

THE STATE OF SOUTH CAROLINA
In the South Carolina Court of Appeals

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APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

MAR 14 2016

SC Court of Appeals

The Honorable Deadra L. Jefferson
The Honorable R. Markley Dennis, Jr.
Charleston County

Trial Court Case No.: 2011-CP-10-08313
2012-CP-10-02867

Appellate Case No.: 2015-001463

Clair Craver Johnson Appellant

v.

John Roberts, M.D. Respondent

And

Clair Craver Johnson Appellant

v.

Medical University of South Carolina Respondent

RECORD ON APPEAL
Volume II of II

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STATE OF SOUTH CAROLINA
IN THE COURT OF COMMON PLEAS
NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON

CLAIR CRAVER JOHNSON,

Plaintiff,

vs.

Case No. 2012-CP-10-2867

JOHN ROBERTS, M.D.,

Defendant.

CLAIR CRAVER JOHNSON,

Plaintiff,

vs.

Case No. 2011-CP-10-8318

MEDICAL UNIVERSITY OF SOUTH CAROLINA,

Defendant.

DEPOSITION OF HAROLD B. BURSZTAJN, M.D.

Cambridge, Massachusetts

Tuesday, October 29, 2013

11:14 a.m.

MAGNA 
LEGAL SERVICES

0368

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1 Deposition of Harold B. Bursztajn, M.D., held at:
2 Harvard University Science Center
3 1 Oxford Street
4 Cambridge, Massachusetts 02138
5
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7

8 Pursuant to agreement, before Victoria S.
9 Reade, Professional Reporter and Notary Public in
10 and for the Commonwealth of Massachusetts
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C O N T E N T S

2

EXAMINATION OF: Harold B. Bursztajn, M.D.

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by Mr. Early

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by Mr. Scott

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

2 MR. EARLY: Doctor, you understand
3 you're still under oath?

4 THE WITNESS: Yes.

5 DIRECT EXAMINATION BY MR. EARLY:

6 Q. Dr. Bursztajn again, Will Early
7 representing MUSC. I am here in Mount Pleasant,
8 South Carolina and you're in either Cambridge or
9 Boston still; is that correct?

10 A. Yes. You should come up, see the Red
11 Sox.

12 Q. Doctor, since I think we last spoke,
13 today is October 30th, I think it was either
14 sometime in July or August when we stopped your
15 deposition.

16 Have you had any discussion with
17 anyone regarding your testimony or this case
18 since that time?

19 A. No.

20 Q. Have you ever reviewed any additional
21 material since we last convened for your
22 deposition?

23 A. Well, I continued to review the
24 literature and then I sent you a specific piece

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1 of law and an order from the South Carolina
2 Department of Mental Health that I focused on and
3 then I just went back over the case file in
4 detail.

5 Q. I understand.

6 A. I'm sorry, also my own deposition, of
7 course, a transcript of my deposition.

8 Q. You did review your transcription?

9 A. Yes, I did. Yes.

10 Q. And believe when we last and I was
11 looking at some of that last night and into this
12 morning, that as far as the liability, and I am
13 going to go through your testing here shortly,
14 but as far as the liability portion, you had
15 indicated to me I think that you had told me all
16 of the areas in which you believed that the
17 Medical University of South Carolina deviated in
18 the standard of care in their treatment of the
19 plaintiff in case already, have you not?

20 A. I believe I have.

21 Q. And if anything, again, comes up as I
22 stated last time between now and trial and you
23 feel you have another area where you'd like to
24 elaborate, would you please let Mr. Ravenel know

1 that so that he can contact me?

2 A. I will.

3 Q. Thank you, sir. And let's look at, if
4 you will, for lack of a better word, your
5 testing, Dr. Bursztajn.

6 Before we go into that, it's my
7 understanding based upon your testimony last time
8 that the areas or ways that you believe Miss
9 Johnson has suffered as a result of what you
10 believe to be malpractice in this case are that
11 she has post-traumatic stress disorder and memory
12 loss; is that a fair statement?

13 A. Well, she has memory loss and brain
14 damage as well as post-traumatic stress disorder,
15 yes.

16 Q. And so are you going to opine that she
17 has any vision problems as a result of
18 electroconvulsive therapy?

19 A. No specific visual problems as a
20 result of ECT, no, that's not my opinion.

21 Q. And as far as you used the word brain
22 damage, can you qualify that and be any more
23 specific than the broad term brain damage?

24 A. Well, when you have permanent fixed

1 brain loss, when you have the loss of a variety
2 of executive functions which is permanent, that's
3 brain damage.

4 You don't have loss of brain function
5 which is permanent and fixed without having brain
6 damage. Psychiatry is not brainless.

7 Q. Is there something specific or any
8 more narrow that you can make it for or me or you
9 just use the word brain damage?

10 A. I think that covers it.

11 Q. And the basis of that diagnosis is
12 anything other than your test of her or is it
13 anything else?

14 A. It's the reports of her family about
15 the changes which occurred over time. It's her
16 own complaints found in the medical records about
17 her memory problems, the changes in memory and
18 executive function that are evidenced over time,
19 and there are corroborated both by her parents
20 and her brother, and by review of her history.

21 That history indicates that before
22 2003 she had been able to even in the midst of
23 the mental illness that she does have, which is
24 bipolar illness, and even subsequent to a

1 youthful period of drug and alcohol use she was
2 able to go ahead and complete college, she was
3 able to have a job and to function like a social
4 human being, and now she doesn't have the memory,
5 doesn't have the autobiographical memory, doesn't
6 have the ability to integrate memorizes, doesn't
7 have the executive functions which depend on the
8 ability to integrate memories that are necessary
9 for her to hold a job, for her to function as a
10 relatively independent social human being.

11 Q. Do you base your opinion with regards
12 to the brain damage based anything to do with any
13 CT scans or any other imaging?

14 A. The CT scans are consistent, the
15 changes with the CT scan are consistent with
16 brain damage, but they don't form the foundation
17 for my opinion.

18 Her history and her presentation and
19 the medical records, the collaborative
20 information, those are foundational stones for my
21 opinion.

22 Q. Dr. Bursztajn, I know you have done a
23 lot of testing. I think I have all those tests.
24 Mr. Ravenel provided those to us.

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1 Is there a document where you
2 summarize the testing itself that we can go
3 through, and if so, can you point it to me?

4 A. Yes. If you look at my report of
5 April 1st 2011 and specifically if you look at,
6 it's Page 10, psychological testing and
7 self-reporting instruments, it's 494 from the way
8 it's marked.

9 Q. Give me just a second to make sure
10 I've got it so we can go through it. I didn't
11 bring yours in a Bates number sequential fashion
12 so can you tell me the title of the document one
13 more time, the first one?

14 A. Yes. The title of it is my April 1st
15 2011 report. It says draft on it.

16 Q. Got it. And you had indicated another
17 document outlined your opinions with regard to
18 her testing, what other document did you say?

19 A. No. That's in the document on Page 10
20 of the document if you look at Page 10.

21 Q. Okay.

22 A. And it begins subsection B as it
23 Boston.

24 Q. Okay. I guess the previous section if

1 you go back to Page 8 talks about your
2 examination and observations and then would
3 Subsection B be the results of the tests
4 themselves?

5 A. Of the tests and the self-report
6 instruments, yes.

7 Q. All right. What is PAI, Personality
8 Assessment Inventory, can you tell me what that
9 is?

10 A. A personality assessment inventory is
11 a standardized test where the respondent's
12 answers are compared to a large sample of people
13 to be able to go ahead and formulate, first of
14 all, whether they were faking, exaggerating or
15 malingering their reported symptomatology.

16 Secondly, to see what other underlying
17 major mental illness or other forms of suffering
18 the person may be experiencing.

19 The test itself even though I
20 administered it, I sent away to be blindly
21 compared to a computer algorithm to a very large
22 sample of people.

23 So this is a way of checking to make
24 sure that just because I am retained by one side

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1 my interpretation does not, therefore, is not
2 therefore biased.

3 So it's compared to a large group of
4 people and to allow the possibility of faking,
5 exaggerating or malingering and also to
6 characterize what forms of suffering the patient
7 may be experiencing in the mental illness
8 arena.

9 Q. What, if anything, did the PAI test
10 show that you performed on Ms. Johnson?

11 A. Well, the findings and I am looking
12 now on Page 11, actually the bottom of Page 10 to
13 Page 11, she answered in a reasonably forthright
14 manner and did not present an unrealistic or
15 inaccurate impression that was either more
16 negative or more positive than the clinical
17 picture would warrant.

18 Therefore, and this is vital, she was
19 not faking, exaggerating or malingering as far as
20 her reports of her symptomatology and
21 impairments.

22 Q. How do you know that? Just in -- give
23 me the basis of that, what do you compare it to,
24 how did you make that determination?

1 A. Well, first of all, I did not make
2 this determination. This determination was made
3 by -- it's consistent with my own determination
4 but the determination I just read to you was not
5 made by me, it was made by a computer protocol
6 which compared her responses to the responses of
7 a large number of people some of whom were
8 faking, malingering and exaggerating.

9 And her responses are not those of
10 someone who is faking, exaggerating or
11 malingering symptomatology.

12 They were also consistent with my own
13 observations during the examination, and they
14 were consistent with her pattern of self-reports
15 which unlike the self-reports of people who fake
16 or exaggerate symptomatology tend to be nuanced
17 and focused and not basically consistent with any
18 pattern of faking, exaggerating or malingering.

19 Similarly, if anything during my
20 examination when I was observing her she had more
21 impairments than she was actually was able to
22 communicate when she was talking about those
23 herself.

24 But basically the impairments which I

1 observed during my examination were consistent
2 with the impairments that she reported in the
3 self-report instruments both which are the NFI
4 and also her own cognitive history checklists
5 that she proceeded to fill out and also are
6 consistent with reports of others including those
7 of her parents.

8 So when we put all this together we
9 have at least three different ways of checking to
10 make sure that she's not faking, exaggerating or
11 malingering.

12 The testing -- actually, four
13 different ways: The testing, the self-report
14 instruments, my observations, the observations of
15 collaborative witnesses, and then on top of that
16 we have a fifth way which is the medical record
17 itself which nowhere notes that she is faking,
18 exaggerating or malingering, so she's not.

19 Q. Other than the malingering you also
20 indicated the PAI showed whether or not she would
21 be suffering from some mental illness; is that
22 right?

23 A. Yes. It gives a differential
24 diagnosis to consider, and the diagnostic

1 considerations it raised were a chronic
2 depressive disorder ruling out a major depressive
3 disorder.

4 There was a question to rule out,
5 which can be ruled out in her case, of a
6 personality disorder not otherwise specified.

7 And that was based on the fact that in
8 her youth she used drugs and alcohol, which would
9 be consistent with her having dissocial features,
10 although, again, overall that particular
11 differential is much lower, and it's much more
12 consistent with the kind of profile in terms of
13 the co-efficient fit which occurs in the
14 post-traumatic spectrum and also in bipolar
15 disorder.

16 Q. Do you believe she had both the
17 chronic depressive disorder and the personality
18 disorder prior to being treated at MUSC?

19 A. I believe, first of all, that she did
20 not have a personality disorder, and she doesn't
21 have a personality disorder at this point.

22 What she does have is a post-traumatic
23 disorder, post-traumatic stress disorder in the
24 context of a bipolar disorder.

1 Prior to receiving involuntary ECT at
2 MUSC, I don't believe that she had a
3 post-traumatic component to her disorder, and I
4 don't believe that she had the, although she may
5 have had a vulnerability to brain damage, there
6 was not the kind of fundamental impairment of
7 memory executive function which she has today
8 which is consistent with having brain damage from
9 ECT.

10 Q. I want to take these one by one,
11 Dr. Bursztajn.

12 Are you saying that your decisions
13 post-traumatic stress disorder PIA test or is it
14 some other test?

15 A. It's not based simply on this test,
16 but this test is consistent with my diagnosis of
17 post-traumatic stress disorder, her natural
18 history, my observations and my examination and
19 the reports of people who have known her over
20 time.

21 Q. You don't believe she has a
22 personality disorder even at this time,
23 correct?

24 A. I don't believe she has a personality

1 disorder. What she has is a chronic
2 post-traumatic stress disorder, brain damage and
3 bipolar disorder.

4 Q. And her chronic depressive disorder, I
5 believe you used that term earlier, or bipolar
6 disorder predated any treatment at MUSC, you
7 agree with that?

8 A. Her bipolar disorder predated it,
9 however, it was episodic rather than -- it was
10 episodic and it repeated itself, but there was
11 not a chronic depressive component in between the
12 major depressive episodes and the manic episodes.

13 Now there is a chronic a depressive
14 component which is consistent with a kind of
15 demobilization that I see when patients have
16 post-traumatic stress disorder.

17 Q. I am no sure I am follow you. Chronic
18 depressive disorder, you don't agree that she had
19 that prior that 2003?

20 A. I don't believe that she had a chronic
21 persistent post-traumatic complication which is
22 chronic demobilization and depression prior to
23 the involuntary ECT in 2003 which went through to
24 2005 and the ECT itself continued through to

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1 2008, no, I don't think so.

2 Q. The next page, I am looking Page 12
3 deals with your self-reporting instruments?

4 A. Yes.

5 Q. Tell me just in lay terms what that
6 is?

7 A. Well, it's a variety of different
8 check lists including the Davidson Trauma Scale,
9 and Behavioral Functional Inventory, the
10 Dissociative Experience Scale and five different
11 cognitive symptom checklists, one for attention,
12 one for memory, one for visual processes, one for
13 receptive languages, one for expressive language
14 and one for executive functions.

15 Q. I am going through those tests, but
16 can you tell me broadly what, if anything, those
17 self-reporting instruments show in your
18 opinion?

19 A. Yes. On the Davidson Trauma Scale,
20 her avoidance and numbing is much higher than the
21 intrusion.

22 That's, again, consistent with someone
23 whose been both traumatized and has memory loss.

24 People who don't have memory loss who

1 have been traumatized have much more intrusion
2 and less of an avoidance numbing response.

3 On the Neurobehavioral functional
4 Inventory she listed some impairments, however,
5 overall she rated her impairments only as being
6 slightly more severe than her mother did but
7 slightly less severe than her friend, Anna Maria
8 did and much less severe than her father did.

9 So overall she sees herself as being
10 less impaired than the people how know her and
11 love here, which, again, is inconsistent with
12 someone who is faking or exaggerating or
13 malingering or simply making a case.

14 Where she reported problems they were
15 mainly in areas of vision which were primarily
16 related to her chronic dystrophy not related to
17 the ECT but with one or two exceptions of
18 integration, but also memory.

19 She also reported a few up obsessions.
20 She did not list any indicators which would be
21 consistent with ongoing disturbance such as
22 epilepsy, so we know that's not the cause of her
23 disorder.

24 She tended to minimize the extend to

1 which said had dissociation but the exceptions
2 were interested because they are were primarily
3 in the area of memory and having no memory from
4 important events in her life and finding that she
5 had done or created things for which she had no
6 memory.

7 Again, this is not someone who
8 randomly is just trying to exaggerate here. It
9 was interesting when there were more specific
10 questions she did report specific deficits in all
11 the areas covered by cognitive symptom checklist,
12 again, consistent with someone who if anything
13 minimizing the amount of deficits she has.

14 When you ask more specific questions,
15 you get more reliable answers. So we can through
16 each of these such as attention and concentration
17 if you just give me a moment, I can look at
18 those.

19 Q. If you can while you're doing that,
20 Doctor, just tell me which test you're pointing
21 to so I can look at it with you, if you would.

22 A. Okay, will do. So I am looking now at
23 this cognitive symptom checklists and we'll begin
24 the, let's see, the first one is

1 attention/concentration.

2 So we can begin with

3 attention/concentration, are you with me?

4 Q. Yes, I am.

5 A. Okay.

6 Q. And just so I understand, this is part
7 of the Davidson Trauma Scale?

8 A. This is separate. These five
9 self-report structured questionnaires are
10 separate from all of those. That's constitutes
11 what's called cognitive symptom checklists and
12 the first one we have is the
13 attention/concentration one, but there is five of
14 them.

15 Q. Okay. What, if anything, does the CSC
16 attention/concentration checklist that -- well,
17 first of all, did she fill this form out
18 herself?

19 A. Yes, she did.

20 Q. So these would be subjective answers
21 that she gave based upon these questions,
22 correct?

23 A. Yes, but, again, objective to the
24 extent that they were corroborated by my own

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1 observations as well as the observations of those
2 people who were closest to her.

3 So they were not simply her subjective
4 answers, but they were also interobjective which
5 makes them much more objective than simply
6 individually subjective.

7 Q. I understand. So, for example, on
8 Page 2 she indicated that she is not experiencing
9 any panic or fear on the date when you tested her
10 which would have been January 31st of 2011; is
11 that what that's saying essentially?

12 A. That is what that is saying, and
13 again, that would be consistent with minimization
14 because when she was talking about the ECT which
15 I saw as a good deal of someone who is very
16 frightened almost horrified.

17 So she tends to minimize how
18 frightened she really is rather than exaggerate
19 her how frightened she really is.

20 It isn't an inconsistency, but it's an
21 inconsistency between the direction of
22 minimization rather than exaggeration.

23 Q. She testified that didn't remember the
24 involuntary ECT treatments, correct?

1 A. Precisely, but when you ask her to try
2 and remember, that's when she gets very
3 frightened and that's what she begins to -- so
4 when she tries to remember, when we try and get
5 into details, that's when she begins to get very
6 hyperaroused and fidgety, but she doesn't see
7 that herself.

8 She will also alternate and then she
9 will go into a numbing state, someone who is
10 basically spaced out disassociated and she says I
11 just don't remember, but what you see first is
12 the fear which she herself overlooks, but you can
13 certainly see it when you try to question her
14 about it.

15 Q. I stopped you, but go ahead and tell
16 me if you would what, if anything, the
17 attention/concentration component of this CSC
18 shows, if anything?

19 A. Yes. She has a great deal of
20 difficulty focusing and she does get easily
21 distracted by any loud noises, which, again, is
22 both consistent with a post-traumatic component
23 it's also consistent with people who have been
24 shell shocked or brain damaged in a variety of

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1 ways.

2 Moving on to Page 3, again, she in
3 terms of sustained concentration she does have
4 difficultly staying on task and being focused.
5 She very easily will space out.

6 Moving onto the next page now focusing
7 on Number 9 and Number 10, she says that she does
8 not have difficulty shifting concentration from
9 one important thing to other things, and by my
10 observation she did have difficultly making
11 shifts of information, not all the way throughout
12 but when she was feeling frightened.

13 She certainly has difficulty keeping
14 track of more than one thing at a time in a
15 fundamental way, although, again, I think she
16 does to some extent tend to minimum that based on
17 my observations and based on the observations of
18 other people.

19 Q. And Doctor, is this -- I am sorry, you
20 had not finished with your answer, had you?

21 A. Well, I was going to ask you if you
22 wanted me to move on to the executive functions
23 which is the next chapter or we can stay with
24 this one, it's up to you.

1 Q. Well, I do have a few more questions
2 about this particular test.

3 Is this test or a similar test given
4 to patients or people in the assistance of
5 diagnosing folks with attention deficit
6 disorder?

7 A. It can be. It can be given to people
8 who have attention deficit disorder,
9 post-traumatic stress disorder and any other
10 disorders, brain damage or any other disorders of
11 attention and concentration. It's a general
12 instrument rather than an exclusive instrument.

13 Q. Were the findings of this particular
14 this attention/concentration checklist that
15 Ms. Johnson gave you on January 31, 2011 consistent
16 with a person with ADHD?

17 A. In and of itself possibly but not
18 likely because people who have ADHD will, for
19 example, will tend to check off -- it's less
20 spotty.

21 For example, they will go ahead and
22 tend to check off focusing on the test when in a
23 large area or staying focused in places where
24 there are many sights and sounds, but it can be.

1 But itself it's not likely, but it can
2 be. What makes it unlikely is the overall
3 pattern, the other components of both this
4 instrument and the other facts that we have at
5 hand.

6 So it is consistent with some forms of
7 ADHD, possibly but not likely but possibly.
8 Again, it's not consistent when taken in
9 context.

10 Q. Let's move on to the executive
11 function portion of the test. Is that also
12 something that she did on her own in answering
13 those questions?

14 A. Yes.

15 Q. What, if anything, is executive
16 function just for a lay understanding is how is
17 that different from the attention portion of the
18 CSC that you just discussed?

19 A. Grossly speaking and forgive me for
20 being so general, the attention portion, the
21 attention/concentration portion focuses on focus
22 itself, that's what it's about.

23 Executive function are about judgment
24 and decision making. Now, that's a general

1 description, but a fair one.

2 Is that clear? Am I communicating
3 that clearly?

4 Q. Yes, sir, I think I understand that.
5 I was trying to look at Page 13 of your report in
6 conjunction with the executive function test and
7 can you tell me what, if anything, the executive
8 function subjective data that Ms. Johnson gave
9 you on January 31st 2011 shows, if anything?

10 A. Well, the findings that she reports
11 are first of all, inconsistent with someone who
12 is exaggerating or faking or malingering because
13 they're quite selective.

14 If anything they're less than what
15 I've observed and what her family and friends
16 have observed.

17 At the same time they are consistent
18 with some problems that she has in her reaction
19 time. She has major problems in initiating and
20 following through, so that's a deep area of
21 weakness.

22 I believe has she more problems in
23 self-correction even though she didn't check any
24 problems with self-correction. I observed

1 problems with self-correction when I was
2 examining her.

3 Again, she's checked off some problems
4 in mental flexibility. I believe those problems
5 tend to be more pervasive than the ones she
6 simply checked off, at least from what I observed
7 and from what other people have said about her.

8 She does have problems with planning.
9 She is aware of major problems in sequencing and
10 completing other tasks, an activity in sequence.

11 She has problems in problem solving.
12 If you give her a problem of any complexity she
13 will not know where to look for information. She
14 is quite disorganized so organizationally she is
15 not able to go ahead and organize and put things
16 together.

17 She has problems in reasoning. For
18 example, I observed and she checked off she could
19 not apply a general rule to a specific case, to a
20 specific example and by the token she couldn't go
21 in the other direction, go from a few specific
22 cases to a more general rule, so she has problems
23 going up and down from the particular to the
24 general and the from the general to the

1 particular.

2 She tends to focus only on one part of
3 a problem. If there is an elephant, she will go
4 ahead and see its trunk and call it a snake
5 basically so she has problems focusing on the
6 part as opposed to being able to see it in
7 context to be able to see it as a whole.

8 So together that makes it very
9 difficult for her to engage in any kind of
10 complex problem solving where you can't lose the
11 forest through the trees, so to speak.

12 Q. Is there anything else about the
13 executive function test that you have opinions on
14 that you haven't just stated to me?

15 A. I think that's basically covers it.
16 Again, having gone through each one in
17 particular, but they were consistent with my
18 observations.

19 Q. And just move onto the language
20 portion of this CSC.

21 A. I am sorry, I interrupted you. Please
22 go on.

23 Q. Well, if you wanted to finish one of
24 your answers, please do.

1 A. I was just going to say when you said
2 moving on to the language portion I would say
3 that overall except with expressive language she
4 is much more intact linguistically, so she sounds
5 better than she really is and that's evident in
6 the language portion.

7 So what we have is someone who has had
8 frontal lobe damage and some parietal lobe damage
9 basically.

10 Q. What was the last one?

11 A. Parietal, frontal and parietal lobe
12 damage, but basically her language function
13 compared to certainly compared to her executive
14 function and her attention is more intact.

15 So this is a picture of a patient who
16 can talk a good game to some extent and she may
17 appear to much more functional than she really
18 is.

19 Q. What is the frontal lobe affect, and
20 that my abe a lot of things, but can you tell me
21 what it affects?

22 A. Well, it primarily affects executive
23 functions and it also integrates so that together
24 way the parietal temporal lobe it -- even though

1 the parietal temporal lobe is more focused on
2 memorizes, the frontal lobe translates memories
3 into decisions.

4 Q. The language test, is there anything
5 about the language test that forms the basis of
6 any of your opinions in this case, and
7 specifically I am referring to the one that she
8 did herself?

9 A. Again, it's consistent with someone
10 who is no faking, exaggerating or malingering her
11 symptoms of brain damage.

12 Q. Let's move onto to, I guess the next
13 would be the memory test?

14 A. Yes.

15 Q. And it looks to me on the first page
16 that she didn't check any problems with her
17 memory on those first two areas; do you agree
18 with that?

19 A. Yes.

20 Q. And do you believe she's not telling
21 the truth when she says she's not having problems
22 with any of these areas?

23 A. Well, I think she's trying her best to
24 tell the truth, but if you notice, for example,

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1 in Number 2 about cooking, difficultly
2 remembering while cooking, she says she doesn't
3 cook.

4 If you don't cook, you don't have
5 difficulties remembering you're cooking, right?

6 So she's tried to adapt to her
7 disability and impairment by avoiding those areas
8 where she is disabled.

9 So again, it's an underestimate based
10 on the fact that she is trying to cope with her
11 deficits.

12 Q. But also in fairness she has no
13 problems regularly shopping for groceries or
14 buying items on her grocery list, correct?

15 A. Again, that's what she says which from
16 what, again, have seen in other areas may be an
17 underestimate because she tends to move in the
18 direction of underestimating her deficits rather
19 than overestimating them or exaggerating her
20 deficits. She's trying to cope as best as she
21 can by avoiding those activities where she's
22 impaired

23 Q. Moving on to Page 2, Dr. Bursztajn, I
24 guess just for the sake of this next question the

1 following three pages has all of the memory test
2 what, if anything, does her subjective answers
3 show in you and does this affect your opinion in
4 any way?

5 A. Well, she does report, although she
6 may be underreporting, significant memory
7 deficits such as routines of daily living, money
8 management, spacial relationships.

9 It seems like she is doing her best to
10 cope with these deficits, but I think to some
11 extent these certainly are not consistent with
12 faking, exaggerating or malingering.

13 They are consistent with someone who
14 is trying to adapt to her deficits and maybe
15 overlooking some of her memory deficit at the
16 same time.

17 Q. Let's go to the visual processes of
18 the CSC.

19 A. Yes.

20 Q. You are aware she has been diagnosed
21 with cone rod dystrophy by the Stromhei
22 (ph)Clinic?

23 A. Yes.

24 Q. And are you aware that cone rod

1 dystrophy can be caused by medications taken
2 over time?

3 A. Yes.

4 Q. And you're aware that Ms. Johnson has,
5 in fact, had mental health medications prescribed
6 to her as far back as her teens?

7 A. Yes.

8 Q. And what, if anything, does this
9 visual processes checklist or how does it bear on
10 your opinions in anyway in this case?

11 A. Well, what's interesting about it is
12 obviously the cone rod dystrophy can complicate
13 analyzing this particular section, but what I
14 found interesting is if you look at Number 8,
15 mental imagery.

16 Q. Yes.

17 A. Now, mental imagery is not dependent
18 on cones or rods. It's not depending on the
19 peripheral visual system.

20 It's depending on central processes of
21 integration and to the extent that connections
22 have been disrupted for her between her frontal
23 lobes and parietal lobes with the rest of the
24 brain and the occipital lobes she reports a major

1 deficit in her mental imagery.

2 Now, that's not the result of cone rod
3 dystrophy. So I think certainly there and also
4 that and Number 10, organization, would be the
5 result of the brain damage that she suffered from
6 ECT rather than cone rod dystrophy.

7 Q. Why is that portion in the visual
8 process exam checklist?

9 A. Because mental imagery is a kind of
10 visualization, but it is an internal
11 visualization as opposed to an external
12 visualization.

13 The same is true of organizing. You
14 close your eyes and you remember something,
15 right, you remember something pleasant, you
16 remember someone that you love, but when she
17 closes her eyes her memory is disrupted she
18 cannot remember and she cannot visualize someone
19 that she loves or someone that loves her or a
20 pleasant experience in her life.

21 The problem with this, you see, is
22 that it points to fundamental disruption of what
23 I call and what's called autobiographical memory.

24 If you can't imagine, if you can't

1 remember enough to imagine, that's a significant
2 deficit especially for someone who has already
3 has bipolar disorder because for someone, and
4 it's huge complication in the treatment of
5 someone with bipolar disorder because someone who
6 has bipolar disorder needs to remember who loves
7 her, who she loves, and if she can't remember
8 enough to be able to visualize them, then she is
9 going to get overwhelmed by emotions and becomes
10 hypersensitive to stress.

11 Am I explaining it in a way that is or
12 am I just making it confusing?

13 Q. No, you're answering fine. Are you
14 aware of the extent of her vision problems as we
15 sit here today?

16 A. I am not aware of the exact extent of
17 her vision problems, but I'm assuming she has
18 some pretty substantial vision problems.

19 Q. Would you agree with me that
20 substantial vision problems apart from blindness
21 can contribute to stress?

22 A. It can contribute to stress. You're
23 making a very good point, Will, it by itself can
24 contribute to stress, but you see, the way we

1 handle stress -- if I feel stressed out, I think
2 of a few of my favorite things and then I don't
3 feel so bad.

4 You start to imagine a few of my
5 favorite people, a few of my favorite
6 relationships. I think of the Red Sox game last
7 night and then I get less stressed out, right?

8 I can imagine that, you can imagine
9 that, but for her that ability to imagine as a
10 way of buffering stress and detoxifying stress is
11 severely limited at this point.

12 Q. Well, and not to make light of the
13 situation, did you read her deposition when she
14 told me in response to a question that she was
15 both crazy and blind?

16 A. Yes. But you see how she is judging
17 herself? It's almost like she is not visualizing
18 herself as being more than just crazy and blind
19 but being also a human being who has had a life.

20 Her mother loved her dearly. Her
21 father loves her in his own way. Her brother
22 loves her, but you see how she reduced herself in
23 that? That's a very harsh judgment that she is
24 making of herself.

1 Q. And I certainly wasn't making light of
2 it.

3 A. I know you weren't.

4 Q. Both of these two things could cause
5 stress. Crazy is a broad term that people use in
6 lay form, but she's had mental health issues for
7 many years and now she's got severe vision
8 problems and both of those can contribute to
9 stress, correct?

10 A. Absolutely they will, but, you see,
11 that's why she needs to have a reservoir of
12 mental imagery and access to that reservoir of
13 mental imagery which is called an
14 autobiographical memory as a way of detoxifying
15 that stress and buffering that stress.

16 As she gets older it's a very grim
17 prognosis for her because the older all kinds of
18 things come up and we begin to have all kinds of
19 health problems which themselves are stressful,
20 well, gee, it helps me to remember the good times
21 I had with my daughter when if I am facing a
22 health problem, for example, because it's a way
23 of buffering stress and trying to modulate one's
24 response to stress.

1 She doesn't have that any more and
2 especially given her mental illness and given her
3 suffering she absolutely needs that.

4 In fact, the reason I am going on is
5 there are some implications for psychotherapy for
6 her, there should be a focus for therapy, help
7 her find ways to work around this lack of mental
8 imagery, this lack of autobiographical memory
9 that she suffers from. That's going to be very
10 important for her.

11 Q. Well, Doctor, how is her coping
12 mechanism prior to getting ECT and dealing with,
13 I know she didn't have the extent of the visual
14 problems, but how was her coping mechanism in
15 dealing with these mania and depressive issues
16 and conditions that she had prior to getting
17 ECT?

18 A. On one hand she could get overwhelmed
19 by intense feelings of helplessness,
20 hopelessness, demobilization and then she could
21 respond by bouncing back and becoming very
22 depressed and then very manic.

23 On the other hand she was always very
24 resilient. She was always able to bounce back

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1 from these episodes. So she had resiliency
2 before and she doesn't have residency now and
3 without resiliency you can't do effective
4 coping.

5 Q. Well, Doctor, to be fair when you say
6 she was resilient she was involuntarily
7 hospitalized multiple times prior to getting ECT
8 at MUSC, and in fact, had involuntary forced
9 medications on multiple occasions prior to going
10 to MUCS and you're saying that is resilient in
11 dealing with these mental health issue that she
12 had?

13 A. She was resilient because she was able
14 to bounce back each time. At no point during any
15 of those hospitalizations, and we talked about
16 this before during our first meeting, Will, at no
17 point was it involuntary ECT necessary or
18 considered to be necessary.

19 So she was always able to go ahead
20 with medication even if it was involuntary for a
21 short period of time she was able to bounce back
22 and pick up her life again.

23 Look, last night I was on the phone
24 with a patient of mine who had had ECT at one

1 point in his life, although it was voluntary.

2 He was becoming psychotic again. I
3 think it's because his father was becoming very
4 fragile and we talked on the phone and we agreed
5 that he would increase his medication.

6 Now, this is a man who had been
7 hospitalized seven times before I ever met him.
8 He was hospitalized once over the 28 years I've
9 worked with him, but you know what, this guy has
10 two careers, a meaningful life, has kids who love
11 him, has an ex-wife who may have ambivalent
12 feelings about him but she they're good friends
13 basically.

14 So it's possible for people like Clair
15 to go ahead and have seven hospitalizations, even
16 to have one course of ECT or two courses of ECT
17 on a limited basis especially if it's voluntary
18 and then it's possible for them to go ahead and
19 age gracefully and have a meaningful life as they
20 age.

21 This person will not wind up in a
22 nursing home. He has his own home, he has
23 friends, he's well-recognized in his field.

24 There was no reason why Clair with

1 appropriate treatment if she had not been brain
2 damaged would not have the same prognosis
3 eventually.

4 Sometimes you have a tremulous youth
5 and middle age but then you have a graceful old
6 age. With good therapy you should be able to do
7 that.

8 Q. And sometimes you don't, correct?

9 A. Sometimes you don't, but if you look
10 at the details enough, and I do second opinion
11 consultations it's because either someone has
12 missed something or not only have they missed
13 something, but they haven't checked back and
14 realized they've missed it.

15 There have been times I've missed
16 things with patients, but I go back and try and
17 see, oh, gee, what did I miss that this person
18 needed to be hospitalized and when I figured out
19 what I missed they're much less likely to be
20 hospitalized.

21 This man was hospitalized once during
22 the time I saw because I had missed something.
23 He came out of the hospital. We figured out what
24 I had missed that he was communicating to me and

1 he hasn't been hospitalized since then.

2 Q. Doctor, I am just trying to get to
3 your opinions so I can turn it over to my
4 colleague.

5 We have talked about the memory issues
6 are there any more tests that substantiate your
7 opinion that Clair Johnson has memory issues
8 resulting from ECT?

9 A. Well, again, in terms of the
10 self-reports that she gives, if we look at the
11 dissociative experience scale.

12 Q. I have got it and I am looking at it.

13 A. She denies that she dissociates except
14 in those area where memory is clearly at work.
15 So in Number 25, Number 26, Number 32 and Number
16 33 -- well, those are more intrusive.

17 If you look at 25 and 26 some people
18 find evidence that they have done some things
19 that they do not remember doing.

20 Some people find their writing,
21 drawing or notes among their belongings which
22 they must have done, but they cannot remember
23 doing, that's, again, consistent with a
24 fundamental disruption of memory.

1 Q. Anything else specifically about this
2 DES that bears on your opinion with regards to
3 memory?

4 A. Not specifically as far as memory
5 itself is concerned, but again, it's in
6 context.

7 Q. I am just trying to cover this because
8 I am going to ask you about PTSD in a second.

9 The next thing I have is the Davidson
10 Trauma Scale that tended, to me at least, to go
11 towards the PTSD diagnosis, is that memory or
12 not?

13 A. That tends to go to PTSD, the PTSD
14 diagnosis, although it's post-traumatic stress
15 disorder which is complicated by her memory
16 deficits.

17 I have seen this often with veterans
18 who have had shell shock like in Iraq, for
19 example, and there you have both a damaged brain
20 and damaged memory both you also have a
21 post-traumatic stress component. You can have
22 both at the same time.

23 Q. Have you told me all the ways you
24 believe or the basis for your opinion that Clair

1 Johnson suffers from memory deficits as a result
2 of electroconvulsive therapy?

3 A. I hope so.

4 Q. Let's shift gears then and talk about
5 your diagnosis of post-traumatic stress disorder.

6 Did you use the Diagnostic Manual to
7 come up with that diagnosis?

8 A. Well, as you may know the diagnostic
9 Manual is not something that's used by
10 experienced clinicians for forensic purposes.

11 In fact, there is a warning against
12 using it that way. It's meant to be a training
13 manual and a research manual.

14 Q. What did you use, if any, concept,
15 theories, basis for determining that Clair
16 Johnson has post-trauma stress disorder as a
17 result of electroconvulsive therapy?

18 A. Over 30 years of clinical experience,
19 forensic experience, my general knowledge of the
20 literature, having treated people with
21 post-traumatic stress disorder, having evaluated
22 people who have had ECT, having evaluated people
23 who have had post-traumatic stress disorder
24 everything that I know and I have learned and I

1 teach and I practice.

2 Q. What criteria do you use when you
3 diagnose someone with post-traumatic stress
4 disorder whether it be from ECT or like you said,
5 a war veteran, what criteria or what elements
6 does a patient have to meet for you to consider
7 them to have post-traumatic stress disorder?

8 A. Have they experienced helplessness, or
9 horror in the face of an or series of events
10 which anyone would reasonably find traumatic.

11 Do they have symptoms of hyperarousal?

12 Do they have symptoms of avoiding or numbing?

13 Do they show any physiologic evidence
14 of hyperarousal or is there intrusion relative to
15 events which one would find to be traumatic, how
16 long have these symptoms lasted?

17 Are these symptoms substantial enough
18 to contribute to a major impairment which has
19 lasted for a good amount of time.

20 Q. And in your opinion Clair Johnson
21 meets all of those criteria?

22 A. It's my opinion which I hold to a
23 reasonable degree of medical certainty that Miss
24 Johnson's suffering includes suffering in the

1 post-traumatic stress disorder spectrum relative
2 to the over 80 ECTs that she received most of
3 which were clearing involuntary.

4 And as a whole all of which were
5 coerced even in the face of her complaints about
6 her memory deficits and the availability of
7 reasonable alternatives for treatment of her
8 bipolar disorder.

9 Q. How about the ones that she
10 voluntarily consented to, do you think those are
11 traumatic enough events to warrant this
12 diagnosis?

13 MR. RAVENEL: Objection to the form of
14 the question.

15 A. Although she did sign some consent
16 forms, there was a lack of voluntariness because
17 the alternative from her perspective and given
18 everything that I seen in reviewing the medical
19 records was that if she did not agree to having
20 additional ECT treatments they would be
21 administered on an involuntary basis.

22 Where there is coercion and there is
23 guidelines such as NICE guidelines from the
24 British National Health Service, if you tell a

1 patient that unless you agree to having ECT we
2 will go ahead and get an order to give you ECT
3 involuntarily.

4 That's not considered to be voluntary
5 ECT by any stretch of the imagination by anyone's
6 accepted standard.

7 Again, I would refer you to the NICE
8 guidelines of the British National Health Service
9 which specifically addresses this issue.

10 So I think it's misleading to say that
11 she voluntarily consented to ECT after an
12 extended period of involuntary ECT treatment with
13 the threat of involuntary ECT treatment hanging
14 over her head.

15 Q. When you saw that she had the threat
16 of involuntary ECT treatment hanging over her
17 head, did Dr. Faust ever indicate that he
18 threatened to involuntarily hospitalize her if
19 she did not have voluntary ECT treatment?

20 A. Again, although there was no explicit
21 threat -- if you can give me a couple of seconds
22 here, let me see if I can refer to something
23 specific. Okay. If we look at Bates stamped
24 01088.

1 Q. I probably don't have that with me.
2 Can you just tell me what it is, what the
3 document is.

4 A. Sure. It's a discharge document from
5 December 21, 2006.

6 Q. Discharge document?

7 A. Yes, Institute of Psychiatry Discharge
8 Summary.

9 Q. Okay. Tell me what you're looking at.

10 A. Hospital course. It's Page 1122 also
11 if that's of any help.

12 Q. Go ahead and read to me what you're
13 referring to.

14 A. "Patient underwent three ECT
15 treatments, a forced medication and ECT protocol
16 was obtained by patient's father, and then it
17 says, but patient agreed to all treatments
18 voluntarily".

19 Well, if you're holding an involuntary
20 protocol and saying well, are you going to agree
21 to in voluntarily or do we have to go
22 involuntary, that's no choice.

23 That's such a violations of human
24 rights and just the basic practice of psychiatry.

1 Again, look at NICE, the National Health Systems,
2 it cautions explicitly against it.

3 So if you say to someone we can do it
4 on an involuntary basis because we already have
5 this first treatment protocol or we can do it on
6 a voluntary basis if you consent to it. That's
7 no choice. That's a choiceless choice.

8 It's exactly the kind of choiceless
9 choice the variety of psychiatrists such as
10 Robert J. Lifton have described in people who
11 have suffered in complex post-traumatic stress
12 disorder.

13 When you give people a choiceless
14 choice like that that's no voluntary, Will.

15 Q. And that's what you believe based upon
16 your review of the medical record what happened
17 reading Dr. Weinstein's note?

18 A. Reading the totality of the record,
19 speaking with Clair, reviewing the totality of
20 the depositions, she was forced, she was given a
21 choiceless choice basically.

22 I have no question about that, Will.
23 Now, it may have been unintentional, but that was
24 it and that's way below the standard of care.

1 Q. And you haven't reviewed anything from
2 Dr. Weinstein himself like a deposition or
3 affidavit or anything like that?

4 A. I have just reviewed the totality of
5 the medical records and the totality of the
6 depositions.

7 Again, it's all consistent with this
8 description, Will. If you tell me there is
9 something inconsistent with it I have missed, I'd
10 be glad to consider it, but it's a choiceless
11 choice which we certainly treat people for, but
12 we don't give me -- we treat people who have been
13 traumatized by choiceless choices.

14 You can't say to someone we'll do it
15 the easy way or the hard way, which way is it
16 going to be. That's no choice.

17 Q. I understand if that's what you're
18 reading in that medical record. I am interested
19 in this post-traumatic stress disorder diagnosis.

20 Is there anything that we haven't
21 talked about that you have used in formulating
22 your opinion that Clair Johnson suffered from
23 PTSD resulting from ECT?

24 A. I think we have we have touched on my

1 basis and they are all in my draft of April 1st
2 of 2011. We can go into more detail if you want,
3 but I think we have given a fair summary.

4 Q. In fairness to my colleague I've been
5 going about an hour, and I may have some follow
6 up in regards to the testing itself depending on
7 how long Jim goes, but can we take about a five
8 minute break and then resume?

9 A. Thank you, Will. It's a plan.

10 (Thereupon there was a short recess
11 taken.)

12 CROSS-EXAMINATION BY MR. SCOTT:

13 Q. Dr. Bursztajn, as you know I represent
14 John Roberts. I am going to try and
15 compartmentalize this case to the degree that we
16 can. I don't want to talk about MUSC. We've
17 talked about them enough.

18 Let's move to Dr. Roberts and I want
19 to ask you if you can to outline any each and
20 every criticisms that you have against
21 Dr. Roberts. If you have none, that's wonderful,
22 we'll stop.

23 If you do I'd like to start in a
24 bullet point fashion the criticisms you plan on

1 testifying against Roberts and then we'll discuss
2 each of those in some level of detail.

3 A. Okay, Jim, that's a plan and in
4 keeping with that I will be referring to my April
5 1, 2011 draft report.

6 First of all, Dr. Roberts should have
7 been aware that Miss Johnson showed significant
8 indications of a preexisting vulnerability to
9 cognitive impairment which is itself a foresee
10 risk of ECT.

11 He was her primary treating
12 psychiatrist on an outpatient basis. He had the
13 best overview of her history.

14 He should have when the question of
15 ECT was brought up made it clear that she was a
16 high risk ECT candidate at best and that
17 alternative treatments should be considered
18 first.

19 Q. Anything else?

20 A. Yes. Number 2, Dr. Roberts should
21 have informed as her primary psychiatrist should
22 have informed Miss Johnson and her family that
23 ECT was not an inevitable choice of treatment and
24 given the fact that it was high risk that she was

1 a high risk patient and that the treatment was
2 going to be involuntary that it was
3 contraindicated.

4 Moreover, Dr. Roberts as the ECT and
5 the involuntary ECT treatment went on should have
6 informed Miss Johnson and her family that a high
7 number of ECTs going up to over 80 was
8 contraindicated given her complaints of memory
9 loss and her preexisting vulnerability.

10 We have a patient who has a
11 preexisting vulnerability where treatment is
12 being recommended on an involuntary basis and
13 where alternatives exist and there is a failure
14 to monitor the foreseeable complications of ECT
15 especially bilateral ECT.

16 Moreover, there is at best an
17 inconsistent and at worst an ineffective response
18 to ECT. His actions as her primary treating
19 psychiatrist were below the standard of care
20 which can be found in the British National Health
21 Service NICE guidelines which focus on the fact
22 that alternatives need to be considered and
23 especially with a patient who is at high risk and
24 where there is a large volume of ECT and the

1 patient is complaining of impairment.

2 Alternatively he should have offered
3 Ms. Johnson and her family alternative treatments
4 to ECT especially once she began to complain of
5 memory impairments.

6 He should have informed Miss Johnson
7 and her family that there was going to be to the
8 extent her competence was compromised there was a
9 need to have a guardian ad litem who is fully
10 informed and fully involved in making decisions
11 for her, and the guardian ad litem should be
12 someone other than the person she was having
13 conflictual relationships which focused on her
14 husband from whom she was separated and
15 eventually who divorced her.

16 He did not in his treatment even
17 though she was complaining about conflicts of
18 interest ever explore with Clair how stressful
19 those conflicts of interest were for her and how
20 those conflicts of interest could have been
21 circumvented by having a non-conflictual
22 guardian.

23 He did not consider reasonable
24 medication choices as an alternative to ECT and

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1 it's true she had had other medications in the
2 past, but, for example, Lamictal was not
3 considered, although she some response to
4 depolarize, those were not instituted.

5 There was no indication that Dr.
6 Roberts ever gave Miss Johnson the opportunity to
7 benefit from a comprehensive program of
8 psychotherapy which she especially needed not
9 only in view of her bipolar illness but
10 subsequently due to her memory deficits and the
11 trauma of involuntary ECT.

12 Dr. Roberts failed to monitor the
13 foreseeable risk of cognitive impairments
14 resulting from long-term bilateral ECT and when
15 she did complain of such impairment there was an
16 insufficient response.

17 Dr. Roberts also failed to explore
18 with Miss Johnson and thereby decrease the stress
19 of the impact of involuntary ECT, the impact of
20 being given a choiceless choices and how
21 traumatic it was for her and would foreseeably
22 continue to be for her without appropriate
23 explorations.

24 Q. Is that it?

1 A. Yes.

2 Q. Thank you. I will go over all of them
3 actually in a little bit.

4 It sounds like to me that some of
5 these may overlap with one another and maybe we
6 can condense the list a little but we'll bridge
7 that as we get to it I guess.

8 Let me ask you we discussed some of
9 your I guess your role as an expert how much time
10 you had put into the case when we last met, how
11 much time have you put into the case since that
12 last testimony in July?

13 A. Oh, I would say at this point well
14 over an additional 30 hours or so.

15 Q. I am going to ask you some general
16 questions. You have probably seen some of these
17 questions from Dr. Bregen's deposition.

18 I am just going to run through some
19 and see if we can agree or disagree.

20 Do you agree that Clair Johnson had a
21 well documented history of non-compliance with
22 her medications over the course of her life?

23 A. She did have a well documented history
24 of having a difficult time adhering to a

1 medication regime throughout the history of her
2 illness.

3 Q. Do you agree that when one is
4 non-compliant with medications it makes it more
5 difficult for the treating psychiatrist to judge
6 the effectiveness of the medications?

7 A. When there is a difficulty in
8 adherence the treating psychiatrist needs to make
9 that much more of an effort to help the patient
10 become adherent, and even in the absence of
11 adherence to go ahead and exercise reasonable
12 professional judgement as to the effectiveness of
13 the medications that are being prescribed.

14 Moreover, when there is a difficulty
15 of adherence, it is the duty of the treating
16 psychiatrist to explore alternatives which a
17 patient may have less difficulty adhering to such
18 as, for example, injectable anti-psychotic
19 medication as opposed to a medication that's
20 taken daily by mouth, a long-term injectable
21 medication, a medication that a patient can
22 receive only once a month by injection as opposed
23 to the patient needing to take it every day.

24 And if the patient is feeling

1 overwhelmed by stress, they may forget to take it
2 or just not be able to take it or refuse to take
3 it without insight as to why they are refusing to
4 take it.

5 So throughout my 30 years of clinical
6 practice and teaching and writing I have
7 emphasized that when there is difficulty with
8 adherence to the medication regimen that's when
9 you really need a psychiatrist, otherwise you
10 could just have a primary care physician
11 prescribe the pill and that's it.

12 But that's why you need a psychiatrist
13 to explore what's the reason for the difficulty,
14 how can we make it easier, how can we get around
15 the difficulty of adherence that you question
16 quite wisely those points.

17 Q. Well, my question was rather simply
18 and that was simply do you agree that it makes
19 more of a challenge for a psychiatrist to judge
20 the effectiveness of medication when the patient
21 is non-compliant with the medication therapy; do
22 you agree with that in general?

23 A. I agree that it's both more of a
24 challenge on the one hand, but also I qualified

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1 it by saying it's more of a duty of the physician
2 to proceed in a careful manner to explore why the
3 difficulty in adherence and what alternative --
4 how can we help the patient become more adherent
5 to the medication regime that I am prescribing.

6 You have more of a challenge so you
7 have more of a duty. That's why we refer
8 patients to psychiatrists rather than primary
9 care physicians.

10 Patients who have major mental illness
11 generally do have some difficulty in adherence
12 and very often we do treat it.

13 Q. The evidence in this case suggests
14 that Dr. Roberts, in fact, was doing that with
15 the Lamictal, right, when Miss Johnson presented
16 today him and he became aware that she had
17 trouble with compliance with the Lamictal he went
18 to another medication in hopes of trying to find
19 a simpler regimen that she could more easily
20 follow, correct?

21 A. He did try that, but what he failed to
22 do was go ahead and explore what her reasons were
23 for difficulty in adhering to the Lamictal
24 regimen and he failed to suggest therapeutic

1 interventions which might have made it easier for
2 her, which would have made it easier for her to
3 adhere.

4 Her lack of adherence should have been
5 a major treatment focus. What's the problem that
6 she's not taking the medications, that's a
7 serious.

8 The question that you're asking right
9 now, Jim, is a serious questions that Dr. Roberts
10 should have focused on fundamentally and provided
11 some treatment for.

12 Q. Do you not agree that the records
13 suggest that Dr. Roberts was actively trying to
14 tweak and intervene with various and sundry
15 medications that he could find that that would be
16 of maximal benefit for Miss. Johnson?

17 A. I agree that he was trying to tweak
18 medications, but it he wasn't providing here with
19 sufficient psychotherapy to help her become
20 adherent, and he wasn't instituting alternatives
21 such as, for example, once a month injectable
22 medication on an ongoing basis which would have
23 made adherence easier.

24 So he was overlooking alternatives

1 which any reasonable and prudent psychiatrist
2 such as comprehensive psychotherapy and an
3 injectable medication regime would have
4 considered at this prior to the recommendation
5 that the patient and her family proceed with
6 involuntary convulsive treatment.

7 Q. Are you testifying that Dr. Roberts
8 breached the standard of care by not attempting
9 to utilize injectable medication as an
10 alternative form of treatment?

11 A. By not presenting it as an alternative
12 to electroconvulsive therapy to the patient, her
13 family and her guardians.

14 Q. What medications do you contend should
15 have been injected into Miss Johnson by Dr.
16 Roberts?

17 A. Dr. Roberts could have recommended
18 given her difficulty she could be on an
19 injectable anti-psychotic medication, any
20 injectable, and those injections can be spaced
21 out from every two weeks to every month.

22 Q. And is that a new criticisms to add to
23 the list that you believe Dr. Roberts failed to
24 offer injectable medication?

1 A. No. It's covered under the fact that
2 electroconvulsive therapy was not an inevitable
3 choice of treatment which is Number 2 and Number
4 6, it's questionable whether reasonable
5 medication choices were considered as
6 alternatives to ECT so it's consistent with those
7 two.

8 Q. All right. Do you agree that Miss
9 Johnson was managed by different medical
10 providers prior to be being treated by
11 Dr. Roberts with little success for her mental
12 health?

13 A. She was being treated by other mental
14 health providers with limited success, however,
15 they were successful enough to avoid involuntary
16 ECT and brain damage they did not make matters
17 worse.

18 Q. Are you contending that they had her
19 mental health disorders under good control prior
20 to her being seen by Dr. Roberts?

21 A. Jim, under limited control. It's not
22 satisfactory, not good enough for sure and there
23 was room for improvement, but there wasn't the
24 kind of deterioration which occurred subsequent

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1 to Dr. Roberts psychiatric treatment management
2 of Miss Johnson's illness.

3 She came to him with one illness and
4 by the time she left she had three.

5 Q. You do understand that Dr. Roberts did
6 not refer the patient -- you're not contending
7 that Dr. Roberts referred the patient for ECT
8 therapy, are you?

9 A. I am not saying that he formally
10 referred her for electroconvulsive therapy,
11 however, he was her primary treating psychiatrist
12 he was aware that that was the recommendation.

13 He could have intervened at any point
14 and certainly when she came back to him
15 complaining of memory deficits.

16 He could have advised her against
17 receiving further electroconvulsive therapy. He
18 also could have advised the clinicians who were
19 administering that, advised her parents, advised
20 the guardian ad litem.

21 A course of ECT beyond a course of 6
22 to 12 ECTs was really counter-indicated. He
23 could have also advised her and her family that
24 she was at a high risk for complications of ECT

1 especially when she began to complain of memory
2 loss and those complications included the
3 possibility of the memory loss becoming permanent
4 and as a result of brain damage from ECT.

5 He could have also advised her and her
6 family about the fact that involuntary ECT is an
7 extreme measure which has also complications of
8 its own which should only be considered after
9 you've tried everything else and nothing else
10 worked basically.

11 Again, I would refer you to the NICE
12 guidelines of the British National Health Service
13 for what I think is a fair statement of when
14 electroconvulsive therapy should be used and also
15 a warning about the dangers and complications of
16 involuntary electroconvulsive therapy.

17 Q. You question the validity of the
18 bipolar disorder diagnosis that had been made in
19 the '80s, I believe?

20 A. No, I do not question the validity of
21 the bipolar diagnosis. However, in light of the
22 diagnosis prescribing Wellbutrin to her,
23 prescribing stimulants to her, which other
24 clinicians did as well, but here is her primary

1 psychiatrist, he should not have done that
2 because that can certainly make bipolar disorder
3 worse and can trip a depressed person into a
4 manic episode.

5 I know he had reservations about
6 prescribing that and he, in fact, advised her
7 against it, but he continued to prescribe it to
8 her.

9 Q. Is this a new opinion, Doctor?

10 A. No. This is well within the opinions
11 which I have already stated and are contained in
12 my draft report.

13 Q. Well, let's talk about this then. You
14 agree that the bipolar disorder was valid,
15 correct, that diagnosis?

16 A. Yes, that's what she came to him with
17 as well as a history when she was much younger of
18 having some head injury and some drug and alcohol
19 abuse.

20 Q. And this issue of the head injury that
21 I have heard so much about, you agree with me
22 that her own family testified that there weren't
23 aware of any hospitalizations that were
24 associated with any head trauma as a child or a

1 teenager, correct?

2 A. Yes.

3 Q. You don't have any idea what level of
4 head injury she might have suffered as a
5 youngster other than the fact that she apparently
6 reported that she hit her head several times when
7 she was young, correct?

8 A. It's noted in the medical records on
9 several occasions. I have not had access to --
10 it's her reports are very consistent on this.

11 Q. It's noted in the medical records that
12 she subjectively reported a rather vague report
13 of having suffered head injuries, that's what
14 you're referring to?

15 A. I am referring to that, yes.

16 Q. All right. But you're not testifying
17 that she suffered a brain injury as a child or a
18 teenager based on everything that you know at
19 this point, correct?

20 A. I don't think that there was any level
21 of brain injury which would cause a substantial
22 level of impairment prior to her receiving the
23 electroconvulsive therapies, the involuntary ECT
24 that she did in 2003, that's right.

1 But she was vulnerable. She was at
2 risk for it both by the history and also by the
3 CT scan which noted some cerebral atrophy in 2002
4 so we have someone who is clearly vulnerable?

5 Q. You agree that cerebral atrophy that
6 was reported to be more advanced for her stated
7 age was most probably related to alcohol and/or
8 drug abuse?

9 A. That's certainly a reasonable
10 possibility, but again, there was no functional
11 impairment, and I think that's very important.
12 What atrophy there was relatively mild.

13 Q. What do you base it on -- I am sorry.
14 Go ahead.

15 A. Well, what atrophy that is reported is
16 relatively mild and minimal and there were no
17 reports of the kind of pervasive memory
18 impairments that she had subsequent to ECT.

19 I am going to just read you the 2002
20 report, give me one second. Looking now at Bates
21 Number 02951.

22 Q. Just tell me what it is, Doctor.

23 A. It's the report of the CT of the head
24 from 2002, from December of 2002, December 12,

1 2002.

2 Q. Yes, sir.

3 A. And basically when it shows is some
4 prominence of cortical sulci which may reflect
5 atrophy, but it's relatively mild and certainly
6 substance abuse could be one potential cause of
7 that.

8 Again, what we see is a very mild form
9 of brain atrophy with, a form of brain atrophy
10 which is not correlated with any functional
11 impairment.

12 We don't have any evidence here of
13 preexisting fixed brain injury which is impairing
14 function. What we have is some data that is
15 consistent with the fact that she has a history
16 of substance and alcohol abuse, given her history
17 of head injuries is vulnerable to a repeated
18 massive cause of bilateral electroconvulsive
19 treatment.

20 Q. The results of that CT scan do not
21 make ECT therapy contraindicated; you agree with
22 that?

23 A. No, I would say that the results of
24 the CT scan when taken with her history of drug

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1 and alcohol abuse, her prior history, the history
2 of head injuries make it relative
3 contraindication.

4 Again, she should have been advised,
5 her family should have been advised that she
6 would be at higher risk for cognitive
7 complications than most patients from bilateral
8 ECT especially massive volumes of bilateral ECT,
9 an overdose of bilateral ECT which she eventually
10 suffered from, over 80 ECTs.

11 Q. You're not opining that the CT scan
12 results from 2013 ordered by Dr. Bragen, the
13 other expert in this case diagnosed any
14 appreciable brain damage resulting from ECT, are
15 you?

16 A. It's my opinion that the subsequent
17 functional impairments are consistent with the
18 progression which otherwise one would not see
19 under the circumstances and those functional
20 impairments are due to the massive doses of ECT
21 that she received on an involuntary basis. It's
22 the volume of ECT that she received.

23 Is the progression between the two CTs
24 scans consistent with that, yes, it is. Do I

1 base my opinion on those two CT scans, is that
2 the foundation of my opinion, no, it's not.

3 The foundation is her natural history
4 and the degree of impairment from before the
5 massive volume of ECT to subsequent.

6 Q. I think I understand your opinion, but
7 I want to be clear about this. You have
8 explained before her cognitive dysfunction and
9 why you think that's related to ECT, but you are
10 not going to opine that the results of that CT
11 scan from May of 2013 are proof of brain injury
12 from the ECT therapy, are you?

13 A. The results of the CT are consistent
14 with ECT related injury, but they're not
15 foundational to my opinion.

16 Q. All right. I understand they're
17 consistent with, but they're not diagnostic of
18 ECT related brain injury, correct?

19 A. Not by itself, no. However, in the
20 context of the fact pattern, yes.

21 By themselves if you just look at the
22 CT scans you can't just say this is due to ECT,
23 not by itself, of course.

24 Q. Well, to be fair it's also consistent

1 with deterioration of the brain over ten years
2 that already had advanced atrophy, did it not?

3 A. She did not have advanced atrophy.
4 She had some evidence of atrophy due to prominent
5 sulci, but she did not have advanced atrophy
6 consistent with functional impairment and she had
7 no functional impairment in 2002.

8 There was no estimate of functional
9 impairment in 2002 prior to the ECTs. If there
10 is, then please let me know.

11 Q. I think you're talking about one thing
12 and I am talking about another.

13 I am simply asking if you intend to
14 testify that the CT scan ordered by Dr. Brangen,
15 the other expert in this case is diagnostic of or
16 can lead one to conclude that she has suffered a
17 brain injury due to the result of the CT scan,
18 there is as is suggested a slight increased
19 atrophy from ten years prior or whatever the
20 verbiage is in that radiographic study?

21 A. Jim, by itself it's not diagnostic,
22 but it is indicative and consistent with a
23 diagnosis of brain damage due to massive ECT.

24 Q. Are you testifying that if you took

1 the ECT therapy out of this case that the CT scan
2 results from May of 2013 would not be consistent
3 with the CT scan of 2002 based on the way the
4 body ages an atrophy occurs?

5 A. It would be unusual, again, anything
6 is possible, but it would certainly be unusual
7 and I am testifying to the functional impairments
8 that we see are not consistent with the way the
9 normal brain ages or even the vulnerable brain
10 ages because.

11 Q. Do you agree that her bipolar disorder
12 or let's say her overall mental health illness, I
13 guess her mental illness could be reasonably
14 characterized as severe when she first came to
15 see Dr. Roberts?

16 A. She had severe episodes of her bipolar
17 illness both in terms of mania and depression.

18 Q. Do you agree that her disease process,
19 her mental health or her mental disease was
20 chronic in nature before she was ever seen by
21 Dr. Roberts?

22 A. It was episodic and recurrent,
23 however, she also had periods of time where she
24 was able to function in a relatively normal

1 manner.

2 Q. Do you agree that it's reasonable for
3 a psychiatrist as I used the term tweaked before,
4 to try and change or tweak medications with a
5 patient in order to find the best regimen for
6 that particular patient?

7 A. Medication monitoring can include
8 changes and what medications the patient is
9 taking in order to be able to minimize the risk
10 and maximize the benefits for the patient and
11 also to help the patient adhere to the
12 recommended medication regimen.

13 This includes, however, having a
14 meaningful psychotherapeutic relationship which
15 focuses on what difficulty the patient is
16 encountering and sticking to that medications
17 regimen which seems to have the best benefit for
18 the patient.

19 Q. Are you contending that Dr. Roberts
20 had no meaningful psychotherapy with Clair
21 Johnson during their doctor/patient
22 relationship?

23 A. From what I can tell, it was
24 ineffective. It wasn't focused on the traumatic

1 issues of memory loss subsequent to involuntary
2 ECT and the high volume of ECT.

3 He also prescribed to her even though
4 he advised against it stimulated which were
5 counter-indicated given her bipolar disorder and
6 he knew better but he continued to prescribe
7 those.

8 So yes, I think there was a failure as
9 far as any comprehensive psychotherapy plan which
10 you need to have, I would need to have if I was
11 treating her.

12 You need to have a plan that the
13 patient agrees to and shares with you. That's
14 part of what psychotherapy is with a bipolar
15 patient.

16 You have to help the patient learn to
17 help you help them, and if they cannot do so,
18 then you have to figure out why not with the
19 patient and with the patient's family and people
20 who love the patient.

21 Q. Do you agree in general that ECT has
22 therapeutic benefits for many patient across
23 America?

24 A. Electroconvulsive therapy when

1 appropriately prescribed and appropriately
2 administered to an informed patient can have
3 therapeutic benefits for patients, yes.

4 Q. Do you agree that antidepressants can
5 have therapeutic benefits for patients?

6 A. Yes, for selected patients who are
7 appropriately informed of the benefits and risks
8 they can, yes.

9 Q. You, in fact, have prescribed many
10 patients with antidepressants over your 30 plus
11 year career, yes?

12 A. And I continue to do so, Jim, yes.

13 Q. And you treat patients that at times
14 actively undergo ECT therapy as part of their
15 therapeutic regime?

16 A. Yes. As I mentioned, I was on the
17 phone with a patient last night who has undergone
18 ECT.

19 I hope we have now been able to go
20 ahead and help him enough that we can avoid
21 future hospitalizations and the need for
22 electroconvulsive therapy, but yes.

23 Q. Do you agree that the consensus in
24 your field or in the literature is that the vast

1 majority of memory loss associated with ECT
2 therapy is felt to be short term in nature?

3 A. There is some controversy about that,
4 Jim. The simple answer is it really depends on
5 the dosage of ECT.

6 There is a consensus that if the
7 dosage is high enough over a long enough period
8 of time and especially if it's bilateral in a
9 high risk patient it's likely to result in
10 permanent rather than transitory loss.

11 In a patient who is at very low risk
12 especially with unilateral placement for a
13 limited number, between six and 12 ECT
14 administrations, then in that instance you have
15 the case that you described which is that with
16 memory loss it is relatively short term.

17 So it depends. You have two groups of
18 patients, low risk patients, small volume of ECT
19 and high risk patients and high volume of ECT and
20 with bilateral ECT being in that category as
21 well.

22 So it's a biphasic curve in terms of
23 short term versus long term. These days since
24 most patients receiving short courses of ECT and

1 generally it's unilateral, then with memory loss
2 it is, in fact, transitory as opposed to
3 permanent.

4 Q. Do you have any citation for the
5 literature to support that notion that the
6 studies are broken into two categories, short
7 term ECT versus long term ECT and the resulting
8 memory deficit from each that's expected, do you
9 have any authority for that?

10 A. Off the top of my head I can't name
11 specific references, I would encourage you to
12 obtain a full copy of the NICE guidelines, those
13 are the National Health Service Guidelines.

14 They do include references which
15 basically are consistent with my opinion that
16 long term high volume ECT is much more likely to
17 result in permanent brain damage and permanent
18 memory loss than short term unilateral low volume
19 ECT. Those references are there.

20 If you look at the document, you can
21 simply find them. I certainly have read them. I
22 looked at those references pro se.

23 Q. Let me ask you this: The mere fact
24 that someone might complain of some aspect of

1 memory loss during ECT does not necessarily mean
2 the ECT should be stopped at that point because
3 frankly short term memory loss is not terribly
4 unexpected, correct?

5 A. If someone complains of memory loss
6 doing a low volume ECT, at the very least you
7 proceed to go ahead and monitor them very
8 carefully including administering formal
9 neuropathological testing to make sure that the
10 memory loss doesn't get worse before you
11 administer additional ECT.

12 You also begin to look at alternatives
13 to continuing a protracted high volume ECT course
14 at that point in time.

15 If you're going to continue ECT you
16 have to monitor them very carefully to make sure
17 that short term memory loss isn't a long-term
18 fixed memory loss.

19 Q. But the mere fact that someone may
20 complain of some memory loss is not in and of
21 itself a basis to stop ECT therapy particularly
22 when someone believes they're getting benefit
23 from the therapy?

24 A. It's not an absolute red light, but

1 it's certainly an orange light to go ahead an
2 institute additional monitoring including formal
3 neuropathological testing and to look at
4 alternatives to continuing with electroconvulsive
5 therapy at that point and make sure the patient
6 regains their memory.

7 Q. Did you not find that Dr. Roberts in
8 his notes after he notes some memory loss that he
9 follows up over the weeks and months and some
10 form of monitoring the memory to see if its
11 improving?

12 A. Not adequately and not according to
13 standard of care that I practice.

14 Q. Which requires what?

15 A. Would require at the very least some
16 referring Clair to a neuropathologist so we can
17 get a baseline set of tests or neuropathological
18 function and then to be able to see whether she
19 is improving from that. That's not being done.
20 He doesn't even do a mini mental
21 status exam in a formal way that I can see. But,
22 again, you would need more than that for someone
23 given the fact that she's complaining of memory
24 loss and she's at higher risk.

1 You would need formal
2 neuropathological testing at that point to show
3 what her baseline is and what recovery of memory
4 function she actually has rather than what
5 recovery she hopes she will have and you hope she
6 will have.

7 He based basically without that the
8 orange light becomes a red light and to continue
9 ECT under those conditions you're moving from an
10 orange light to a red light and then you are in
11 violation of what I consider to be the standard
12 of care.

13 Q. Even if he feels the memory is
14 improving?

15 A. It's not up to his feeling. You need
16 to have a formal baseline at that point. You
17 have a patient who is clearly complaining of
18 memory loss.

19 I may feel she is improving, but how
20 do I know that my observations may not be
21 observations at the moment as opposed to
22 observations of her average function.

23 How do I know she's not putting on her
24 game face or her best face for me. So you really

1 need to get neuropathologic testing done at this
2 point and you really need to consider alternative
3 forms of treatment that she can be adherent to
4 and still focusing on exploring what the
5 difficulty has been in adhering to non-ECT forms
6 treatment.

7 Most people with bipolar disorder are
8 able to get by without ECT. It's not inevitable
9 and most people who have failed multiple
10 medication regimens can get by with either no ECT
11 or at the most six to 12 ECTs, not over 80.

12 Q. ECT was a reasonable option to explore
13 in this case, correct?

14 A. It was a reasonable option to explore
15 but only in the context of recognizing that she
16 was at higher risk for complications and then
17 subsequently carefully monitoring her and
18 presenting her with meaningful alternatives to
19 over 80 ECTs.

20 What was reasonable between six and 12
21 stops being reasonable at 80. It's an overdose
22 in a high risk patient.

23 Q. Do you agree or disagree that the
24 standard of care in psychiatry allows bipolar

1 patients to be treated with antidepressants and
2 mood stabilizers so long as they're carefully
3 monitored while on this medication?

4 A. Yes, so long as they're carefully
5 monitored and they're carefully educated about
6 the risks and benefits so they can be carefully
7 monitored.

8 Q. You agree that there were indications
9 of a good response to the ECT therapy when it was
10 instituted?

11 A. There were mixed indications as to
12 what the response was. It was questionable as to
13 how good the response actually was.

14 Q. Do you agree as a general matter that
15 there is no standard of care limiting the
16 duration of maintenance ECT?

17 A. There is, again, I am referring to the
18 National Health Service of Britain, the NICE
19 guidelines, once you go beyond six to 12 ECTs you
20 have to be very careful about maintenance ECT,
21 extraordinarily careful and you need to go ahead
22 and make sure whatever consent there is
23 absolutely voluntary.

24 Certainly 80 bilateral ECTs for

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1 someone who is complaining of memory loss is
2 below any standard of care that I am familiar
3 with.

4 Q. I understand what you're saying, but
5 my question is a general question that there is
6 no standard of care as to any certain number of
7 maintenance ECT treatment one can undergo, there
8 is nothing that says you have to stop at 12 or 15
9 of anything of that nature?

10 A. There is no absolute number that one
11 can refer to, but it's a little like radiation
12 treatment for cancer.

13 Generally a little can be of help, but
14 once you get beyond a certain point you kill the
15 patient so I feel once you get up to 80.

16 So it's foreseeable with a patient who
17 is vulnerable and complaining of memory loss
18 throughout there is going to be brain injury and
19 brain damage.

20 Certainly the standard of care that
21 I am familiar with as a general rule of practice
22 would not indicate over 80 ECT treatments to a
23 patient who is vulnerable and complaining of
24 memory damage as Miss Johnson was and still is.

1 Q. You agree with the following two
2 sentences: Brain imaging in 2002 showed some
3 brain atrophy more advanced than would be
4 expected for her age.

5 This finding by itself does not
6 definitively show vulnerability to brain damage
7 to ECT".

8 Do you agree with those statements?

9 A. Well, not by itself but in the context
10 of her overall history, of substance and alcohol
11 abuse, the trauma history, then that's different.
12 Context matters here. History matters.

13 Q. I understand. I am just asking if you
14 agree that the imaging from '02 shows some brain
15 atrophy -- you agree that Lamictal has not been
16 proven effective in reducing Miss Johnson's
17 symptomatology?

18 A. Lamictal seems to have been or seems
19 to be of some limited effectiveness. Is it
20 totally effective, no.

21 Q. Do you agree that evaluating the
22 effects of medications in Miss Johnson's case was
23 a challenge for the treating physicians given her
24 labile condition, irregular compliance, chronic

1 dissatisfaction and exaggerated complaints?

2 A. Well, I am not sure of the exaggerated
3 complaints, but I can tell you what you've just
4 described about one-third of my bipolar patients.

5 So it's very standard. That's what
6 you expect as a psychiatrist. That's why they
7 come to you as a psychiatrist and not having the
8 family physician manage your medication because
9 you don't need a psychiatrist to just write
10 prescriptions, right.

11 Q. Did you write the November 1, 2010
12 initial analysis of merit that you sent to
13 Mr. Ravenel, did you author that?

14 A. Yes.

15 Q. What I just read to you, does that not
16 sound familiar?

17 A. Can I go ahead and take a look at
18 that?

19 Q. Sure.

20 A. For some reason I only have the cover
21 letter for it. I don't see the actual analysis
22 of merit.

23 MR. EARLY: Dr. Bursztajn, if that's
24 what I sent you, which I think you're referring

1 to in the notebook, it's separated by cover
2 letter, but if you flip back about five, six,
3 seven tabs you'll see another analysis, 11/1/10
4 that Jim is referring to.

5 Q. I am reading from Page 4, Paragraph F
6 of your report. All these questions I am getting
7 from your report.

8 A. I appreciate that. Let me find the
9 report so I can place your questions in context
10 so let me go ahead and find it. No, I am still
11 not finding it. Okay. November 1, 2010, I found
12 it. Can you tell me again what page you're
13 looking at.

14 Q. Yes, Page 4, Paragraph F.

15 A. Okay. And.

16 Q. The sentence starts in the middle of
17 the paragraph and it starts with admittedly.

18 A. Okay. Okay.

19 Q. I was just asking if you agree with
20 your own sentence that says admittedly evaluating
21 the effects of medications in Miss Johnson's case
22 was a challenge given her labile condition and
23 irregular compliance, chronic dissatisfaction and
24 exaggerated complaints together with the fact

1 that the medications were prescribed with her in
2 complex and changing combinations with potential
3 interaction effects?

4 A. I do agree with that, and as I go on
5 to say, however, with the foreseeable risks of
6 ECT medication management merited most serious
7 consideration.

8 It would have been reasonable and
9 prudent to give careful consideration to the
10 context in which medications were prescribed and
11 monitored which might have addressed by
12 psychotherapy.

13 In other words, this is the kind of
14 challenge that I regularly face as a psychiatrist
15 when you consult or treat a patient who has had a
16 series of recurrent episodes of depression and
17 mania.

18 So yes, I agree with it, but this is
19 why I chose to be a psychiatrist so I could go
20 ahead and treat those challenging patients as
21 opposed to simply being a medication dispenser.

22 Q. Okay. You agree that the maintenance
23 ECT was decided on in a family meeting in October
24 of 2005 at MUSC included her parents and

1 outpatient and inpatient clinicians as well as
2 the patient?

3 A. There was such a meeting, yes.

4 Q. And as rule such shared decision
5 making amongst the patient, family and physicians
6 increasing the chance of making a wise decision
7 that will benefit the patient?

8 A. It does to the extent that such shared
9 decision making is informed.

10 When it's uninformed, it's no longer
11 shared decision making. And it was uninformed in
12 this instance because the family was not informed
13 that she was at high risk and that special
14 precautions would need to be taken given the fact
15 that she was at high risk and that alternative
16 given the fact that she was at high risk,
17 alternatives should have been given precedence.

18 Q. All right. Let's talk about those
19 high risk for a minute.

20 I know you mentioned this before, but
21 just outline by bullet point. I see it in your
22 report, but tell me again what these high risks
23 are for adverse outcome related to ECT.

24 A. A preexisting history of substance

1 abuse or a preexisting history of brain trauma, a
2 patient who begins to complain of memory loss, a
3 high volume of ECT, bilateral ECT versus
4 unilateral ECT.

5 Q. Well, let me start with that last one.
6 Bilateral ECT is approved by the APA, correct?

7 A. Well, the APA has issued reports which
8 certainly have included bilateral ECT and some
9 clinicians do use bilateral ECT, but generally
10 it's avoided in high risk patients.

11 Unilateral ECT is considered an
12 alternative to try before you go to bilateral
13 ECT. There is a sequence here.

14 Just because something is possible
15 doesn't mean that it's indicated or the standard
16 of care.

17 Is it something that people use? Yes.
18 Can it be used in low risk patients
19 appropriately? Yes.

20 Was Miss Johnson a low risk patient?
21 No, especially after she began to complain of
22 memory loss.

23 Q. Well, let's stick with our outline
24 that you gave us here.

1 So we've got bilateral ECT and I think
2 somewhere in there you acknowledged that
3 bilateral ECT is within the standard of care,
4 correct? It's used all across America today,
5 correct?

6 A. It's used appropriately with low risk
7 patients, yes.

8 Q. Now, high volume of ECT, now, the
9 question was when they had this family meeting
10 why was she at heightened risk?

11 Nobody knew what the number of ECT
12 treatments were going to be at the time they met
13 to discuss the possibility of maintenance ECT,
14 correct?

15 A. Yes.

16 Q. Now, the complaint of memory loss when
17 they met with the clinicians and the family to
18 talk about maintenance ECT, there was no ongoing
19 complaint of memory loss, correct?

20 A. During which meeting now?

21 Q. The whole premise of the question was
22 the initial family meeting to discuss maintenance
23 ECT, October of '05, and my question was for you
24 to bullet point each and every factor that made

1 her a high risk?

2 A. By October of '05 there was already
3 data from the 2003 hospitalization that she had
4 been complaining of memory loss, so it's
5 misleading to say that there had been no history
6 of memory loss by 2005. There had been, Jim.

7 Q. So as early as '03 your contention is
8 there was evidence of a sustained or a long-term
9 memory loss?

10 A. There was evidence that she had
11 complained of memory loss and that memory loss
12 was even monitored prior to 2005.

13 There was no neuropsychological
14 testing done. Without adequate monitoring we
15 have the Hippocratic oath and the Hippocratic
16 oath says primum non nocere, first of all, do no
17 harm.

18 Without the proper monitoring since
19 she had complaints of memory loss, you have to
20 assume that it's there or test and show that it's
21 not there. You can't simply go ahead and go by
22 your feelings whatever your feelings may be.

23 Q. Well, point to me in the -- I am not
24 disputing that there is this evidence, but I want

1 you to point to me in the chart when exactly it
2 is from 2003 that you're going to rely on to
3 support the position that she was already
4 suffering from memory loss.

5 A. Well, let me see what I have here.
6 Okay. Let's begin. If we look at the medical
7 record itself from MUSC it's December 9th of
8 2003.

9 Q. Go ahead. I don't know that I have
10 the MUSC chart handy, but go ahead and tell me
11 what you have.

12 A. On the one hand the patient herself,
13 Clair, expresses an interest in continuing the
14 Geodon which is a potent anti-psychotic on an
15 inpatient/outpatient basis.

16 On the other hand, she's agitated
17 about continuing with any additional ECT and then
18 we note on her discharge summary which is
19 dictated by Dr. Richard Holt he notes that she
20 continues to at the time of discharge the patient
21 still had some residual effects from ECT such as
22 affective flattening, mild memory and
23 concentration deficits.

24 That's in 2003 in the discharge

1 summary. Let's continue here. Now, I am moving
2 on to Dr. Roberts' notes.

3 Q. Do they have Bates numbers on them?

4 A. They do, so let me find you the first
5 one here. Bates Number 00209.

6 Q. Just give me the date of the note when
7 you're ready.

8 A. This is actually subsequent to 2005,
9 so this is in 2006 that she's complaining of
10 memory deficits in Dr. Roberts' notes. 2004 even
11 though she has been discharged with memory
12 impairments in 2003, on Bates 00055 Dr. Roberts
13 failed to note any assessment of memory.

14 There was no formal -- so what's
15 missing here -- she was discharged in 2003 with
16 memory impairments and there is a failure by
17 Dr. Roberts to provide a systematic assessment of
18 memory improvement from discharge on.

19 So it's a bit like Sherlock Holmes,
20 she's discharged with memory impairments.

21 Dr. Roberts is not doing any
22 systematic memory assessment that we can see from
23 his notes here.

24 So by 2005 I think it's a reasonable

1 inference to accept her family's understanding
2 that she still was having some memory
3 impairments.

4 Q. All right. Doctor, let me see if we
5 can agree on something or not.

6 Do you agree that after pretty much
7 any regimen of ECT therapy you expect to see the
8 results that you described from a discharge
9 summary, that would be the mild effects, the
10 flattened effects, the mild memory loss, that's
11 not unexpected, is it?

12 A. It is not unexpected for a low risk
13 patient, but it's certainly a reason to monitor
14 even a lost risk patient and a high risk patient
15 such as Clair, it's certainly reason to go ahead
16 an initiate referral for formal neuropathological
17 assessment and testing.

18 Q. So essentially what you're saying is
19 that every patient after a round of ECT if they
20 complained of mild deficits such as you described
21 the standard of care requires formal neurological
22 assessment for memory impairment?

23 A. The standard of care for every high
24 risk patient who complains of memory loss

1 subsequent to a course of ECT before initiating
2 another course of ECT is to go ahead and get some
3 memory testing done, some neuropsychological
4 testing, sure.

5 Q. What was the date of that discharge?

6 A. It was 2003.

7 Q. What the month, do you remember?
8 December?

9 A. I believe it was.

10 Q. It's been suggested that it may be
11 December 23rd, does that sound right?

12 A. It sounds right because there was a
13 follow up with Dr. John Roberts on the bottom on
14 Monday the 29th at 4 p.m. so there to the extent
15 there was a follow up on December 29th '03, that
16 sound right to me, Jim.

17 Q. Well, I am going to turn your
18 attention back to Dr. Roberts' notes and I don't
19 have the Bates labels, but I have got the dates
20 up in the left-hand corner, I can help you with
21 that.

22 A. I don't have all of Dr. Roberts' notes
23 here so I would need to see the actual note.

24 Q. All right. So you don't really know

1 if she was even checking on her memory or not
2 after that discharge, do you?

3 A. No, I do know. I've read those notes
4 thoroughly and basically there was an inadequate
5 attention was being paid to checking memory and
6 there was never any referral for any
7 metapsychological testing that's being done even
8 while additional ECT is being considered and
9 subsequently recommended to the family as being
10 the best alternative, in fact, from what I can
11 tell, the only alternative.

12 Q. Right, and you told me a minute ago
13 after she was discharged with those memory
14 complaints that Dr. Roberts didn't do any
15 evaluation to see if her memory was improving or
16 worsening or anything, that's what you told me,
17 correct?

18 A. What I told you is he did not do any
19 appropriate intervention as it merited for a high
20 risk patient who subsequent to ECT is complaining
21 of memory loss.

22 Q. High risk based on those bullet points
23 that you described for me earlier, correct?

24 A. Based on my overall assessment and as

1 communicated and the points which I have
2 enumerated for you.

3 Q. Now, where were going here, I want to
4 get us back on track is I was asking you about
5 each of these bullet points that qualified her as
6 high risk and one of them that we were talking
7 about was complaints of memory loss, and I think
8 unless you have got something else the sum total
9 of what you've been able to point to me was the
10 on the discharge summary December of '03 there
11 was some mild effects described by the treating
12 physician that included flat affect and some
13 memory loss, is that everything you have?

14 A. That's what I have to illustrate.
15 However, again, there were other complaints of
16 her having memory loss which I don't have in
17 front of me to illustrate for you.

18 But, again, if you need I will
19 certainly go ahead and identify each and every
20 one of them when I have the complete record in
21 front of me to illustrate.

22 Q. Well, I don't know how to respond to
23 that. If you're not prepared to tell me each
24 basis for your believe that she had existing and

1 ongoing memory problems related to ECT in 2003, I
2 am not sure I'll ask you the question.

3 A. I have given you the basis. The
4 discharge summary and the lack of appropriate
5 subsequent follow up and the fact that she was at
6 high risk to begin with.

7 Q. Well, this seems a bit circular
8 because you're saying she was at high risk to
9 begin with, but the basis for you're saying she
10 was high risk was these memory problems so I am
11 just trying to figure out --

12 A. No, not, you're getting confused now,
13 Jim. She was at high risk because of the fact
14 that she had a history of drug and alcohol abuse,
15 she had a history of head trauma.

16 There was a CT scan which at least
17 showed at least showed some mild atrophy and
18 subsequent to her initial ECT course she did have
19 memory loss on top of all that.

20 So you have to put -- it's a
21 constellation of factors which make her at high
22 risk, not any one single factor. You have to
23 think of constellations of risk factors, Jim, not
24 just any one single risk factor.

1 Q. The brain trauma that you're talking
2 about, I think we've beaten this to death, that
3 is this issue about her self-reporting that she
4 hit her head when she was doing gymnastics as a
5 teenager or something to that effect?

6 A. Well, there were specific reports in
7 the medical record which predates the ECT her
8 reporting that she had head trauma. There was
9 also a substantiated history of drug and alcohol
10 use.

11 Q. And just explain to me briefly how the
12 drug and alcohol abuse and her history puts her
13 at high risk for ECT?

14 A. Drug and alcohol use creates a
15 vulnerability to the brain being damaged to the
16 extent that it reduces the brain reserves.

17 Q. So you believe that the drug and
18 alcohol use did cause brain damage?

19 A. No, I believe the drug and alcohol use
20 did not produce any functional damage, but it did
21 reduce her reserve capacity and made her more
22 vulnerable to the ECT therapy producing permanent
23 brain damage which has reduced her ability to
24 function in this world, in this life.

1 Q. Do you agree that the 2002 brain
2 atrophy did not definitively show vulnerability
3 to brain damage from ECT, you agree with that
4 statement?

5 A. In the context of the constellation of
6 factors which I have enumerated it is certainly
7 consistent with a vulnerability to a high volume
8 of ECT.

9 Q. Now, you brought this issue up about
10 the Wellbutrin and the Concerta, the stimulant
11 medication so I need to ask you a couple of
12 questions about that. That's not anywhere in
13 your report that I could find, am I wrong about
14 that?

15 A. It's under Number 2 and Number 6, I
16 believe, of the draft report. I indicate
17 although I don't name those medications
18 specifically, I do indicate a failure to consider
19 reasonable alternative medications which in this
20 instance means not prescribing Wellbutrin and not
21 prescribing Concerta.

22 Q. Well, you don't dispute that she had
23 periods of depression between her manic episodes,
24 do you?

1 A. She did have periods of depression
2 between her manic episodes, however, as soon
3 as -- there was alternatives to Wellbutrin and
4 Concerta as far as the treatment of depression is
5 concerned, for example, intensive psychotherapy,
6 cognitive therapy for depression, group therapy,
7 referring her to a day hospital even.

8 There was a variety of alternatives
9 when you have a bipolar patient who may be
10 exquisitely sensitive to having their depression
11 turn into mania with a stimulant like Wellbutrin.

12 Q. Are you testifying that it was the
13 stimulant medication that caused her manic
14 episodes?

15 A. It certainly did not cause all her
16 manic episodes because once they were established
17 they had a life of their own to some extent, but
18 they simply placed her at higher risk for having
19 a rapid cycling, having more episodes and having
20 those episodes be more intense and having her
21 suffering become more intense.

22 They should not have continued to
23 prescribe them to her. Alternative means to
24 treat her depression needed to be implemented in

1 a comprehensive manner.

2 Q. Well, the records, do they not bare
3 out that Dr. Roberts tried many different forms
4 of medication therapy over the years for
5 Miss Johnson?

6 A. He tried many different forms of
7 medication for her, but he never initiated from
8 what I can tell a comprehensive psychotherapy
9 program, referring her for group therapy,
10 referring her for social occupational therapy.

11 There is a variety of non-mania
12 precipitating measures one can put into place for
13 a bipolar patient such as Miss Johnson who seems
14 to be sensitive to stimulants and Wellbutrin.

15 Q. You have noted in the chart where
16 Dr. Roberts indicates that as a part of his
17 evaluation that they had processed Miss Johnson's
18 feeling and explored options, you seem to note at
19 various visits that Miss Johnson had with
20 Dr. Roberts, correct?

21 A. And it seems to have all the
22 characteristics of it lacks detail and has all
23 the characteristics of being a pro forma note
24 rather than a comprehensive description of what

1 was being done and what the plan was.

2 Q. I understand you're not happy with the
3 length of the note, but you do admit that that is
4 capturing some type of therapy, that he was
5 working with her more than just a medication
6 regimen, that there was some psychotherapy
7 ongoing?

8 A. As I read those notes they seem to me
9 to be more place holders rather than an
10 indication of an active comprehensive
11 psychotherapy plan focusing on how to help her
12 reduce the level of impairment she was suffering
13 from which was foreseeably demobilizing and
14 foreseeably precipitating first her depression
15 and then mania.

16 He also did not focus with her from
17 what I can tell in his notes or in his deposition
18 on what difficulty she had adhering to the
19 various medication regimens that he was trying.
20 Why was she having such a difficult time with
21 that.

22 Q. Are you contending that Dr. Roberts
23 was not working with her from a psychotherapeutic
24 perspective -- or you called it a place holder, I

1 am not sure what that means.

2 A. What I am saying is the notes
3 themselves seem more like place holders in the
4 sense that they seem pro forma. There was no
5 detail in them.

6 There was no description of any
7 meaningful psychotherapeutic focus or plan and
8 what progress is being made and with a patient
9 who is at as high a risk as Clair Johnson one
10 needs to have an explicit plan for psychotherapy.
11 There was no indication of any referral for group
12 therapy.

13 There is no indication for a referral
14 for occupational therapy. I don't see any
15 psychotherapy plan here what I see is medication
16 prescribing but not the practice of psychiatry.

17 Q. All right. Well, would part of a
18 reasonable psychotherapeutic plan for Clair
19 Johnson include assessing how the patient has
20 been doing from a subjective report from the
21 patient asking how she has been doing, would that
22 be one part of?

23 A. That would be one part of ongoing
24 monitoring, but one needs to supplement that with

1 a more compressive monitoring and a more
2 comprehensive treatment plan.

3 Q. I am just trying to gets through this,
4 but go ahead.

5 A. , Please go on.

6 Q. Is another part of a reasonable plan
7 include allowing the patient to talk and express
8 her feelings of what's going on and how she is
9 doing?

10 A. It can be in the context of a
11 comprehensive treatment plan, yes.

12 Q. Is one part of the plan to assess the
13 medication regimen to see if the patient is
14 compliant and what types of benefits or adverse
15 reactions they might be getting from the
16 medication?

17 A. Patient adherence is something that
18 does need to be assessed and any difficulties
19 which are revealed in the patient adhering to the
20 medications need to be explored and resolved in
21 order for successful treatment to proceed so by
22 itself it's a necessary step, but itself it's not
23 a sufficient step.

24 Q. Is one part of a reasonable

1 psychotherapeutic plan for Clair Johnson
2 assessing her sleep pattern and her appetite and
3 energy?

4 A. Again, necessary by not sufficient.

5 Q. By itself you mean?

6 A. Precisely, but itself but also in the
7 context of everything else that I've seen
8 documented and what Dr. Roberts testified to it
9 was below the standard of care as I understand
10 it.

11 Q. What about as part of a reasonable
12 psychotherapeutic plan for Clair Johnson would it
13 include assessing suicidal or homicidal
14 ideations?

15 A. Again, necessary but not sufficient.

16 Q. How about redirecting her focus to
17 positive aspects of her life, is that part of a
18 reasonable psychotherapeutic plan?

19 A. Maybe, maybe not because simply
20 redirecting her focus to positive aspects of her
21 life without allowing her to do the grief work
22 that she needed to do mourn the loss of her
23 hopes, of her memory and of her marriage would
24 inadequate.

1 If you simply say to a patient, just
2 don't think about it, look at the bright side of
3 life, this is a patient who has lost her memory
4 and a patient who has lost her husband and has
5 basically lost an opportunity at a meaningful
6 life to just say think about the positive stuff,
7 that's actually going to be counter-therapeutic
8 and counter-indicated.

9 Q. Doctor, you say that as if to suggest
10 that's actually what Dr. Roberts and we both know
11 that's not what he did, correct?

12 A. I don't know that. You may know that.
13 Dr. Roberts may know that. If he does, he has
14 not expressed it in his deposition and he's not
15 expressed it in his notes.

16 Q. Well, did you get from his deposition
17 the impression that he was the type of therapist
18 that would just merely suggest think about
19 something happy and move on?

20 A. Well, again, my impression was that he
21 did not do meaningful grief work with her that
22 needed to be done in the context of her very
23 serious losses. There was a deep failure here,
24 Jim.

1 Q. Okay.

2 A. This woman needed to have a safe place
3 to grieve her losses, not redirected to simply
4 what's positive.

5 Q. So allowing Miss Johnson to talk about
6 the stressors in her life and to express how
7 she's been doing and if necessary let her rant
8 and rave a little bit, is that not part of what
9 you're talking about?

10 A. No. Meaningful grieving is not simply
11 ranting and raving and talking about the
12 stressors in your life, no, Jim, that's not the
13 same.

14 And if Dr. Roberts was under the
15 impression that what you're saying is the same,
16 then that would be a departure from the standard
17 of care.

18 Q. Dr. B, I am asking these questions,
19 not Dr. Roberts and I am not a doctor, but you
20 agree that Clair Johnson was predisposed to do a
21 lot of ranting and raving in a lot of different
22 circumstances of her life, right?

23 A. I think Clair Johnson was deeply upset
24 and when she was deeply upset and when she was

1 deeply sad it was easier for her to be mad than
2 sad.

3 And what you need to do for a patient
4 for whom it's easier to be mad than sad is to
5 help them be in a safe place where it's okay to
6 be sad an okay to grieve.

7 Q. And he didn't do that, Dr. Roberts did
8 not do that?

9 A. He did not provide her with such a
10 save environment especially in view of her
11 opposition to continue with ECT and his support
12 of continued involuntary electroconvulsive
13 therapy, her coerced electroconvulsive therapy as
14 it was she was already quite frightened and quite
15 sad and to coerce her into having involuntary
16 high volume ECT undermined the chance of any
17 meaningful therapeutic alliance between the two
18 of them.

19 Q. Are you testifying that Dr. Roberts
20 coerced her into involuntary ECT therapy?

21 A. To the extent that Dr. Roberts did not
22 himself address the fact that there were
23 alternatives to ECT that it wasn't simply a
24 matter of gee, well, if you don't agree to this

1 then we'll tell your father and we'll convince
2 him to agree to this.

3 That undermines the therapeutic
4 alliance between the two of them. Dr. Roberts
5 failed to do what is standard for any good
6 meaningful psychotherapy with a patient who is
7 suffering from major mental illness to A, create
8 a therapeutic alliance and B, address those
9 factors which may be underlying the therapeutic
10 alliance such as coerced electroconvulsive
11 therapy and the unresolved grief that this
12 patient was experiencing.

13 Q. What do you mean by therapeutic
14 alliance?

15 A. A therapeutic alliance involves the
16 therapist creating a safe enough environment for
17 the patient and removing any obstructions from
18 the patient's path to be able to trust the
19 therapist, and if the patient herself is
20 expressing a refusal for electroconvulsive
21 therapy absent, then you have go ahead that see
22 what that refusal is about.

23 And if you recommend involuntary ECT
24 and then don't explore with the patient what is

1 meant to have recommended or to have agreed do
2 the recommendation of involuntary
3 electroconvulsive therapy or have not objected to
4 involuntary electroconvulsive therapy for your
5 patient, then you will not have a therapeutic
6 alliance.

7 The patient expects their physician to
8 protect them and protect their autonomy and
9 involuntary electroconvulsive therapy does not
10 protect the patient's autonomy, and it's not
11 something which unexplored and by itself will
12 lead to a therapeutic alliance.

13 Once it occurs, then the primary
14 psychiatrist needs to explore with the patient
15 what the meaning of the involuntary
16 electroconvulsive therapy is to the patient and
17 whether or not the patient sees the therapist as
18 being against her rather than with her as far as
19 her wishes and aspirations are concerned and her
20 best interest it concerned.

21 The patient has to trust her
22 psychiatrist, and if her psychiatrist is not
23 addressing with the patient what foreseeable
24 areas of mistrust there may be, then the

1 therapist isn't doing their job.

2 They're not helping to create a
3 therapeutic alliance. If you don't trust me and
4 we don't talk about it, you will continue not to
5 trust me. You may continue not to trust me
6 anyway, but that's another matter.

7 Q. You got the impression from this case
8 that she didn't trust Dr. Roberts? Did you read
9 her deposition?

10 A. I did. I think she initially trusted
11 him blindly almost and the problem was as the ECT
12 continued Dr. Roberts did not step in and say
13 wait a minute, we need to find another
14 alternative here.

15 That was undermined in a foreseeable
16 manner to the point where it's now difficult to
17 trust any treating clinician, although she still
18 tries to, as I understand.

19 Q. Did you read in her deposition that
20 she loved Dr. Roberts?

21 A. I am sure she did. And you see, when
22 someone who you love betrays you, then you fell
23 that much more hurt and that much more
24 disappointed and you trust the person much less.

1 You don't love me, so you don't trust
2 me and that's okay, right, but if you love
3 someone and then they seem to be violating your
4 trust like in a boundary violation, then that
5 violation of trust is that much greater.

6 Let's face it, involuntary ECT is a
7 form of boundary crossing. I can become a
8 boundary violation when the patient or the
9 patient's guardian isn't informed of that.

10 Q. Where are you getting the notion that
11 Dr. Roberts violated her trust and that she was
12 so devastated because of his violation of trust,
13 where is that coming from?

14 A. It's coming from my both talking with
15 her, my observing the fact that she does love
16 Dr. Roberts and yet she could not express any
17 negative feelings about him relative to the fact
18 that he was standing by and allowing involuntary
19 ECT to be the only alternative that she was being
20 offered.

21 Q. So Miss Johnson told you that
22 Dr. Roberts violated their relationship, their
23 trust?

24 A. Miss Johnson told me that she was

1 bewildered by Dr. Roberts not protecting her from
2 involuntary electroconvulsive therapy. She just
3 didn't understand.

4 Q. Is that in your notes?

5 A. It's not in my notes, but certainly
6 part of my examination of her.

7 Q. You produced several articles in this
8 case; is that right?

9 A. I have referenced several articles in
10 this case, yes.

11 Q. You may not have produced them, I
12 apologize. My impression was that you produced,
13 for example, there is something called
14 "Neuropsychiatric Practice and Opinion",
15 "Neuropsychiatric Considerations and the Use of
16 ECT", Andrew Crystal and Edward Coffee, maybe I
17 just pulled these because you reference them, I
18 don't know.

19 A. I believe you pulled them because I
20 referenced them.

21 Q. Okay. And why did you reference those
22 various articles that I pulled? Did you find
23 them to be useful in your opinion or what was
24 that?

1 A. They form the overall background of
2 what knowledge there exists and did exists about
3 involuntary massive electroconvulsive therapy.

4 I would have to look at each specific
5 reference to tell you how each one is relevant to
6 the overall theme, but they are part of a
7 background of knowledge that's easily
8 available.

9 Q. You know either Andrew Crystal or
10 Edward Coffee?

11 A. I do not.

12 Q. Do you agree that at present ECT is
13 recognized as the most effective treatment for
14 serious major depression and that it's been shown
15 to be efficacious in mania and certain types of
16 schizophrenia?

17 A. It can be. It depends, again, on what
18 level of risk the patient is and what benefits
19 the patient has.

20 Q. You agree that the available evidence
21 suggests that ECT does not cause damage to the
22 brain?

23 A. I do not agree with that. I think
24 that's only true for low risk patients but not

1 for high risk patients.

2 You have to divide up your patient
3 pools between low risk for brain damaged patients
4 and high risk for brain damaged patients.

5 Q. Do you agree that there is evidence
6 that ECT sometimes is associated with a temporary
7 retrograde and anterograde amnesia predominantly
8 affecting several weeks preceding and following
9 the ECT CT course?

10 A. There is such evidence and for high
11 risk patients there is also evidence that such
12 amnesia is not temporary but permanent.

13 Q. If you have or produce or plan to go
14 research any literature to support what you just
15 said, I need that produced before trial, okay?

16 A. Okay.

17 Q. You agree that maintenance ECT has
18 been successfully and safely used as prophylactic
19 therapy in individuals?

20 A. Yes, in appropriately selected and
21 monitored low risk individuals at appropriate
22 volumes.

23 Q. The article that you reference in your
24 reports, are those reasonable articles if one

1 wants to learn about ECT and the various
2 advantages and disadvantages of ECT therapy?

3 A. They include articles which have some
4 reasonable information in it, some unreasonable
5 information and some misleading information. Any
6 article which I myself write probably has the
7 same.

8 Q. So you've cited articles to support
9 your opinions that have unreasonable information
10 in them?

11 A. No article that I know from top to
12 bottom has reasonable information. It has some
13 information that becomes outdated, some
14 information that simply may be misstated and some
15 information which is valuable and helpful. We
16 don't have any articles like the Bible, Jim.

17 Q. Is that a yes to my question?

18 A. It's a qualified yes which is that any
19 article has information that's helpful and
20 information that's mistaken and information
21 that's not helpful. It has all of that. You
22 have to read mindfully, not mindlessly.

23 Q. Let me ask you this: Do you agree
24 with the following that ECT is indicated when one

1 of the following exists: Number 1, medical or
2 psychiatric need for a rapid definitive response;
3 Number 2, there is a history of prior episodes of
4 the same condition that responded to ECT but not
5 other available therapies; Number 3, in the
6 present episode the patient has been intolerant
7 or failed to respond to other available therapies
8 or Number 4, the patient prefers ECT over the
9 alternatives; do you agree with that?

10 A. In general for low risk patients,
11 yes.

12 Q. Do you agree that there are no
13 absolute contraindications for ECT therapy?

14 A. Again, there are no absolutes in
15 medicine, but there is what a reasonable and
16 prudent physician would do and certainly a
17 prudent physician would not go ahead and give the
18 high volume of involuntary ECT to a vulnerable
19 patient like Miss Johnson.

20 You don't go over 80 with a patient
21 who is as vulnerable as she is on an involuntary
22 basis.

23 Q. Do you agree that the literature
24 suggests that there may be a greater risk

1 associated with ECT in conjunction with the brain
2 injury if the brain injury occurs close in time
3 to the ECT therapy rather than remote?

4 A. It depends on the nature of the brain
5 injury per se. Again, the probably with
6 statistics is it doesn't distinguish among
7 different kinds of injuries.

8 Some injuries if they occur close to
9 can make the patient more vulnerable but that
10 doesn't mean that an injury that has occurred ten
11 or 15 years previously doesn't make the patient
12 vulnerable. It still does.

13 Q. But we don't know the nature of her
14 brain injury, correct?

15 A. I think we don't know the specific
16 brain injury, but it is consistent with drug and
17 alcohol use and possibly with some brain trauma
18 as well.

19 Q. Who is Fink?

20 A. He is someone who advocates the use of
21 electroconvulsive therapy and a very
22 controversial figure in American psychiatry and
23 psychiatry in general. Some people think he's a
24 fink, other people think not.

1 Q. Bear with me earn. I think some
2 things have been covered by Will at the first
3 deposition so bear with me.

4 A. Take your time, Jim.

5 Q. Is it fair to say based on the numbers
6 we've been talking about that you've earned over
7 \$100,000 on this case thus far?

8 A. I don't think it's been over that.

9 Q. Getting close, I think we were at 80
10 something the last time we deposed you.

11 A. I am not sure what the amount is, but
12 anyway I would say 80 something would be a guess
13 on my part.

14 Again, I don't keep track of that
15 myself. But will be sure to have my office send
16 you via Mr. Ravenel any billing statements that
17 we have or he can send them to you directly.

18 Q. Let me take a break. I do have some
19 more questions, but I want to take a five minute
20 break.

21 A. Please feel free, Jim.

22 (Thereupon, there was a short recess
23 taken.)

24 Q. Dr. B, I am going to try and run

1 through the bullet points that we started with.

2 I think we have covered several of
3 them. You're welcome to say what you need to
4 say, but part of this process is simply going to
5 be to confirm your opinion and if we have talked
6 about it I'll just ask if there is anything more
7 you need to say about it and if we haven't then
8 we'll explore it, does that make sense?

9 A. Okay, Jim. Please proceed.

10 Q. The first one I had was this issue
11 about Miss Johnson being vulnerable or being at
12 high risk and Dr. Roberts needing to be aware
13 that she was at high risk and making her aware of
14 that, is that an accurate summary of your first
15 criticism?

16 A. That's fair, Jim, yes.

17 Q. And I believe we have talked at length
18 about why she was at high risk and your feelings
19 on what that meant for her that she was at high
20 risk, have we covered your opinions on the aspect
21 of her being at high risk with the ECT therapy?

22 A. Yes. Again, what needs to happen is a
23 dynamic risk assessment.

24 She was at high risk to begin with and

1 as time went on and they were more and more ECTs
2 she became at even higher risk.

3 Q. All right. Do you agree that she had
4 not had adequate success in the years prior to
5 ECT with medication therapy; you agree with
6 that?

7 A. She only had limited success and there
8 were areas where she would get recurrent episodes
9 of depression and mania so by success we mean was
10 she able to totally prevent or was her treating
11 clinician able to treat the depression and mania
12 and the answer is no.

13 When you're treating someone with an
14 episodic recurrent illness you sometimes need to
15 go ahead and get them through that phase of their
16 illness so that they can go ahead eventually and
17 reach a plateau and hopefully eventually recover
18 or at least stabilize and stop having these kinds
19 of episodes.

20 Q. But you agree that her response to the
21 various and sundry medication therapies was less
22 than you would hope for as a treating
23 clinician?

24 A. Yes, absolutely, Jim.

1 Q. Now, you mentioned that ECT was not an
2 inevitable choice for treatment and then you
3 mentioned that it was, my notes trail off, and
4 then you indicate it was contraindicated, are you
5 opining that ECT was absolutely contraindicated
6 in this case?

7 A. Initially it was not absolutely
8 contraindicated, but if it was going to be given
9 and needed to be given in a limited manner with
10 extremely careful monitoring, again, unilaterally
11 to begin with in a manner which was informed and
12 what was contraindicated was involuntary ECT for
13 this particular patient who would be particularly
14 sensitive to the involuntary coerced nature of
15 ECT.

16 Q. Why did it have to be unilateral?
17 Bilateral is standard of care, is it not?

18 A. Bilateral ECT for manic patients who
19 are at low risk is certainly something which can
20 be given.

21 However, unilateral ECT for patients
22 who are at high risk is less likely to go ahead
23 and produce memory damage.

24 Now, if unilateral ECT fails and there

1 is no memory damage, you certainly can proceed to
2 bilateral ECT, but you need to do it in a
3 sequence rather than jumping right away to
4 bilateral involuntary ECT.

5 Q. Do you consider yourself an expert in
6 ECT therapy?

7 A. I consider myself, I practice
8 psychiatry which included expertise in evaluating
9 patients as candidates for ECT and the kind of
10 ECT administration that any particular patient
11 would, in fact, have it be optimal for.

12 I don't administer at this point ECT
13 myself, but I certainly have consulted on
14 patients who have undergone ECT or who are
15 candidates to undergo ECT to see whether or not
16 they're appropriate candidates and whether
17 appropriate informed consent has been obtained,
18 and I do consider what other potential treatment
19 options for the patients I treat.

20 Q. You mentioned as one of the bullet
21 points as involuntary treatment went on the
22 number of treatments was a contraindication given
23 her vulnerabilities and her memory loss, and I
24 think we've talked about that.

1 You're talking about the number of
2 maintenance ECT and the fact that she complained
3 of memory loss over time, is that what you're
4 talking about?

5 A. Yes, and the fact, again, that they
6 were initiated and maintained on an involuntary
7 basis or subsequently on a coerced basis.

8 Q. And can you agree with me that
9 Dr. Roberts does document, does chart, if you
10 will, observations of memory but your position is
11 that is not sufficient, he needed to do
12 neurocognitive testing to test the memory is what
13 you told earlier; is that correct?

14 A. He needed to do neurocognitive
15 testing. He needed to go ahead and at the very
16 least do some formal mini mental status testing
17 which he didn't do.

18 He really needed more than that. He
19 needed to refer her for neuropsychological
20 testing and follow her with neuropsychological
21 testing.

22 Q. Are there any circumstances where an
23 outpatient clinician such as yourself or
24 Dr. Roberts can note some subjective memory loss

1 and monitor it to see if it improves over time
2 and be within the standard of care when someone
3 has ongoing ECT therapy?

4 A. Not when someone has ongoing ECT
5 therapy because ECT therapy, especially in a high
6 risk patient, can foreseeably lead to permanent
7 memory loss and brain damage, which is manifested
8 as permanent memory loss and also loss of other
9 brain function such as executive functions.

10 Q. Dr. B, it seems to me a large aspect
11 of your opinion hinges on your position that she
12 was a high risk patient; is that a fair
13 characterization?

14 A. Not just that she was a high risk
15 patient but also that this was involuntary
16 treatment and there was a high volume of
17 treatment, 80.

18 Again, if you look at the NICE
19 guidelines, I think those are fair guidelines.
20 They're written by the British National Health
21 Service, which is no dog in the fight here.

22 You have to be extraordinarily careful
23 with a higher volume especially when it's coerced
24 or involuntary ECT.

1 So she was at high risk to begin with
2 and by virtue of the fact that this was a high
3 volume and involuntary it became overwhelming.

4 I try and look at any fact that is
5 presented to me from both sides because I consult
6 as much for defense attorneys as I do for
7 plaintiff's attorney, I consult to other
8 clinicians, and I just don't see given how her
9 initial level of risk, how her risk increased,
10 that this was coerced and involuntary why such a
11 low level of monitoring and such a pro forma
12 level of informed consent.

13 Just having people sign consent forms
14 rather than it being a process. I know that's
15 something which people wanted to have happen, it
16 just didn't happen here from what I can tell.

17 Q. Let me ask you this: Is it fair to
18 say that over the last ten years that you have
19 earned over a million dollars off expert fees?

20 A. I would imagine so.

21 Q. The next one on my outline is
22 alternatives need to be considered, should have
23 offered alternative treatment to ECT. I think we
24 have discussed this.

1 Can you just as briefly as you can
2 tell me what alternatives you're talking about, I
3 think you told me about psychotherapy?

4 A. A comprehensive program of
5 psychotherapy focusing on issues around a
6 therapeutic alliance, difficulty in her adherence
7 to medication, grief and unresolved grieve,
8 issues around her memory loss including
9 potentially group psychotherapy, occupational
10 therapy, medication management such as
11 intramuscular long lasting neuroleptic medication
12 such as Prolixin, for example, potentially trying
13 to add to that a clonopin regimen that she could
14 stick to and adhere to or some other kind of
15 benzos, mood stabilizer, Lamictal in this context
16 could be more beneficial than it actually was if
17 it was done in a proper psychotherapeutic and
18 overall medications management context.

19 Q. But you agree with me that she had had
20 prior to ECT psychotherapy and medication
21 management not only by Dr. Roberts but by several
22 other treating clinicians as we described earlier
23 or characterized earlier with limited success?

24 A. It was with limited success, however,

1 it was successful enough to prevented an extended
2 course of high dose involuntary ECT, so it was at
3 least of limited success but of much less harm,
4 again, primum non nocere, you do no harm as a
5 physician.

6 Q. You next said in this bullet point
7 list that Dr. Roberts should have advised the
8 patient for the need for a guardian ad litem?

9 A. Yes, either that for perhaps have the
10 patient create a living will document where she
11 could go ahead and specify what her treatment
12 should be should she become incapacitated like
13 being psychotic given the conflicts of interest
14 that existed with her husband who was both
15 separating from her eventually divorced her, the
16 fact that there was an institution involved where
17 her husband's brother-in-law was the chair of the
18 board of trustees.

19 She needed to have an independent
20 well-informed decision maker as her guardian ad
21 litem.

22 Q. What --

23 A. She herself complained actually during
24 her first hospitalization of conflicts of

1 interest so she herself had brought this up.

2 This should have been validated and an
3 alternative should have been provided to her with
4 a non-conflicted guardian ad litem who could
5 reasonably weight risks, benefits and
6 alternatives including the risk of her proceeding
7 with treatment in a situation which was filled
8 with conflicts of interest that she herself was
9 complaining about.

10 Q. What's your position on what Miss
11 Johnson was complaining about Dr. Roberts
12 relative to the ECT treatment?

13 A. I am not sure I understand your
14 question.

15 Q. What do you contend Miss Johnson was
16 telling Dr. Roberts about the ECT therapy as she
17 was undergoing it?

18 Do you contend that she was telling
19 him, hey, they're over here brutalizing me giving
20 me involuntary treatment, I don't want to go
21 back, please help me?

22 What do you contend she was telling
23 him or that he was aware of in that regard?

24 A. He was aware in his meetings with her

1 that she did not want the ECT treatment. He
2 should have had access to the medical record and
3 the discharge summary from the hospital as a
4 treating psychiatrist where she speaks about
5 conflicts of interest at MUSC and how suspicious
6 she is of that given her husband's position and
7 her husband's brother-in-law's position as chair
8 of the board of trustees there.

9 He should have explored with her the
10 alternative of having any additional
11 hospitalizations occur outside of the MUSC system
12 given her complaints during the hospitalization
13 about potential conflicts of interest.

14 He should have explored with her
15 alternatives to electroconvulsive therapy given
16 her complaints about electroconvulsive therapy?

17 Dr. Roberts could have certainly asked
18 for the medical record as well as I was able to
19 ask for it with Miss Johnson's consent. She
20 never refused him access to the MUSC medical
21 record at least as far as what I know and I can
22 tell.

23 Q. You say there was no evidence that
24 Dr. Roberts gave her the opportunity to benefit

1 from psychotherapy, what is that based on?

2 A. The lack of any documentation, of any
3 comprehensive plan of psychotherapy which
4 includes grief work and a focus on the
5 therapeutic alliance as well as Dr. Roberts' own
6 testimony what he is describing is at best
7 superficial and at worst just close to nothing
8 basically to the extent that she's being simply
9 redirected to look at what's positive in her
10 life.

11 Q. What do you base that on? Is that
12 based on the question I asked you earlier about
13 redirection or is there something you're actually
14 referring to in the chart about that?

15 A. No, just referring to the question you
16 had asked me previously, however, in reading
17 Dr. Roberts' deposition I don't see any evidence
18 that he provided her with any meaningful grief
19 work, any specific exploration of what factors
20 made it so difficult for her to adhere to her
21 medication regime. Similarly in reading his
22 notes I just don't see that at all.

23 I don't see any referral for group
24 psychotherapy. I don't see any referral for

1 occupational therapy.

2 It's not only a failed treatment plan,
3 it's a below the standard of care treatment
4 plan.

5 Q. Was Miss Johnson a candidate for group
6 psychotherapy given her condition?

7 A. Once her condition had stabilized
8 certainly introducing her to a group, yes. I
9 have had patients who have had manic depressive
10 episodes in group therapy.

11 I've practiced group psychotherapy and
12 such patients can do very well because they don't
13 feel so alone, so helpless, so hopeless.

14 She was also a candidate for ongoing
15 family therapy. When there was separation from
16 her husband she should have been told about it.

17 She shouldn't have been the last
18 person to know about it when she was
19 hospitalized.

20 To the extent that she was the last
21 person to know about it when she was
22 hospitalized, Dr. Roberts when she became an
23 outpatient had those records, he could have
24 addressed those issues with her, which is

1 certainly a focus for mistrust.

2 Q. You next told me that failed to
3 monitor her cognitive impairments, I think we've
4 talked about that, correct?

5 A. Yes.

6 Q. And then we talked about the
7 Wellbutrin and Conerta issues, correct?

8 A. Correct.

9 Q. Have you diagnosed her with
10 post-traumatic stress disorder?

11 A. Again, she suffers from impairments in
12 the post-traumatic stress disorder spectrum. I
13 understand it to be a spectrum rather than simply
14 a category. The category simply refers to a
15 group of patients.

16 Her suffering is in the spectrum, so
17 yes, she does suffer in the post-traumatic stress
18 disorder spectrum secondary to the brain damage
19 which was done and the memory loss that she's had
20 and the involuntary nature of the ECT itself.

21 Q. So you have diagnosed her with
22 post-traumatic stress disorder, correct?

23 A. I have diagnosed her as suffering in
24 the post-traumatic stress disorder spectrum.

1 Q. Has any clinician before you diagnosed
2 her with post-traumatic stress disorder?

3 A. There has been no attempt made to
4 either rule in or rule out post-traumatic stress
5 disorder.

6 The focus has been on her bipolar
7 disorder rather than on the consequences of her
8 ECT as far as I can tell.

9 Q. Can some of the mental impairments
10 that come with a severe bipolar disorder patient
11 overlap into the realm of the criteria that is
12 utilized to diagnose PTSD?

13 A. Of course there can be some overlap,
14 but elephant's trunks and snakes feel the same,
15 but elephants and snakes are different.

16 Q. Are you suggesting that there is not
17 the potential for some overlap in the testing
18 that you administered that some of those answers
19 may merely reflect her mental disease from the
20 bipolar disorder rather than a PTSD?

21 A. Some of the may but all of them
22 cannot.

23 Q. Does bipolar disease progress over
24 time or can it progress over time?

1 A. It can be progressive. It can also go
2 ahead and reach a plateau and also people can
3 stabilize and simply be maintained with a program
4 of psychotherapy and psychotherapy medication so
5 that it doesn't continue to recur.

6 It can be a progressive disorder with
7 recurrence recurring more and more frequently
8 especially in the face of loss, or it can be a
9 disorder which is recurrent but eventually
10 becomes more of a vulnerability than an ongoing
11 impairment.

12 Q. The PAI test that you spoke of earlier
13 you agree that that is a subjective report from
14 the patient?

15 A. No. It's takes subjective from the
16 patient and compares them objectively against a
17 group of patients and compares them blindly
18 without any knowledge of their being any
19 litigation or anything else about the patient's
20 condition.

21 It's an objective measure of whether
22 or not the patient is faking, exaggerating or
23 malingering and the simple answer is she is not
24 by that test or any other measure that I have

1 seen.

2 Q. And these tests are to be effectively
3 utilized on a patient who suffers from brain
4 damage?

5 A. They can, it depends on the extent of
6 brain damage as to how effectively they can be
7 utilized the extent the patient has brain damage,
8 but they simply can be used with patients who
9 have some degree of brain damage.

10 Q. How would you characterize Clair
11 Johnson's brain damage?

12 A. In terms of the impact that it has on
13 her life, it's been catastrophic especially in
14 view of the fact that she suffers from the trauma
15 of coerced ECT over the course of five years,
16 involuntary ECT over the course of five years and
17 she suffers from bipolar illness.

18 And she also has suffered from a
19 variety of losses where her autobiographical
20 memory would be very helpful.

21 On the other hand she is someone who
22 has had resiliency, although her resiliency was
23 largely exhausted by the trauma of atrogenesis
24 namely the foreseeable side effects of a

1 treatment that was counter-indicated to being
2 with, nonetheless, she tries her best.

3 She's able to bounce back at least for
4 periods of time. So I think relative to where
5 she was before the ECT, it's been major. On the
6 other hand, she does not yet require
7 institutionalization.

8 Q. So she's had catastrophic brain injury
9 but you think that she's functional to perform a
10 PAI test and get results that are reliable out of
11 it?

12 A. Yes.

13 Q. The PAI is not diagnostic of PTSD,
14 correct?

15 A. In and of itself it is not diagnostic
16 of classic post-traumatic stress disorder.

17 Q. And how do you diagnose someone with
18 post-traumatic stress disorder when they tell you
19 that they don't remember the trauma that's
20 inciting the PTSD?

21 A. Because even if they don't remember,
22 they tell you they don't remember, you can
23 observe their physiological responses.

24 They can become fidgety. They can

1 become numb. They can space out the way she did.
2 Their pupils can become dilated which is
3 consistent with arousal.

4 She also herself on the Davidson
5 questionnaire does report some intrusive elements
6 and foreseeably anyone who has lost a good part
7 of their memory and their brain function due to
8 something which they did not consent to is going
9 to be traumatized by it.

10 You wouldn't be human if you weren't
11 traumatized by it and especially if you were to
12 begin with have a vulnerability to having a
13 bipolar condition.

14 Q. Even if you don't remember?

15 A. You may not remember it, but your body
16 remembers it. You may not be aware of it, but
17 you still see people's physical reactions and
18 still see where they are avoiding trying to talk
19 about it.

20 Q. Was part of your evaluation for
21 physiological responses to certain stimuli?

22 A. Part of my evaluation was to observe
23 her and observe her demeanor, which is what I
24 usually do with patients to see what their

1 responses were as far as who their demeanor
2 changed as we talked about various areas of her
3 experience, and this is a particularly
4 distressing area of her experience.

5 Q. Did you record anywhere in your
6 reports her physiological responses?

7 A. No, but I did mention that this was
8 consistent with my observation.

9 Well, I should say actually -- let me
10 just take a look here. If you look at Page 8,
11 Number 3.

12 Q. From what report, your most recent
13 one?

14 A. This will be April 1st, 2011 and it
15 says examination/observations. Number 3, Miss
16 Johnson observed difficulty in maintaining
17 attention and concentration so as to present a
18 coherency collection of facts and ideas was
19 especially pronounced when she spoke about the
20 period in which she was subjected to ECT without
21 meaningful consent.

22 This selective impairment
23 unaccompanied by signs of faking, malingering or
24 exaggerating is consistent with all the

1 indications in the records that both the ECT
2 itself and its forces administration over an
3 extended period of time constituted a significant
4 traumatic experience for Miss Johnson involving
5 feelings of helplessness and terror.

6 Such traumatic emotional experience
7 will foreseeably compound the physiological
8 effects of ECT in causing cognitive impairment.

9 Q. So you would talk to her about the
10 time period that she was getting ECT and she
11 would not remember it?

12 A. It's more than just not remember it,
13 she would become scattered and disorganized and
14 very anxious and observably so around that time.

15 She would become hyperaroused and
16 space out and become numb. She had a variety of
17 responses that I expect when someone has been
18 traumatized and avoiding talking about something
19 which she cannot quite put into true words but
20 they nonetheless are feeling the trauma.

21 Q. Is that not consistent with her
22 underlying demeanor from her disease process?

23 A. Not by itself because her demeanor was
24 more composed when she was talking about her

1 memory impairment themselves or about other areas
2 of her life which are conflictual and stressful
3 did not produced the same kind of numbing,
4 spacing out and hyperarousal that was produced
5 when I put up the issue of what was it like for
6 her to receive involuntary ECT.

7 Q. Any other aspect of your physiological
8 evaluation to support this diagnosis of PTSD
9 other than what's contained in Paragraph 3 on
10 Page 8 of your report?

11 A. That's the gist of it.

12 Q. So it was your physiological
13 assessment and the Davidson checklist, are those
14 the components of your post-traumatic stress
15 disorder diagnosis?

16 A. The overall fact and the totality of
17 the information which I have reviewed and
18 analyzed and have spent time reviewing and
19 analyzing.

20 Q. Did the Davidson trauma scale have any
21 validity scales built in?

22 A. It does have some validity scales
23 built in if we look at the Davidson trauma scale.
24 But basically what's most consistent her

1 avoidance numbing score is twice as high as her
2 intrusion score and her hyperarousal score which
3 is consistent with someone who has a dissociative
4 response to trauma and also has gotten and has
5 difficulty maintaining conscious awareness of the
6 trauma.

7 And if you look at her responses and
8 the nature of her responses and that plus the
9 NFI, those would be consistent with someone who
10 suffers impairments in the post-traumatic
11 spectrum.

12 Q. Part of this assessment included her
13 trauma being the cone rod dystrophy?

14 A. Yes, we did talk about that and
15 discuss it and she was able to go ahead and
16 maintain an appropriate level of attention,
17 concentration and demeanor when discussing this
18 particular health problem that she also has.

19 Q. Did you not find that some of her
20 responses in the Davidson Trauma Scale are
21 inconsistent with the others?

22 A. Can you be more specific perhaps. I
23 am not sure what you mean by inconsistent with
24 the others.

1 Q. Let's just take the first five
2 questions. Is four the maximum score?

3 A. Four is the maximum score in terms of
4 frequency.

5 Q. So look at those five, you don't have
6 to read them outloud. There are three of them
7 that she scores zero on and two of them she
8 scores four on.

9 And I am a lay person, but it looks to
10 me like these overlap with each other for
11 consistency sake, sometimes they repeat the
12 questions slightly different ways, is that not
13 the case here?

14 A. No because, in fact, people who would
15 score every one of them as being four I would be
16 very suspicious of as faking, exaggerating or
17 malingering, no.

18 It's one thing to have had some
19 painful images and memories of the event, but
20 sometimes people just don't dream, especially
21 people who have been somewhat brain damaged or
22 don't have dreams related to that event.

23 People may have painful memories or
24 thoughts, but they not feel as if the event is

1 recurrent.

2 On the other hand, it makes sense that
3 they would be upset if they're reminded of
4 something especially if there is a memory deficit
5 onto of the PTSD.

6 In terms of being physically upset,
7 people are very often not aware of being
8 physically upset although you can observe.

9 Sometimes I will look at people and I
10 know their heart is racing and they never say to
11 me my heart is racing because they just block it
12 out.

13 If you have someone, Jim, who gives
14 you all fours on these, then it would raise a red
15 flag for me that they are, in fact, faking,
16 exaggerating or malingering.

17 This is much more consistent with
18 someone who is doing her best to cope with the
19 distress that she feels.

20 Q. Were the validity scale scored in this
21 case?

22 A. The validity scales were added up in
23 this case, yes.

24 Q. And where are they?

1 A. Go to Page 3 on this, on the DTS.

2 Q. Okay. Just give us the results,
3 please.

4 A. It's more likely that she has
5 post-traumatic stress disorder rather than not
6 post-traumatic stress disorder.

7 Q. Say that another way. What do the
8 validity scales tell us? Is there an indication
9 of some fawning or exaggeration or not?

10 A. No.

11 Q. So she is basically scored with no
12 indication of any inaccuracies or invalidates or
13 whatever the terms of art is?

14 A. I think the only inaccuracies that
15 might be there could be easily understood in
16 terms of her memory loss.

17 Q. And this is a 17 question exam that's
18 filled out by the patient, she reads the question
19 and then fills out her answer on a scale of zero
20 to four, that's how this is administered,
21 correct?

22 A. That is how this is administered, yes.
23 Again, when you have someone with memory loss,
24 the validity scales in and of themselves can be

1 somewhat misleading.

2 That's why you have to rely on the PAI
3 which is more robust as far as the possibility of
4 exaggeration, faking or malingering is
5 concerned.

6 Q. Is it your testimony that her bipolar
7 illness could not cause -- I am not going to go
8 through each test because we have done that, but
9 is it your position that bipolar disorder
10 especially to the degree that she had as we know
11 even before ECT therapy could not account for
12 some of the responses, either bipolar disorder,
13 depression, and/or ADHD could not account for the
14 responses that we have on the executive function,
15 the language, the memory and these various other
16 checklists that she went through?

17 A. A few, yes, some maybe, but absolutely
18 not the total.

19 Q. Can bipolar patients such as with the
20 executive function, would it be unusual for a
21 bipolar patient with her degree of illness have
22 problems with sequencing and problems with follow
23 through and things of the like, would that be a
24 surprise to have her score or report those

1 deficiencies?

2 A. During the active phase it would be no
3 surprise, however, during a non-active phase of
4 the illness this would be unusual.

5 Q. Well, I understand that, but all she
6 did was a checklist, in other words, this was no
7 true testing.

8 You gave her a checklist questionnaire
9 where she checked if she had problems with these
10 issues; isn't that right?

11 A. No because what you are overlooking is
12 that this was part of a battery where, in fact,
13 she also received a PAI, which did not show her
14 to be actively manic or she wouldn't have been
15 able to attend.

16 During my own observations she was not
17 actively manic at the time. She wasn't actively
18 manic, Jim, so the symptoms that she was
19 reporting experiencing at the time cannot be
20 attributed to mania.

21 Q. So it's your position that the
22 checklist questionnaire was specifically asking
23 her if she was having problems at the very moment
24 with these various issues as opposed to a recent

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1 history of those issues?

2 A. I was asking her when she was
3 functioning the way she was functioning when I
4 saw her what was her experience, and I made it
5 clear that I was not speaking about an acute
6 manic episode or a major depressive episode, but
7 when she was functioning the way she was
8 functioning when I saw her.

9 Q. Did you report, you may have, and I am
10 just overlooking, but did report anywhere where
11 she specifically expressed to you thoughts or
12 feelings regarding the involuntary ECT that
13 you've been talking about?

14 Aside from all these checklists which
15 are non-specific, did you actually record
16 something where she told you specifically about
17 the ECT therapy?

18 A. As I noted previously in the paragraph
19 which I read to you, she became very disorganized
20 and very frightened when trying to go ahead and
21 talk about it when we tried to talk about it.

22 Q. Anything other than that paragraph
23 where you recorded that she specifically
24 expressed to you the stress, the trauma, the

1 outrage or anything of the like that she has
2 undergone as a result of the ECT therapy?

3 A. More precisely the fear, the loss.
4 Again, she communicated that she evoked that.

5 I could observe her demeanor change
6 when she was trying to talk about it and could
7 not talk about it.

8 The trauma even at this stage is
9 largely unspeakable for her but because it's
10 unspeakable it doesn't mean she's not suffering.
11 The two are not the same.

12 Q. All I am asking is if you recorded
13 that specifically anywhere in all of these notes,
14 reports of anything of the like other than that
15 paragraph that you have referred me to?

16 A. That paragraph summarized the gist of
17 my observations from my examination.

18 Q. So is the answer to my question no?

19 A. Which question is that?

20 Q. Have you recorded anywhere else in any
21 of your notes or reports or anywhere else her
22 expression to you of her fear, anxiety,
23 overwhelming sense of doom or loss or whatever
24 associated with this involuntary ECT, did you

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1 record that anywhere other than that paragraph
2 that you referred me to?

3 A. No. The gist of my observations is
4 contained in that particular paragraph.

5 Q. Do you have any other opinions as to
6 Dr. Roberts that we have not yet reviewed?

7 A. I believe that you have the gist of my
8 opinions regarding Dr. Roberts as well, I hope
9 you do, and I hope I've communicated them in a
10 manner which is not confusing.

11 Q. I noted in some of the materials that
12 we were provided that you were given a copy of a
13 case out of Columbia, what we call the Salters
14 case, are you familiar with is that?

15 A. I remember looking at it, but it
16 wasn't the foundation of my opinion.

17 Q. That's all I was going to ask you.
18 Does it have any bearing on your opinions in this
19 case?

20 A. No.

21 Q. Are there any textbooks that you are
22 partial to that you think are good go-to
23 textbooks that might be considered authoritative
24 in the field of psychiatry particularly relative

1 to ECT or bipolar disorder?

2 A. No. As I teach my students unlike
3 religion we don't have any authoritative texts.

4 Every book we have has some
5 information in it which is helpful, some that's
6 not helpful, some that is valid, some that's
7 mistaken and some that has simply outlived its
8 usefulness.

9 So you have to be a mindful reader.
10 You can't simply go ahead and scan the text and
11 have what you need to be able to treat patients
12 well.

13 Q. What text do you teach your students
14 out of?

15 A. I don't use any specific texts. My
16 students simply look at this text and that text
17 for various bits of information, but there is no
18 Bible of psychiatry contrary to the opinion of
19 some attorneys.

20 Q. All right. You agree that physicians
21 being sued for medical malpractice should not be
22 judged with hindsight, they should be judged by
23 the experts as if they were sitting in their
24 shoes at the time?

1 A. Yes, and that means two directions.
2 On the one hand, one doesn't want to go ahead and
3 assume that a clinician could have prevented a
4 harm when they couldn't have.

5 On the other hand, one doesn't want to
6 buy into denial which is that que sera sera that
7 whatever happened happened was inevitable.

8 Both types of policies can be a
9 result of hindsight. A clinician who is overly
10 critical of himself can assume they could have
11 prevented something when they couldn't have.

12 A clinical who is into denial and who
13 thinks that that they cannot have possibly
14 practiced below the standard of care will simply
15 say that what happened was inevitable and it had
16 to happen, and it was just the natural course of
17 illness and there was nothing they could have
18 done. Both types of error need to be avoided
19 from hindsight.

20 Q. Do you agree that standard of care
21 does not require perfection?

22 A. The standard of care does not require
23 perfection, but it does requires reasonable
24 prudence.

1 Q. Have you ever treated bipolar patients
2 who suffered with depression as a part of their
3 disease with antidepressant medication as a part
4 of your medication regime?

5 A. Under carefully controlled conditions,
6 yes, especially if there is no indication that
7 those antidepressants were, in fact,
8 precipitating hypermanic or manic episodes, and
9 if there was additional appropriate psychotherapy
10 and medication as part of a comprehensive
11 treatment plan.

12 Q. Well, that's something that you as a
13 clinician when you decide that the benefits
14 outweigh the risks and you go forward with that
15 regimen you simply are left to watch the
16 medication to see if it drives the cycle, right,
17 and then if it does you have to work to get the
18 patient off of the medication until the cycle
19 subsides, isn't's that how that work?

20 A. That's a great question, Jim, because
21 it's partially true, but there is on addition I
22 would make to it that it's absolutely crucial to
23 inform the patient of the possibility that the
24 antidepressant medication that you're giving them

1 may, in fact, precipitate mania or may
2 precipitate more rapid cycling, so that when it
3 happens the patient knows what to expect and the
4 patient can work with you as part of a
5 therapeutic alliance to catch it early enough
6 before it gets out of hand and the patient
7 requires hospitalization.

8 So educating patients and families
9 about the fact that this carries some foreseeable
10 risk and how to monitor that risk is absolutely
11 helpful.

12 In some instances I've asked family --
13 I've said to patients we're going to be using
14 antidepressants here. You may become hypomanic.
15 I need to see you more frequently. I need to be
16 able to talk to your family about how you're
17 doing and I get permission to do that.

18 Q. Do you disagree that the recent
19 hospitalizations Clair Johnson has undergone in
20 the recent years obviously since the ECT was
21 stopped is most probably related to her
22 underlying severe bipolar disorder?

23 A. I think it's an over simplification to
24 reduce it to that. Of course her underlying

1 bipolar disorder contributes to her
2 vulnerability, but so does the stress that, the
3 trauma that she suffered from due to her loss of
4 memory and the involuntary ECT due to the brain
5 injury that she suffered as well as the loss of
6 autonomy that she experienced while the ECT was
7 being administered on an involuntary basis and
8 then the fact that her mother became ill and she
9 lost her mother and the grief that she would have
10 experienced around her mother becoming more
11 fragile and losing her mother. That's huge.

12 It would be difficult enough for
13 anyone, more difficult for a patient with bipolar
14 disorder, you're absolutely right about that,
15 much more difficult for a patient who suffers
16 from major impairments in autobiographical memory
17 and has to grieve the loss of her memory and her
18 autonomy due to the involuntary massive doses of
19 involuntary ECT that she was subject to.

20 Q. And the loss of that autobiographical
21 memory is, you're basing that opinion on that
22 checklist that you went through with Mr. Early
23 earlier where she checked a few boxes saying she
24 didn't have that good autobiographical memory

1 anymore?

2 A. Not just based on her checking, but
3 when we tried to explore various dimensions, it's
4 clear that she had to think very long and very
5 hard to be able to retrieve pieces of her own
6 biography and in some instances she simply wasn't
7 able to do so. It's tragic.

8 Q. Did her deposition shed any light on
9 that as far as what she was able to tell us about
10 her history and her going to college and her high
11 school friends and things like that?

12 A. No, the deposition itself was
13 relatively superficial. It was not an
14 exploration of those areas of her life which
15 would be conflictual or involve deep -- in a
16 deposition what you -- the answer is no.

17 A deposition is not a psychiatric
18 examination of someone's autobiographical memory,
19 no.

20 Q. Well, is there any in depth
21 psychiatric evaluation of her autobiographical
22 memory performed by you other than that checklist
23 we went over earlier?

24 A. We talked and I observed what she was

1 able to remember and what she wasn't able to
2 remember and there were gaps in her memory about
3 her life.

4 Q. Have you offered any opinions in any
5 print anywhere, on any paper anywhere as far as
6 recommendations for dealing with the
7 post-traumatic stress disorder? I didn't see it
8 anywhere in your report.

9 A. I have not put in it writing, but she
10 certainly needs to do a great deal of grief work
11 around the loss of memory that she has
12 experienced.

13 She needs to, once again, feel a sense
14 of justice. It's going to be -- and she needs to
15 learn to adapt to the fact that she doesn't have
16 the easy access or any access in some instances
17 to meaningful relationships in her memory when
18 she needs to access her memory.

19 She needs to grieve. If I were to
20 reduce it in a simple, she needs to grieve the
21 loss of access to meaningful memories.

22 Q. I need to be clear if I am
23 understanding you, are you attributing the PTSD
24 to the loss of memory or the trauma of the

1 involuntary commitment because it sounds like the
2 therapy you'r recommending is more so for the
3 loss of her memory than it is for dealing with
4 this, what she alleges to be this traumatic
5 experience?

6 A. It's not the involuntary commitment
7 per se, that's something that she can metabolize,
8 but the involuntary administration of ECT which
9 led to the loss of her autobiographical memory.

10 That's the trauma that she lives with
11 and has not been able to go ahead and grieve
12 yet.

13 Q. Have you attempted to put any monetary
14 figure on the value of the necessary therapy to
15 appropriately deal with those issues?

16 A. No.

17 Q. Well, has anybody asked you to that
18 thus far?

19 A. No.

20 Q. If at any time you're asked to do
21 something along those lines or asked to bolster
22 your opinions in anyway or argument your opinions
23 in that regard, please somebody let us know so we
24 can do this again and find out what you're going

1 to say.

2 MR. RAVENEL: You'll be the first to
3 know.

4 A. You have what I understand at this
5 point.

6 Q. Thank you for your time.

7 REDIRECT EXAMINATION BY MR. EARLY:

8 Q. Doctor, I really just have one
9 question maybe. Are you familiar with the terms
10 state of the art?

11 A. Yes, more or less state of the art is
12 a terms which is used in many different ways.

13 Q. Well, I'll tell you the context. In
14 the context that something may be considered
15 malpractice by the standards of 2010, but might
16 not be by the malpractice standards of 1998, in
17 other words, medicine evolves and what doctors
18 understand and the risks and foreseeability of
19 certain things and certain procedures change over
20 time, you agree with that concept?

21 A. I do. What stays constant is being
22 reasonable prudent and primum non nocere.

23 Q. But the knowledge, if you will, that
24 goes into that prudence certainly changes over

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1 time in medicine as it does in law as in many
2 other fields; do you agree with that?

3 A. Yes.

4 Q. Thank you, Doctor.

5 RECROSS-EXAMINATION BY MR. SCOTT:

6 Q. I do actually have a couple more
7 questions, if you don't mind. You signed an
8 affidavit early on in this case; do you remember
9 that?

10 A. Yes.

11 Q. And you were of the opinion that, as I
12 understand, it's your opinion that Clair Johnson
13 did not regain the mental capacity to understand
14 and appreciate the harm she suffered as a
15 consequence of the negligent acts or omissions
16 specified above particularly regarding the
17 involuntary ECT until she began reviewing the
18 records in January of 2010, correct?

19 A. Yes.

20 Q. I just wanted to confirm that that was
21 your opinion. Can you explain the basis for that
22 opinion?

23 A. Well, if you have major gaps in your
24 autobiographical memory because of massive doses

1 of involuntary ECT, you won't recognize what harm
2 it caused you and put two and two together until
3 such time you have something riding in front of
4 you which can go ahead and help you understand or
5 remind you of how you felt about it and what
6 happened.

7 Q. But what are you relying on is what I
8 am getting at? What are you relying for the
9 expert opinion that it wasn't until June 2010
10 until she appreciated this?

11 A. Because of the loss of
12 autobiographical memory. That was evident in my
13 examination, that was evident in her self-reports
14 and at the same time it's consistent with the
15 totality of the data which I reviewed and
16 analyzed.

17 Q. So you believe she regained her mental
18 capacity in June of 2010 basically at which time
19 she had regained her mental capacity and when she
20 reviewed those medical records that's when she
21 appreciated the harm; is that what you're saying
22 in essence.

23 A. No. What I am saying is that by
24 review those medical records she was able to have

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1 the information she needed to go ahead and
2 appreciate the harm that had occurred to her.

3 Without reviewing those she could not
4 rely on her own memory to exercise her judgment.

5 It's the deficits of her
6 autobiographical memory and her executive
7 function that I was describing previously.

8 Q. Okay. And as far as the information
9 as far as when she reviewed those records to
10 appreciate this information, your basing that on
11 what she reported to you?

12 A. I am basing that on what she reported
13 to me, my observations of her during the
14 examination itself.

15 Q. Dr. B, where does the date of June
16 2010 come from, is that the date itself? I know
17 she didn't meet you until after that, but where
18 are you getting the date of June 2010 from?

19 A. That when she reported that she began
20 to read the medical records that she had, that
21 she was able to go ahead and get over given the
22 loss of her autobiographical memory, the trauma
23 that she suffered and the foreseeable avoidance
24 that she would have of that information because

1 she didn't want to be upset, she couldn't stand
2 being upset, that's when she said she began to
3 read those medical records in detail.

4 Q. Do you know when she ordered those
5 records?

6 A. I don't, but I wouldn't be surprised
7 it was years earlier even, but that's when she
8 actually began to study them.

9 Q. Okay. Thank you for your time.

10 A. Thank you, Will, and thank you, Jim,
11 appreciate it.

12 (Whereupon, the deposition was
13 concluded at 4:00 p.m.)

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1 COMMONWEALTH OF MASSACHUSETTS

2 Middlesex, ss

3

4 I, Victoria S. Reade, Professional Court
5 Reporter and Notary Public in and for the
6 Commonwealth of Massachusetts, do hereby certify
7 that the witness whose deposition is hereinbefore
8 set forth, was duly sworn by me and that such
9 deposition is a true record of the testimony
10 given by the witness.

11 I further certify that I am neither related
12 to nor employed by any of the parties in or
13 counsel to this action, nor am I financially
14 interested in this action.

15 In witness whereof, I have hereunto set my
16 hand and affixed my seal on this 11th day of
17 November 2013.

18

19

20 Victoria S. Reade

21 NOTARY PUBLIC

22 My Commission Expires:

23 August 8, 2014

24

1 COMMONWEALTH OF MASSACHUSETTS

2 Middlesex, ss

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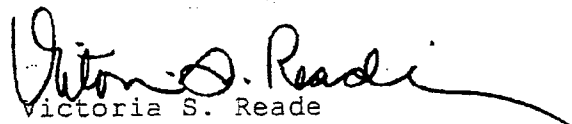
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24

I, Victoria S. Reade, Professional Court
Reporter and Notary Public in and for the
Commonwealth of Massachusetts, do hereby certify
that the witness whose deposition is hereinbefore
set forth, was duly sworn by me and that such
deposition is a true record of the testimony
given by the witness.

I further certify that I am neither related
to nor employed by any of the parties in or
counsel to this action, nor am I financially
interested in this action.

In witness whereof, I have hereunto set my
hand and affixed my seal on this 11th day of
November 2013.


Victoria S. Reade

NOTARY PUBLIC

My Commission Expires:

August 8, 2014

THE STATE OF SOUTH CAROLINA
In the South Carolina Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

The Honorable Deadra L. Jefferson
The Honorable R. Markley Dennis, Jr.
Charleston County

Trial Court Case No.: 2011-CP-10-08313
2012-CP-10-02867

Appellate Case No.: 2015-001463

Clair Craver Johnson Appellant

v.

John Roberts, M.D. Respondent

And

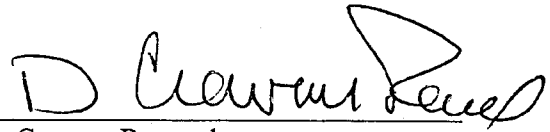
Clair Craver Johnson Appellant

v.

Medical University of South Carolina Respondent

CERTIFICATE OF COUNSEL

Pursuant to Rule 210(g), SCACR the undersigned hereby certifies that the Record on Appeal contains all material proposed to be included by any of the parties and does not contain any other material.



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March 1, 2016

THE STATE OF SOUTH CAROLINA
In the South Carolina Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

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MAR 14 2016

The Honorable Deadra L. Jefferson
The Honorable R. Markley Dennis, Jr.
Charleston County

SC Court of Appeals

Trial Court Case No.: 2011-CP-10-08313
2012-CP-10-02867

Appellate Case No.: 2015-001463

Clair Craver Johnson Appellant

v.

John Roberts, M.D. Respondent

And

Clair Craver Johnson Appellant

v.

Medical University of South Carolina Respondent

PROOF OF SERVICE

I, D. Cravens Ravenel, an employee of Baker, Ravenel & Bender, L.L.P., attorneys for Appellant Clair Craver Johnson, hereby certify that I have, on this 14th day of March 2016, served counsel below with Appellant Clair Craver Johnson's Record on Appeal, Volumes I and II, and Certificate of Counsel to Respondents The Medical University of South Carolina and John Roberts, M.D. by mailing copies of same via United States Mail, postage pre-paid and return address clearly indicated on said envelope to counsel at the following addresses:

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March 14, 2016

HAND DELIVERY

The Honorable Jenny Abbott Kitchings
Clerk of Court, South Carolina Court of Appeals
P.O. Box 11629
Columbia, South Carolina 29211

RE: Clair Craver Johnson, Appellant v. John Roberts M.D., Respondent
And
Clair Craver Johnson, Appellant v. Medical University of South Carolina,
Respondent
Appellate Case No.: 2015-001463
Our File No.: 10517.2

Dear Ms. Kitchings:

Enclosed for filing in the above-referenced matter are the original (unbound) and fifteen (15) bound copies of Appellant's Record on Appeal, Certificate of Counsel and Proof of Service thereof. I have enclosed an extra copy, which I would appreciate your clocking in and returning to me via courier delivering same.

By copy hereof, I am serving same upon counsel for Respondents.

Thank you very much.

Sincerely yours,

D. Cravens Ravenel
DCR:sr
Enclosure

cc w/Encl.:

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MAR 14 2016

SC Court of Appeals

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