there're going
24 to be some examples of that in your daily life.
25 You know, maybe you think the glass of water is

1 talking to you. You know, maybe that's going to
2 occur at some point. Maybe you think the people in
3 the hospital are -- are out to harm you.

4 But, you know, for the most part, it looks
5 like what Ms. Argoe is saying is, "You know, I'll
6 go to group. I'll do whatever you say. I'll go
7 home because you're giving me this damn medication.
8 I don't want to take the medication anymore. I'd
9 rather -- you know what, I don't want to be in
10 assisted living. I'm -- I'm 62 years old."

11 Q But you're -- but that's a catch-22, isn't it?

12 A It's absolutely -- it --

13 MR. DODSON: I'm sorry. (To the deponent)

14 Did you finish your previous answer?

15 A It -- it's a catch-22 for Ms. Argoe that's been set
16 up by that system. And I -- I agree: No matter
17 what she says, she's damned if she does, she's
18 damned if she doesn't.

19 Q But these physicians didn't put her in the -- in
20 there, did they? The court system put her in
21 there, right?

22 MR. DODSON: Object to the form.

23 A The physicians have a responsibility to the
24 patient, and that -- part of that responsibility is
25 if -- if you're not psychotic, you know, they can

1 petition the Court and say, "Hey, she's no longer -
2 - she's no longer a danger to herself. Let's
3 release her."

4 Q Okay.

5 A "We don't -- we don't think there's a problem here.
6 Let's let her go home."

7 Q You -- you're critical of the medications?

8 A Antipsychotic medications are very appropriate and
9 very good if they are required. I'm not sure --
10 well, pretty sure there is no evidence that Ms.
11 Argoe required these medications.

12 Q Let's assume she did require it. Are you critical
13 of the medication, even though you're not qualified
14 to -- to prescribe it?

15 A It -- it -- it -- well --

16 MR. DODSON: Object to the form. He can --

17 (To the deponent) You can still answer.

18 A Yeah. You -- you -- you -- you're exactly right in
19 that I -- I can't prescribe medication. I -- I --
20 I do teach psychopharmacology, so I know a little
21 bit about them. Just a tiny, but not much.

22 But Risperdal is a very good and very
23 effective medication to use in the treatment of
24 psychosis. Haldol is a old-line medication still
25 used some, but it was one of the ones that used to

1 be referred to as "the chemical straightjacket."
2 It -- it is a harsh medication, even though she was
3 just given a small dosage. I -- I was kind of
4 surprised to see that she was prescribed that. So
5 I do not have standing in South Carolina to
6 prescribe medications, but I was a little shocked
7 to see that.

8 The other medications -- the Geodon, that
9 would -- that's something that's often tried. It
10 did not work. They took her off of that. The
11 Ativan to -- to calm her down -- well, she was
12 situationally agitated. That made perfect sense to
13 me. So, yeah. That's -- the only -- the only
14 criticism I have is I -- I'm not sure she required
15 the medication in the first place.

16 Q Okay. But, again, if -- if you -- you don't --

17 A I don't --

18 Q -- have any --

19 A I --

20 Q If she is --

21 A If she's psychotic --

22 Q -- psychotic, then you can't say anything about the
23 medication, can you?

24 MR. DODSON: Object to the form. (To the
25 deponent) Go ahead.

1 A Two -- two -- two parts to that answer: One would
2 be, it's presumptuous of me to make that statement,
3 probably, but given my experience in education, the
4 only thing I would say -- the only thing that I --
5 I might would question at all would be the use of
6 Haldol because it's a harsh old-line antipsychotic
7 that has numerous nasty side effects. It was
8 prescribed, but it was prescribed at a small dosage
9 and seemingly appropriately.

10 Q And even if -- even if Ms. Argoe had been
11 discharged earlier by anyone in this case, under
12 the court order, she still had to have an
13 antipsychotic for at least a year, correct?

14 A That is the -- that's the ruling of the Court.
15 However, I -- often, those things are somewhat left
16 to the discretion of the physician.

17 Q Right. And we discussed that earlier. And the
18 people at Coastal did not petition the Court --

19 A Right.

20 Q -- and did taper the medication over a period of
21 time, but she still remained on an antipsychotic
22 medication for a year, so it didn't really make a
23 difference. If she had been diagnosed earlier, she
24 was going to get a year of medication?

25 A Right.

1 MR. DODSON: Object to the form.

2 A I -- I understand your question. Yes.

3 Q You agree with that, right?

4 A Yeah.

5 Q Okay.

6 MR. DODSON: Same objection.

7 Q So, as I understand it, in your opinion, once Dr.

8 Dodds came on and took over the coverage for Ms.

9 Argoe on June 27th, within a day, if she had

10 reviewed the file, in your opinion, she should have

11 discharged Ms. Argoe to the outpatient care?

12 A Well, you're telling me that she -- she probably
13 couldn't have done that, but I think very quickly

14 Dr. Dodds should've recognized that not only is

15 this woman not psychotic, she probably had never

16 been psychotic. And to either petition the Court

17 or have made some recommendation as to -- for

18 outpatient or -- or whatever, that would've been a

19 more appropriate setting for this particular lady.

20 Q Well, let me make sure I -- you understand. I'm

21 not saying she couldn't have discharged her

22 immediately. That --

23 A Okay.

24 Q -- may have been --

25 A Okay.

1 Q -- an -- an earlier question.

2 A Oh, yeah. Okay.

3 Q I -- I think if you read Dr. Dodds's deposition, I
4 think she said her job was to make sure that Ms.
5 Argoe was stable to be able to discharge her --

6 A Right.

7 Q -- to outpatient.

8 A Right. Right. And it --

9 Q So it -- the -- the opinion is if -- once she
10 evaluated and assessed everything she needed to
11 know from the -- from admission, in your opinion,
12 it should have required a discharge to outpatient?

13 A My -- my opinion was that Ms. Argoe was stable from
14 the beginning. And that -- that, yes. She was
15 being treated for a condition that she did not
16 truly have.

17 Q Okay. And when Ms. Argoe came to your practice in
18 September 2006, you found her without any psychotic
19 symptoms, correct?

20 A Correct.

21 Q Without any -- any actual mental illness of any
22 import that I -- I didn't see any of that in your
23 record, correct?

24 A Well --

25 Q Other than compulsive shopping?

1 A The possibility of compulsive shopping and marital
2 issues, that's right. Ms. -- Ms. Argoe -- Ms.
3 Argoe is -- is -- is probably what, in the South,
4 we refer to as "a character." And she's a very
5 unusual lady. But I saw nothing that would suggest
6 any mental illness, any symptoms, any signs. There
7 was nothing in her history prior to the commitment
8 that suggested that. She had never received
9 treatment for that. And during the period of time
10 I saw her, no symptoms.

11 Q And -- and when you treated her, you told us, I
12 thought earlier, that it -- it -- you could've
13 easily have said in that first session, "Hey,
14 everything's great," but you were working with her
15 to -- through the divorce and through the other
16 problems to get her back on her feet, having
17 undergone, what she described to you as, an
18 "abusive marriage," correct?

19 A That and, as I said, I had the luxury of -- of --
20 of watching this lady over a full year to see if
21 there was any -- if -- if, indeed, I was wrong and
22 that there were, you know, some psychoses or
23 whatever that had not reared their ugly head. I
24 had a long enough period of time to see her to
25 that.

1 But, predominantly, I think Mr. Warner had
2 referred her over for some -- just supportive
3 therapy because, not only had she been through this
4 traumatic experience, but she was also going
5 through a divorce and, evidently, several other
6 legal issues, and just wanted to be sure that she
7 was okay through that process.

8 Q And if you thought that she had some kind of
9 residual or permanent damage from this admission,
10 you would've continued to treat her, right?

11 A Thought she had some --

12 MR. DODSON: Object to the form.

13 A -- permanent damage or residual -- that's an
14 interesting question. At the time that we broke
15 off treatment in 2007, Ms. Argoe, as far as I could
16 tell, was symptom free. I can't guarantee you that
17 she won't begin exhibiting symptoms like our
18 esteemed police chief, but that's a whole different
19 issue.

20 Q That she will or will not?

21 A I was joking, but I said --

22 Q Well, I -- no. I got --

23 A I -- I said I --

24 Q -- my own opinion about that, too.

25 A I -- I -- I -- I can't -- I can't guarantee you

1 that that won't happen, but I do not believe that
2 to be the case.

3 Q And I guess the last thing, you criticized the
4 family for saying they're supportive, but you do
5 that because you disagree with what they were
6 trying to do, correct?

7 A No. I criticized the -- the people in the hospital
8 for listing as an -- a patient asset a supportive
9 family. But I do that because what we find out, at
10 the end of the day, is these people were not very
11 supportive, and, indeed, much of what Ms. Argoe was
12 saying turns out to be true, not delusional.

13 Q Well, I mean -- but you're criticizing a family who
14 has their own opinion about what they see, and --
15 even if they're lay people -- that you believe
16 turned out to be untrue. But a supportive family
17 that thought someone is a -- a danger to themselves
18 or others -- I mean, a -- a family that thinks
19 you're a danger to yourself or others because of
20 your actions would be supportive if they were
21 trying to get you treatment, would they not?

22 MR. DODSON: Object to the form.

23 A Okay. I -- I would appreciate the effort of any
24 family member that would seek to get me any
25 treatment that they thought I needed, whether,

1 indeed, that were the case or not, if their intent
2 were good.

3 Unfortunately, in this world, there're people
4 who is -- whose intent is not so good, who seek to
5 have people committed, diagnosed, treated for
6 nefarious reasons. But if -- if -- if the intent
7 is good, yes. I would support any family trying to
8 get help for a member.

9 Q All right. Because, I mean, like in your gambling
10 practice, if -- if the family is saying, "This guy
11 is gambling all our -- all the money away."

12 And he's going, "I'm -- I'm not a compulsive
13 gambler. I'm not addicted to it. I'm not."

14 And they keep saying, "He is. He is." And
15 they want to get him treatment. And they want to
16 get him into a program like you, but they could
17 easily have a reason for doing that because they
18 don't want him to gamble away all the money they
19 don't -- they'll get. Do you see that?

20 MR. DODSON: Object to the form.

21 A I'm -- I -- yeah. I understand what you're saying.

22 Q Okay. But you're going to take what they're saying
23 as being true on its face because this guy is
24 gambling and he's saying he doesn't have a problem,
25 but they say he does?

1 A As far as --

2 MR. DODSON: Object to the form.

3 A -- as far as I know, in the state of South
4 Carolina, you cannot commit someone for
5 pathological --

6 Q I didn't say that.

7 A Well --

8 Q I'm talking about treatment. I'm talking about
9 treatment.

10 A Oh, well, you -- as far as I know, you can't force
11 someone into treatment in South Carolina for
12 pathological gambling either.

13 Q Well, you know, I -- I don't think I have an eating
14 problem, but my waist may tell you differently,
15 since you talked about being fat earlier, so, I
16 mean, that -- that's just agreement of subjective
17 opinion, right?

18 A Well, I have a call from your wife right now that
19 has suggested I --

20 Q Well, that'd be interesting because I'm not
21 married.

22 A You know, if the lady says you're married. You
23 know, but that -- there's --

24 Q That may be -- may be one of the ones that's
25 getting money from me. I don't know, but -- but,

1 then again, you took that at face value then, too,
2 didn't you?

3 A I --- I took it at face value.

4 Q Okay.

5 A Yep.

6 Q And you acted upon --

7 MR. DODSON: Object to the form.

8 Q -- until you found out differently, right?

9 A Haven't -- haven't acted on it yet. I -- I was
10 keeping it --

11 MR. DODSON: Object to the form.

12 A -- quiet till you brought it up.

13 MR. PARHAM: That's all I have. Thanks.

14 THE DEPONENT: Thank you.

15 MR. COLE: You want to take break or you want
16 me to go?

17 MR. DODSON: Let's take a short break.

18 (Off the record from 1:50 p.m. until
19 2:00 p.m.)

20 EXAMINATION

21 BY MR. COLE:

22 Defendants' Exhibit Number 2, "Table of
23 Contents for Experts Review."

24 Q First, my name is Andrew Cole. I'm here on behalf
25 of Three Rivers and Nurse Burrell. While we were

1 off the record, we marked, as Exhibit Number 2, an
2 index that came out of the notebook of file
3 materials that you have; is that correct?

4 A Yeah.

5 Q That -- that "yes"?

6 A Yes. I'm sorry.

7 Q Okay.

8 A I'm afraid I'm --

9 Q Thank you.

10 A -- losing my voice now.

11 Q All right. Well, I'm hopefully not going to be too
12 long, so that's not a --

13 A Okay.

14 Q -- that's not an issue. Again, I understand that
15 that notebook has all of the information that
16 you've received in this case, plus you've also --
17 have the affidavit from Dr. Davis?

18 A -- Dr. Davis.

19 Q Okay. What deposition transcripts have you
20 actually received and have in your notebook there?

21 A All -- all the ones listed. It'd be --

22 Q Okay. So they're all listed on here?

23 A Yes.

24 Q So you've not received the deposition transcripts
25 from Albert Reid Lewin or Donna Lewin Powell?

1 A Those are Ms. Argoe's brother and sister?

2 Q Correct.

3 A I have read those, but I'm -- I'm thinking they
4 may've been provided by Jan Warner years ago. But
5 I read those at some point. But I -- I do have
6 those.

7 Q All right. I'll -- I'll represent to you that
8 those depositions were taken last year --

9 A Oh, then I --

10 Q -- after --

11 A -- then I don't --

12 Q -- Mr. Warner passed, so --

13 A Then I -- I had something from them from years ago
14 I thought. I don't -- I don't think I have a
15 deposition from -- a recent deposition from either
16 of those two.

17 Q Okay.

18 A I have -- maybe an affidavit's what I have from
19 them back in -- from 2005 or something, related to
20 her commitment.

21 Q All right. Well, I'll represent to you that I'm
22 not familiar of any --

23 A Okay.

24 Q -- affidavits that either of them --

25 A If --

1 Q -- filed.

2 A If I can find that, I -- you would like for me to
3 provide that to you?

4 Q If you do, I would like for you --

5 A I -- I will --

6 Q -- to provide that, because --

7 A I will do so.

8 Q -- I'm not familiar with -- with either of those.

9 A Okay.

10 Q So --

11 A But I do not have a recent deposition from either
12 of those people or any other correspondence.

13 Q Okay. So you have not read their depositions,
14 then, from 2012?

15 A No.

16 Q Okay. And you haven't read in their depositions
17 where both of them said that they thought that Ms.
18 Argoe was a danger to herself and to others?

19 A No.

20 Q And you have not read that both of them were
21 concerned that she may cause harm to her husband,
22 in particular?

23 MR. DODSON: Object to the form.

24 A I -- I haven't read their depositions, period. So

25 --

1 Q Okay. And so you haven't read that her brother is
2 actually a physician and --

3 A I knew that, yeah.

4 Q Okay. And that her brother actually gave advice to
5 the husband to start the process?

6 MR. DODSON: Object to the form.

7 A I have not read their deposition, so no.

8 Q Okay. And you haven't read his deposition where he
9 said that Mr. Argoe came to him concerned because
10 he had spent many years hiding issues that Ms.
11 Argoe had in her lifetime? That they never did
12 anything public, but had things that he was able to
13 keep quiet because they had certain privileges and
14 were able to maintain a relatively normal family?

15 A I --

16 MR. DODSON: Object to the form.

17 A Once more, I -- I've -- I've not read their
18 deposition at all, no.

19 Q You mentioned, briefly, off the record before we
20 started up here, that, in a former name of the
21 facility -- that you spent a little time working
22 with what is now known as Three Rivers, although it
23 has different owners?

24 A Right.

25 Q What did you do and when did you work with them?

1 A I had several different positions. The --
2 originally, I came on as the -- I was in charge of
3 the family therapy program for the addictions
4 program. And then I became the director for
5 outpatient services, which meant I operate -- I
6 opened, ran, operated, supervised the counseling
7 centers that they established throughout the state.
8 And I served as part of the management team for the
9 hospital.

10 Q And when did you do that?

11 A That started in -- from, roughly, 1986 through 19 -
12 - the -- which part? The -- I started there,
13 originally, in roughly '84/'85, but then I became
14 the director of outreach/outpatient in '86, I
15 believe, and I continued there until June of 1990.

16 Q And that's when it was called Charter Rivers?

17 A It was called Charter Rivers in those days.

18 Q Yeah. Since June of 1990, have you been back to
19 the facility for any reason in a professional
20 capacity?

21 A I've been there -- I mean, that's been a long time.
22 I know I've been over there maybe two or three
23 times. One when -- that I -- I distinctly remember
24 when -- when Andy Hanner was the administrator,
25 went over to talk with him about -- he -- he --

1 there was some issue about possibly referring
2 people when they came out back to our practice. We
3 had -- our -- our practice originally had been one
4 of the ones that opened that hospital, Carolina
5 Psychiatric Services, and -- and our physicians had
6 been the medical director and all the director of
7 all the services for numerous years before we had,
8 kind of, a split.

9 Q Okay. What are your opinions in this case
10 regarding Three Rivers?

11 A The -- the -- the only opinions that I have
12 regarding Three Rivers is, as -- as -- as I've
13 stated very briefly with the -- well, actually,
14 extensively, that I -- I -- I feel like they did
15 not fulfill their duties in terms of appropriate
16 care for this lady. She was there for 41 days.

17 It -- it is still just not clear that she met
18 the diagnostic criteria for any of the diagnoses
19 that she was given. And, in terms of her treatment
20 there, it certainly would be appropriate if,
21 indeed, she met that diagnostic criteria -- those
22 diagnostic criteria. I do not believe that to be
23 the case.

24 Q It sounds like your opinion about Three Rivers is
25 the same as what you were saying about the

1 physicians that --

2 A Absolutely.

3 Q -- you were asked about earlier?

4 A Yes.

5 Q Okay. While -- let me back up. Do you know Regena
6 Sellers?

7 A I -- I worked with her when her name was Regena
8 King, for many years at Charter. And she's --
9 gosh, she must've been there 30-something years
10 now.

11 Q Do you have any opinions about her?

12 A Very nice lady.

13 Q Okay. And you read her deposition in this case?

14 A I did.

15 Q Okay.

16 A It -- yeah.

17 Q Okay.

18 A I -- I don't have any comment or opinion about
19 that.

20 Q You know Nurse Burrell?

21 A I do not know her.

22 Q Okay. And you've read her deposition in this case?

23 A I did.

24 Q Okay. And Nurse Burrell was one of the designated
25 examiners, correct?

1 A She was.

2 Q And you said that you've had some history a long
3 time ago being a designated examiner?

4 A Right.

5 Q And, when you have a designated examiner, you have
6 one physician and one non-physician who can be a
7 clinician or --

8 A Right.

9 Q -- anyone else, correct?

10 A Correct.

11 Q And so you were in the same capacity that she was
12 in?

13 A Absolutely.

14 Q Okay. After the hearing on June 21, 2005, Nurse
15 Burrell didn't have anything to do with the care or
16 treatment of Ms. Argoe, correct?

17 A I do not believe she had anything after that. The
18 -- I think she was involved in the intake and then
19 with the -- as a DE.

20 Q Okay.

21 A As far as I can tell.

22 Q If she was involved with the intake, that would've
23 been before the --

24 A Oh, yeah. Yeah.

25 Q -- probate court hearing?

1 A Yes. I -- I'm sorry. Yeah. The -- those are the
2 only two things that I think she was involved in.

3 Q Okay. What opinions do you have regarding Nurse
4 Burrell?

5 A Well, in -- in reading her deposition, it -- it
6 appears that her opinion of Ms. Argoe's condition
7 is based solely -- or, almost solely on the
8 physician's opinion. It -- it -- it's really not
9 very clear, based on her deposition, that -- even
10 though she said she met with Ms. -- Ms. Argoe, it -
11 - it appears that she -- she just, sort of, went
12 along for the ride, to me.

13 Q And what specific deviation in the standard of care
14 that she would be as a designated examiner do you
15 say she --

16 A Okay.

17 Q -- is volitive of?

18 A I think as a -- as a designated examiner, you're --
19 you're charged with the idea of -- of making the
20 best determination you can, gathering as much
21 information. And, certainly, should take seriously
22 the idea of whether or not someone's commitment
23 should be upheld or -- or dismissed, just as you
24 should take very seriously whether or not someone
25 is a danger to themselves or to others.

1 Ms. -- Ms. -- Ms. Burnell (as spoken), when
2 you -- when you read this, she -- you get the sense
3 that she just sort of said, "Well, you know, the
4 doctor said she was crazy, so I think she's crazy."

5 Q And that's solely based on your analysis of her
6 deposition?

7 A Yes. Because, as you said, I think -- I think she
8 may've been involved in the initial intake. I
9 thought I saw her name on something in the intake.
10 And she's just taking in information the family
11 gave her. But then, in this deposition, it's --
12 she continually just sort of comes back to saying
13 things, like, "Well, you know, the doctor felt like
14 she needed to be there, and so I think she needs to
15 be here."

16 I -- I -- I don't know. I think someone does
17 ask her, you know, "Did you talk to -- did you talk
18 to Ms. Argoe?"

19 And she says, "Yeah."

20 And she -- they said, "Did you look at the
21 charts that we" --

22 "Yeah. Yeah. I did look at that."

23 "And -- and then what?"

24 "Well" -- you know, I -- I don't get the sense
25 that there is much effort going into that. And --

1 and -- and it should be. This is a very serious
2 kind of thing to commit someone.

3 Q The position that she's in, she can't make a
4 diagnosis or a recommendation for a diagnosis,
5 correct?

6 A Absolutely.

7 Q And she's not attempting to do that, correct?

8 A Absolutely.

9 Q Okay. And who ultimately made the decision, on the
10 21st, that Ms. Argoe needed to have continued
11 inpatient treatment?

12 MR. DODSON: Object to the form.

13 A Okay. But as we've discussed earlier, the -- the
14 judge gets to make the ultimate decision based on
15 information and recommendations of the two
16 designated examiners.

17 Q So what could Nurse Burrell have done different at
18 that point?

19 A She could've said, "I disagree. I do not believe
20 this lady meets the criteria for commitment. And
21 whether Dr. Mobley does or not, I -- I don't -- I
22 don't see anything here that suggests she's a
23 danger to herself or to anyone else."

24 Q Okay. And even if she had said that, the Court
25 could've still said, "We believe that she needs to

1 still have involuntary commitment"?

2 A Absolutely.

3 Q All right.

4 MR. DODSON: Object to the form.

5 A Absolutely, they could've -- the judge gets to do
6 whatever they wish.

7 Q You know, I think that's all I'm going to ask you.

8 A Okay.

9 Q Thank you.

10 A Thank you.

11 MS. GANES: I have nothing.

12 MR. DODSON: I have no questions.

13 MR. PARHAM: We're done.

14 MR. HAILE: Nope.

15 THE DEPONENT: What about this fellow's?

16 MR. COLE: Chip, we're finished, unless you
17 got anything else?

18 THE DEPONENT: What about Mr. Davis (as
19 spoken) and his --

20 MR. DODSON: He's not going to ask you
21 anything.

22 THE DEPONENT: Oh. Thank you.

23 MR. PARHAM: I want to use this as an exhibit,
24 I think.

25 MR. HICKS: I have no questions. Thanks.

1 FURTHER DEPONENT SAITH NOT.

2 Signing reserved.

3 (Whereupon, there being no further
4 questions, the deposition was
5 concluded at 2:14 p.m.)

6 (*This transcript may contain quoted material.
7 Such material is reproduced as read or quoted
8 by the speaker.)

9 (**Certificate accompanies sealed original
10 only.)

09/27/2006 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady was bright, cheerful and quite appropriate. Her affect and mood were both congruent and she appeared full of energy. This individual has been working approximately 27 hours a week at Cracker Barrel, managing her own finances, and making good choices. I will continue working with her in a supportive fashion and see her in 1 week.

Frank L. Quinn, PhD FLQ/tab 09/30/2006



10/04/2006 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady continues to work diligently at Cracker Barrel. She has expanded the number of hours. She is handling all of her affairs successfully and appears to be doing quite well socially. She seems greatly relieved to no longer be living with her husband and says that she feels free for the 1st time in years. I will continue working with her in a supportive fashion and see her in 1 week.

Frank L. Quinn, PhD FLQ/tab 10/09/2006



10/11/2006 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady is doing extremely well. Her affect and mood are greatly improved. She appears to be taking much better care of herself. She is working 26 - 28 hours a week. She is handling her affairs with a seeming ease and appears quite cheerful. I will continue working with her in a supportive fashion and see her in 1 week.

Frank L. Quinn, PhD FLQ/tab 10/16/2006



10/18/2006 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. Ms. Argoe, as always, appears quite chipper. She is neatly groomed and well dressed. She reports that she worked fewer hours at Taco Bell last week, but still enjoys her job very much. She has been working diligently on some information for her attorney and her accountant. I will continue working with her in a supportive fashion and see her in 1 week.

Frank L. Quinn, PhD FLQ/tab 10/21/2006

CPS, P.A.

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10/25/2006 Martha L. Argoe, Chart # 165155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady is doing significantly better. Affect and mood are greatly improved. She continues to work at least 20 hours a week at the Cracker Barrel. She is handling all of her personal affairs. She appears to be doing things orderly. Her thought processes appear clear and intact. Her judgment also appears uncompromised. I will continue working with her in a supportive fashion and see her in 1 week.

10/31/2006

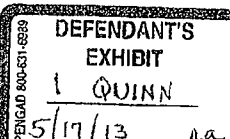
Frank L. Quinn, PhD FLQ/tab



11/01/2006 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady continues to appear quite bright and clear. She is still working at Cracker Barrel part-time and does remain somewhat self-sustaining. Ms. Argoe is expanding her circle of friends. She has been attending church periodically when she is not working and has a couple of people in the church that she is meeting with for Bible study. I will continue working with her in a supportive fashion and see her in 1 week.

Frank L. Quinn, PhD FLQ/tab 11/08/2006

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11/08/2006 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady continues to present a bright, clear and alert affect. She continues to work at least 20 - 25 hours a week and handle her personal affairs. By all reports, she appears to be doing quite well. Emotionally she seems much happier than she has in years, she reports. I will continue working with her in a supportive fashion and see her in 1 week.

Frank L. Quinn, PhD FLQ/tab 11/15/2006



11/15/2006 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. She appears to be flourishing. Affect and mood are both appropriate and stable. Her thoughts appear to be clear and concrete. She appears to be taking care of all of her business and to be handling her financial affairs quite well. I will continue working with her in a supportive fashion and see her in 1 week.

Frank L. Quinn, PhD

FLQ/tab 11/25/2006



12/06/2006 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This individual appears to still be doing quite well. She continues to handle her own affairs and to work at the Cracker Barrel. Additionally, she is making an attempt to enrich her own life. I will continue working with her in a supportive fashion and see her in 1 week.

Frank L. Quinn, PhD FLQ/tab 12/11/2006



11/29/2006 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady continues to make improvement. Affect and mood continue to show normal fluctuations. She continues to be able to work and manage her own affairs and reports that she is feeling greatly liberated from her husband's control. I will continue working with her in a supportive fashion and see her in 1 week.

Frank L. Quinn,

PhD FLQ/tab 12/05/2006

12/13/2006 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady's mood and affect are greatly improved. She continues to be quite clear and rational. She is able to manage her own affairs. She continues to work at Cracker Barrel and seems much more upbeat than when she first was seen in this office. I will continue to work with her in a supportive fashion and see her in 1 week.

Frank L. Quinn, PhD FLQ/tab 12/19/2006

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12/20/2006 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady appears to be making amazing progress. She is taking much more charge in her life. She continues to work at the Cracker Barrel and has been nominated for Employee of the Month. She has undergone an initial deposition in her case against her husband and it appears that this all went well. I will continue working with her in a supportive fashion and see her after Christmas.

Frank L. Quinn, PhD FLQ/tab 12/28/2006

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12/27/2006 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady was bright and cheerful as always. She continues to enjoy her work at the Cracker Barrel and to stay on top of her personal finances. She reports that she has received a message from her husband's attorney that he wants to settle the divorce case and that they will be moving towards that end. I will continue working with her in a supportive fashion and see her in 1 week. _____ Frank L. Quinn, PhD FLQ/tab 12/29/2006

01/03/2006 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. Her affect and mood appear not only appropriate and congruent, but quite lightened. This lady seemingly is feeling much better now that her divorce is progressing and that she is no longer frightened by the prospect of her husband having control in her life. She continues to work regularly and to manage her affairs. I will see her again in approximately 1 week. _____ Frank L. Quinn, PhD FLQ/tab 01/09/2007

01/10/2006 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady continues to show exceptionally resiliency to all the stress that she has undergone in her life. She is cheerful, bright, concrete and clear. She appears to be making good decisions and managing her affairs. She reported that she has had a hearing involving her commitment several months ago and after reviewing the information, it appears that the judge is ruling in her favor. Ms. Argoe will continue pursuing divorce with her estranged husband and making plans to move on in her life. I will continue working with her in a supportive fashion and I will see her in 1 week. _____ Frank L. Quinn, PhD FLQ/tab 01/16/2007

01/17/2007 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady arrived a few minutes late due to a mix-up on the part of our step. This flustered her a little because she was adamant about always trying to be on time for appointments and has always arrived early. However, she reports that things are going quite well. She is still working at Cracker Barrel. She is still managing her own affairs. She is still actively involved in some of her legal issues and appears to be doing quite well. I will see her in 1 week. _____ Frank L. Quinn, PhD FLQ/tab 01/22/2007

01/24/2007 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady continues to make excellent progress. Even though she still has periods of depression, she has not exhibited any symptoms of mania lately. School appears to be going well for her. She is back in a relationship that seems more supportive at this point and she seems slightly happier. I will continue working with her in a supportive fashion and see her in 1 week. _____

Frank L. Quinn, PhD FLQ/tab 01/30/2007

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01/31/2007 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady is doing exceptionally well. Affect and mood are congruent and appropriate. She appears to be handling all of her affairs very rationally. She continues to work part-time and, as she says it, see doctors and lawyers. I will continue working with her in a supportive fashion and I will see her in 1 week. _____ Frank L. Quinn, PhD
FLQ/tab 02/05/2007

02/07/2007 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady was quite chipper. Her affect and mood are appropriate and congruent. She does not appear to be under any undue emotional distress other than the ongoing issues surrounding her divorce. She continues to handle her affairs quite well and is still working part-time at Cracker Barrel. I will see her again in 1 week. _____ Frank L. Quinn, PhD
FLQ/tab 02/11/2007

02/14/2007 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. She continues to do exceptionally well. Affect and mood are appropriate and congruent. She is clear in thought and speech. She appears to be handling all of her daily living issues quite well. In general, she is taking quite good care of herself. I will see her again in 1 week. _____ Frank L. Quinn, PhD
FLQ/tab 02/21/2007

02/21/2007 Martha L. Argoe, Chart # 465155. Mr. Argoe was seen in our office on today's date for a 1-hour session. She remains bright, alert, oriented and capable. During this session, she was able to outline several things that she has recently done to take care of herself. She expressed some concern over some expenditures that she has had. She has a rather large vet bill for her cat and some other necessary expenses. We discussed this at length and it appears that she has thought all of this through and is not wasting her money. She is quite concerned that other people may think that, though, and appears to be very cautious in spending money. I will continue working with her in a supportive fashion and see her in 1 week.
_____ Frank L. Quinn, PhD
FLQ/tab 02/25/2007

02/28/2007 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady continues to make excellent progress. She appears to be handling all of her daily chores and finances with no difficulty. She always presents in a cheerful mood and in good spirits. She is quite eager to move on with her life. She continues to work part-time at the Cracker Barrel. I will see her again in approximately 1 week.

_____ Frank L. Quinn, PhD
FLQ/tab 03/04/2007

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03/07/2007 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. Ms. Argoe continues to do well. She is somewhat concerned about the recent offer for settlement her husband has made that appears to be one-sided. She does not feel that she can trust him to follow through even with his suggestions, so she will be seeking further advice from her attorney. I will continue working with her in a supportive fashion and see her in 1 week.

Frank L. Quinn, PhD FLQ/tab 03/13/2007

3/14/07, Martha L. Argoe: Chart #465155 Ms. Argoe was seen in our office on today's date for a one hour session. This lady continues to do quite well. She has become much more assertive. She is taking much better care of herself. She still presents without any significant mental health issues or pathology. I will continue working with her in a supportive fashion and see her in one week. Frank L. Quinn, Ph.D. FLQ:smc 3/21

3/21/07, Martha L. Argoe: Chart #465155 Ms. Argoe was seen in our office on today's date for a one hour session. This lady continues to show improvement. Affect and mood are appropriate and congruent. She appeared oriented x4 and in general quite capable. She continues to work part-time and to manage her finances with no problems. At this point she does not appear stressed out as she has been in the past, she says primarily because she is free of the domination of her husband. I will continue working with her in a supportive fashion and I will see her in one week. Frank L. Quinn, Ph.D. FLQ:smc 3/28

3/28/07, Martha L. Argoe: Chart #465155 Ms. Argoe was seen in our office on today's date for a one hour session. This lady continues to present an excellent mood, affect, and appearance. We completed a Mini Mental Status Examination today and her score was a perfect 30 out of 30. I will see her in approximately one week and she will be seeing her attorney later today. Frank L. Quinn, Ph.D. FLQ:smc 4/04

04/04/2007 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady was just delightful today. Affect and mood were bright. She is oriented times four. She appears to be dealing with all the stressors in her life with dignity, grace and élan and at this point is feeling that she is in charge of her own destiny and responsible for herself only for the 1st time in a long time. I will continue working with her in a supportive fashion and see her in 1 week. Frank L. Quinn, PhD FLQ/tab 04/11/2007

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04/11/2007 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. Ms. Argoe continues to demonstrate her ability to manage her own affairs and to live a comfortable and capable life. She currently still works at the Cracker Barrel, pays all of her own bills and is a delight to with. I will continue working with her and see her in 1 week. Frank L. Quinn, PhD FLQ/tab 04/15/2007

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04/18/2007 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady continues to do well. She functions at an extremely high level for someone who supposedly is incapable of managing her own affairs. She has been able to work, maintain relationships, communicate, handle her finances and, in general, lead a normal, healthy, happy life. I will continue working with her in a supportive fashion and see her in 1 week.

Frank L. Quinn, PhD FLQ/tab 04/23/2007

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04/25/2007 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady continues to do extremely well. Affect and mood are appropriate. Additionally, her cognition appears clear, her judgment intact and her insight good. We spoke at length about some of her treatment in a psychiatric hospital and how she felt like her rights were abused. At this point, she seems quite capable of taking care of herself and her finances. I will see her again in 1 week.

Frank L. Quinn, PhD FLQ/tab 04/30/2007

05/02/2007 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady continues to present in a very healthy and happy fashion. We did some brief orientation questions today and she is oriented by 4. Her thoughts are clear. Her speech is concise. She appears to have good insight and judgment and is handling her daily matters with no problems. She continues to work and attend church, but has chosen not to socialize very much beyond that, at this point. I will continue working with her in a supportive fashion and see her in 1 week.

Frank L. Quinn, PhD FLQ/tab 05/08/2007

05/09/2007 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. Ms. Argoe continues to present as an oriented and well adjusted individual. Her affect and mood are appropriate. Her speech is well in the normal ranges. She demonstrates no symptoms of psychosis and is quite astute in managing her own affairs. I will continue working with her in a supportive fashion and see her in 1 week.

Frank L. Quinn, PhD FLQ/tab 05/16/2007

05/16/2007 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. Ms. Argoe continues to present as a lively and very interesting lady. Her affect and mood are appropriate and congruent. Her thought processes appear clear and concrete. However, she is able to demonstrate excellent abstract thought processes, also. Her judgment and insight appear both appropriate and intact. Ms. Argoe continues to manage all of her own financial affairs and appears to be doing quite well. I will continue working with her in a supportive fashion and see her in 1 week.

Frank L. Quinn, PhD FLQ/tab 05/23/2007

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05/23/2007 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady continues to make good progress. Today she was somewhat upset that her cat has been ill and has required some large expenditures and she is afraid that her husband will attempt to use this as a sign that she does not know how to deal with her money. We spoke at length about how important this cat was in her life and how her expenditures were actually quite rational given the situation. Ms. Argoe continues to work at Cracker Barrel and to manage all of her own affairs. I will continue to work with her in a supportive fashion and see her in 1 week. _____ Frank L. Quinn, PhD FLQ/tab 05/25/2007

05/30/2007 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. She reports that her cat has made a recent recover and although she is concerned that his treatment was somewhat expensive, the relationship between she and the cat warrants this expense and she is gratified to have his companionship once more. Ms. Argoe continues to work at the Cracker Barrel and to manage her own personal affairs. I will continue working with her in a supportive fashion and see her in 1 week. _____ Frank L. Quinn, PhD FLQ/tab 06/05/2007

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06/06/2007 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady continues to do quite well. She continues to work at Cracker Barrel, manage her own finances and to help with her legal situation. She was excited today that her attorney has filed a motion against the hospital that she was held against her will for almost a month. She seems to understand fully all of the ramifications of this. I will continue working with her in a supportive fashion and see her in 1 week. _____ Frank L. Quinn, PhD FLQ/tab 06/13/2007

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06/13/2007 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady continues to function quite well. She continues to manage her own affairs. She continues to work part time and she continues to express her happiness that she has been liberated from the oppression of her husband. I will continue working with her in a supportive fashion and see her in 1 week. _____ Frank L. Quinn, PhD FLQ/tab 06/18/2007

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06/20/2007 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. Ms. Argoe appears once more to be doing quite well. Affect and mood are normal, appropriate and congruent. She also continues to handle all of her financial affairs and continues to work part time at Cracker Barrel. Part of this session was spent discussing a recent court hearing, during which she was able to conduct herself with grace and dignity. I will continue working with Ms. Argoe in a supportive fashion and see her in 1 week. _____ Frank L. Quinn, PhD FLQ/tab 06/27/2007

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06/27/2007 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. She was quite chipper, alert, task oriented and focused. Most of this session was spent reviewing her week. It appears that she is continuing to work at the Cracker Barrel, handle her own financial affairs and deal with all the legal problems that she has with a great deal of ease and insight. I will continue working with her in a supportive fashion and see her in 1 week. _____ Frank L. Quinn, PhD FLQ/tab 06/30/2007

08/01/2007 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady continues to demonstrate an ability to manage her own life including her finances and her own legal affairs. She reports that the depositions have started in one of her legal suits and that she and her husband have reached a divorce agreement. I will continue working with her in a supportive fashion and see her in 1 week. _____ Frank L. Quinn, PhD FLQ/tab 08/07/2007

09/05/2007 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady continues to present in a very bright and clear manner. Her affect is both appropriate and congruent with her mood. She presented no overt cognitive difficulties. A mini mental status exam was conducted and she scored a perfect 30 out of 30. At this point, Ms. Argoe is still dealing with numerous legal and financial issues, but appears to be managing all this by herself and doing it quite well. I will continue working with her in a supportive fashion and I will see her in several weeks. _____ Frank L. Quinn, PhD FLQ/tab 09/11/2007

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10/03/2007 Martha L. Argoe, Chart # 465155. Ms. Argoe was seen in our office on today's date for a 1-hour session. This lady continues to do quite well. Her affect and mood are appropriate and congruent. Cognitively, she is clear of any delusions or psychotic symptoms. She denies any manic or depressive symptoms and is currently quite self sufficient. She continues to have numerous legal stressors and is dealing with these quite well. I will continue to work with her in a supportive fashion and see her in several weeks. _____ Frank L. Quinn, PhD FLQ/tab 10/09/2007

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