IN THE SUPERIOR COURT OF THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

IN THE MATTER OF THE NECESSITY)
FOR THE HOSPITALIZATION OF)
WILLIAM S. BIGLEY,)
)
Respondent.)
)
Case No. 3AN-08-1252 PR

DEPOSITION OF [redacted], M.D.

Tuesday, November 4, 2008
10:00 a.m.

Taken by Counsel for William S. Bigley
at
The Offices of Law Project for
Psychiatric Rights
406 G Street, Suite 206
Anchorage, Alaska

A-P-P-E-A-R-A-N-C-E-S

For William S. Bigley:
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I-N-D-E-X

ANCHORAGE, ALASKA; NOVEMBER 4, 2008
10:00 A.M.
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[redacted]
deponent herein, being sworn on oath,
was examined and testified as follows:

MS. POHLAND: The state would like to object that discovery is taking place. We believe discovery is impermissible under the statute, and that, furthermore, notice was improper for these depositions.

The state is going to be filing a motion for reconsideration on its motions to quash, and the state will also be filing an additional protective order to maintain the confidentiality of these deposition transcripts.

EXAMINATION

BY MR. GOTTSTEIN:

Q. What's your name?

A. [redacted].

Q. I'm going to give you a copy of the subpoena. Does that look familiar?

A. Yes, it does.

Q. And then the back side had this attached to it.

A. Yes, I do.

MR. GOTTSTEIN: Could we mark that as

EXHIBIT A.

(Exhibit A marked.)

Q. It listed a number of things for you to bring. Did you bring any of those?

A. The only thing that I thought that is appropriate to bring was my resume and my board certification, and my resume is not the most update.

It's the one that I wrote two years ago, but very much everything is the same. And my board certification is the most recent one.

Q. Okay. But you have been employed at API since then, right; is that correct?

A. Yes.

MR. GOTTSTEIN: Could we mark that as B, I guess?

(Exhibit B marked.)

Q. And then the third thing is -- the second thing is a chart, but API provided me a copy of that, so that's fine.

Then the third one, so you don't have -- you didn't bring a report, right?

A. No, I did not.

Q. Have you ever had your deposition taken before?

A. No. I don't recall. I think this may be my first deposition.

Q. Do you know what it's for? I should have started that out --
A. No. If you would educate me, that would be great.
Q. Of course, you filed, or API has filed a petition to give the respondent drugs against his wishes, and so I'm his attorney.
This part is what's called discovery, which Ms. Pohland doesn't think that I'm entitled to do, but in any event, the idea is for me to get a chance to find out what -- well, you know, what your version of the facts are, let us say, in order to allow me to prepare.
So this is -- it's like testimony in court, except that, you know, the idea is that we will kind of hone things down so we don't have to take that much time with everybody in the courtroom, so that's the way I would describe it.
You filed a petition -- I think -- did you sign the petition?
A. Yes.
Q. So did you consider -- do you know about the Myers case?
A. To some level. To some level, but if you want to review it, that would be great.
Q. So I guess my question is what factors under

Myers did you consider before filing the petition?
MS. POHLAND: Objection. The deponent has already stated that she is not that familiar with the case.
Can you rephrase the question, please? She is not an attorney.
Q. Are you unfamiliar with the Myers' requirements?
A. As I said, I am familiar to the superficial level, so in order for me to answer that question, probably I would ask you to review in the summary of a few statements then I would be more comfortable.
Q. Have you ever consulted -- I'm not asking about any content, but have you ever consulted with anybody at the attorney general's office about the requirements of Myers?
A. Actually, I should be honest, API is very good at it, continuously updates us with some of these cases.
But for me, I need to recall it again, review it and make sure my understanding is exactly what API educated me about.
Q. What did they educate you about --
A. As I said --
Q. -- with respect to --
A. It had to do -- the case had to do with that individual, with Myers, who has taken medication against

his wishes and he did not want that and that went to the court.
Q. What medications are you -- medication or medications are you seeking authorization to use to administer to the respondent, Mr. Bigley, under that petition, not counting the emergency medications, just the regular ones?
A. I think it's still early. I still would like to see if I could bring it up to discuss it, even though Bill or Mr. Bigley is in a state that cannot make a rational thinking, but I would like to bring it up before I start any medication to give him a chance and discuss a few options that I have in mind, and then to finalize my decision.
Q. So at this point, you don't really know what medication you are going to ask the court to authorize?
A. No, I'm not saying that. I am considering both, more favoring towards the typical antipsychotic, the new antipsychotic medication, which is newer, but, again, I would like to give that opportunity to Mr. Bigley and then give him a few options of the old antipsychotic medication versus new antipsychotic medication.
And I am favoring more towards new antipsychotic medication because the record has indicated some sensitivity to the older antipsychotic medication.

Q. Here is my problem is that under Myers, and your lawyers may disagree with you, that -- or with me, I should say, that you need to seek specific authorization to administer specific drugs against his wishes with specific doses, and so -- and I'm trying to find out what you're going to ask the court tomorrow.
What I understand is that you don't really know at this point?
A. No, I do know. As I said, to be specific, at this point, I am focusing more on Risperidone, or second choice is probably I go to Zyprexa.
And the main part of it is sticking more with Risperidone versus Zyprexa is because Mr. Bigley has a long-standing medication noncompliance, and the Risperidone comes in the long-acting form, which he could receive some injection form, could say more stable and then helps him be more compliant.
So in that aspect, as I said, probably that is what I'm focusing on, but just like any of my other patients, I like to give them that opportunity to discuss it with them to see if they could give a rational thought and give me choices that is more favorable to them versus what I recommend to them.
Q. Would Risperidone be basically the same as what you were asking for in May?

A. I believe so, but I have to look at that record, but high probability it was Risperidone.
Q. That dosages and stuff?
A. Well, dosages probably would be the same. However, the long-acting form is very fixed. You start with 25 milligrams. The next one is 37 and a half, and then 50 milligram every two weeks.
Just like any other patient, I try to start low dose. Even though he has been exposed to that medication in the past, still I like to go very safe, very conservative, low dose, and then gradually increase it based on how he responds to the first initial dose.
Q. What side effects would you consider in making that decision?
A. Well, overall with the newer antipsychotic medication, I would disclose to the patient that they have lower possibility of tardive dyskinesia and EPS that they have faced with older antipsychotic medication, and this is the side effect, the TD.
I haven't seen it, but his old chart indicated that he may have shown or he has shown some sensitivity, so keeping that in mind that they have a lower risk, the possibility is a lot lower.
But the side effect of Risperidone specifically would be weight gain, which in this case for Mr. Bigley

probably would be beneficial; some sedation, which, again, giving it perhaps it improves his sleep. And I said about weight gain.
Hypertension, some mild headache and hyperprolactinemia. Those are some of the main significant side effects that I would be concerned and I would be monitoring very closely.
And if Bill has the threshold to listen and be able to rationally process, I would share it with him. And along with the other side effects which I mentioned, but is not as -- of course, every side effect is significant, but is not -- the percentage of it is kind of in a lower rate.
Along with those side effects, with every patient, we do monitor for any other side effects because every individual may respond to a medication and have a different side effect that may not have been -- have not been observed in other individuals.
Q. Okay. So if Mr. Bigley agreed to take the medications then that would be -- then that's what you would give him?
MS. DERRY: Objection. That's a leading question that is going to one of the elements of the charge.
MR. GOTTSTEIN: It's not --

MS. DERRY: Mr. Gottstein, are you asking her -- for my own clarification to decide whether or not she should answer the question -- whether or not if she asks him if he would take a medication that that means he is capable of informed consent?
Are you asking her that in the guise of a hidden question?
MR. GOTTSTEIN: No, I think that's the -- I think that's a legal conclusion from it, so I asked her if he agreed to it, would she give it to him. That was the question.
MS. DERRY: Without a court order? I would like this question to be more specific.
MR. GOTTSTEIN: Yeah, without a court order.
A. Well, I'm not clear without court order. As far as I understand right now, my patient is in a psychotic state. He doesn't have any insight to his mental illness.
He cannot give me informed consent from my evaluation, so I respect the statute. I cannot give any medication against their wishes unless it's an emergency situation, so until the court really does grant me that, I cannot make any conclusion from my approach.
Q. Okay. What do you consider Mr. Bigley's prognosis with and without the medication?

A. Unfortunately, based on his long-standing mental illness and long history of hospitalization, and long history of non-medication compliance, he continues to deteriorate, and every time his baseline is changing.
So putting those together, and then his lack of psychosocial support is really declining his symptoms, so prognosis is gradually declining, and is already, unfortunately, not very promising, very favoring.
But definitely with medication, he has shown some level of stability and was able to have a higher quality of life.
Q. So is it fair to say that his condition has declined over time?
A. It's very difficult for me to answer that question from the aspect of since I have not known Bill -- I got to know Bill for a year or two years, so I'm just only judging based on the record and based on my evaluation.
And definitely since I have been working with him, with more time, admission to API, I have not -- definitely I have seen him deteriorated more by him going more to the prison, not having a stable home setting.
Even the Paradise Inn, which is his residential state, it seems like that is also a challenge, so

putting that on the picture, so I think the answer is that it's not very positive.
Q. So when you say "review his record," how far back did you go?
A. I can't pinpoint -- I could say I have seen it from 2006, but from past, I may have gone further, but I'm not really sure. I have to look at my note.
Every day I look at all of my patients, try to go as far back as I can, so I cannot really specifically say how far back, but, definitely, I have seen his chart sometime from 2006 up to this date.
MR. GOTTSTEIN: You know, let's mark this as C.
(Exhibit C marked.)
Q. So on page one there, it's kind of -- the footer is right in some handwriting there, which I didn't notice before I printed it out.
Is that a record from API?
MS. DERRY: Objection.
A. It looks familiar.
MS. DERRY: Dr. [redacted] doesn't have personal knowledge of this. This is not the record that she has created herself.
Q. Does it look -- is it a record from API?
A. It says -- it looks like API record. It says

Alaska Psychiatric Institute and our form looks like that, so I would imagine it should be.
Q. Now, down at the bottom there is an asterisk. Again, it got covered up a little bit.
A. Uh-huh.
Q. Can you read what it says?
A. It says, "No emergency IM medication."
Q. So why would that be put there?
MS. DERRY: Objection; speculation. Do not answer that question.
MS. POHLAND: I'm going to object on the relevance given that --
MR. GOTTSTEIN: Are you instructing her not to answer?
MS. DERRY: Mr. Gottstein, if she didn't create this record, how do you expect her to answer that question?
BY MR. GOTTSTEIN:
Q. Let me ask a different question. Reading that, what would you understand that to mean?
MS. POHLAND: Object to relevance. This is for -- it appears to be from April 2008. The hearing at issue is for an October 2008 indication.
Q. You can go ahead and answer that.
A. So as I said, I did not write that order and I do

not -- this is basically -- it means to me that this individual should not be given emergency IM medication.
Usually what that means that if this individual, the crisis does come to the point that it becomes a concern of safety for himself and others, then they need to contact the clinician who is assigned to him or who is on call to be contacted.
Q. So why should it be different for Mr. Bigley than other patients?
A. I don't know if it is different or not. I cannot answer that question.
Q. If it's not different, why would it be written there?
A. Like I say, I cannot answer that question at the present time.
Q. Turning to the second page.
A. Uh-huh.
Q. The second entry.
A. Uh-huh.
Q. Can you read that to me?
MS. POHLAND: Object to relevance. Can we just do a continuing objection based on relevance?
MR. GOTTSTEIN: Sure.
A. Are you talking about the handwritten?
Q. Yeah. The order part. It's 5/6/08, 12:20 is the

time. And then just what does the order say? It's on the back side.
A. It says on 5/6/2008, 12:20, it says, "Haloperidol five milligrams IM every six hours PRN for severe agitation and psychosis, emergency IM, and 24 hours, I think."
Then they are saying Dr. Hobson, who was our medical director at that time, has ordered that medication.
Q. So what does "PRN" mean?
A. It means on a needed base.
Q. As needed?
A. Uh-huh.
Q. So it says -- what -- so does that mean as needed for severe agitation?
A. For severe agitation and psychosis, yes.
Q. So what does "severe agitation" mean?
A. Well, for every -- I don't know what you mean severe agitation, from what aspect you are discussing it.
Q. Well, would that include yelling and screaming and slamming doors, for example?
A. It is a combination of things. Every individual is different. So every individual is different, and the meaning just doesn't go for yelling and screaming.

Q. So have you been given training on emergency medication?
A. I think that is --
MS. POHLAND: Objection to relevance.
A. I don't really know what you mean by "training". As a physician, as a clinician, you're trained for everything that is necessary to manage a patient.
Q. Did you get any training from API on emergency medication?
A. Well, in what aspect? We do have P&P, which talks about emergency medication, and the statute or limitation, and what situation is considered more of an emergency than non-emergency.
Q. And then what's your understanding of what constitutes an emergency under the statute?
MS. POHLAND: Objection; relevance.
A. Emergency is, as I said, every individual patient is different. You cannot just put -- you cannot take it under -- you have to look at the whole aspect of the situation, but in most cases, as the situation comes in, or to be specific for Mr. Bigley, when he is showing marked psychotic symptoms to the point that he may put himself in a vulnerable situation or other people around himself in a vulnerable situation, or become a concern, severe concern that he may hurt himself by, in his case

recently, like hitting his body against the wall may cause a fracture, or through posturing it may invite another individual, another patient to bring harm to him.
So those are in summary of it. And also when the individual is not responding to de-escalation that the hospital takes when the oral medication is offered, when time out is offered, when quiet room is offered, all of those is not -- is not directly -- due to his state of mind at that time, that he cannot process and he cannot evaluate to see the vulnerability that he is putting himself and others basically for his safety and others, then at that situation emergency medication would take place.
Q. So down at the bottom there -- 5/15, 2300 -- and I'm sorry. I just have a hard time reading this, so if you could read that one.
MR. POHLAND: You understand that Dr. [redacted] did not actually make these?
MR. GOTTSTEIN: But if she can read it, that would be great because then I can understand it.
MS. POHLAND: Is that the point of the deposition though to have her read it for you?
MR. GOTTSTEIN: I'm asking questions about the chart.

MS. POHLAND: Which are irrelevant given that they don't relate to the admission at issue.
MR. GOTTSTEIN: Well, you can prolong this as long as you want.
BY MR. GOTTSTEIN:
Q. So it starts -- I think the first word is "Abilify"?
A. It says, "Abilify 9.75 milligrams IM. Benadryl 50 milligrams IM every six hours PRN for severe agitation, psychosis. Emergency IM times 24 hours if --" I can't read the other word -- "is still agitated, give --"
Probably it is "continues to be still agitated give Ativan 1 milligram times one IM," and so phone order by Dr. Gomez.
Q. What does "IM" mean?
A. Intramuscular, the injection.
Q. What does one milligram times one IM mean?
A. That means only one time. They could give Ativan one milligram only one time.
Q. When it says "Emergency IM times 24," that means what?
A. That means that emergency, it said "every six hours," so that means within 24 hours if another emergency crisis comes and the consent continues to

exist, then another IM -- another order can be given.
Q. So this was written by Dr. Gomez; is that right?
A. The phone order by Dr. Gomez.
Q. And so now, who acts on this?
A. The nursing staff, the staff in the hospital.
Q. And who is that on Taku?
A. I don't know at that time what was under Taku.
Q. Who is it now on Taku?
A. Right now, we have Monica. I forgot her last name. I'm not very good with names.
Q. "Atanik" or something like that?
A. That's his social worker.
Q. Monica something or another. Who else?
A. What do you mean "who else"?
Q. This is telling staff that you can do -- you know, administer these drugs under these conditions, and I want to know who it is that makes those decisions that those conditions exist.
A. The doctor makes the decision to give the order and the nurses give the medication to the patient.
Q. Right. And then I want to know who the nurses are. It's the nurses that decide whether or not the person is severely agitated?
A. No. It's the doctor evaluates -- the doctor gets the information. The doctor decides if the patient

needs the medication or not, but the medication is given by the nurses.

And then the different shifts, different dates we do have different nurses in the unit.

Q. But this says "as needed," so who decides whether it's as needed?

A. Well, for that situation, the order is given by the doctor. When they review the chart, they review the patient, they understand the patient, then they give that.

Yes, at that time, based on the criteria that the hospital follows, then the nurses would take the action to give the medication.

Q. And so what I'm looking for is the names of the nurses that --

MS. DERRY: Objection. Dr. [redacted] wasn't the doctor who signed this order and cannot tell you who gave that injection that day.

MR. GOTTSTEIN: Well, currently on Taku.

MS. DERRY: What does that have to do with this record though, Mr. Gottstein?

MR. GOTTSTEIN: That's not the question.

MS. DERRY: You're asking her questions about --

MS. POHLAND: Mr. Gottstein, if you would

would like the names of employees who work on Taku, you are more than welcome to serve interrogatories upon API to get that.

Dr. [redacted] has already testified that she is not good with names. She gave you the name of one nurse that she recalled.

BY MR. GOTTSTEIN:

Q. But I'm asking you now, what are the names of other nurses?

MS. POHLAND: Objection; asked and answered.

A. I can get you the names by tomorrow's court hearing. I would be happy to get the list of all the nurses, different shifts, and it can be provided to you.

Q. Can you do that by fax this afternoon?

A. I will see what the hospital could do.

Q. The next page, it's page 3 of 37, it says, "5/15/ Lorazepam."

A. Uh-huh.

Q. No, up above that, "Six hours PRN AAI." What does "AAI" mean?

A. For agitation, aggression and psychosis -- no, insomnia.

Q. Now, does that mean if either one of those exist? In other words, if someone is -- can it be given just for insomnia?

A. No. No. As I said, you just cannot take it lightly just because what is there. They have to look at the whole aspect.

IM medication usually is not given very lightly to a patient. It's been evaluated and taken very seriously before they consider to give IM medication, so it's not as simple as somebody is agitated or somebody cannot sleep, okay, we give him an IM medication.

API staff have a lot more respect for the patient than to just lightly give that medication in the IM form.

Q. So does that mean that all three of those have to exist?

A. It's not actually exactly just all those three have to exist. Those three exist, plus they look at the whole global aspect of the thing, but sometimes you cannot write three pages of a chart to name everything.

And they are trained, they know, they are trained, and every specific patient is individualized, so it is discussed in the treatment team with the staff.

So every patient we look at differently, but, however, that pneumonic is, as I said, stands for agitation, anxiety and insomnia.

Q. Actually, I think you said aggression.

A. Anxiety, agitation.

Q. Initially, you said agitation, aggression and insomnia.

A. Agitation, aggression and insomnia.

Q. Which one is it?

A. I look at it as agitation, aggression and insomnia.

Q. So someone else might interpret that as agitation, anxiety and insomnia?

MS. DERRY: Objection; calls for speculation.

A. No. Usually, the pneumonic is very standard.

Q. I'm just asking because you just said anxiety, so I was just asking.

So there is -- so let me say, if someone was extremely agitated, but not aggressive or have insomnia, would that apply?

A. Again, it depends on the level of anxiety. As I said, we talked about before what causes the -- what pertains for the emergency medication, so it's not only just because somebody is anxious or anxiety qualifies them to get antipsychotic medication in the IM form.

Very much it stays with what I stated earlier when you asked the question how we give the emergency IM medication.

Q. So the nurses decide when that exists?

MS. POHLAND: Objection; asked and answered.
A. I think I answered that before also.
Q. That was PRN, so this is the same thing?
A. Yeah. This is very much the same thing.
Q. It says "PRN" here too.
A. Yes.
Q. I mean, I don't want to necessarily raise the eye of your lawyers, so it depends basically, is that fair?
A. What do you mean by "depends"?
Q. Depends on the patient?
A. What I tried to say is that the care for every patient is individualized, and it has to be individualized because everybody presents themselves clinically different.

So just because one person -- as I said, every individual person presents different. So in that case, you do go for individualized care, but the emergency medication at the end would conclude very much in a way that then becomes the concern of the safety of that individual or how they put themselves or others around themselves in a high risk of the safety.

Then emergency medication would come when all the other aspect has not -- not able to de-escalate them. It is exactly very much what I mentioned earlier.
Q. I understand that, let's say, with aggression.

Okay. So it seems to me that at a certain level of aggression clearly raises a safety issue, right?
A. Uh-huh.
Q. So let's leave that aside for now, but maybe we'll come back to it. But it's very hard for me to see how insomnia is a safety issue.

MS. POHLAND: Objection to form.

A. I did not say that. Actually, when you asked me earlier about it, I said agitation by itself, insomnia by itself does not -- just because somebody is not sleeping qualifies us to give them IM medication.

I also mentioned earlier do not take that definition lightly. Not just because somebody has insomnia medication is forced.

In that case, if that is the case, probably 90 percent -- I'm just making -- that is not a solid 90 percent. I'm saying a lot of individuals do have problems with sleep, so that means every individual gets IM medication? No.

That is why I mentioned earlier don't get that small word of AAI as a whole global aspect of giving a patient IM medication.
Q. So it seems like it's up to the discretion of the nurse; is that correct?
A. It's not the discretion. At the end it comes

back, when the IM medication comes into the picture, the significant consent exists that individuals could hurt themselves or somebody around themselves, when that is very vivid and seen by every individual with the team, with the nursing, with the other staff that are working on providing care in that unit for that patient.

MS. POHLAND: Mr. Gottstein, could we move onto perhaps something that Dr. [redacted] actually authored and/or the admission at question?

(There was a short break.)

MS. POHLAND: Note my continued objection to all of this questioning on emergency medication and admissions that don't relate to the current admission.

BY MR. GOTTSTEIN:
Q. Okay. The second one down, that's 5/16?
A. Uh-huh.
Q. 0100. I think that is actually you that signed that one, isn't it?
A. Yes.
Q. Now, I read that -- how do you say that, Thorazine?
A. Thorazine.
Q. "50 milligrams IM, now AAI, locked seclusion."
A. Uh-huh.
Q. So what does "now" mean?

A. It means at that time.
Q. So does that mean give it then?
A. Yes. That means there is no time. The patient is so psychotic -- it always is like that, but, however, that means we need to act on it immediately.
Q. Okay. And is that -- is that -- I have seen that in other places.

Is that standard? When you see "now" on it, that means it's not like a PRN, it's do it now?
A. Exactly.
Q. I'm just trying to understand.

MS. DERRY: Mr. Gottstein, can we clarify here? Are we looking at -- you just mentioned "locked seclusion".

Are we looking at the second entry or the first?

MR. GOTTSTEIN: Second.

A. Also, I want to clarify. That order, I cosigned. Actually, it was ordered by Dr. Gomez, but I cosigned that order.
Q. Why was that?
A. Well, usually it is very common in every hospital, for example, when the doctor -- this has happened in the morning, 1:00, so Dr. Gomez was on call, so they have contacted him and they have expressed the

concern and they presented his clinical symptom.
And Dr. Gomez found it appropriate for the patient to get medication at that time. And the next day, as I was his clinician who provided care for him -- of course, you know, every morning, I review to see where my patients are and how they are doing and what has happened the night before.
I recognized that, and then I confirmed that I have seen that order and that is how it goes.
Q. Okay. Now, what does "locked seclusion" mean?
A. That means the patient has been -- was not following -- from the aspect he was so agitated, he was so psychotic -- again, I wasn't there. I don't know.
But in an aspect of a picture, by seeing that, probably he was markedly psychotic, he was not responding to redirection, he was not taking oral medication, he was not following all the aspects that I talked earlier about emergency medication.
And still they decide to put him in the quiet room, which is different than the room that they stay, and then they locked it because they could not restrain him.
And he was probably putting himself in a more vulnerable situation, so they decided that probably he would benefit from the medication, plus in a place that

the door could be locked that he put himself inside instead of coming out and put himself in more vulnerable state.
Q. So I'm a little confused. Did this authorize locked seclusion or did it ratify locked seclusion?
MS. DERRY: Objection.
A. Explain to me what you mean by "ratify".
Q. Did they -- was he put in locked seclusion and then you signed and say, "Yes that was okay," or does this signing this say it is okay to put him in locked seclusion?
A. This tells me that Dr. Gomez ordered this medication should be given to the patient and he should be put in the quiet room, and then, for that moment, the door should be locked.
Usually, that doesn't mean they stay locked for a long time. It all depends when the patient is calm and could be safe again to come out of that room.
For that moment, it just meant for that moment. Of course, in 10 minutes or 15 minutes or 1 hour later the setting may happen totally different.
As the patient takes medication, he may calm down, respond to the medication and he did not need to be anymore in the locked seclusion.
Q. Now, on the fourth one, or second one up from the

bottom, you know, I can never say --
A. Chlorpromazine.
Q. "50 milligram IM now for AAI," and then it looks like "XT dose due to psychotic agitation."
Is that correct?
A. Uh-huh.
Q. And "XT" means?
A. It means one time, times one time dose, only one time. This is authorized only one time. This is the one I did order because it shows that.
Q. Now, were you actually -- did you actually observe him or was this called in or do you remember?
A. I can't remember. I have to look at the chart.
Q. On page seven, under "prognosis," it says, "The patient refuses psychiatric treatment and this refusal is facilitated by his attorney."
A. Uh-huh.
Q. I assume that's me?
MS. DERRY: Objection; calls for speculation.
Q. Is that me?
A. I'm not really sure. I have to look at the chart and see what it meant.
MS. POHLAND: Mr. Gottstein, just to remind you, Dr. [redacted] has to get back to work, so we're going

to want to try to wrap things up so Ms. Derry has time to ask some questions as well.
Q. I mean, it's obviously -- okay. And going back to that, so I would read into that that patient's refusal -- by "psychiatric treatment" you mean the drug, right, drugs?
MS. POHLAND: Objection. Dr. [redacted] didn't author this record.
MR. GOTTSTEIN: I believe she did.
MS. DERRY: Where does it say that?
A. Actually, Dr. Michaud wrote that and then I cosigned it.
Q. So is your understanding that "refuses psychiatric treatment" means refuses the medication?
A. I have to see what Dr. Michaud meant by that, but in my aspect, no, it's not only the medication. It's the whole aspect of getting appropriate --
For example, the treatment intervention that inside the hospital is offered, and probably, in this case, also when he gets discharged, he is not willing to work with his outpatient provider, he is not willing to have case management, he is not willing to work with the structure and social support that the clinician may feel like the patient would benefit from, so it's not only medication.