# Exhibit 3

# IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NEBRASKA

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PLANNED PARENTHOOD OF THE ) HEARTLAND, )		
Plaintiff, )		7
v. )		. *
DAVE HEINEMAN, Governor of Nebraska, in his official capacity;	Case No. 4:10-cv-3122	
JON BRUNING, Attorney General of Nebraska; ) in his official capacity; )		
KERRY WINTERER, Chief Executive Officer, and DR. JOANN SCHAEFER, Director of the Division of Public Health, Nebraska Department of Health and Human Services, in their official capacities; and		
CRYSTAL HIGGINS, President, Nebraska Board ) of Nursing, and BRENDA BERGMAN-EVANS, ) President, Nebraska Board of Advanced Practice ) Registered Nurses, in their official capacities, )		
Defendants. )  AFFIDAVIT OF PAUL S. AF	PPELBAUM, M.D.	
STATE OF NEW YORK ) ss. COUNTY OF NEW YORK )		
I, PAUL S. APPELBAUM, M.D., being first d	uly sworn upon oath, depose	and state as
follows:		
1. I am over 18 years of age and competer	nt to provide this affidavit.	
2. I have been made aware of Legislative	Bill 594, the proposed new la	w that would
govern informed consent for abortion in Nebraska ("th	e Act"). I submit this affida	it in support

of Plaintiff's Motion for a Preliminary Injunction and for a Temporary Restraining Order, preventing the Act from taking effect.

- 3. As I understand it, the Act would require medical providers to evaluate each woman who has decided to have an abortion for the presence of any "risk factor associated with abortion" (as broadly defined in the Act) that has been published in any peer-reviewed journal included in certain search services or journal lists as being associated with any "complication associated with abortion" (again, as broadly defined in the Act). If such a "risk factor" is present, the medical provider would have to inform the woman of each "complication" associated with it. These requirements would be imposed as part of the informed consent process.
- 4. As I understand it, to comply with the Act's requirements, the medical provider would have to be familiar with an enormous body of literature; engage in an extensive evaluation process of each woman; and then disclose a laundry list of information to the woman based on the results of that process. And as I understand it, the Act appears on its face to require medical providers to conduct these evaluations and make these disclosures without regard to the validity of the findings in the article or articles that linked the "risk factor" or "complication," and without regard to whether the information is material and helpful to the particular patient.
- 5. Putting to the side the question of whether it is even possible to literally comply with the Act's requirements a question that I understand is being addressed by a different affidavit these requirements bear little or no resemblance to how informed consent is typically provided in any other area of clinical practice. I will detail this in the first section of my affidavit, below.

6. Furthermore, trying to comply with these requirements would be detrimental to the informed consent process, and would actually leave women with *less* information – not more – about the risks and potential downsides of the decision they are considering. I will detail this in the second section of my affidavit, below.

## **Qualifications and Experience**

- 7. I am a board-certified psychiatrist; the Elizabeth K. Dollard Professor of Psychiatry, Medicine and Law at the Columbia University College of Physicians and Surgeons (that is, Columbia University's medical school); the Director of the Division of Psychiatry, Law and Ethics, also at the Columbia University College of Physicians and Surgeons; and a Research Scientist at the New York State Psychiatric Institute.
- 8. I am the co-author of one of the leading textbooks on informed consent, Jessica W. Berg, Paul S. Appelbaum, Charles W. Lidz & Lisa S. Parker, *Informed Consent: Legal Theory and Clinical Practice* (Oxford Univ. Press 2d ed. 2001) (1987). I teach informed consent in several contexts, including to residents and fellows at the Columbia University Medical Center, at grand rounds presentations across the country, and at the Columbia Law School. I have conducted research on informed consent for over thirty years, and have also published over 200 peer-reviewed research articles, including many on informed consent issues. I am a journal referee (meaning that I conduct peer review for articles) for dozens of journals, and also serve on the editorial boards of numerous publications.
- 9. In addition to my academic and research positions, I treat patients with a broad variety of problems, including depression, anxiety, and adjustment problems.
- 10. I was the President of the American Psychiatric Association from 2002-2003, and have also served as its Secretary, Vice President, and a member of its Board of Trustees.

- 11. Prior to joining the faculty at Columbia, I taught at the University of Pittsburgh, the Harvard Medical School, the University of Massachusetts, and Georgetown University.
- 12. A copy of my curriculum vitae is annexed hereto as Exhibit A.
  The Act's Definitions of "Risk Factor" and "Complication"
- 13. Before continuing, I think it is useful to discuss the Act's definitions of two key terms.
- 14. The Act's definition of "complications associated with abortion" is broader than the way the term "complications" is generally used in the medical context. The Act's definition is: "any adverse physical, psychological, or emotional reaction that is reported in a peer-reviewed journal to be statistically associated with abortion such that there is less than a five percent probability . . . that the result is due to chance." Nothing in this definition appears to exclude expected after-effects of an abortion, or reactions that are mild and transient.
- 15. In conventional medical usage, a "complication" would never include the expected after-effects of a procedure or treatment. It would be misleading and inaccurate to refer to expected after-effects as a "complication," as the term connotes that something unexpected or unusual has happened. For example, discomfort is not a "complication" of starting an intravenous line; it is a consequence. Nor would conventional medical usage of the term "complication" include reactions that are mild and transient. For example, if I start a patient on certain antidepressant medications he or she may experience a consequence of mild sleepiness for several days, until his or her body adjusts to the medication. I would not consider that to be a complication; it is a temporary side effect.
- 16. Turning to the definition of "risk factor associated with abortion," the Act's definition is, in relevant part: "any factor, including any physical, psychological, emotional,

demographic, or situational factor, for which there is a statistical association with one or more complications associated with abortion such that there is less than a five percent probability . . . that such statistical association is due to chance." This definition is also very broad, and captures a range of factors that the literature would not necessarily identify as risk factors.

## I. How Informed Consent Is Typically Provided

- state, and the specifics of practice vary from provider to provider, the basic goal of informed consent remains the same: to enable the patient to make a meaningful decision about what treatment to have, or whether to undergo a particular procedure, by providing the information that is likely to be most salient to the patient's decision. Enabling meaningful decision-making is the foundational goal and guiding principle of informed consent.
- 18. Physicians have a professional obligation to develop general knowledge of and familiarity with the significant risks and benefits of the medical treatment or procedure being considered, as well as any risk factors that would, if present, significantly change those risks and benefits. This does not mean being aware of, much less disclosing, every potential risk factor or complication of the treatment or procedure that has ever been discussed in the medical literature. Even putting aside issues of the reliability of findings that have not been replicated, are out of date, have been rebutted, or for other reasons are of questionable applicability to your patient (an issue to which I will return later), almost any medical intervention, whether pharmacologic or surgical, has a large number of risks and potential risk factors associated with it, and it would be neither practical nor desirable to discuss each one with a patient making a medical decision.
- 19. Rather, the physician's professional obligation is to develop general knowledge of and familiarity with the *significant* risks and benefits of the treatment or procedure being

considered. For risks, "significance" is determined by some combination of frequency and severity. That is, if a risk is very severe (such as death), a physician should disclose it even if it is relatively rare, and conversely, even a relatively non-severe risk should be disclosed if it is common. However, these rules cannot be taken to the extreme. A patient could die from anaphylactic shock as a response to aspirin, but no physician would disclose death as a risk of aspirin. This is so because neither frequency nor risk level alone is sufficient to make a risk appropriate for disclosure; rather, what risks to disclose depends on the interaction between the two.

- 20. Similarly, if something is a risk factor for a complication that is extremely rare, or transient, or for whatever other reason not something the physician would disclose to a patient as part of the informed consent process, whether the risk factor is present is immaterial. And the same is true if the presence or absence of the potential risk factor has only a relatively small effect on the patient's risk of experiencing a particular complication, or (in some cases) if the complication is one that will be discussed with the patient regardless of the presence of the risk factor.
- 21. The reason that physicians focus on significant risks and risk factors is that these are the ones likely to be material to the patient that is, relevant to the patient in making a meaningfully informed medical decision. Exercising medical judgment to determine which risks are likely to be material to the patient is an essential part of the physician's role.
- 22. I mentioned above that physicians have a professional obligation to develop general knowledge of and familiarity with the risks and benefits of the medical treatment or procedure being considered, as well as certain risk factors that may increase a patient's risk of experiencing a particular complication. In contrast to the requirements of the Act, physicians do

not develop this knowledge by doing a literature survey of every article ever published on the treatment or procedure. Conducting such a survey simply would not be feasible; among other problems, it would require a staggering time commitment.

- 23. Rather, in typical practice, physicians develop this knowledge and familiarity from a variety of sources that synthesize and digest the information in the medical literature, including publications and practice guidelines from professional organizations, review articles in major medical journals, presentations at medical association meetings, and conversations with other physicians about their practices.
- 24. Nor would the average individual physician have the expertise necessary to understand and evaluate all of the published literature on a medical procedure or treatment, and start from scratch in developing appropriate risk factor screening and informed consent disclosures. The average practicing physician would not even be aware of the number of choices that go into determining the methodology of a research study, or how its results are analyzed much less be in a position to evaluate the statistical and methodological issues implicated in each article, or to understand the article's conclusions in the context of those issues and the broader literature.
- 25. In contrast, when a professional organization proposes to issue guidance on a procedure or treatment, it typically has a committee that will review the risks and benefits of the procedure or treatment, and then make recommendations to the professional organization. At least some members of the committee will have methodological and statistical expertise, whereas others may have more clinical expertise. Thus, the recommendations of the committee as a whole will be more informed than the product that the individual members (much less other physicians) would be able to produce. In my capacities as President of the American Psychiatric

Association and as a member of the Board of Trustees of the same organization, I had oversight responsibility for this process for guidance to be issued by the American Psychiatric Association.

- It is worth noting that the task professional organizations undertake when they 26. propose to issue guidance on a procedure or treatment is very different from what the Act appears to require, if taken literally. In conventional practice, what professional organizations seek to do is identify the risks that should be considered in deciding on a treatment because they are likely to be material to patients, as well as certain risk factors for which patients should be screened to see whether the patient is at increased risk of experiencing a complication. However, there would also be an enormous category of risks and risk factors that have been published in a peer-reviewed journal but that professional organizations would never identify as a basis for treatment decision-making for a variety of reasons, including that they have not been replicated; have been rebutted; are insignificant, rare, transient, or out-of-date; apply to patient populations significantly different from the patients at issue; or for other, similar reasons. As with individual physicians, it is an essential part of the role of professional organizations issuing practice guidance to exercise medical judgment in determining what risk factors and complications to include. These guidance documents are then frequently, and appropriately, used by medical providers as a guide for their informed consent disclosures.
- 27. Nor would a professional organization that proposes to issue guidance on a procedure or treatment start by conducting an exhaustive literature survey, much less one from the beginning of time. Rather, it would build on a certain level of knowledge that committee members already have. In part, this is because treatments, procedures, and medications change over time, and risk factors and complications do not stay the same. And in part this is because

older medical literature is often less methodologically precise, and therefore less reliable, than the recent literature, because research standards have changed.

28. In short, in a variety of ways, the Act's requirements bear little or no resemblance to the ways that informed consent is generally provided, and in fact, if taken literally, deprive physicians of the medical judgment that normally permeates the informed consent process.

## II. The Act's Requirements are Detrimental to True Informed Consent

- 29. As stated above, the basic purpose of informed consent is to enable meaningful decision-making by providing the information that is helpful to a patient in making a medical decision. This is the principle by which any specific informed consent requirement or practice must be evaluated.
- 30. The Act's requirements would force healthcare providers to violate this principle by forcing them to disclose information to patients based on a single citation in the medical literature, without any ability to exercise medical judgment either as to the reliability, validity, and applicability of the risk factor or complication at issue, or as to its materiality to the patient's medical decision-making. This is antithetical to the informed consent process, as described below in more detail.
- 31. To enable meaningful informed consent, a medical provider must be able to select the information that is the most material to the patient's decision, and distill it into a form that the patient is able to digest and understand. Providing extraneous information is counterproductive, as patients get "flooded" and are no longer able to process the information in any meaningful way. People have the ability to attend to only limited amounts of information.

  If a medical provider overwhelms a patient's capacity to integrate that information, rather than

being informed, the patient is likely to be bewildered, flustered, anxious, and less able to make a truly informed decision.

- 32. For example, the FDA-approved prescribing information for Prozac (generic name: fluoxetine), the first of the SSRI-anti-depressants, and quite a safe medication, lists sixty-three adverse effects that have been attributed to the medication, and singles out twelve issues for specific warnings. Putting aside the time it would take to discuss and explain all of these possible side effects, disclosing them all would flood patients with information of little importance to them (e.g., people who take Prozac are significantly more likely to experience yawning), while distracting them from the few items that are important for them to focus on (e.g., an increased risk of anxiety and insomnia). Effective informed consent practices require physicians to focus on the subset of risks that patients should take into account in their decision-making.
- 33. Indeed, since the 1960s it has been known that the more information that is provided to patients beyond a basic description of a treatment and its risks and benefits, the less absolute information patients will retain. (Epstein, L.C. and Lasagna, L. (1969). Obtaining Informed Consent: Form or Substance. *Archives of Internal Medicine*, 123, 682-688.) The reason for this effect was suggested more than a half-century ago, when experiments indicated that on average, people could retain about seven different items in their working memory, including for the purposes of making decisions, at any point in time. (Miller, G.A. (1956). The Magical Number Seven, Plus or Minus Two: Some Limits on Our Capacity for Processing Information. *Psychological Review* 63, 81-97.) More recent studies indicate that the limit may be even lower. (Cowan, N. (2010). The Magical Mystery Four: How is Working Memory Capacity Limited, and Why? *Current Directions in Psychological Science* 19, 51-57.) Thus,

merely providing more information to patients does not help them make better decisions, and may overwhelm their abilities to process the information they receive.

- 34. Thus, requiring a healthcare provider to give information on every "risk factor" and associated "complication" published in any of a laundry list of peer-reviewed journals, without any ability to exercise judgment as to what information is material to the patient or even what information is reliable, would undermine the informed consent process. At the end of these disclosures, patients may have received more information in theory, but in practice they will retain and process far less information than had the provider been allowed to have an appropriately tailored conversation. And because flooding a patient with information will all but ensure that the patient fails to pay attention to the most important information, any significant risks are likely to be drowned out by a host of findings from the literature that (as discussed below) are unreplicated, disproven, out-of-date, inapplicable, misleading, or methodologically suspect.
- 35. Further, as I understand it, the Act appears to require information to be provided to the patient without any medical judgment as to the quality or relevance of the information, based solely on the fact that the information appeared in a peer-reviewed journal that is included in MedLine, PubMed, or the Thomson Reuters Master Journal List. This is enormously problematic.
- 36. First, a physician would almost never normally rely on a single study merely on the basis of its being published in a peer-reviewed journal, and assume that the study's finding is valid. The essence of science is confirmation. In general, unless a finding is replicated, it cannot be relied on. Yet, as I understand it, the Act appears to require healthcare providers to evaluate

patients for supposed risk factors and disclose supposedly associated complications based on a single study.

- 37. Second, medical knowledge is constantly evolving and developing, and it happens routinely that findings or associations that were once believed to be valid and confirmed are subsequently disproven. One highly publicized recent example is that an article published in one of the world's leading journals, *The Lancet*, found an association between vaccinations and autism. This led many parents not to vaccinate their children, leaving them exposed to a variety of childhood illnesses. The article has now been widely rejected among the medical community, and accepted as disproven. If every pediatrician were required to disclose to parents that vaccines can cause autism based on this disproven article, it would make a travesty of the informed consent process and could lead to significant loss of life. And yet, as I understand it, nothing on the face of the Act allows medical providers to avoid evaluating patients for a supposed risk factor or disclosing a supposed complication on the ground that the claimed association has been disproven. This is a truly astonishing and perverse aspect of this legislation, as it would require physicians to violate their professional responsibility by giving the patient information that is not true.
- 38. Third, even for findings that have not been disproved, the fact that the state of medical knowledge is constantly developing and evolving means that procedures and medications do not stay the same, and nor do risk factors and complications. For example, excessive bleeding may be a common complication of the way a surgical procedure used to be done, but not of the more recent version of the procedure. Thus, requiring evaluations and disclosures based on out-of-date articles would lead to patients getting poor-quality information

that in some cases will be highly misleading, and will also distract patients from more material and reliable information.

- 39. Fourth, even current and replicated findings cannot be applied mechanically outside the context in which they were made; considerable medical judgment and knowledge goes into determining to which patients a study's findings can reasonably be applied. The Act ignores this complexity, and instead requires providers to give automatic disclosures to their patients based on the presence of a single risk factor regardless of the study's context, despite the fact that in many cases the resulting disclosures will be irrelevant or misleading to patients, as well as distracting them from more material information.
- 40. For example, the provision of medical services varies widely from country to country, as do many characteristics that are relevant to risk factors and complications, and yet the Act does not on its face appear to allow the physician to engage in any medical judgment as to whether an international article's findings can be applied to patients in Nebraska. It would be obviously misleading to require automatic disclosure to Nebraska patients of complication rates associated with a particular risk factor in patients receiving a medical service in a developing country, in which medical services, baseline health and nutrition levels, and social context may all be very different from what is found in Nebraska.
- 41. The same is true for studies done on some populations in the United States. In considering how broadly a particular study's findings can be applied, doctors and/or professional organizations must consider the characteristics of the population that was studied, including such factors as access to adequate medical services, nutritional habits, age, race, adherence to follow-up care instructions, and many others. To give an obvious example, if the average age of women in a study is fifty-five, and my patient is twenty-five, the complication

rates in the study may not be relevant to my patient (and in fact would be misleading) despite the fact that my patient has some risk factor identified in the study as associated with the complication.

- 42. And similarly, suppose that a study shows that women over forty are at risk of a particular complication, but a subsequent study shows that the risk applies only if the woman has never been pregnant. The first study has not been disproven, but its findings have been refined with a demonstration of a relevant protective effect. Thus, disclosure of the risk to a woman over forty who has been pregnant would be misleading and yet would appear to be required by the Act, because the woman has the risk factor of being over forty.
- 43. These complexities and ambiguities are entirely typical of the medical literature and the way that medical knowledge develops. And yet, if taken literally, the Act appears to fail to recognize this complexity, or to allow healthcare providers to exercise appropriate medical judgment to determine what risk factors and complications may apply to their patients.
- 44. Fifth, the fact that a study is published in a peer-reviewed journal is no guarantee of its quality or reliability. I do peer review for dozens of journals, including the *Journal of the American Medical Association*, the *New England Journal of Medicine*, *The Lancet*, the *Archives of Internal Medicine*, and the *American Journal of Public Health*, and am highly familiar with the process. Although the goal of peer review is to provide some check on the quality of evidence entering the medical literature, it is known to be a highly imperfect system. As noted above, the state of medical knowledge is constantly evolving, and part of the reason this is so is that many findings that are published even in the best journals much less in the broader range of peer-reviewed journals are subsequently disproven. Many are also subsequently understood to be methodologically suspect in ways that were not understood at the time.

- journals. Part of what differentiates prestigious, highly reliable journals such as the *New England Journal of Medicine* or the *Journal of the American Medical Association* is that they have rigorous peer review. Many other journals have less rigorous peer review, both because they attract less expert peer reviewers and because they impose lesser editorial standards.

  Whereas a journal such as the *New England Journal of Medicine* rejects the vast majority of articles that are submitted, other smaller journals may be less concerned with maintaining the highest standards than with ensuring that they have sufficient articles to fill the next issue; the majority of journals fall somewhere between these two extremes. Further, there is no requirement that peer-reviewed journals reject articles that receive negative responses from peer-reviewers; this is a highly discretionary determination by the journal editor, especially if the reviews are mixed.
- 46. In my professional experience, patients are likely to overestimate the import of a finding they are told has been published in a peer-reviewed journal, and believe such publication to mean that the information is valid. The average patient has no concept that there is a range of quality and reliability in the published literature, much less that articles published in even the best of journals are often subsequently disproven or significantly refined. Indeed, many patients are familiar with the phrase "peer-reviewed study" (which frequently occurs in the popular media) and assume this is the sole criterion for validity. This common misperception would make the disclosures required by the Act particularly misleading for patients, and is an additional reason why they would be harmful to the informed consent process.
- 47. This effect would be exacerbated by the fact that, in my professional experience, patients assume that their physician or physician's staff would not give them information unless

the physician thought the information was important. In a typical informed consent process, the information the patient receives reflects the physician's medical judgment about what it is important for the patient to know. Taken at face value, the Act would change that rule in ways that I believe would be difficult for patients to understand, and ultimately would make the disclosures required by the Act very misleading for patients.

- 48. Aside from publication in a peer-reviewed journal (which, as noted above, is far from adequate quality control), my understanding is that on the face of the Act, the only attempt at controlling the quality of a study that would trigger an evaluation and disclosure obligation is that the study has to claim a "p-value" of less than .05, meaning that there is a less than 5% probability that the statistical association is due to chance. This p-value requirement is not adequate quality control, for several reasons.
- 49. First, p-values are very limited in what they purport to measure. For example, a p-value provides no information about a study's methodological soundness, including such factors as the representativeness or randomness of the sample being studied or the appropriateness of any comparison group. Nor would a study's p-value provide any indication of serious problems in selection of variables, data collection, or data analysis. If a study's methodology is poor, its p-value is meaningless as an indicator of the validity of the study's finding.
- 50. This is a critical limitation, as study design is complex and involves a large number of discretionary decisions, each of which is an opportunity for bias based on the predilections of the researcher to be built into the study. These discretionary decisions include, among others, selection of the control group, selection of the population or sample studied, what measures are used to test outcomes, and how these measures are applied (including who does the

rating, how objective that person's administration of the selected measures is, and whether that person knows the hypothesis being tested and/or knows the subject's status as a member of the control or experimental group). Each of these factors has an enormous impact on the associations that end up being reported as statistically significant, as measured by p-value.

- 51. Second, p-values give no indication of the magnitude of the difference being measured, or its importance; rather, they indicate only that a non-chance difference appears to exist. It is common for a difference between two populations to be statistically significant but clinically irrelevant. In fact, with a large enough sample it is a given that even very small differences, which are likely to be clinically irrelevant, will be statistically significant.
- 52. Third, p-values provide no information on whether a study's results may be applied to a different population than the one that was studied.
- 53. Fourth, p-values provide no information on a study's reliability, that is, whether its findings can be replicated by future studies using different data sets. In fact, even with a p-value of less than .05, a certain percentage of findings (up to 1 out of 20) will be due to chance. This is part of the reason why replication is so important, and it is bad medicine to require evaluation or disclosures based on a single study.
- 54. Finally, although .05 is a reasonable and conventionally-accepted p-value requirement to use in many contexts as a way to eliminate the majority of false associations, in other contexts it is inadequate. For example, if studies based on the same data set look at multiple potential risk factors, the appropriate p-value has to be decreased in order to avoid suggesting false statistical associations. Statisticians refer to this as a "correction for multiple comparisons." If this correction is not done, it is highly likely that some of the potential risk factors being evaluated will appear to be associated with a complication when in fact the

association is purely random and would not be replicated if the study were repeated with another data set.

55. In short, the Act appears to require mechanical disclosures based on any risk factor published in a peer-reviewed journal as associated with any complication of abortion, and thus inhibits the normal process that medical providers engage in when deciding what risk factors and complications are valid, significant, applicable, and material to their patients. As discussed above, giving patients inapplicable or immaterial information is harmful to the informed consent process, both because the patient will become overburdened with extraneous information and unable to absorb the critical information, and because the patient is likely to overestimate the likelihood that the information *does* apply to her. And there can be no doubt that requiring medical providers to give patients information that is unreliable or misleading is directly harmful to the informed consent process. For these reasons, if the Act's requirements are taken literally, the disclosures it requires would leave women less, not more, able to make informed decisions about their care.

Further affiant sayeth not.

Dated this **SO**day of June, 2010.

Paul S. Appelbaugh, M.D.

Subscribed and sworn to before me this O

day of June, 2010.

Qualified in Onondaga County
Commission Expires Sept. 12, 2012

Notary Public, State of New Yor No. 01PH6133193

Notary Public Notary Public, State of New

Notary Public, State of New York No. 01PH6133193 Qualified in Onondaga County

Commission Expires Sept. 12, 20 3

# Exhibit A

June 2010

### Curriculum Vitae

#### **Personal Data**

Name: Paul S. Appelbaum, M.D.

Title: Elizabeth K. Dollard Professor of Psychiatry, Medicine, and Law

Director, Division of Psychiatry, Law and Ethics

Department of Psychiatry

Columbia University College of Physicians and Surgeons

Research Scientist

New York State Psychiatric Institute

Director, Center for ELSI (Ethical, Legal and Social Implications) Research on Psychiatric, Neurologic, and Behavioral Genetics

Department of Psychiatry

Columbia University College of Physicians and Surgeons

Address: New York State Psychiatric Institute/

Columbia University Medical Center 1051 Riverside Drive, Box 122 New York, NY 10032 (office)

Date of Birth: November 30, 1951
Place of Birth: Brooklyn, New York

### **Academic Training**

1968		Stuyvesant High School, NY
1972	A.B.	Columbia College (Biology)
1976	M.D.	Harvard Medical School

1979-1980 Harvard Law School (special student) 1983-1984 Graduate School of Public Health,

University of Pittsburgh (special student)

### **Traineeship**

1976-1977	Intern in Medicine, Soroka Hospital, Beersheva, Israel
1977-1979	Resident in Psychiatry, Massachusetts Mental Health Center/Harvard
	Medical School, Boston, MA
1979-1980	Chief Resident in Legal Psychiatry, Massachusetts Mental Health
	Center/Harvard Medical School, Boston, MA
1979-1980	Fellow in Mental Health Administration, Massachusetts Mental Health
	Center/Harvard Medical School, Boston, MA

## **Licensure and Certification**

1977	Massachusetts License No. 53808 (no longer active)
1980	Pennsylvania License No. MD-023867-E (no longer active)

1981	Board Certification in Psychiatry, American Board of Psychiatry and
	Neurology, Certificate #22719
1988	District of Columbia License No. 17336 (no longer active)
1994	Added Qualifications in Forensic Psychiatry, American Board of
	Psychiatry and Neurology, Certificate #18 (renewed, 2004)
2005	New York License No. 237042

# **Professional Organizations and Societies**

# Memberships in Professional Societies:

1979-	American Psychiatric Association
1979-1980	Massachusetts Psychiatric Society
1980-1984	Pennsylvania Psychiatric Society
1980-	American Academy of Psychiatry and the Law
1983-	American Society of Law, Medicine, and Ethics
1984-2006	Massachusetts Psychiatric Society
1988-	International Academy of Law and Mental Health
1996-2005	Association for the Advancement of Philosophy and Psychiatry
1998-2006	American Medical Association
2005-2009	American College of Psychiatrists
2005-	New York Academy of Medicine
2006-	New York County Psychiatric Society
2006-	New York Psychiatric Society
2007-	Neuroethics Society

# Service:

# American Psychiatric Association:

1980-1984	Committee on State Hospitals, (corresponding member 1982-1984)
1980-1983	Task Force on Psychiatric Participation in Sentencing
1981-1990	Commission on Judicial Action (consultant 1981-1984; chairman
	1984-1990)
1984-1994	Joint Reference Committee (ex-officio member)
1984-1986	Task Force on Tardive Dyskinesia (consultant)
1990-1995	Council on Psychiatry and Law (chair, 1990-1994)
1995-2001	Isaac Ray Award Board (chair, 1995-2000)
1995-2000	Committee on the Use of the Litigation Fund (vice-chair, 1999-2000)
1997-2006	Board of Trustees
1997-1999	Secretary
1997-1999	Ethics Appeals Board (chair)
1997-1998	Task Force to Review APA Conflict of Interest Policy
1998-1999	Editorial Advisory Committee (chair)
1998-1999	Board Subcommittee to Review the By-Laws of the Research Institute
1999-2001	Vice-President
1999-2002	Joint Reference Committee (chair, 2001-2002)
1999-2001	Committee on District Branch Relations (consultant, 1999-2000;

		aboin 2000 2001)
	1999	chair, 2000-2001) Task Force to Review Future Options for the Journal of Psychotherapy
	1777	Practice and Research (chair)
	2000	Ad Hoc Task Force to Develop Procedures for Revenue Sharing (co-chair)
	1999-2002	Commission on Public Policy, Advocacy and Litigation
		(consultant, 2001-2002)
	2000	Work Group on Selection of Directors for the American Psychiatric
		Publishing Group (chair)
	2000-2002	Task Force on Research Ethics (Board liaison)
	2001-2002	President-Elect
	2001-2003	Board of Directors, American Psychiatric Institute for Research &
		Education (Executive Committee, 2001-2003)
	2001-2003	Board of Directors, American Psychiatric Publishing, Inc.
	2001-2003	Distinguished Service Award Committee (chair)
	2002-2003	President
	2003-2004	Nominating Committee (chair)
	2004-	Council on Psychiatry & Law (chair, 2004-2008)
	2004-2008	Joint Reference Committee (ex officio)
	2004-2008	Committee on Advocacy & Litigation Funding
	2008-	Ad Hoc Workgroup on Relationships Between Psychiatrists and Industry
	2009-	(chair) Committee on Judicial Action (consultant, 2009-2010; chair 2010-)
	American Acc	ademy of Psychiatry and the Law:
	1982-1985	Program Committee
	1984-1986	Committee on Ethics
	1984-1986	Rappeport Fellowship Committee (chairman)
	1987-1990	Councilor
	1995-1996	President (president-elect, 1994-1995; executive council, 1994-1997)
	1997-2002	Long Range Planning Committee
	1997-1999 1998-2000	Nominating Committee Awards Committee (chair, 1998-2000)
	Massachusett	ts Psychiatric Society:
	1992-1993	President (president-elect, 1991-1992; executive committee, 1991-1994)
	1995	Task Force on Confidentiality (chair)
A cade	emic Appointn	nents
Acau		
	1977-1980	Clinical Fellow in Psychiatry, Harvard Medical School
	1980-1984	Assistant Professor of Psychiatry, University of Pittsburgh School of
	1001 1002	Medicine  Assistant Professor of Law (secondary and sintenent). University of
	1981-1982	Assistant Professor of Law (secondary appointment), University of
	1982-1984	Pittsburgh School of Law Associate Professor of Law (secondary appointment) University of
	1704-1704	Associate Professor of Law (secondary appointment), University of Pittsburgh School of Law
		I Insourgh school of Law

1984	Associate Professor of Psychiatry, University of Pittsburgh School of Medicine
1984-1985	Lecturer in Psychiatry, Harvard Medical School
1985	Associate Professor of Psychiatry, Harvard Medical School
1988-1989	Visiting Interdisciplinary Professor, Georgetown University Law Center
1985-2005	A.F. Zeleznik Distinguished Professor of Psychiatry, University of
	Massachusetts Medical School, Worcester, MA (tenured)
1992-2005	Chairman, Department of Psychiatry, University of Massachusetts Medical
	School
1996-1997	Fellow, Center for Advanced Study in the Behavioral Sciences, Stanford,
	CA
2006-	Faculty Associate, Columbia University Center for Bioethics
2006-	Affiliated Faculty Member, Columbia Law School
2006-	Member, Center for Human Genetics, Columbia University
2006-	Elizabeth K. Dollard Professor of Psychiatry, Medicine, and Law, and
	Director, Division of Psychiatry, Law and Ethics, Department of
	Psychiatry, Columbia University College of Physicians and Surgeons
	(tenured)

# **Hospital Appointments**

1979-1980	Director, Legal Psychiatry Consultation Service, Massachusetts Mental
	Health Center, Boston, MA
1980-1981	Medical Consultant, Family Therapy Clinic, Western Psychiatric Institute
	and Clinic, Pittsburgh, PA
1980-1984	Consultant, Law and Psychiatry Consult Service, Western Psychiatric
	Institute and Clinic, Pittsburgh, PA
1981-1984	Medical Consultant, Special Therapies and Mood Disorders Modules,
	Western Psychiatric Institute and Clinic, Pittsburgh, PA
1983-1984	Co-director, Law and Psychiatry Program, Western Psychiatric Institute
	and Clinic, Pittsburgh, PA
1984	Director, Law and Psychiatry Program, Western Psychiatric Institute and
	Clinic, Pittsburgh, PA
1984-1985	Executive Officer, Massachusetts Mental Health Center, Boston, MA
1984-1985	Director, Program in Psychiatry and the Law, Massachusetts Mental
	Health Center, Boston, MA
1985-2005	Director, Law and Psychiatry Program, University of Massachusetts
	Medical School, Worcester, MA
1992-2005	Chairman, Department of Psychiatry, University of Massachusetts Medical
	Center/UMass Memorial Medical Center
2006-	Attending Psychiatrist, New York Presbyterian Hospital
2006-	Research Psychiatrist, New York State Psychiatric Institute

# **Honors**

1972	Phi Beta Kappa
1979-1980	Sol. W. Ginzburg Fellowship, Group for the Advancement of Psychiatry

1980	Honorable Mention, 22nd Annual Harry C. Solomon Essay Award,
	Massachusetts Mental Health Center
1981	First Prize, 23rd Annual Harry C. Solomon Essay Award, Massachusetts
	Mental Health Center
1983	Manfred S. Guttmacher Award of the American Psychiatric Association
	and the American Academy of Psychiatry and the Law for the outstanding
	contribution to the literature of forensic psychiatry (awarded for the
	Clinical Handbook of Psychiatry and the Law)
1983	3rd Annual Norbert Enzer Memorial Lecture, Mt. Sinai Hospital,
	Milwaukee
1983-1984	Research Scientist Career Awardee, National Institute of Mental Health
1984	Honorable Mention, Nellie Westerman Prize of the American Federation
	for Clinical Research for research in medical ethics
1986	Dean's Alumni Award, Columbia College
1986	Sam G. Dunn Lecture in Medicine and the Humanities, University of
	Texas Medical Branch at Galveston
1986	4th Samuel and Kathryn Yochelson Lecture, Yale University, New Haven
1990	1st Bruce Siegel Memorial Lecture, Mount Carmel Medical Center,
	Columbus, Ohio
1990	Fellow, American Psychiatric Association
1990	Isaac Ray Award of the American Psychiatric Association for outstanding
	contributions to forensic psychiatry and the psychiatric aspects of
	jurisprudence
1991	Isaac Ray Award Lectures: Massachusetts Mental Health Center, Boston;
	Western Psychiatric Institute and Clinic, Pittsburgh
1992-	Best Doctors in America, 1st edition and all subsequent editions
1992-	Who's Who in America, 43rd edition and all subsequent editions
1992	5th P. Browning Hoffman Memorial Lecture, University of Virginia Law
	School, Charlottesville
1993	Kinsman Lecture on Medical Ethics, Oregon Health Sciences University,
	Portland
1993	Saleem Shah Memorial Award of the State Mental Health Forensic
	Directors Association for contributions to forensic mental health services
1994	Jacob Finesinger Memorial Lecture, University of Maryland Medical
1004	School, Baltimore
1994	4th Paul Mendelsohn Memorial Grand Rounds, Tufts-New England
	Medical Center, Boston
1995	Pfizer Visiting Professor, Department of Psychiatry, University of
	California at Davis
1995	Will Solimene Award for Excellence in Medical Communication, New
	England Chapter, American Medical Writers Association (awarded for
100-	Almost a Revolution: Mental Health Law and the Limits of Change)
1996	Manfred S. Guttmacher Award of the American Psychiatric Association
	and the American Academy of Psychiatry & the Law for the outstanding
	contribution to the literature of forensic psychiatry (awarded for <i>Almost a</i>
1005155	Revolution: Mental Health Law & the Limits of Change)
1996-1997	Fritz Redlich Fellow, Center for Advanced Study in the Behavioral

## **Grant Support**

### **Past Funding**

1979-1980	Principal Investigator, Patients' Competence to Consent to Hospitalization, Foundations Fund for Research in Psychiatry.
1980-1983	Principal Investigator, Clinical Training in Forensic Psychiatry, National Institute of Mental Health.
1980-1984	Co-Investigator, Legal and Ethical Issues in Psychiatric Research, Foundations Fund for Research in Psychiatry. (Loren H. Roth, M.D., Principal Investigator)

1981-1982	Principal Investigator, Patients Who Refuse Treatment in Medical Hospitals, President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.
1983-1984	Principal Investigator, Studies of Civil Commitment of the Mentally Ill, Research Scientist Development Award, National Institute of Mental Health.
1987-1988	Principal Investigator, Neuropsychological Correlates of Competence, Basic Science Research Grant (NIH), University of Massachusetts Medical Center.
1989-1996	Co-Principal Investigator, Assessing the Decision-making Capacities of the Mentally Ill, John D. and Catherine T. MacArthur Foundation (with Thomas Grisso, PhD), \$1,084,873.
1989-1997	Co-Principal Investigator and Site PI, Risk Assessment of Violence in the Mentally Disordered (Henry Steadman, PhD, Principal Investigator), John D. and Catherine T. MacArthur Foundation, approx. \$1,200,000.
1998-2000	Co-Principal Investigator, Informed Consent and the Therapeutic Misconception, NIMH, (Charles Lidz, PhD, Principal Investigator), \$600,000.
1999-2004	Consultant, Clinical Antipsychotic Trials in Intervention Effectiveness, NIMH Grant # R01-MH90001 (Jeffrey Lieberman, M.D., Principal Investigator), \$42,750.
2000-2004	Co-Investigator, Research Ethics in Schizophrenia, NIMH Grant # R01 MH58898-06 (Will Carpenter, MD, Principal Investigator), subcontract \$85,000.
2001-2003	Co-Investigator and Site PI, Violence Risk Assessment Software (SBIR), NIMH Grant # R44-MH59453-02 (Henry Steadman, PhD, Principal Investigator) subcontract \$14,690.
2002-2004	Co-Principal Investigator and Site PI, Prevalence Study of Leverage in Community Treatment, John D. and Catherine T. MacArthur Foundation, \$73, 797.
2005	Principal Investigator, Leverage in Assertive Community Treatment Programs. John D. and Catherine T. MacArthur Foundation, \$43,000.
2004-2006	Co-Investigator, Competition Between Science and Care In Clinical Trials, NINDS Grant # R01-NS049595 (Charles Lidz, PhD, Principal Investigator), \$436,365.
2002-2006	Co-Investigator, Effectively Implementing Psychiatric Advance Directives, NIMH Grant # R01 MH063949-02 (Jeffrey Swanson, PhD, Principal Investigator), subcontract \$44,902.

2007-2008	Principal Investigator, Voluntary Decision Making About Participation in
	Human Subjects Research. Greenwall Foundation, \$48,900.

2004-2008 Co-Investigator, DVD Consent for Research in Older Schizophrenia Patients, NIMH Grant #1-R01-MH067902-01 (Dilip Jeste, MD, Principal Investigator), subcontract \$33,430.

## **Active Funding**

- 2004-2010 Co-Investigator, Research Ethics in Schizophrenia, NIMH Grant #2 R01 MH58898-06 (Will Carpenter, MD, Principal Investigator), subcontract \$119,156.
- 2006-2011 Co-Investigator and Site PI, An Observational Description Study of IRB Practices, NCI Grant #1R01CA107295 (Charles Lidz, PhD, Principal Investigator), subcontract \$207,000.
- 2006-2011 Co-Investigator, Clinical and Translational Science Award, NIH Grant #1 UL1 RR024156-01 (Henry Ginsberg, MD, Principal Investigator), 10% FTE.
- 2007-2012 Co-Investigator, Proxy Decision-Making for Alzheimer Disease Research, NIA Grant # 1RO1AG027986 (Laura Dunn, MD, Principal Investigator). subcontract \$79,250.
- 2008-2013 Co-Director of the Ethics and Policy Core, HIV Center for Clinical and Behavioral Studies. NIMH Grant # P30 MH43520 (Anke Ehrhardt, PhD, Principal Investigator). \$1,587,706, 10% FTE.
- 2008-2010 Co-Investigator, Capacity to Appoint a Proxy for Dementia Research, NIMH Grant #R01 MH075023 (Scott Kim, MD, PhD, Principal Investigator), subcontract \$48,933.
- 2008-2012 Co-Investigator, Ethical Issues in Surrogate Consent for Dementia, NIA Grant #RO1 AG029550 (Scott Kim, MD, PhD, Principal Investigator), subcontract \$111,333.
- 2008-2010 Co-Investigator, Examining Ethical Issues in Research on Deep Brain Stimulation, Greenwall Foundation, (Laura Dunn, MD, Principal Investigator), subcontract \$10,980.
- 2009-2011 Co-Investigator, Capacity of Children and Teens to Decide About Cancer Trials, NCI Grant # 1 R21 CA134864-01A1 (Steven Joffe, MD, PhD, Principal Investigator), subcontract \$62,632.

2009-2011	Co-Investigator, The Blurring of Treatment and Research in Clinical
	Trials: Two Problems, NINR Grant #1RC1 NR011612-01 (Chuck Lidz,
	PhD, Principal Investigator), subcontract \$123,584
2010-2013	Principal Investigator, Center for ELSI Research on Psychiatric, Neurologic, and Behavioral Genetics, NHGRI grant # 1P20HG005535-01, \$150,000

# **Departmental and University Committees**

University of Pittsburgh School of Medicine:	University	of Pittsburgh	School	of Medicine:
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1983-1984	Mental Health Clinical Research Center Seed Monies Committee,
	Department of Psychiatry
1983-1984	Academic Promotions Committee, Department of Psychiatry

## Harvard Medical School:

1984-1985	Committee on Governance, Department of Psychiatry
1984-1995	Working Group on Mental Health Policy, Division of Health Policy
	Research and Education
1994, 1995	Ad Hoc Committee on Professorial Appointment

# University of Massachusetts Medical School:

1985-1986	Task Force on Medical Humanities
1986-1988	Task Force on the Impaired Student
1986-2005	Executive Committee, Department of Psychiatry
1991-1992	Ethicist Search Committee (Chair)
1992-1998	Chancellor's Advisory Committee
1992-2005	Executive Faculty Council (Secretary, 1995-1996; President 1997-99)
1993-1995	Pharmacology Chair Search Committee
1994-1995	Task Force on Multi-year Contracts (Chair)
1994-1995	Task Force on Tenure Policy
2003	Work Group on Composite Assessment of the Clinical Departments (Chair)
2004-2005	Search Committee for Neurology Chair

# University of Massachusetts Medical Center

1985-1992	Treatment Issues Committee (Chair, Subcommittee on Consent, 1988; Vice-Chair, 1986-1988; Chair, 1989-1992)
1992-1998	Hospital Executive Committee
1992-1998	Group Practice Advisory Committee
1993-1998	Clinical Policies Committee
1995-1996	Task Force on the Role of the Clinical Chairs (Co-Chair)

### UMass Memorial Health Care

1998-2001	Physician's Advisory Board
1998-2005	Leadership Council (prior to 2003, Clinical Chairs Council)

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1998-1999	Group Practice Advisory Committee
1998-2005	UMass Memorial Behavioral Health System
	(President and Chairman of the Board)
1998-2001	Ethics and Treatment Issues Committee
1999-2003	Board of Directors, UMass Memorial Medical Group
2003-2005	Palliative Care Steering Committee
2004-2005	Finance Committee, UMass Memorial Medical Group

# Columbia University

2006-2007	Ethics Committee, Department of Psychiatry
2006-2007	Sachar Award Selection Committee, Department of Psychiatry
2006-	Advisory Board, Center for the Study of Science and Religion
2006-2007	Geriatric Psychiatry Division Director Search Committee, Department of
	Psychiatry (Chair)
2006-	Steering Committee, Clinical and Translational Research Award (CTSA),
	Columbia University Medical Center
2007-2008	Committee to Review Medical Student Teaching in Psychiatry,
	Department of Psychiatry (Chair)
2007-2008	Committee on Conflicts of Interest Policy at the College of Physicians and
	Surgeons
2007-	Ethics Advisory Board, Department of Psychiatry (Co-chair)
2007-2008	Residency Training Director Search Committee, Department of Psychiatry
2007-	Member, Prevention, Control and Disparities Program, Columbia Cancer
	Center
2008	Committee to Review the Residency Training Curriculum, Department of
	Psychiatry (Chair)
2008-	Executive Advisory Committee, Department of Psychiatry
2008	Subcommittee on Consent and Privacy, Biobank Planning Committee
	(chair)

# **Teaching Experience and Responsibilities**

1971-1972	Teaching assistant in biology, Columbia University
1974	Teaching assistant in neuropathology, Harvard Medical School
1977-1979	Clinical supervisor of medical students on psychiatry rotations, Harvard
	Medical School
1978-1979	Seminar leader and psychiatric consultant, Harvard Voluntary Defenders,
	Harvard Law School
1979-1980	Organizer and Director, Ethics Rounds, Massachusetts Mental Health
	Center
1979-1980	Supervisor of residents in legal psychiatry, Massachusetts Mental Health
	Center
1980-	Lecturer at grand rounds, symposia, and seminars in the United States and
	Canada
1980-1984	Supervisor of and lecturer to medical students and residents on legal psychiatry rotations, Western Psychiatric Institute and Clinic

1980-1981	Organizer and lecturer, course on Introduction to Psychiatry, psychology and social work trainees, Family Therapy Clinic, Western Psychiatric Institute and Clinic
1981-1984	Supervisor of residents in psychotherapy, Western Psychiatric Institute and Clinic
1982-1984	Teacher and co-teacher, Mental Health Law, University of Pittsburgh School of Law
1983-1984	Co-teacher, Law and Medicine, University of Pittsburgh School of Law
1985-2005	Supervisor of residents in psychotherapy, University of Massachusetts Medical School
1985-2005	Lecturer on legal and ethical issues in the practice of psychiatry and medicine to medical students and residents, University of Massachusetts Medical School
1988-1989	Lecturer, Law and Psychiatry (seminar for faculty); The Concept of Mental Competence in Law (seminars for faculty and students), Georgetown University Law Center
1993-2005	Small group leader, Mind, Brain, Behavior II Course, University of Massachusetts Medical School
1996	Co-organizer and lecturer, Law & Medicine (elective course for medical students), University of Massachusetts Medical School.
2004-2005	Lecturer on Suicide, Mind, Brain, Behavior II Course, University of Massachusetts Medical School
2006-	Seminar leader on law and psychiatry, Psychiatry Residency Training Program, Columbia University
2006-	Supervisor, Forensic Psychiatry Fellowship Program, Columbia University
2006-	Seminar on Informed Consent, Columbia Law School
2007-	Seminar on Mental Health Law, Columbia Law School

# **Other Professional Activities**

1978	Task Force on Involuntary Medication, Massachusetts Department of
	Mental Health
1978-1980	Committee on Human Studies, Joslin Diabetes Foundation, Boston, MA
1981-1983	Advisory Board, Involuntary Civil Commitment Project, National Center
	for State Courts, Williamsburg, VA
1981-1983	Advisory Board, Patients' Rights Research Project, Human Interaction
	Research Institute, Los Angeles, CA
1982-1987	Commission on the Mentally Disabled, American Bar Association
1982-1984	Ethics/Human Rights Committee, Presbyterian-University Hospital,
	Pittsburgh, PA
1984	Forensic Subcommittee, Special Advisory Committee on Public Policy,
	United Mental Health of Western Pennsylvania, Pittsburgh, PA
1984-1988	National Task Force on Standards for Involuntary Civil Commitment,
	National Center for State Courts, Williamsburg, VA
1984-1986	Mental Health Law Committee, American Society of Law and Medicine
	(co-chairman)

1985-1986	Advisory Board, Legal Procedures for Handicapped Infant Care Project,
1007 1007	American Bar Association
1987-1996	Research Network on Mental Health & the Law, John D. and Catherine T. MacArthur Foundation
1987	Participant, National Invitational Conference on the Future of Psychiatry
1987-1990	Advisory Committee to the American Academy of Forensic Sciences
1907-1990	Committee on Ethics
1989-1991	Massachusetts House Committee on Physician/Therapist Sexual
1707 1771	Misconduct, Subcommittee on Criminal/Civil Statutes
1992-2005	Board of Directors, Community HealthLink, Inc. (formerly Worcester
	Area Community Mental Health Center)(executive committee, 1992-2005)
1992-1994	Working Group on Guidelines for Maintenance of Boundaries in
	Psychotherapy, Massachusetts Board of Registration in Medicine
1993-1994	Ad Hoc Working Group for Mental Health and Criminal Justice
	Systems, Center for Mental Health Services, Substance Abuse and
	Mental Health Services Administration
1994-2000	Forensic Advisory Council, Massachusetts Department of Mental Health
1995-1996	Ethics Advisory Board, BRCA-1 Genetic Screening Project, Dana-
	Farber Cancer Center, Boston
1995-1996	Project on Human Research Ethics, Center for Bioethics, University of
	Pennsylvania
1996-2004	Research Advisory Committee, United States Secret Service
2000-2005	Ethics Committee, Clinical Antipsychotic Trials of Intervention
• • • • •	Effectiveness (CATIE) (chair)
2000-	Research Network on Mandated Community Treatment, John D. and
2000	Catherine T. MacArthur Foundation
2000	Work Group on Informed Consent and Ethical Issues in Human Studies,
2001 2004	National Institute of Mental Health  Read on Neuroscience and Relevieural Health Institute of Medicine of the
2001-2004	Board on Neuroscience and Behavioral Health, Institute of Medicine of the
2002-2005	National Academy of Sciences Advisory Board, TRIAD Project, National Alliance for the Mentally III
2002-2003	Steering Committee on the Genetics of Addiction, Institute of Medicine
2004-2005	Committee on Crossing the Quality Chasm: Adaptation to Mental Health
2001 2003	And Addictive Disorders, Institute of Medicine
2004-2007	Ethics Advisory Board, Treatment Units for Research on Neurocognition
	in Schizophrenia (TURNS) Program (chair)
2006-	Advisory Board, National Resource Center on Psychiatric Advance
	Directives
2006-2009	Subcommittee on Research Involving Individuals with Impaired Decision-
	Making Capacity, Secretary's Advisory Committee on Human Research
	Protections (SACHRP), U.S. Department of Health and Human Services
2007	Roundtable on Student Mental Health and the Law, Jed Foundation (chair)
2007-2009	Scientific Advisory Panel, Assisted Outpatient Treatment Study, NY State
	Office of Mental Health
2007-2009	Committee on Health Research and the Privacy of Health Information: the
	HIPAA Privacy Rule, Institute of Medicine

2007-	Clinical Research Ethics Key Function Committee, Clinical and Translational Science Award (CTSA) Consortium, NIH (chair, 2007-
	2009)
2007-	Advisory Board, Scattergood Program in Applied Ethics of Psychiatry and
	Behavioral Health, University of Pennsylvania
2008	Planning Committee for a Conference on Military Medical Ethics, Institute
	of Medicine
2008-	Consultant, Committee on the Development of the 3 <sup>rd</sup> Edition of the
	Reference Manual on Scientific Evidence, Federal Judicial
	Center/National Academy of Sciences
2008-	Scientific Council, National Alliance on Mental Illness
2008-	Standing Committee on Ethics, World Psychiatric Association
2008-	Advisory Committee, Voting and Cognitive Impairments Project,
	American Bar Association
2009-	Honorary Advisor, Chinese Dementia Research Association
2010-	Board member, Israel Healthcare Foundation
2010-	Board of Advisors, Saks Institute for Mental Health Law, Policy and
	Ethics, University of Southern California

#### **Grant Reviewer:**

National Institute of Mental Health (ad hoc, including NIH Challenge Grants in Health and Science Research; member, College of Reviewers, Center for Scientific Review); National Science Foundation; Social Sciences and Humanities Research Council (Canada); Wellcome Trust (UK); Netherlands Organization for Scientific Research; Alzheimer's Association; Dana Foundation; Institute of Neurosciences, Mental Health and Addiction, Canadian Institutes of Health Research; National Institute of Health Research (UK); Netherlands Organization for Health Research and Development; John D. and Catherine T. MacArthur Foundation; Policy Research Program, Department of Health (UK).

#### Journal Referee:

American Journal of Psychiatry; Psychiatric Services (formerly Hospital and Community Psychiatry); Journal (formerly Bulletin) of the American Academy of Psychiatry and the Law; International Journal of Law and Psychiatry; Law and Human Behavior; Law and Society Review; General Hospital Psychiatry; Journal of Nervous and Mental Diseases; Journal of the American Medical Association; New England Journal of Medicine; Psychosomatics; Journal of Health Policy, Politics and Law; American Psychologist; Archives of General Psychiatry; Psychiatry; Qualitative Sociology; Journal of Intensive Care Medicine; Hastings Center Report; Journal of Clinical Medical Ethics; Behavioral Sciences & The Law; American Journal of Geriatric Psychiatry; Milbank Quarterly; Schizophrenia Bulletin; Journal of Clinical Psychiatry; Medical Principles and Practice; International Journal of Psychiatry in Medicine; Southern Medical Journal; Archives of Internal Medicine; Academic Psychiatry & Behavioral Health; Journal of Law, Medicine & Ethics; Philosophy, Psychiatry and Psychology; Biological Psychiatry; Psychosomatic

Medicine; Journal of the American Academy of Dermatology; Journal of Public Health Policy; Israel Journal of Psychiatry; Neuropsychopharmacology; Journal of Clinical Oncology; Journal of Forensic Psychiatry; Journal of Forensic Psychology Practice; Kennedy Institute of Ethics Journal; International Journal of Neuropsychopharmacology; American Journal of Public Health; Lancet; Journal of Traumatic Stress; Health Affairs; Medical Anthropology Quarterly; Journal of Clinical Psychiatry; Theoretical Medicine & Bioethics; Journal of Affective Disorders; Behavior Research and Therapy; International Journal of Forensic Mental Health; Journal of Neuropsychiatry and Clinical Neuroscience; BioMed Central: Public Health; Harvard Review of Psychiatry; Community Mental Health Journal; BioMed Central: Psychiatry; Canadian Journal of Psychiatry; Administration and Policy in Mental Health and Mental Health Services Research; European Journal of Psychiatry; Journal of Social and Clinical Psychology; American Journal of Bioethics; BioMed Central: Medical Ethics; Psychological Medicine; Psychological Reports; Accountability in Research; Journal of the International Neuropsychological Society; Neurology; American Journal of Bioethics; Journal of Child Psychopharmacology; Current Psychiatry; Social Psychiatry and Psychiatric Epidemiology; Journal of the American Geriatrics Society; European Journal of Cognitive Psychology; International Psychogeriatrics; Acta Psychiatrica Scandinavica; IRB: Ethics & Human Research; Journal of Clinical Psychology; Jurimetrics; International Journal of Methods in Psychiatric Research; American Journal of Bioethics: Primary Research; Journal of Ethics in Mental Health.

#### **Editorial Boards:**

1981-	Contributing Editor (Law and Psychiatry), Psychiatric Services (prior to
	1995, Hospital and Community Psychiatry)
1982-1986	Editorial Board, Contemporary Psychiatry
1982-1987	Editorial Advisory Board, Mental and Physical Disability Law Reporter
	(chairman, 1982-1987)
1983-1992	Editorial Board, Law, Medicine and Health Care
1983-1990	Associate Editor, Bulletin of the American Academy of Psychiatry and the
	Law
1984-1994	Editorial Board, International Journal of Law and Psychiatry
1984-	Editorial Advisory Board, Law and Human Behavior
1986-1993	Editorial Advisory Board, Law and Mental Health Professionals series,
	American Psychological Association
1989-1994	Editorial Board, Criminal Behavior and Mental Health
1990-1994	Associate Editor, American Journal of Psychiatry
1993-1996	Editorial Advisory Board, Clinical Psychiatry News
1993-	Editorial Advisory Board, Psychiatry
1995-	Consulting Editor, Ethics and Behavior
1995-2006	Editorial Board, Behavioral Sciences and the Law
1999-	Editorial Board, Journal of Forensic Psychiatry and Psychology (UK)
2005-	Editorial Board, Schizophrenia Bulletin
2004-	International Editorial Board, Journal of Ethics in Mental Health
2005-	Advisory Board, International Review of Psychiatry
2005-	Editorial Board, BioMed Central: Psychiatry

### **Bibliography**

#### PEER REVIEWED ARTICLES:

#### 1977

1. Shader RI, Jackson AH, Harmatz JS, Appelbaum PS: Patterns of violent behavior among schizophrenic inpatients. Diseases of the Nervous System 1977; 38:13-16

#### 1979

- 2. \*Appelbaum PS, Vasile RG, Orsulak PJ, Schildkraut JJ: Clinical utility of tricyclic antidepressant blood levels: a case report. American Journal of Psychiatry 1979; 136:339-341
- 3. \*Appelbaum PS, Shader RI, Funkenstein HH, Hanson MA: Difficulties in the clinical diagnosis of lithium toxicity. American Journal of Psychiatry 1979; 136:1212-1213
- 4. \*Appelbaum PS, Gutheil TG: Rotting with their rights on: constitutional theory and clinical reality in drug refusal by psychiatric patients. Bulletin of the American Academy of Psychiatry and the Law 1979; 7:308-317

#### 1980

- 5. \*Appelbaum PS, Gutheil TG: Drug refusal: a study of psychiatric inpatients. American Journal of Psychiatry 1980; 137:340-346
- 6. \*Appelbaum PS: The therapeutic adversary: resolving the impasse. Journal of Psychiatric Treatment and Evaluation 1980; 2(2):95-96
- 7. \*Appelbaum PS, Gutheil TG: The Boston State Hospital case: "involuntary mind control," the constitution, and the right to rot. American Journal of Psychiatry 1980; 137:720-723
- 8. \*Appelbaum PS, Bateman AL: Competency to consent to voluntary psychiatric hospitalization: a theoretical approach. Bulletin of the American Academy of Psychiatry and the Law 1980; 7:390-399
- 9. Gutheil TG, Appelbaum PS: Substituted judgment and the physician's ethical dilemma: with special reference to the problem of the psychiatric patient. Journal of Clinical Psychiatry 1980; 41:303-305
- 10. \*Appelbaum PS: The legal psychiatry consultation service: a new service model for "forensic" psychiatry. Bulletin of the American Academy of Psychiatry and the Law 1980; 8:233-239

#### 1981

11. \*Appelbaum PS, Mirkin SA, Bateman AL: Empirical assessment of competency to consent to psychiatric hospitalization. American Journal of Psychiatry 1981; 138:1170-1176

- 12. \*Appelbaum PS, Roth LH: Clinical issues in the assessment of competency. American Journal of Psychiatry 1981; 138:1462-1467
- 13. \*Appelbaum PS, Reiser SJ: Ethics rounds: a model for teaching ethics in the psychiatric setting. Hospital & Community Psychiatry 1981; 32:555-560

- 14. \*Appelbaum PS, Roth LH: Competency to consent to research: a psychiatric overview. Archives of General Psychiatry 1982; 39:951-958. Reprinted as Les aspects psychiatriques du consentement valable en recherche, in Wachter M, Roy DJ, Doucet H, et al., (eds.): Cahiers de Bioethique, 4: Medicine et Experimentation. Quebec, Les Presses de L'Universite Laval, 1982. Excerpted in Reisner R, Slobogin C. (1990) Law and the Mental Health System: Civil and Criminal Aspects, 2nd edition, West Publishing, St. Paul, MN.
- 15. \*Appelbaum PS, Hamm R: Decision to seek commitment: psychiatric decision making in a legal context. Archives of General Psychiatry 1982; 39:555-560
- 16. Roth LH, Appelbaum PS, Sallee R, Reynolds C, Huber G: The dilemma of denial in the assessment of competency to refuse treatment. American Journal of Psychiatry 1982; 139:910-913
- 17. \*Appelbaum PS, Kemp KN: The evolution of commitment law in the nineteenth century: a reinterpretation. Law and Human Behavior 1982; 6:343-354
- 18. Huber G, Roth LH, Appelbaum PS, Ore T: Hospitalization, arrest or discharge: important clinical and legal issues in the emergency evaluation of persons believed dangerous to others. Law and Contemporary Problems 1982; 45:501-525
- 19. \*Appelbaum PS, Gutheil TG: Clinical aspects of treatment refusal. Comprehensive Psychiatry 1982; 23:560-566
- 20. \*Appelbaum PS, Roth LH, Lidz C: The therapeutic misconception: informed consent in psychiatric research. International Journal of Law and Psychiatry 1982; 5:319-329

- 21. \*Appelbaum PS, Jackson AH, Shader RI: Psychiatrists' responses to violence: pharmacologic management of psychiatric inpatients. American Journal of Psychiatry 1983; 140:301-304. Letter and reply. American Journal of Psychiatry 1983; 140:1274-1275
- 22. McEvoy JP, Hatcher A, Appelbaum PS, Abernathy V: Chronic schizophrenic women's attitudes toward sex, pregnancy, birth control and childbearing. Hospital & Community Psychiatry 1983; 34:536-539
- 23. Schmid D, Appelbaum PS, Roth LH, Lidz C: Confidentiality in psychiatry: a study of the patient's view. Hospital & Community Psychiatry 1983; 34:353-355

- 24. Gutheil TG, Appelbaum PS: Substituted judgment: best interests in disguise. Hastings Center Report 1983; 13(3):8-11
- 25. \*Appelbaum PS, Kapoor W: Imipramine-induced vasospasm. American Journal of Psychiatry 1983; 140:913-915
- 26. Gutheil TG, Appelbaum PS, Wexler DB: The inappropriateness of "least restrictive alternative" analysis for involuntary procedures with the institutionalized mentally ill. Journal of Psychiatry & Law 1983; 11:7-17
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