COUNTY OF HENNEPIN

FOURTH JUDICIAL DISTRICT Medical Malpractice/Wrongful Death

Court File No. 27-CV-07-1679 Judge John L. Holahan

Mary Weiss, on her own behalf, and as next of kin and Trustee of the estate of Dan Markingson, deceased,	
Plaintiff,	 DEFENDANTS DR. STEPHEN OLSON'S AND DR. CHARLES
VS.) SCHULZ'S AND THE UNIVERSITY OF MINNESOTA PHYSICIANS'
Board of Regents For the University of	DISCLOSURE OF FINDINGS AND
Minnesota; Dr. Stephen Olson; Dr. Charles	OPINIONS OF EXPERT WITNESS
Schultz; Institutional Review Board for the	JAN FAWCETT, M.D.
University of Minnesota; Astrazeneca	
Pharmaceuticals LP; Astrazeneca LP;	
and Zeneca, Inc.,	
Defendants.	

It is expected that Jan Fawcett, M.D., a medical doctor and psychiatrist duly licensed to practice in the States of Illinois and New Mexico, will be called to testify as an expert witness at the time of trial. A copy of his Curriculum Vitae is attached as Exhibit "A" which sets forth information pertaining to his background, education, training, hospital appointments, board certification, licensure, professional affiliations, honors/awards, publications and presentations.

Dr. Fawcett has reviewed the following documents and case-related materials:

- 1. Copies of the medical charts and records of Dan Markingson, also known as Daniel Weiss, deceased, from the following healthcare providers:
 - a. Fairview University Medical Center;
 - b. Minnesota Regional Coroner's Office;
 - c. Regions Hospital;
 - d. Theodore I Residence/Boston Health Care Systems;
 - e. Dr. Victor Amira;
 - f. Children's Health of St. Paul;
 - g. Group Health/HealthPartners;
 - h. Dr. Joseph Gryskiewicz;
 - i. University Health Service, Ann Arbor;

- j. University of Minnesota, Department of Psychiatry;
- k. Dakota County;
- 1. Eagan Counseling Clinic;
- m. Pharmerica;

He also reviewed the following documents and materials:

- n. Deposition transcript of Dr. Olson;
- o. Deposition transcript of Dr. Schulz;
- p. Deposition transcript of Mary Weiss;
- q. Deposition transcript of Mike Howard;
- r. Deposition transcript of Dr. Arlow Andersen;
- s. Deposition transcript of David Pettit;
- t. Deposition transcript of Stacy Hohler;
- u. Deposition transcript of April Arnold;
- v. Deposition transcript of Daniel Buse;
- w. Expert Disclosures of James I. Hudson, M.D. and Harrison G. Pope, M.D., Keith A. Horton, M.D., Paul Root Wolpe, Ph.D., and Donald L. Frankenfeld, Economist.
- x. E-mails written by Dan Markingson to his mother, Mary Weiss;
- y. Investigative report of the Office of the Ombudsman; and
- z. Report of Department of Health & Human Services.
- aa. July 22, 2005 Establishment and Inspection Report by the FDA written by Sharon L. Matson, Investigator.
- bb. Informed Consent Document.
- cc. Pre-petition Screening Team Recommendations dated November 14, 2003.
- dd. Order to Confine, to Transport for Examination, Hearing, Appointment of Attorney, Examiner and Notice by Judge Edward Lynch dated November 17, 2003.
- ee. Adult Consent Form for CAFÉ Study Participation signed on November 21, 2003.
- ff. Findings of Fact, Conclusions of Law, and Order for Stay of Commitment by Judge Robert F. Carolan dated November 20, 2003.
- gg. Various correspondences written by Mary Weiss.
- hh. Letters written back to Mary Weiss from a variety of individuals.
- ii. Journals kept by Mr. Markingson.

Dr. Fawcett is expected to testify at trial on issues of the standard of care, causation, damages, and the nature, extent and duration of Dan Markingson's medical condition. He will also respond to any and all findings and opinions expressed by each and every one of the Plaintiff's medical experts.

Dr. Fawcett's testimony will be based upon his education, training and experience, as well as his understanding of the medical teachings and practices which pertain to the issues presented in this case. In formulating his findings and opinions, he has reviewed and taken into

consideration Mr. Markingson's medical records, information and additional discovery materials provided to him for his review as listed above. All of Dr. Fawcett's opinions will be stated to a reasonable degree of medical and psychiatric certainty, unless otherwise specified.

Dr. Fawcett is expected to testify that that Dr. Stephen Olson and Dr. Charles Schulz both provided reasonable and appropriate care and treatment to Mr. Markingson. He will opine that each one of them satisfied the standard of care applied to them as physicians in their individual roles as study investigators, and in the case of Dr. Schulz, as the head of the Department of Psychiatry at the University of Minnesota. Dr. Fawcett will testify that Mr. Markingson's participation in the CAFÉ Study in conjunction with all of the additional care and treatment he was receiving through Theodore I House, adult group therapy at the Fairview Day Treatment Center, individual therapy with Dr. Arlow Andersen, and monitoring by David Pettit of Dakota County was reasonable and appropriate care and treatment for Mr. Markingson. Dr. Fawcett is also expected to testify that the care and treatment rendered to Mr. Markingson by Dr. Olson and Dr. Schulz did not cause or contribute to Mr. Markingson's suicide and ultimate death.

Factual Background

Daniel Weiss was born on November 25, 1976. He was the only son of Mary Weiss and Tom Rosner, who never married. Ms. Weiss raised her son as a single parent. Mr. Markingson did not have a relationship with his biological father. It does not appear that Mr. Markingson had a strong male influence in his life during his formative years.

Beginning in approximately 1983, Mr. Markingson was seen repeatedly throughout his childhood for complaints of headaches. His medical records reflect the fact that the source of his headaches may have been stress-related. On October 3, 1984, counseling was recommended to Ms. Weiss for her son's ongoing headache complaints. The same recommendation again occurred on January 29, 1985. It does not appear that Mr. Markingson received the counseling that was recommended.

From April 1986 through 1992, Ms. Weiss had her son seen many times for headache complaints. He received neurology, relaxation therapy, chiropractic care, saw an ophthalmologist and also saw allergists to determine the source of the headaches. A neurologist suggested to Ms. Weiss that the source of the headaches were muscle contraction, i.e., stress.

In August 1989, Mr. Markingson was placed on amitriptyline, brand name Elavil. Elavil is often prescribed for the relief of symptoms of mental depression. It is a member of the group of drugs called tricyclic antidepressants. It is unclear, based on the records, why Mr. Markingson was placed on this medication. It appears that Mr. Markingson may have remained on Elavil throughout his high school years.

Mr. Markingson completed his high school education and then took one year off to write a book and/or screenplay. Thereafter, he attended Hamline University for his freshman and sophomore years. He transferred to the University of Michigan where he completed his studies in 2000, and received a B.A. in English. In the late summer or early fall of 2000, Mr. Markingson moved to Los Angeles, California.

The records reflect that Mr. Markingson's intended career path was to become an actor and/or writer. When he first arrived in Los Angeles, he worked a series of odd jobs, which included selling papers for the L.A. Times and doing office work in an accountant's office. The only steady job he held was at Star Line Tours as a tour guide. He was employed there from February 15, 2002 through August 2003. Initially, he worked full time at Star Line Tours, but changed his status to part time in early 2003. It is believed Mr. Markingson unexpectedly resigned from that position in August 2003.

Ms. Weiss visited her son shortly after he moved to California in 2000. However, according to Ms. Weiss, their relationship completely changed after that visit. Ms. Weiss described the fact that her relationship with Mr. Markingson "totally deteriorated." He stopped calling her and he stopped writing to her. She described the fact that after that visit, communication between herself and her son completely ended. During Mr. Markingson's residency in California, he changed his last name from Weiss to Markingson. It is unknown why Mr. Markingson chose to change his last name.

Ms. Weiss went to California in August 2003 to attempt to reconnect with her son. When she went out to Los Angeles, she had difficulty finding him and had to contact his employer to discern his whereabouts. Ultimately, Ms. Weiss was able to find her son and, after some time, convince him to return to Minnesota. Ms. Weiss testified that upon seeing her son during this initial visit to Los Angeles, she believed that he was mentally ill. He made comments about the fact that there would be an event that was going to occur, that people were watching him, and that there were aliens present in his home. He also commented that he may be called upon to harm people prior to his return to Minnesota

Upon his return to Minnesota, Ms. Weiss arranged for her son to be seen at Group Health/HealthPartners. This visit occurred on September 4, 2003. Prior to the visit, Ms. Weiss had called the office to report that her son had been experiencing memory loss and weight loss. A physical examination was conducted which appeared to be normal. Mr. Markingson also underwent laboratory tests. Those results showed a slightly underactive thyroid. Mr. Markingson's mental health was not specifically addressed at that visit. Mr. Markingson did not see a psychiatrist, psychologist, therapist, or any other mental healthcare provider at that time.

The records reflect that on or about September 9, 2003, Mr. Markingson returned to California. After his return to California, Mr. Markingson began exchanging e-mails with "Guardian Angel Daisy@ hotmail.com" and "Michael the Archangell@hotmail.com." These e-mails were exchanged from September 19 through September 23, 2003. Ms. Weiss assumed the identity of "Guardian Angel Daisy" and "Michael the Archangel" and exchanged these e-mails with Mr. Markingson. It is unknown whether or not Mr. Markingson knew that his mother was the author of these e-mails. In the context of these e-mails, Mr. Markingson discussed an event that was purportedly going to occur in Duluth where he may be called upon to kill certain individuals. It was the promise of this "big event" that prompted Mr. Markingson to return to Minnesota.

Mr. Markingson returned to Minnesota and moved into his mother's home, where she resided with a male companion. Purportedly, Mr. Markingson spent the majority of his days alone in his childhood room. According to his mother and her companion, he continued to exhibit what they believed to be delusional and paranoid behavior. He would repeatedly make reference to the "big event," "being the chosen one," and his belief that there were references being made about him on television. From the time of Mr. Markingson's return to Minnesota in late September 2003, up until November 12, 2003, he did not see a psychologist, psychiatrist, therapist, or a physician for his mental health condition.

Purportedly, on November 12, 2003, Mr. Markingson told Ms. Weiss' companion, Michael Howard, that he intended to slit his mother's throat. This threat prompted Ms. Weiss and Mr. Howard to contact the police via 911. Mr. Markingson was transported in handcuffs from Ms. Weiss's home to Regions Hospital. The police report indicates that Mr. Markingson was aggressive verbally at his mother's home and indicated that he was unwilling to go to the hospital. However, Mr. Markingson calmed down prior to his arrival at Regions Hospital.

Hospitalization

Mr. Markingson was originally transported to Regions Hospital emergently. A history was taken from his mother by a social worker about Mr. Markingson's current mental health condition and history. She reported that Mr. Markingson had been discussing a "big event" that was satanic in nature. She reported that he had made threats to cause her harm on the day of his transport to the hospital. Mr. Markingson originally denied making these threats, but later acknowledged that he may be contacted in the future to do so as a result of the upcoming "big event." He stated that he would decide whether or not to follow through. He also denied any suicidal ideation or thoughts of harming others. The initial intake at Regions Hospital was done by Dr. Darren Manthey and Dr. Bradley Hernandez. They determined that Mr. Markingson was paranoid, delusional, grandiose and threatening to harm others. Due to a space issue, Mr. Markingson was transferred to Fairview University Medical Center ("FUMC").

Mr. Markingson was admitted to FUMC on a 72-hour hold by Dr. John Darling, a resident. Dr. Darling's admission assessment of Mr. Markingson was verified by Dr. Olson on November 13, at which time, he signed off as the attending psychiatrist. Prior to his admission to the psychiatric ward at FUMC, Drs. Darling and Olson took a history and performed an examination of Mr. Markingson. Drs. Darling and Olson found that the patient's eye contact was good, but intense at times. His mood was noted to be "good," and his affect was bright, and at times expansive. Drs. Darling and Olson found that his thought process was coherent and linear. Drs. Darling and Olson also found that the patient's thought content was positive for delusions, paranoia and ideas of reference. Mr. Markingson's insight and judgment were noted to be impaired by his significant delusional framework. Dr. Olson's initial impression was that Mr. Markingson had a recent onset of multiple delusions and psychotic symptoms that had been developing in recent months. Dr. Olson's diagnosis was psychosis and mood disorder, to rule out bipolar affective disorder, psychosis and schizophrenia.

On November 13, 2003, Dr. Olson wrote his admission note for Mr. Markingson. The basis of the information contained in that note came from both Mr. Markingson himself, as well

as his mother. Mr. Markingson acknowledged at that time that he did have some unusual beliefs, but attributed them to a lack of sleep and anxiety. Ms. Weiss advised Dr. Olson that she had had very little contact with her son over the last year and a half. Ms. Weiss also informed Dr. Olson she recently exchanged e-mails with her son using false identities. Dr. Olson's notes reflect that Mr. Markingson appeared to be downplaying his psychosis and trying to present himself in the best possible light. Dr. Olson's diagnosis for Axis I. was Psychosis NOS, and to rule out paranoid schizophrenia, schizoaffective disorder, and bipolar disorder with manic psychosis. Dr. Olson noted that the patient had an extended period of deterioration and elaborate, disorganized and fragmentary delusional thinking suggestive of paranoid schizophrenia. However, Dr. Olson could not rule out bipolar given the patient's claim of a sleep disorder and increased level of self-esteem. The 72-hour hold was to remain in place and Dr. Olson prescribed Risperdal for the patient. Mr. Markingson refused the Risperdal.

On November 14, 2003, Mr. Markingson met with the pre-petition screening team. At that point in time, it was noted that the patient did not have the capacity to make decisions regarding neuroleptic medication, and a Jarvis petition was being considered. During the interview, Mr. Markingson advised the screening team that he would be willing to be a voluntary patient and follow his physician's recommendations, but that he did not want to take any neuroleptic medication. Dr. Olson also spoke to the pre-petition screening team, and advised them that the patient had bizarre beliefs and lacked insight into the cause of those beliefs. There was also concern about whether the patient would follow through without patient care or whether an admission to an inpatient facility would be necessary. Commitment was ultimately recommended by the screening team and Dr. Olson.

In conjunction with the recommendation of the screening team for commitment, Dr. Olson wrote an examiner's statement in support of the petition for commitment. This was written on November 14, 2003. Dr. Olson described the history of the bizarre thinking of the patient and his threats to harm his mother. Dr. Olson advised the court that the development of the delusional thinking appeared to have occurred in the last 6-18 months and that the patient lacked a prior history of psychosis. He also reported to the court that the patient lacked insight into the causation of his delusional thinking. Dr. Olson advised the court that his diagnostic impressions and conclusions were that the patient had psychosis NOS; paranoid schizophrenia versus psychotic mania versus psychosis due to a medical condition. In Dr. Olson's opinion at that time, Mr. Markingson was at high risk for acting on his delusions. This was submitted to the court, along with the pre-petition screening team's recommendation for commitment.

Despite Mr. Markingson's statement on November 14th, indicating a refusal to take medication, it appears from the records that on the evening of November 13, 2003, Mr. Markingson agreed to take the prescribed anti-psychotic medication Risperdal. Thus, his medication use started at that time. Also, during Dr. Olson's meeting with Mr. Markingson, he admitted that his unusual beliefs had gone on longer than he had originally acknowledged, but would not reveal for how long. He also continued to deny some of the history that had been reported by his mother. However, he did admit that he had been concerned about a satanic cult, his mother's identity, being "the one," and having Angelina Jolie as his sister. Overall, Dr. Olson noted that the patient appeared to be minimizing his past thoughts, and that his insight and judgment were impaired. Dr. Olson questioned whether or not Mr. Markingson was sincere

about voluntarily agreeing to seek treatment. Thus, he was of the opinion that going forward with the commitment would be appropriate and that a Jarvis hearing may be necessary if the patient did not continue to be medication compliant.

On November 17, 2003, a judge from Dakota County, Minnesota, set forth an Order to Confine, to Transport for Examination, Hearing, Appointment of Attorney, Examiner and Notice. The petition was brought by Kathryn Knight for judicial commitment of Daniel Markingson as a mentally ill person. The judge ordered that FUMC was to retain custody of Mr. Markingson for observation, evaluation, diagnosis and emergency treatment. A Jarvis petition was not sought because Mr. Markingson had remained compliant and was taking his Risperdal as prescribed.

After taking the medication for several days, Mr. Markingson's case manager and therapist, Kathleen Bernhaft, wrote the treating physician's recommendations to the court. The recommendation of FUMC and Dr. Olson was that a stay of commitment would be appropriate. The reason being that Mr. Markingson had been cooperative with his inpatient treatment and was in the process of developing an aftercare plan. Further, Mr. Markingson had been medication compliant. The diagnosis at that time was psychosis NOS, mood disorder NOS, rule out bipolar effective disorder with psychosis and schizophrenia.

Erin Holker, Ph.D. LP at FUMC performed a neuropsychological evaluation of Mr. Markingson on November 18, 2003. Testing was done to determine Mr. Markingson's intellectual functioning level and his cognitive impairment, if any. The testing revealed that Mr. Markingson's overall intellectual functioning was in the superior range. Moreover, no cognitive difficulties were noted which could potentially interfere with Mr. Markingson's ability to actively participate in his own care and treatment. Mr. Markingson told Dr. Holker of his desire to continue the use of Risperdal and that he was committed to participating in his care and treatment.

On or about November 19, 2003, Dr. Olson discussed the CAFÉ Study with Mr. Markingson and his mother. According to his November 19 note, both Mr. Markingson and his mother were interested in the Study. Dr. Olson provided them both with materials for their review and consideration. However, informed consent was not limited to that meeting. According to Dr. Olson, this was an ongoing conversation with Mr. Markingson. Dr. Olson continued to assess whether or not Mr. Markingson was able to understand all of the information presented to him. Dr. Olson also continued to provide information to Mr. Markingson about alternative care available besides the CAFÉ Study.

Dr. James Jacobson conducted an examination of Mr. Markingson on November 19, 2003, pursuant to the court's order. Dr. Jacobson's diagnosis for Axis I of Markingson was psychosis, NOS, rule out mood disorder, NOS, and rule out bipolar disorder with psychosis versus rule out schizophrenia. Dr. Jacobson took a history and performed an exam on Mr. Markingson. Dr. Jacobson found that Mr. Markingson was fully oriented and that his thinking was logical and goal directed. He did not appear to be delusional, but did admit having peculiar thoughts in the past. He expressed to Dr. Jacobson his consent to the stay of commitment. Dr. Jacobson's recommendation to the court was that Mr. Markingson remain hospitalized for

continued evaluation to ensure that his recent mental health improvements continued. He also recommended that a commitment or a stay of commitment would be appropriate for Mr. Markingson. A Jarvis hearing was not recommended by Dr. Jacobson because Mr. Markingson was compliant with his medication and he agreed to continue to take his medication.

On November 20, 2003, Mr. Markingson appeared in court. During this proceeding, he was represented by an attorney. At that time, Mr. Markingson indicated that he voluntarily was agreeing to a stay of commitment. He admitted to being mentally ill and in need of treatment. The commitment was to be stayed for six months with a list of terms that included: "(a) that the respondent remain hospitalized, cooperative with the treatment plan at Fairview University Medical Center until medically discharged, and follow all of the aftercare recommendations of the treatment team; (b) that the respondent enter, participate in and satisfactorily complete the inpatient/outpatient treatment program and aftercare recommendations as determined by his social worker; (c) that the respondent cooperate with the treatment plan and follow the rules at any living facility as arranged by his social worker; (d) that the respondent consent to admission or re-admission to a hospital or other appropriate care facility as determined by the respondent's social worker in the event of a relapse; (e) that the respondent take drugs or medications only as prescribed, and abstain from the use of any non-prescribed drugs or alcohol; (f) that the respondent see a psychiatrist and/or therapist as frequently as recommended; (g) that the respondent engage in no behavior which is threatening or injurious to self or others; (h) that the respondent participate in any day treatment program or community support services: (i) that the respondent participate in family therapy if recommended; (j) that the respondent sign releases of information authorizing his social worker and the various service providers to exchange information; and (k) that the respondent cooperate with his social worker as determined."

On or about November 21, 2003, Mr. Markingson agreed to participate in the Café Study. Prior to signing the informed consent, he underwent an evaluation with Jeanne Kenney, a Study coordinator, and Liz Lemke, an assistant working on the Study. Both Ms. Kenney Ms. Lemke had undergone training to assess potential participant competence. Mr. Markingson was deemed to be competent because he was able to provide information about potential side effects, things expected of him, and his right to withdraw from the Study at any point in time. Thereafter, Mr. Markingson read the consent form, had the consent form read to him, and signed the consent form in the presence of Dr. Olson and Ms. Kenney. The informed consent set forth the purpose of the Study, the Study sponsor, Mr. Markingson's right to withdraw from the Study at any time, and alternative care and treatment available to Mr. Markingson. Mr. Markingson had the opportunity to ask any questions and raise any concerns prior to signing the information consent. Ultimately, he agreed to participate and signed.

Despite signing the informed consent to participate in the CAFÉ Study, Mr. Markingson did not begin the medication for that Study until December 5, 2003. He continued on Risperdal. He was slowly tapered off the Risperdal after December 5, 2003. From November 21 until December 5, Mr. Markingson was in Phase I of the Study. Phase I is commonly referred to as he screening period. Pursuant to Study protocol, this phase could last 1-21 days. During this phase, assessments were made to determine whether Mr. Markingson met the inclusion/exclusion criteria for the Study. Mr. Markingson's December 5 baseline visit was delayed to ensure that his condition had stabilized.

Mr. Markingson's first screening visit for the CAFÉ Study occurred on November 24, 2003. A history of Mr. Markingson's onset of his mental illness was taken at that point in time. It was noted that the medication he was taking at the time of that visit was Risperdal and Ativan prn. The diagnosis was schizophrenia paranoid type, to rule out psychosis NOS and schizophreniform. It was noted that the patient did in fact meet the criteria for schizophrenia, and therefore did meet the diagnostic criteria for the trial.

By November 25, 2005, Mr. Markingson was noted to be tolerating his Risperdal without difficulty. He also appeared to be gaining more insight into his prior delusional and paranoid behavior. Mr. Markingson reported at that point in time that he was having tension with his mother and was noted to be upset with her for her decision to not allow him to reside in her home post discharge.

On November 26, 2003, Mr. Markingson met for the first time with his case manager and/or assigned social worker from Dakota County, David Pettit. During this meeting, Mr. Pettit met with Dr. Olson, Ms. Weiss and Mr. Markingson. At that point in time, Dr. Olson presented the CAFÉ Study to Mr. Pettit for his review and consideration. Mr. Pettit acknowledged that he believed that the care and treatment provided in the CAFÉ Study was reasonable and appropriate. He also stated that in his opinion, this provided Mr. Markingson with more interaction with his medical care providers than if he was discharged in the normal fashion. Ultimately, Mr. Pettit agreed to allow Mr. Markingson to participate in the CAFÉ Study.

On December 3, 2003, Dr. Olson did an additional assessment of Mr. Markingson for the CAFÉ Study. Mr. Markingson indicated that he was working on being comfortable with the fact that he had psychosis. He also indicated a willingness to move to a group home. Once again, Mr. Markingson consented to treatment and to his participation in the CAFÉ Study.

On December 8, 2003, Mr. Markingson was discharged from FUMC. He was being transferred to Theodore I House run by Boston Health Care Systems. The Theodore I House ("Theo House") at the time was a Rule 36 facility with around-the-clock awake staff. The decision to have Mr. Markingson at this facility was based upon the recommendations of Mr. Pettit.

Dr. Olson's discharge diagnosis on December 8, 2003, was psychosis NOS, probable schizophrenia, and questionable history of alcohol abuse versus dependence. Mr. Markingson was noted to have mild hypothyroidism and had been placed on Synthroid. Over the course of Mr. Markingson's hospitalization, Dr. Olson became aware of the fact that he and his mother had a stressful relationship. Further, that according to the history provided by Ms. Weiss, she and her son had not had contact for a substantial period of time. Dr. Olson noted that throughout Mr. Markingson's hospitalization, he remained guarded and superficial. Although, he did admit to having unusual and delusional thoughts. Dr. Olson also noted that Mr. Markingson continued to minimize his mental illness and the events leading up to his hospitalization.

CAFÉ Study

The CAFÉ Study was a 52 week randomized, double-blind, flexible dose multicenter study to evaluate the overall effectiveness, as measured by treatment, discontinuation rates of Olanzapine, Quetiapine and Risperidone in patients early in the course of psychotic illness. There were 24 sites throughout the United States where the CAFÉ Study was conducted. Joseph P. McEvoy and Jeffrey Lieberman served as the head research physicians of the Study. The Study was sponsored by Astrazeneca Pharmaceutical Company. A total of 400 patients were randomly assigned to treatment with one of the three drugs. The University of Minnesota was one of the site locations. Dr. Olson served as the principal investigator at the University of Minnesota site, with Dr. S. Charles Schulz and Dr. John Vuchetich serving as co-investigators.

The CAFÉ Study was modeled after the CATIE Study that had been conducted by the National Institute of Mental Health (NIMH). That Study was conducted to determine the long-terms effects and usefulness of antipsychotic medications in persons with schizophrenia. The Study tested the anti-psychotic medications Olanzapine, Quetiapine, Risperidone, Clozapine and Ziprasidone, as well as Perphenazine and Fluphenazine Decanoate. The Study lasted for approximately 18 months. The majority of sites which conducted the CAFÉ Study, also participated in the CATIE Study. The CAFÉ Study was unique to other clinical research studies because it was to mimic real-world clinical care. Thus, the restrictions and limitations normally placed on trial subjects were not part of the CAFÉ Study protocol.

Mr. Markingson attended 11 visits during his participation in the Café Study. The summary of assessment ratings for the CAFÉ visits, was as follows:

SUMMARY OF ASSESSMENT RATINGS AT CAFÉ VISITS

Date and Visit #	Screen 11/24/03	Baseline 12/5/03	Visit 1 12/11/03	Visit 2 12/19/03	Visit 3 12/24/03	Visit 4 12/31/03	Visit 5 1/8/04	Visit 6 1/16/04	Visit 7 1/30/04	Visit 8 2/13/04	Visit 9 3/2/04	Visit 10 3/31/04	Visit 11 4/28/04
PANSS									-				<u> </u>
Positive symptoms Negative symptoms		13 11	7 11	12 10		10 7		7 9	7 7	7 9	7 10	13 20	10 18
Calgary Depression Rating Scale		10	9 - absent	9		9		9	9	9	9	9	9
*Suicide Sub-rating			1	1	į	1		1	1	1	1	1	1
Positive and Negative Syndrome Scale	23 - not complete	44	40	45		40		35	32	35	36	52	55
Clinical Global Impressions	5	4	3	3	2		2	2	2	2	2	4	3
Adverse Event/Side Effects		None	None	None	3 - sleepine ss	3 - sleepiness	None	None	2 sleepiness 2- insomnia	None	None	None	None
Abnormal Involuntary Movement Scale		0	0	0		0		0	0		0	0	0
Barnes Rating for Drug Induced Akathisia		0	0	0		0		0	0			0	0
Simpson Angus Abbrev		0	0	0		0		0	0		<u> </u>	0	1
Medication Adherence			9	8	9	8	9	8	9	8	8	8	8
Alcohol/Drug Use Scale		l - abstinent				1 - abstinent		2 - alcohol			1 - abstinent	1- abstinent	2 alcohol
Health Care Service Utilization		32				30		32			30	34	27
Heinrich Carpenter Quality of Life		98									92		
Insight and Treatment Attitude		16									22		

During each of the visits, Mr. Markingson also underwent PANSS Ratings and Evaluation under the Calgary Depression Scale. These rating scales demonstrate an improvement in the positive symptoms of schizophrenia seen with treatment and the low level of schizophrenia and depressive symptoms throughout the duration of the Study. The PANSS test has 30 items scored 1-7. Those are divided into 7 items for positive, 7 items for negative, and 16 for a general. The lowest rating for positive items would be "7," the lowest rating for negative would be "7," and the lowest rating for general would be "16." A "7" under the positive or negative subscales would be the equivalent of an "absent" rating.

The November 24, 2003 screening visit totaled 23, indicative of moderately severe symptomology. This assessment was a retrospective rating of the worst period of psychosis and was based on only five symptom items. A score of 23 on this subscale, with a range of 5-35 demonstrated significant psychosis. However, by the time of the baseline ratings, Mr. Markingson's score had dropped to 13 and remained in the range of 7-13 for the entire six months prior to his death. His scores of 7-13 represent a near total resolution of psychosis showing a marked improvement. Further, these scores reflect that Mr. Markingson's delusional thoughts, hallucinations and paranoia were nearly totally absent.

The PANSS Ratings had minimum scores of 7 for positive and negative subscales and 16 for general symptom subscale. Mr. Markingson's negative subscales scores increased from 11 at his baseline visit to 18-20 by visits 10 and 11; his general scores went from 20 at baseline to 26-28 at visits 10 and 11. These scores are in the minimal to mild range, and as reflected in the clinical notes, a moderate deterioration in self-care and grooming. In general, antipsychotic medications exert their therapeutic benefit almost exclusively on positive symptoms, and there is no requirement to change medication due to an increase in negative symptoms.

The medication that Mr. Markingson was assigned in the Study was learned after his death to be Seroquel, also known as Quetiapine. Each capsule of the Study medication contained 100 mg of Quetiapine. The maximal dose was 8 capsules per day, corresponding to a total maximum dose of 800 mg. From December 5, 2003 to December 10, 2003, Mr. Markingson was taking two pills per day. From December 11, 2003 to December 13, 2003, he was taking a total of four pills per day. From December 14, 2003 to December 19, 2003, he was taking a total of five pills per day. From December 20, 2003 through March 31, 2004, Mr. Markingson was taking a total of 7 pills per day. From April 1, 2004 onward, he was taking a total of 8 pills per day. At that point, he reached the maximum dose of 800 mg. of Seroquel. The increase in dosage represents an attempt to address Mr. Markingson's ongoing negative symptoms. Mr. Markingson reported no side effects from the medication at any dose

1. Dr. Olson

Dr. Olson provided care and treatment to Mr. Markingson throughout the course of his hospitalization. In addition, Dr. Olson saw Mr. Markingson after his discharge. His visits with Mr. Markingson occurred on December 11 and 19, March 2 and 31, and April 9. All of these visits were 30 minutes to one hour in length. Dr. Olson also saw Mr. Markingson for 15 minutes to one-half hour on January 30. Dr. Olson met with Mr. Markingson after concerns were raised about his medication compliance. Dr. Olson addressed those concerns and also reinforced to Mr.

Markingson his need to remain on medication. In addition, Dr. Olson was present at several additional visits that were conducted by Jeanne Kenney. Ms. Kenney was the Study coordinator who had been trained to do the necessary testing for the Study.

At those visits where Mr. Markingson was evaluated by Ms. Kenney, she performed symptom ratings, side effect assessments, psychosocial education sessions, and other components of the Study. Dr. Olson testified that he often came in midway through those visits with Ms. Kenney and Mr. Markingson. When this occurred, Dr. Olson would examine Mr. Markingson and assess his condition. He would provide appropriate direction to Ms. Kenney about Mr. Markingson's assessment, medication and ongoing needs.

In addition, Dr. Olson and Ms. Kenney would discuss all of her findings and the progress of Mr. Markingson. This would occur while Mr. Markingson was still at FUMC/ARC. Ms. Kenney and Dr. Olson would discuss whether or not Mr. Markingson was showing signs of relapse, possible side effects, or if there was any other major problem that had presented. Dr. Olson noted that he was available at all times to see Mr. Markingson if such a problem arose.

Mr. Markingson was also participating in a day treatment program at FUMC. The multidisciplinary team at the day treatment facility met monthly to discuss clients. Dr. Olson participated in those monthly meetings. During those monthly meetings, Dr. Olson and the day treatment team would discuss Mr. Markingson's behavior and progress. Dr. Olson also recalls having 2-3 private conversations with Dan Buse, Mr. Markingson's primary therapist in the day treatment program, regarding Mr. Markingson's mental state, progress and his mother's concern about his ongoing alleged psychosis.

2. Dr. Charles Schulz

Dr. Schulz saw Dr. Markingson on one occasion during his hospitalization at FUMC. That visit occurred on November 29, 2003. Dr. Schulz had reviewed Mr. Markingson's medical chart and interviewed him. Mr. Markingson was also examined by Dr. Schulz. Dr. Schulz found that the patient's thought process was logical, his mood was pleasant, and that his affect was appropriate.

Dr. Schulz, as a co-investigator in the CAFÉ Study, did not have any one on one visits or evaluations with Mr. Markingson. He allegedly was sent 2-3 letters from the patient's mother, Mary Weiss, in 2004. However, Dr. Schulz only recalls receiving one letter. After having received this letter from Ms. Weiss, Dr. Schulz investigated her concerns. Dr. Schulz met with Dr. Olson and Jeanne Kenney to discuss Mr. Markingson's involvement in the CAFÉ Study. That conversation included a review of Mr. Markingson's progress, medication use, and overall mental health. Dr. Schulz then crafted a response to Ms. Weiss addressing each of her concerns.

Dr. Schulz, as a co-investigator on the Study, gave 10% of his overall time to the project. In addition to serving as a co-investigator on the Study, Dr. Schulz is also the head of the Department of Psychiatry at the University of Minnesota. His role as a co-investigator was to be available as a backup rater for Dr. Olson if that was necessary. In addition, he was always

available to Dr. Olson to answer any questions he might have, to discuss the progress of the study, or to discuss individual patients participating in the Study.

As previously indicated, Dr. Schulz is also the head of the Department of Psychiatry at the University of Minnesota. The majority of his duties are administrative in nature. He also does clinical work each year for 2-4 weeks working as an attending psychiatrist in the inpatient service. Dr. Schulz also sees some outpatients two to four hours per week. During that timeframe, he will be teaching residents and conducting supervision over his entire staff. Dr. Schulz also monitors all of the physicians, fellows, residents, and other staff members working in the Department of Psychiatry at the University of Minnesota.

3. <u>Eagan Counseling Center</u>

For individual therapy, Mr. Markingson was seen by Dr. Arlow Andersen, Ph.D. LP, of the Eagan Counseling Clinic located in Eagan, Minnesota. Dr. Andersen saw Mr. Markingson on December 11, 2003, January 12, 2004, February 16, 2004, March 29, 2004, and April 26, 2004. Each of Dr. Andersen's visits with Mr. Markingson lasted approximately one hour. This one-on-one therapy was a part of Mr. Markingson's discharge plan from the hospital. It was also part of the outpatient work suggested by Mr. Pettit as a part of Mr. Markingson's stay of commitment.

Dr. Andersen was aware of Mr. Markingson's participation in the CAFÉ Study. That information was learned from Mr. Markingson. In each of Dr. Andersen's visits, he found Mr. Markingson's thought process to be logical and coherent. Dr. Andersen also found Mr. Markingson to have good insight and good judgment. In each of Dr. Andersen's visits, he assessed whether or not Mr. Markingson was showing signs of harm to himself or others. In each of his visits, he noted that this was either low without plan or absent. In fact, on his last visit with Mr. Markingson on April 26, 2004, he noted that any risk to self was absent.

Dr. Andersen testified that he did not believe that Mr. Markingson showed signs of being suicidal during their last visit. They also discussed the fact that Mr. Markingson's stay of commitment had been extended at his last visit. Mr. Markingson reported to Dr. Anderson that he did not object to the extension because he realized he was not prepared to return to California.

4. Day Treatment

Mr. Markingson participated in adult mental health day treatment at FUMC. This program was recommended by his social worker, David Pettit, as well as Dr. Olson. His participation was from January 14, 2004 through May 5, 2004. He was seen by Daniel Buse, HSW LLCSW, and Len Bennati, OTR/L. Mr. Markingson attended day treatment on Monday, Wednesday and Friday each week for three hours per day. Two hours of the visits were in group therapy, and one hour was dedicated to occupational group therapy.

Mr. Markingson had been referred to day treatment to provide structure, support and education about his mental illness. The medical records of Mr. Buse indicate that throughout Mr. Markingson's stay in day treatment, he presented as stable and denied any psychotic

symptoms. Mr. Markingson also willingly acknowledged past delusional thoughts, and recognized that his thoughts were bizarre in nature and content. Mr. Buse acknowledged that on occasion, Mr. Markingson presented with some negative symptoms which included some effect flattening, social withdrawal and avoidance. Mr. Buse noted that Mr. Markingson had excellent attendance throughout the course of his participation in day treatment.

Mr. Buse noted in his discharge summary that Mr. Markingson indicated a willingness to be discharged from day treatment as of May 5, 2004. Similarly, Mr. Bennati, in charge of his occupational therapy, found that Mr. Markingson acknowledged his diagnosis of schizophrenia and was receptive to continuing his medication use. Mr. Markingson's presentation in occupational therapy was noted throughout to be reserved and quiet. Some negative symptoms noted by Mr. Bennati were that Mr. Markingson had a blunted effect, on occasion appeared disheveled in his appearance, and at times was withdrawn. However, Mr. Buse and Mr. Bennati both thought Mr. Markingson was mentally stable enough to be discharged from day treatment.

Mr. Markingson graduated from his day treatment program on or about May 5, 2004. He rarely missed his scheduled appointments. The records from all of his providers seemed to indicate that he was ready for his transition into independent living, and that he was committed to seeking further care and treatment for his ongoing mental illness.

5. Theodore I House

After being discharged from FUMC, Mr. Markingson resided in a group home. This home was a Rule 36 facility known as Theodore I House ("Theo House") run by Boston Health Care. This facility was comprised of clients who were mentally ill, but not developmentally disabled. The group home provided 24 hours a day, 7 days a week, awake staff care and monitoring. The staff notes and depositions from staff members indicate that Mr. Markingson was quiet, reserved, but never exhibited delusions, hallucinations, or paranoid thinking. Mr. Markingson was a resident of Theo House from December 8, 2003 until the time of his death on the very early morning hours of May 8, 2004.

On or about January 23, 2004, the staff at Theo House became somewhat suspicious that Mr. Markingson may be cheeking or palming his medication. In an effort to stop that behavior, the staff put into a place a protocol where Mr. Markingson was required to take his medication straight from a cup, not allowing him to place it in his hand; he had to consume his medication in staff presence, and had to stay in the presence of staff for several minutes to ensure that he swallowed the medication. This protocol began shortly after January 23, 2005, and persisted up until the time of Mr. Markingson's death. Staff believed Mr. Markingson continued to take his medication as prescribed up until the time of his death.

According to the staff notes from Theo House, Mr. Markingson accepted extension of his stay of commitment. Further, the staff notes reflect that Mr. Markingson was looking forward to transitioning into his own apartment and living independently. Staff notes and depositions indicate that no one had any reason to believe that Mr. Markingson was considering suicide or exhibiting behavior which would demonstrate he had suicidal ideation.

Assessment, Opinions and Findings

1. Dr. Stephen Olson

In the opinion of Dr. Fawcett, Dr. Olson did not violate the standard of care by having three simultaneous roles in regard to the care and treatment he rendered to Dan Markingson. Based upon the training, experience, and knowledge of Dr. Fawcett, it is reasonable and appropriate for an individual to serve as a principal investigator in a clinical trial, to be the personal psychiatrist of a clinical trial, and also to be the primary care psychiatrist for a patient. Dr. Olson satisfied the standard of care in each of these roles. Further there was no conflict between these roles. Dr. Fawcett will opine that Dr. Olson provided good treatment to Mr. Markingson in all three roles. Further, his judgment in each of those roles was not impaired. Dr. Olson in no way violated the ethical code of conduct nor did he violate the applicable standard of care.

It is the opinion of Dr. Fawcett that the Nuremburg Code, Declaration of Helsinki, the International Conference on Harmonization Good Clinical Practice Guideline, and FDA Regulations and Guidelines are guidelines for the ethical conduct of research. However these principles only address a portion of what constitutes the standard of care. While they do address ethical considerations in clinical research they do no address the process of making clinical treatment decisions. The standard of care as defined by the above principles, as well as the standard of care for clinical treatment of a patient, was not breached in the care and treatment rendered to Mr. Markingson by Dr. Olson according to Dr. Fawcett.

Dr. Fawcett will opine that in obtaining informed consent from Mr. Markingson to participate in the CAFÉ Study, reasonable and appropriate methods were utilized. In his opinion, the standard of care was satisfied when obtaining informed consent from Mr. Markingson. Informed consent is a process and is not limited to the signature on a single document. Dr. Olson followed all of the steps necessary to ensure that Mr. Markingson was not only competent to give informed consent, but actually voluntarily wanted to participate in the CAFÉ Study.

As previously indicated, Mr. Markingson had been hospitalized since November 12, 2003. On or about November 13, Mr. Markingson began taking Risperdal. The notes reflect that the Risperdal had the desired effect on Mr. Markingson by helping him control his psychotic symptoms. He remained on Risperdal from November 13 until December 5, 2003, at which time began to taper off of the Risperdal and began the CAFÉ Study medication. This medication was later learned to be Seroquel. During that timeframe, Mr. Markingson's psychotic symptoms began to stabilize, he was no longer having active hallucinations or delusions, and his thought processes were described to be reactive and organized. Further, he had coherent and clear thoughts.

In the opinion of Dr. Fawcett, Mr. Markingson's medical records revealed that he was competent to give informed consent on November 21, 2003. A neuropsychological examination performed by Erin Holker, Ph.D. LP on November 18, 2003, indicates that by that date Mr. Markingson did not have cognitive impairments. Specifically, Dr. Holker's report indicates that

Mr. Markingson's overall intellectual functioning was in the superior range. Further, Dr. Holker noted that Mr. Markingson did not have cognitive difficulties that would interfere with his ability to actively participate in his own treatment. In the opinion of Dr. Fawcett, cognitively Mr. Markingson was able to provide informed consent.

Dr. Olson did not introduce information about the CAFÉ Study to Mr. Markingson until it was determined that he had no cognitive limitations on his ability to participate in his treatment. On or about November 19, 2003, Dr. Olson introduced the CAFÉ Study to Mr. Markingson. During this visit, Dr. Olson simply presented the CAFÉ Study as a potential treatment option for Mr. Markingson. At no point in time did he advise him that he had to participate in the Study, but simply allowed him to consider this as an alternative to standard care. Mr. Markingson indicated at that time a willingness to consider the CAFÉ Study for treatment. Dr. Olson provided written materials for Mr. Markingson to review.

According to Dr. Fawcett, additional evidence that Mr. Markingson was in a position to give viable informed consent can be found in the examination done by Dr. James Jacobson. According to Dr. Fawcett, Dr. Jacobson found that during his assessment of Mr. Markingson, he was fully oriented and showed logical and goal-directed thinking. This is further evidence, according to Dr. Fawcett, that Mr. Markingson was able to give informed consent.

The informed consent form was signed by Mr. Markingson on November 21, 2003. In the opinion of Dr. Fawcett, Mr. Markingson was competent and able to understand the CAFÉ Study, and also to understand the informed consent process at that time. Mr. Markingson remained competent throughout his participation in the CAFÉ Study, and according to Dr. Fawcett, was able to give ongoing informed consent which satisfied the applicable standard of care.

On November 21, 2003, Mr. Markingson met with Dr. Olson, Jeanne Kenney, the Study coordinator, and Elizabeth Lemke, an assistant on the CAFÉ Study. Prior to executing the informed consent, Mr. Markingson had to undergo an evaluation to determine whether or not he was competent to provide informed consent. This was a test that was based upon the MacArthur Evaluation Form used in the CATIE Study. The MacArthur Evaluation Form is a well-known and well-regarded informed consent competency test. Mr. Markingson was determined to be competent after that evaluation. In the opinion of Dr. Fawcett, having Mr. Markingson undergo this evaluation, was a reasonable and appropriate step to ensure that Mr. Markingson was competent. Dr. Fawcett will opine that this was above and beyond the required standard of care.

After Mr. Markingson underwent the evaluation, he then had the informed consent document read to him. Once again, according to Dr. Fawcett, this was reasonable, appropriate, and satisfied the standard of care. Taking the time to read the document to Mr. Markingson insured that Mr. Markingson fully understood the information contained in the consent form. Dr. Fawcett will opine that this step was an extra assurance to garnering informed consent from Mr. Markingson. Mr. Markingson was then given the opportunity to ask any questions and raise any concerns he might have had about the CAFÉ Study. It was only after all of these steps had been satisfied, that Mr. Markingson ultimately provided his signature on the informed consent form. Dr. Fawcett will testify that all of the steps were reasonable and appropriate care and treatment

for Mr. Markingson. Further, the applicable standard of care was satisfied in garnering informed consent from Mr. Markingson.

Dr. Fawcett will testify that it was reasonable and appropriate to have Jeanne Kenney participate in the informed consent process. She had been adequately trained through the CAFÉ Study on competence as well as doing the competency evaluation. Further, she had extensive knowledge about the CAFÉ Study, and therefore, was a reasonable and appropriate person to participate in the informed consent process.

Dr. Fawcett will also opine that Dr. Olson's participation in garnering informed consent from Mr. Markingson was reasonable, appropriate and satisfied the applicable standard of care. Dr. Olson followed every precaution to ensure that Mr. Markingson was competent to participate in giving informed consent. Further, Dr. Fawcett will opine that Dr. Olson reasonably presented the CAFÉ Study as alternative care and treatment and did not coerce Mr. Markingson into participating. Dr. Fawcett will opine that Dr. Olson satisfied the standard of care when obtaining informed consent from Mr. Markingson. In the opinion of Dr. Fawcett, the informed consent process in no way caused or contributed to Mr. Markingson's death.

Dr. Fawcett will testify that Mr. Markingson was not coerced into participating in the CAFÉ Study. In the opinion of Dr. Fawcett, regardless of Mr. Markingson's stay of commitment, he was still able to provide informed consent to participate in the CAFÉ Study. Further, Dr. Fawcett will testify that the stay of commitment did not order Mr. Markingson to participate in the CAFÉ Study. Rather, the stay of commitment order simply required Mr. Markingson to remain hospitalized and cooperate with treatment until he was medically discharged. At that point, he was to enter, participate and complete in an inpatient/outpatient treatment program and aftercare recommendations as determined by his social worker. The order of the court did not require Mr. Markingson to participate in the CAFÉ Study. Further, Dr. Olson simply presented the CAFÉ Study as alternative care and treatment for Mr. Markingson. Dr. Fawcett will opine that Mr. Markingson's participation in the CAFÉ Study was reasonable and appropriate care, and that Mr. Markingson was not in any way forced or coerced into participating in the Study.

Dr. Fawcett will also point out that despite signing the informed consent document on November 21, 2003, Mr. Markingson's initial screening visit for the CAFÉ Study was not commenced until November 24, 2003. From November 21 to December 5, Mr. Markingson was in the screening phase of the Study with ongoing assessments of whether he was an appropriate study subject. Further, he did not start CAFÉ Study medication until December 5, 2003.

On November 26, 2003, Mr. Markingson and Dr. Olson met with David Pettit, the Dakota County case manager/social worker assigned to be an advocate for Mr. Markingson. David Pettit's notes from Dakota County point out that he discussed the CAFÉ Study with Dr. Olson and that he found this to be reasonable and appropriate care and treatment for Mr. Markingson. Dr. Fawcett will also note that Mr. Pettit stated in his deposition that if he had not felt that the CAFÉ Study was reasonable and appropriate care and treatment for Mr. Markingson, he could have had him withdrawn from the Study. Mr. Pettit did not because he thought that the care provided in the CAFÉ Study would be more than Mr. Markingson would have received in

standard medical care. Thus, before Mr. Markingson became a true participant in the CAFÉ Study, his participation was reviewed and approved by his county case manager. This is further evidence according to Dr. Fawcett that Mr. Markingson's participation in the Study was reasonable and appropriate care and treatment and was in no way coerced.

Dr. Fawcett is also supportive of the informed consent document utilized in the CAFÉ Study. In his opinion, this document reasonably set forth the risks and benefits of participating in the CAFÉ Study. It stated the names of all of the study investigators. It also set forth the study sponsor, Astrazeneca. More importantly, it set forth information that Mr. Markingson's participation in the Study was voluntary and that he could withdraw from the Study at any point in time. Dr. Fawcett will opine that the document set forth a reasonable and appropriate amount of alternative care which Mr. Markingson could have sought. Dr. Fawcett will also testify that the document did not exaggerate nor unduly emphasize any benefits of Mr. Markingson's participation in the Study. Thus, in the opinion of Dr. Fawcett, the informed consent document in and of itself was reasonable and appropriate and satisfied the standard of care.

Dr. Fawcett will testify that Dr. Olson did not violate the standard of care by asking Mr. Markingson if he was interested in participating in the CAFÉ Study. Dr. Fawcett is of the opinion that Mr. Markingson was competent to give informed consent by November 21, 2003. In his opinion, all of the evidence shows that Mr. Markingson willingly wanted to participate in the Study, and was mentally capable of providing informed consent. Further, Mr. Markingson's stay of commitment did not in any way impinge upon Mr. Markingson's ability to provide informed consent. Thus, in the opinion of Dr. Fawcett, asking Mr. Markingson, a competent individual under a stay of commitment, to participate in the CAFÉ Study was reasonable, appropriate and did not in any way violate the standard of care.

Dr. Fawcett will also opine that there was no evidence of bias or unethical judgment by Dr. Olson because Astrazeneca paid to have the study conducted. Moreover, there is absolutely no evidence of unlawful payment to Dr. Olson or Dr. Schulz by Astrazeneca. The method of payment for the Study, according to Dr. Fawcett, was reasonable and appropriate. In no way did it cause or contribute to Mr. Markingson's cause of death.

The CAFÉ Study resulted in overhead costs to the University of Minnesota. Astrazeneca, the pharmaceutical company who was the Study sponsor, provided payments to the University of Minnesota for being a trial Study site. However, Dr. Olson and Dr. Schulz were not personally paid for conducting the clinical trial. Payments to the University of Minnesota by Astrazeneca Pharmaceutical Company in no way compromised Dr. Olson's or Dr. Schulz's ability to remain objective and did not create a conflict of interest. Neither Dr. Olson nor Dr. Schulz had a financial motivation to seek Mr. Markingson's participation in the CAFÉ Study. Further, Dr. Fawcett finds absolutely no credible evidence that Dr. Olson signed Mr. Markingson up as a CAFÉ Study participant due to an impairment in judgment or based upon a financial motivation. Thus, Dr. Fawcett is of the opinion that there was no financial conflict of interest on the part of Dr. Olson or Dr. Schulz.

Dr. Fawcett will testify that it was reasonable and appropriate for Mr. Markingson to participate in the CAFÉ Study. The CAFÉ Study utilized three FDA-approved antipsychotic

medications. No placebo was involved in the Study. Dr. Fawcett agrees that Dr. Olson's assessment that Mr. Markingson was schizophrenic was an appropriate diagnosis. As such, Dr. Fawcett will opine that Mr. Markingson fit the parameters of the Study protocol. Thus, Dr. Olson was aware that any three of the medications involved in the Study would effectively have provided care and treatment for Mr. Markingson's psychotic symptoms. Thus, reasonable and appropriate care and treatment was being offered to Mr. Markingson through his participation in the CAFÉ Study via the CAFÉ Study medication.

The CAFÉ Study did not involve a placebo. In the opinion of Dr. Fawcett, this is an exceptionally important aspect of the CAFÉ Study. At no point in time was Mr. Markingson at risk of having his psychotic symptoms go unmedicated. Instead, the CAFÉ Study involved three antipsychotic medication which have a marked impact on the positive symptoms and psychotic indications for one with schizophrenia. Thus, in the opinion of Dr. Fawcett, Mr. Markingson's participation in the CAFÉ Study was reasonable, appropriate and satisfied the standard of care.

Dr. Fawcett will also testify about the numerous benefits Mr. Markingson received by his participation in the CAFÉ study. Mr. Markingson received the benefit of intense treatment and close monitoring of his disease. He also received the benefit of having regularly scheduled follow up visits. Further, Mr. Markingson received the benefit of free medication. If not in the study, Mr. Markingson would have been discharged from the hospital with a one month supply of medication according to Dr. Fawcett.

According to Dr. Fawcett if Mr. Markingson had not participated in the study he would have still needed antipsychotic medication for his condition. In order to obtain that medication more likely than not, that would have been an out-of-pocket expense personally incurred by Mr. Markingson. Dr. Fawcett will opine that in 2004 the approximate cost of a 200 mg Seroquel tablet would have been \$680.00 for a of 100 pills, or \$7.00 per day. Mr. Markingson was taking 700 mg throughout most of the study, which would have cost approximately \$25.00 per day, or \$750.00 per month. If he had been randomized to Zyprexa in the study and needed the same dose equivallant Dr. Fawcett will opine the cost to Mr. Markingson would have been approximately \$700 per month. According Dr. Fawcett Risperdal would have been approximately one-half of the cost of either Seroqeul or Zyprexa. Thus, Dr. Fawcett will opine that the free medication through the study not only helped stable Mr. Markingson's mental illness, but also was a significant financial benefit to him.

The most important aspect of the CAFÉ Study to Dr. Fawcett was the amount of care Mr. Markingson was receiving as a part of his participation in the CAFÉ Study. In standard care, most often patients would be prescribed medication and asked to return within a few weeks of discharge on a somewhat regular basis. Generally, a patient will go approximately 4-6 weeks between visits with a psychiatrist. The distinct advantage of Mr. Markingson's participation in the CAFÉ Study, according to Dr. Fawcett, was the fact that he was seen on a more frequent basis with much longer individual visits. Further, he was receiving care and monitoring by a variety of individuals.

In the opinion of Dr. Fawcett, this provided more frequent and a much closer monitoring of Mr. Markingson. Moreover, Dr. Fawcett will opine that the close monitoring of Mr.

Markingson through the CAFÉ Study, enhances the probability of medication compliance and scrutiny for ongoing psychotic symptoms. Mr. Markingson's participation in the CAFÉ Study, and the greater amount of monitoring that occurred as a result of his participation in that Study, substantially decreased his chance for re-hospitalization according to Dr. Fawcett. Dr. Fawcett will testify that Mr. Markingson received greater care in the CAFÉ Study than he would have if he had not chosen to be a participant.

Dr. Fawcett will also point out that the care Mr. Markingson was receiving through the CAFÉ Study was not the only care and treatment being provided. In addition to seeing Dr. Olson, participating in the CAFÉ Study, Mr. Markingson was also receiving 24 hours a day, 7 days a week monitoring at the Theo House. The Theo House ensured greater medication compliance because Mr. Markingson was not charged with taking his own medication. Instead, because he was a client at Theo House, his medication was regularly distributed to him by a staff member who would closely watch and scrutinize whether or not he was taking his medication. Due to his residency at Theo House, Mr. Markingson was being regularly observed and closely monitored for adverse effects of medication, the failure to take medication, and any ongoing psychotic symptoms. According to Dr. Fawcett, this is care that one generally would not receive if they had been discharged from the hospital and received standard medical care.

According to Dr. Fawcett, Mr. Markingson's participation in the CAFÉ study also provided close monitoring of his medication compliance. One of the difficulties in treating a patient diagnosed with schizophrenia is their inability to remain complaint with their medication. The CAFÉ study used the standard method of medication compliance monitoring by doing pill counts. Dr. Fawcett will opine that pill counting was additional monitoring Mr. Markingson received because of his participation in the CAFÉ study. It also showed a commitment on the part of Dr. Olson to supervise Mr. Markingson's medication compliance. Dr. Fawcett will opine this satisfied the standard of care and did not cause or contribute to Mr. Markingson's death.

Mr. Markingson was also a participant in individual therapy through Dr. Arlow Andersen. Dr. Andersen met with Mr. Markingson for approximately one hour each month. This therapy was conducted in addition to all of the other care and treatment received by Mr. Markingson. Once again, in the opinion of Dr. Fawcett, this care by Dr. Andersen was additional monitoring of Mr. Markingson and was reasonable and appropriate.

Dr. Fawcett will also point out that Mr. Markingson was a participant in an adult day treatment program at Fairview University Medical Center. The day treatment program met for three hours a day, three times a week. Mr. Markingson's attendance at day treatment was consistent and regular. Again, Mr. Markingson's participation in adult day treatment was above and beyond what one would generally receive in standard medical care. Mr. Markingson was being monitored and observed by staff members in day treatment for any ongoing psychotic symptoms. Throughout Mr. Markingson's participation in day treatment, he presented in stable condition. Again, in the opinion of Dr. Fawcett, this was reasonable and appropriate care and treatment for Mr. Markingson.

Taking into consideration all of the care and treatment Mr. Markingson was receiving while he was a participant in the CAFÉ Study, showed that he was receiving close monitoring

and scrutiny of his medication compliance, any adverse effects of the medication, and his overall mental health wellbeing. As previously explained, an example of that monitoring would be the pill count of Mr. Markingson's medication. According to Dr. Fawcett, the amount and frequency of care Mr. Markingson was receiving, was beyond standard medical care. Thus, Dr. Fawcett will testify that the care and treatment rendered to Mr. Markingson was reasonable, appropriate and satisfied the standard of care. He will further opine that in no way did any of the care and treatment Mr. Markingson received cause or contribute to his death.

The evidence throughout the medical records indicate that Mr. Markingson was made well aware of his opportunity to seek alternative care and treatment, to seek a second opinion, and to withdraw from the CAFÉ Study. Providing Mr. Markingson with this vital information was reasonable and appropriate according to Dr. Fawcett. Mr. Markingson was a competent adult and was the only one who could make that decision. Further, his county case manager never requested alternative care for him. Dr. Fawcett will opine that providing Mr. Markingson with all of this information satisfied the standard of care. This did not cause or contribute to his death.

The informed consent document in and of itself states that Mr. Markingson is able to seek alternative care and treatment. It also advised Mr. Markingson that he had the right to withdraw from the Study at any point in time. According to Dr. Fawcett, this is reasonable and appropriate notification of alternative treatment in an informed consent document. He will opine that this did not cause or contribute to Mr. Markingson's death.

The medical records also indicate that Dr. Olson, advised Mr. Markingson of his right to have a second opinion on several occasions. Mr. Markingson refused that offer and indicated a willingness to continue with the care provided by Dr. Olson and the CAFÉ Study. Dr. Fawcett will testify that Mr. Markingson was a competent adult and could not be forced to obtain a second opinion against his will. Dr. Fawcett will opine that providing Mr. Markingson with that information was reasonable, appropriate and satisfied the standard of care. Further, in no way did that cause or contribute to Mr. Markingson's cause of death.

Dr. Olson also testified that he provided information to Mr. Markingson about alternatives to his participation in the CAFÉ Study. According to Dr. Olson, he described for Mr. Markingson his right to seek standard medical care. Providing verbal information, in addition to the written information received by Mr. Markingson, was reasonable and appropriate according to Dr. Fawcett. Dr. Fawcett will testify that providing this information to Mr. Markingson in no way caused or contributed to Mr. Markingson's cause of death.

Dr. Fawcett is of the opinion that it was reasonable and appropriate to seek an extension of Mr. Markingson's stay of commitment in May 2004. In March and April 2004, Mr. Markingson began to comment upon his desire to return to California. He indicated that he was going to travel there without any realistic financial planning to get there, and he did not have in place any healthcare system which could continue to address and assist him with his ongoing mental illness. Further, Ms. Weiss continued to raise concerns about Mr. Markingson's mental health. The decision of Dr. Olson to support the extension of the stay of commitment was a sign of how Dr. Olson was attuned to Mr. Markingson's on-going problems and appropriately responding to them. Further, it also demonstrated Dr. Olson's careful consideration and response

to the concerns Ms. Weiss was raising about her son. In the opinion of Dr. Fawcett the extension of Mr. Markingson's stay of commitment was reasonable and appropriate care that was in no way coercive.

In an April 9, 2004 meeting, an extension of Mr. Markingson's stay of commitment was brought up by David Pettit, his Dakota County case manager. Mr. Markingson's agreed that an extension of his treatment time and stay of commitment was reasonable and appropriate. Mr. Pettit went on to testify in his deposition that it was he who initiated a discussion of whether or not the stay should be extended. Dr. Olson was supportive of this measure and filled out the practitioner's report in support of an extension.

Dr. Fawcett will opine that there is no evidence that the stay of commitment was sought for any other reason than to ensure appropriate care and treatment for Mr. Markingson. There is absolutely no evidence that the stay of commitment was sought based upon a desire to retain Mr. Markingson in the CAFÉ Study. Further, Dr. Fawcett will opine that there was no coercion by Dr. Olson to have Mr. Markingson continue to participate in the stay of commitment. At any point in time, Mr. Markingson could have withdrawn his consent from participation in the CAFÉ Study. The decision to extend the stay of commitment was reasonable and appropriate and satisfied the standard of care according to Dr. Fawcett.

Dr. Fawcett will opine that Mr. Markingson's entry into, and participation in, the CAFÉ Study, provided appropriate care and treatment for his schizophrenia. The medication prescribed, along with Mr. Markingson's participation in the CAFÉ Study, follow-up care at day treatment, follow-up care with Dr. Andersen, and continuous monitoring at the Theo House, along with his interactions with Mr. Pettit, provided reasonable care and treatment, as well as exceptional monitoring of Mr. Markingson's wellbeing. In the opinion of Dr. Fawcett, Mr. Markingson's participation in the CAFÉ Study did not, in any way, cause or contribute to Mr. Markingson's suicide.

Dr. Fawcett will opine there was no evidence that Mr. Markingson's psychotic symptoms persisted which in any way caused or contributed to his death. The type of testing Mr. Markingson was receiving in the CAFÉ study was state of the art and not available to vast majority of patients. Thus, he was receiving some of the best available monitoring of his illness according to Dr. Fawcett.

Dr. Fawcett will opine that laboratory testing to determine the blood level of antipsychotic medication in Mr. Markingson was not necessary. He will opine that it is not possible for every lab to conduct the type of test necessary to determine medication levels. Often times, the blood samples would have to be sent to an outside lab. According to Dr. Fawcett this will cause a delay in receipt of the results which usually makes it difficult to contribute to clinical decisions. Dr. Fawcett will also opine that the use of such laboratory results has limited use in clinical treatment because it is one isolated sample. In that regard it may or may not be a true indication of medication compliance. Further, there is conflicting information in the research literature on whether the level of quetiapine found in blood samples is in any way related to clinical response according to Dr. Fawcett.

In his opinion, obtaining such testing is a very rare occurrence even in standard medical care. It is reserved for those extreme cases where one is exhibiting chronic and severe psychotic symptoms. Dr. Fawcett will opine that Mr. Markingson's mental health and condition did not rise to that level. Dr. Fawcett will opine that Dr. Olson's decision to not run any blood laboratory screening to determine Mr. Markingson's medication level, was reasonable and appropriate. Further, he will opine that this did not cause or contribute to Mr. Markingson's death.

Dr. Fawcett is also prepared to address the assertion that Dr. Olson should have placed Mr. Markingson on a different antipsychotic medication. The use of Seroquel, or any of the antipsychotic medication in the Study, was reasonable and appropriate care and treatment. In the opinion of Dr. Fawcett, the use of Seroquel did stabilize Mr. Markingson and substantially reduced and minimized his psychotic symptoms. The ongoing problems experienced by Mr. Markingson were his negative symptoms. Dr. Fawcett will testify and explain that negative symptoms generally are not easily treated through any medication. However, those negative symptoms were being addressed by the different therapies Mr. Markingson was receiving. Dr. Fawcett will also opine that Dr. Olson was increasing Mr. Markingson's medication dose that was within the range of the study as well as the patients' clinical state. Dr. Fawcett will testify that Dr. Olson was reasonably and appropriately attempting to address Mr. Markingon's negative symptoms through an increase in his medication. In the opinion of Dr. Fawcett, alternative antipsychotic medication was not necessary for Mr. Markingson. Further, Mr. Markingson did not remain psychotic and this did not cause or contribute to Mr. Markingson's cause of death.

Dr. Olson did provide good clinical care both as Mr. Markingson's primary care psychiatrist, as well as the principal investigator and Study psychiatrist for the CAFÉ Study, according to Dr. Fawcett. In fact it is very common for a principal investigator to be a treating psychiatrist in a clinical treatment study and to take on the role of patient management according to Dr. Fawcett. Dr. Olson saw Mr. Markingson on a consistent and regular basis throughout his hospitalization at FUMC. Further, Dr. Olson saw Mr. Markingson on December 11, December 19, 2003, January 30, 2004, March 2, March 31, and April 9. Dr. Olson testified that there were several visits from December through February where he saw Mr. Markingson at the end of his CAFÉ visits during which time he met with Mr. Markingson and evaluated him. In addition, Dr. Olson was meeting once a month with the day treatment staff to discuss Mr. Markingson's progress and overall wellbeing. Dr. Olson would also have regular interaction with Jeanne Kenney and would discuss her observations of Mr. Markingson, as well as her assessments of his progress. The care and treatment rendered by Dr. Olson was reasonable, appropriate, and ethical care. By taking the additional steps to interact with other persons providing care to Mr. Markingson, Dr. Olson demonstrated his clinical commitment to the patient. In the opinion of Dr. Fawcett, Dr. Olson satisfied the standard of care and in no way did his care and treatment cause or contribute to Mr. Markingson's death.

According to Dr. Fawcett, there is absolutely no validity to the allegation that Dr. Olson was an "absent" psychiatrist. As noted above, Dr. Olson saw and evaluated Mr. Markingson but also discussed his care with many of his other care providers. Dr. Olson went beyond the role of being just a medication distributor, but was instead actively engaged in Mr. Markingson's care. The amount of interaction Dr. Olson personally had with Mr. Markingson, as well as his

interactions with other individuals who were involved in Mr. Markingson's care, was reasonable and appropriate. In no way did the care and treatment rendered by Dr. Olson as the principal investigator of the Study, the Study psychiatrist, nor as Mr. Markingson's primary psychiatrist, in any way cause or contribute to Mr. Markingson's death. Dr. Olson satisfied the standard of care required of him in each of those roles.

Dr. Fawcett will also opine that it was reasonable and appropriate to have Jeanne Kenney participate in the evaluations and diagnostic interviews with Mr. Markingson. In his experience, oftentimes these roles will be designated to individuals who have been trained on the individual Study and know how to do the testing and assessment. Ms. Kenney received the necessary training. Ms. Kenney always provided Dr. Olson with the information garnered from those visits and assessments prior to Mr. Markingson's leaving his individual CAFÉ Study visits. Dr. Olson would consider the information provided to him by Ms. Kenney and personally evaluate Mr. Markingson's progress. Dr. Fawcett will testify that it was reasonable and appropriate care for Ms. Kenney to assist Dr. Olson in this manner. Further, he is of the opinion that this satisfied the standard of care and in no way caused or contributed to Mr. Markingson's death.

Dr. Olson also reasonably and appropriately considered the concerns being rendered by Ms. Weiss. The record reflects that Ms. Weiss sent Dr. Olson two letters in November 2003. Those letters set forth some concerns she had about her son's participation in the CAFÉ Study, and alleged ongoing psychotic symptoms. He also on occasion received messages from Ms. Weiss raising her concerns. Dr. Olson always took into consideration these concerns. He would consider that information against the presentation that Mr. Markingson made at his CAFÉ Study visits. In addition, he would weigh these concerns against information being received from the Theo House and the observations of Mr. Markingson being made during adult day treatment. In all instances, Mr. Markingson presented as being stable and no one could verify the concerns raised by Ms. Weiss. Thus, Dr. Olson reasonably and appropriately assessed and evaluated the concerns rendered by Ms. Weiss. Dr. Olson did not disregard those comments by Ms. Weiss, but continued to consider them as a part of his ongoing care and treatment of Mr. Markingson. One example of this is Dr. Olson's agreement to seek an extension of Mr. Markingson's stay of commitment. These assessments were reasonable, appropriate and satisfied the applicable standard of care. In no way did this cause or contribute to Mr. Markingson's cause of death.

Based upon his review of the medical records, the deposition transcripts, and the applicable discovery information, Dr. Fawcett will opine that Mr. Markingson was not in any way exhibiting evidence of severe deterioration. Mr. Markingson did show evidence of having ongoing negative symptoms, which Dr. Olson reasonably attempted to address by increasing the dose of mediation according to Dr. Fawcett. There was no clinical evidence to suggest it was necessary or appropriate to withdraw Mr. Markingson from the CAFÉ Study. All care providers reported that Mr. Markingson appeared stable without ongoing psychotic concerns such as active hallucinations or delusions. Thus, in the opinion of Dr. Fawcett, it was not necessary for Dr. Olson to withdraw Mr. Markingson from the CAFÉ Study at any point in time. His continued participation in the Study satisfied the standard of care and was reasonable and appropriate. Further, this in no way caused or contributed to his death.

In the opinion of Dr. Fawcett, Dr. Olson satisfied the standard of care for a treating psychiatrist. Dr. Olson always took into consideration the best interests of Mr. Markingson and attempted to ensure that those were satisfied. In the opinion of Dr. Fawcett, Dr. Olson was diligent in monitoring Mr. Markingson's condition, and took into account information provided to him by available outside sources. The care and treatment prescribed to Mr. Markingson was always reasonable, appropriate, and satisfied the standard of care. There was no evidence that Mr. Markingson was experiencing a recurrence of serious psychotic symptoms. Instead, the evidence was completely to the contrary. Mr. Markingson appeared to be stable, goal oriented and competent. Dr. Olson was appropriately attuned to the status of Mr. Markingson's condition throughout his participation in the CAFÉ Study and as his primary care psychiatrist. Dr. Olson's care and treatment satisfied the standard of care, and in no way caused or contributed to Mr. Markingson's death.

Dr. Fawcett will opine that there was no clinical evidence that re-hospitalization for Mr. Markingson was necessary. There was no clinical evidence to support that he was having recurrent psychotic symptoms based on his behavioral ratings that were not being reasonably controlled by his medication. The behavioral ratings used in Mr. Markingson's care are the standard ratings used in mental health assessments according to Dr. Fawcett. Mr. Markingson's condition had stabilized and he was not presenting with active hallucinations or delusions. Mr. Markingson no longer was making threats against others nor himself. In Dr. Fawcett's opinion, hospitalization was neither necessary nor appropriate for Mr. Markingson. There was no clinical evidence of a need to re-hospitalize Mr. Markingson during the entire course of his participation in the study.

Dr. Fawcett will testify that those with mental illness have a greater rate of suicide than the average population. Individuals who are mentally ill have the capability of committing suicide even if they are hospitalized in a locked ward. In the case of Mr. Markingson, he was receiving a greater amoun of care and monitoring then he would have received in a standard care setting. His decision to take his own life was not caused or contributed to by the care and treatment rendered by Dr. Olson as the principal investigator of the CAFÉ Study, Dr. Olson as primary care psychiatrist of the CAFÉ Study, nor as Mr. Markingson's individual primary care psychiatrist.

Dr. Fawcett will testify that he did review the Department of Health and Human Services report regarding their review of the death of Mr. Markingson. In his opinion, there were absolutely no adverse findings related to Dr. Olson, the University of Minnesota, the CAFÉ Study, nor Dr. Schulz.

Dr. Fawcett has also reviewed the investigation conducted by the Food and Drug Administration by Sharon L. Matson, Investigator, in January of 2005. Dr. Fawcett will testify that the investigation conducted by the FDA found no adverse care and treatment by Dr. Olson, Dr. Schulz, or any other person involved in Mr. Markingson's care and treatment. The FDA found that Mr. Markingson's diagnosis of schizophrenia was reasonable and appropriate.

In reviewing that document, Dr. Fawcett also noted that the FDA found that the court order did not require Mr. Markingson's participation in the CAFÉ Study. Thus, there was no

evidence of inappropriate coercion. The commitment terms indicated that Mr. Markingson would participate in treatment that was acceptable by Mr. Markingson's social worker. Thus, the FDA found that ultimately David Pettit had the ability to discern whether or not the CAFÉ Study was appropriate care and treatment for Mr. Markingson. Based upon Mr. Markingson's participation after Mr. Pettit's involvement in the case, the FDA found that that care and treatment was reasonable and appropriate. The FDA investigator found that Mr. Markingson received more care than he would have received in standard medical care by his participation in the CAFÉ Study.

The FDA also found that Mr. Markingson was in a state to give voluntary, informed consent on November 21, 2003. The FDA investigator noted that at that point in time, Mr. Markingson had undergone an internal medicine evaluation, an MRI and thyroid study, a neuropsychological evaluation, a chemical dependency evaluation, and had been seen by a variety of care providers and staff on station 12. Mr. Markingson's psychosis had stabilized by the use of Risperdal and he was evaluated to be in a competent state of mind. Based upon his review of this report, Dr. Fawcett will opine that the FDA did in fact find that Mr. Markingson was able to give voluntary informed consent.

The FDA also noted in their report that Mr. Markingson did not remain in the study despite deterioration. The FDA report noted the variety and exceptional amount of monitoring and care Mr. Markingson was receiving. All of this care was done in addition to Mr. Markingson's CAFÉ Study visits and visits with Dr. Olson. Not one of those individuals had anticipated that Mr. Markingson would commit suicide. Further, not one of those providers ever mentioned or thought that Mr. Markingson was deteriorating. In the opinion of Dr. Fawcett, the FDA report did not find Mr. Markingson was deteriorating while he participated in the CAFÉ Study. The FDA also found there was no reason for Mr. Markingson to have been withdrawn from the Study.

Dr. Fawcett will point out that not one of the other care providers involved in Mr. Markingson's care and treatment ever attempted to contact Dr. Olson. Dr. Fawcett will opine that if Dr. Andersen, Mr. Pettit, the Theo House staff, or the day treatment staff, had any questions or concerns about Mr. Markingson's progress or stability in the CAFÉ Study, it would have been incumbent upon them to contact Dr. Olson. According to Dr. Fawcett, it is very telling that at no point in time did any of these care providers contact Dr. Olson with concerns about Mr. Markingson. Instead, individuals from each one of these facilities have indicated that they believe that Mr. Markingson was stable and did not need additional assessment by Dr. Olson. This again goes to the heart of the fact that in no way did the care and treatment Mr. Markingson received by Dr. Olson in any of his capacities fall below the standard of care. Instead, it reiterates that the care and treatment received by Mr. Markingson was reasonable and appropriate.

Dr. Fawcett will also offer the opinion that by engaging in an e-mail exchange with her son, Ms. Weiss likely caused his delusions to become set. According to Dr. Fawcett, Mr. Markingson was in a delusional state at the point in time he was exchanging e-mails with a person whom he did not know to be his mother. By actively engaging her son's delusions, Ms. Weiss likely caused his delusional state to become more fixed. According to Dr. Fawcett, this e-

mail exchange would be a functional equivalent of playing with someone's mind, and was not in the best interests of Mr. Markingson. In the opinion of Dr. Fawcett, this exchange of e-mails likely caused or contributed to Mr. Markingson's ongoing inability to gain insight into his mental illness. Dr. Fawcett will also opine Mr. Markingson was a highly intelligent person who later on likely figured out his mother sent him those e-mails. In the opinion of Dr. Fawcett, this was a factor in undermining his trust and relationship with his mother. However, he does acknowledge that as a lay person and a concerned mother, Ms. Weiss was doing whatever she could to try to assist her son in getting care and treatment.

According to Dr. Fawcett, it has been assumed if Mr. Markingson had been provided with information about potential adverse effects of medication use, he would have withdrawn from the CAFÉ Study and/or that he would have stopped taking the CAFÉ Study medication. Dr. Fawcett will testify that it is unusual for a patient to stop medication use based on knowledge of side effects and/or adverse effects that they are not experiencing. For example, if Mr. Markingson would have been advised of the risk of diabetes associated with some antipsychotic medications, there is no proof he would have stopped taking his medication or withdrawn from the Study. Dr. Fawcett will testify this information, which was ultimately provided to Mr. Markingson, did not cause him to withdraw from the CAFÉ Study. In his opinion, this in no way caused or contributed to Mr. Markingson's death nor did it violate the standard of care.

In the opinion of Dr. Fawcett, Dr. Olson at all times provided reasonable and appropriate care and treatment to Mr. Markingson. In his role as principal investigator of the CAFÉ Study, CAFÉ Study psychiatrist, and primary psychiatrist to Mr. Markingson, he provided reasonable and appropriate care and treatment, all of which satisfied the standard of care. Further, in his opinion, in no way did the care and treatment provided by Dr. Olson cause or contribute to Mr. Markingson's death. Dr. Fawcett will opine that the care provided by Dr. Olson, Dr. Schulz, the University of Minnesota Physicians, nurses, all other physicians, psychiatrists, psychologists, social workers, day treatment personnel, and Theo I staff was reasonable and appropriate. In his opinion, none of their care caused or contributed to Mr. Markingson's death.

2. Dr. S. Charles Schulz

During Mr. Markingson's hospitalization, he saw Dr. Schulz on one occasion on or about November 29, 2003. Dr. Schulz was covering rounds at the hospital for Dr. Olson during that timeframe. Dr. Schulz performed a history and examination of Mr. Markingson during this visit. Dr. Schulz found Mr. Markingson's thought process to be logical and that his mood was pleasant and his affect was appropriate. He was noted to be on Risperdal at that time and Dr. Schulz continued the patient's use of that medication.

In the opinion of Dr. Fawcett, the care and treatment rendered by Dr. Schulz to Mr. Markingson on this single visit was reasonable, appropriate, and satisfied the standard of care. His examination and assessment of this patient, along with the continuation of Mr. Markingson's medication, was appropriate care. Dr. Fawcett will opine that Dr. Schulz's care and treatment of this patient did not cause or contribute to his death.

Dr. Fawcett is also expected to testify and opine that Dr. Schulz did not violate the standard of care for a co-investigator of a clinical trial, nor as the head of the Department of Psychiatry. Dr. Fawcett will opine that Dr. Schulz fully satisfied the standard of care applicable to both of those roles. Further, Dr. Fawcett will provide the opinion that Dr. Schulz neither caused nor contributed to Mr. Markingson's death.

It has been stated that the standard of care as a co-investigator and as the head of the Department of Psychiatry are set forth in regulations and guidelines such as the Nuremburg Code, Declaration of Helsinki, Belmont Report, FDA Regulations and Guidelines, and in the International Conference on Harmonization Good Clinical Practice Guideline. In the opinion of Dr. Fawcett, these documents are ethical guides which set forth ethical principles to be followed in a research study. However, these do not set forth the standard of care in a clinical treatment decisions, other than all decisions must be made with the best interest of the patient in mind.

According to Dr. Fawcett, the evidence will show that Dr. Olson and the CAFÉ Study treatment team were involved in obtaining informed consent from Mr. Markingson. Dr. Schulz did not interact with Mr. Markingson after his single visit with him in the hospital. Dr. Schulz did not present to Mr. Markingson any information about the CAFÉ Study. Dr. Schulz did not make an assessment of Mr. Markingson's competence at any point in time during his hospitalization. Further, all of the evidence will show that Dr. Schulz in no way participated in the informed consent process conducted on November 21, 2003. Dr. Schulz's lack of involvement in the informed consent process, could not have been a component or a causal factor in Mr. Markingson's death. Dr. Fawcett will testify that the standard of care did not require Dr. Schulz to participate in the informed consent process.

As a co-investigator of the CAFÉ Study, Dr. Schulz was aware of the information contained in the informed consent document. That document had been reviewed by the Institutional Review Board at the University of Minnesota. That Institutional Review Board took into consideration the reasonableness and appropriateness of that document for use amongst human subjects. After making several changes to the document, the Institutional Review Board approved the use of that document which had been utilized to enroll other subjects in the CAFÉ Study for the year or more that it had been conducted at the University of Minnesota site prior to Mr. Markingson's involvement. Dr. Fawcett is of the opinion that the information contained in the CAFÉ Study informed consent document was reasonable and appropriate. It is his opinion that that document fully set forth information about Mr. Markingson's right to withdraw from the Study, alternative treatment, the risks of the Study, and the benefits. To a reasonable degree of psychiatric and medical certainty, Dr. Fawcett will opine that this document was reasonable, appropriate and satisfied the standard of care. In no way was the document exploitive nor coercive.

Dr. Fawcett will also testify that as a co-investigator on the Study, Dr. Schulz was only responsible for the care provided to those patients he was seeing. Dr. Schulz never saw Mr. Markingson as a participant in the CAFÉ Study. Therefore, Dr. Schulz did not have any care responsibilities specifically for Mr. Markingson. Dr. Fawcett will opine that Dr. Schulz, as a co-investigator, had no duty of care toward Mr. Markingson. Therefore, he did satisfy the standard of care.

Dr. Fawcett will also opine that Dr. Schulz was not involved in Mr. Markingson's commitment nor stay of commitment. Nevertheless, Dr. Fawcett will opine that regardless of Mr. Markingson's stay of commitment, he was still a reasonable and appropriate candidate to participate in the CAFÉ Study. Further, regardless of the fact that he was functioning under a stay of commitment, did not negate the fact that Mr. Markingson was competent and able to voluntarily agree to participate in the CAFÉ Study. Dr. Fawcett will also provide the opinion that the stay of commitment in force at the time that Mr. Markingson signed the informed consent, did not in any way indicate that Mr. Markingson had to participate in the CAFÉ Study in order to be compliant with the order of the court. Dr. Fawcett will opine that it was reasonable and appropriate for Dr. Schulz, as a co-investigator of the CAFÉ Study and as the head of the Department of Psychiatry at the University of Minnesota, to allow Mr. Markingson to participate in the CAFÉ Study given his competence, voluntary choice to participate in the Study, and approval of Mr. Markingson's case manager/social worker, David Pettit.

Dr. Fawcett will opine that given his role in Mr. Markingson's care and treatment, Dr. Schulz was not obligated nor would he be able to ensure that Mr. Markingson obtained a second opinion. A competent, adult patient, such as Mr. Markingson cannot be forced to seek a second opinion according to Dr. Fawcett. The medical records reflect that Mr. Markingson was satisfied with the care he was receiving from Dr. Olson and in the CAFÉ Study. The records also reflect that Dr. Olson, on several occasions, expressed to Mr. Markingson that he had the right to seek a second opinion, yet each time Mr. Markingson refused. The standard of care did not require Dr. Schulz to force or even suggest to Mr. Markingson that a second opinion was reasonable, appropriate or necessary.

Dr. Fawcett will opine that acquiring a blood test to discern the level of antipsychotic medication in Mr. Markingson's blood, was not required. Dr. Fawcett incorporate by reference all of the opinions he tendered on the topic of blood and/or laboratory testing in the section on Dr Olson into this section. Dr. Schulz had no reason to personally conduct such a test or to request that Dr. Olson or the CAFÉ Study staff perform such testing. Further, Dr. Olson had no reason to seek such testing. Dr. Fawcett will opine that blood level testing is usually only done in rare circumstances, and certainly was not called for in this case. Further, Dr. Fawcett will testify that when there was concern about whether or not Mr. Markingson was taking his medication, reasonable and appropriate steps were taken to ensure the patient maintained compliance. Dr. Schulz's position as co-investigator and department head did not require him to seek a blood level for Mr. Markingson. Dr. Schulz did not violate the standard of care and did not cause or contribute to Mr. Markingson's death in this regard.

Dr. Fawcett will also address the suggestion that there was a conflict of interest based upon an alleged financial gain by Dr. Schulz. Dr. Fawcett will opine that he has reviewed the records and does not see any evidence of a financial motivation which would have in any way impaired or hindered Dr. Schulz's judgment. Further, there is no evidence of any financial misconduct in how Astrazeneca paid for the performance of the Study. Dr. Schulz, as both a co-investigator and the head of the Department of Psychiatry, insured that Dr. Olson and all the staff members participating in the CAFÉ Study were providing reasonable and appropriate care and treatment to all of the participants, including Mr. Markingson.

Dr. Schulz adequately fulfilled his roles as both the head of the Department of Psychiatry and as a co-investigator of the CAFÉ Study to insure that all of the staff, including Dr. Olson, did so in a manner that satisfied the standard of care according to Dr. Fawcett. In the opinion of Dr. Fawcett, Dr. Schulz reasonably and appropriately monitored the CAFÉ Study and was available to assist. He allowed Dr. Olson, a seasoned, skilled and highly knowledgeable member of his staff, to serve as the principal investigator of the CAFÉ Study. Dr. Fawcett will opine that Dr. Olson's skill and knowledge level called for Dr. Schulz to allow Dr. Olson to conduct this Study independently knowing that he would provide the level of care necessary for participants. Dr. Schulz was, in the opinion of Dr. Fawcett, right in that assessment as Dr. Olson did provide appropriate and thoughtful care. Therefore, Dr. Schulz satisfied the standard of care by allowing the CAFÉ Study to be conducted pursuant to the study protocol as approved by the Institutional Review Board and in an ethical manner at the University of Minnesota.

There has been a suggestion that Dr. Schulz was either informed or made aware of the fact that Dr. Olson allegedly had no contact with Mr. Markingson after his discharge from the hospital. According to Dr. Fawcett, the medical records in this case, along with the testimony of Dr. Olson, Jeanne Kenney, and Daniel Buse show otherwise. Dr. Schulz knew that Dr. Olson was a conscientious principal investigator, CAFÉ Study psychiatrist, and primary psychiatrist, and that he would do whatever was necessary to provide reasonable and appropriate care to Mr. Markingson. Dr. Olson did have reasonable and appropriate contact with Mr. Markingson throughout the course of his hospitalization, and his aftercare prior to his death. Dr. Schulz reasonably and appropriately monitored Dr. Olson's contact with Mr. Markingson, and all of the CAFÉ Study participants, both as a co-investigator and as the head of the Department of Psychiatry at the University of Minnesota.

Dr. Fawcett understands that one of the criticisms that has been rendered against Dr. Schulz, both as a co-investigator and as the head of the Department of Psychiatry, is his failure to reasonably and appropriately respond to concerns being raised by Ms. Weiss. Dr. Fawcett is of the opinion that Dr. Schulz reasonably and appropriately investigated and considered the information he received from Ms. Weiss. Further, Dr. Fawcett will opine that Dr. Schulz's investigation of the subject matter was reasonable, appropriate and satisfied the standard of care. Dr. Fawcett will also testify that Dr. Schulz provided Ms. Weiss with a timely response addressing her concerns.

When Dr. Schulz received Ms. Weiss's letter, he contacted Jeanne Kenney and Dr. Olson to review Mr. Markingson's participation in the CAFÉ Study. Dr. Schulz testified that he spent more than one hour talking to them to discern whether or not there was any validity to the concerns she was making about Mr. Markingson's behavior, progress, and continued participation in the CAFÉ Study. Dr. Schulz extensively questioned both Ms. Kenney and Dr. Olson about her concerns, and after investigating that matter, felt satisfied that Mr. Markingson was progressing appropriately, his condition had stabilized, and that he was an appropriate candidate to be a participant in the CAFÉ Study. Further, it was appropriate for Dr. Schulz to allow Mr. Markingson to remain in the study after his investigation into his mother's concerns in the opinion of Dr. Fawcett.

Dr. Schulz addressed each and every one of Ms. Weiss's concerns. He discussed Mr. Markingson's change in behavior and improvement in his condition since his participation in the CAFÉ Study. He also reiterated to Ms. Weiss that if Mr. Markingson was not responding to the CAFÉ medication or indicated a desire to withdraw, he could do so. Dr. Schulz advised Ms. Weiss that Mr. Markingson had not asked to be removed from the Study, and that his medication appeared to be helping with his symptoms. Further, Dr. Schulz reiterated to Ms. Weiss that Mr. Markingson had the right to seek a second opinion, but that decision was Mr. Markingson's alone. Finally, Dr. Schulz addressed Mr. Markingson's living situation and indicated to her that a trial run in a local apartment would certainly be better than Mr. Markingson's desire to return to California without supervision. The letter written by Dr. Schulz, in the opinion of Dr. Fawcett, was reasonable, appropriate and satisfied the standard of care. The investigation conducted by Dr. Olson also satisfied the standard of care. Dr. Fawcett will testify that in no way did Dr. Schulz's actions cause or contribute to Mr. Markingson's death.

After receiving the letter from Ms. Weiss, Dr. Schulz's meeting with Dr. Olson and Ms. Kenney brought more attention to the concerns of Ms. Weiss. In the opinion of Dr. Fawcett, this caused the CAFÉ Study treatment team to pay even more attention to Mr. Markingson and his condition.

Dr. Fawcett will testify that there was absolutely no evidence which would have indicated to Dr. Schulz that Dr. Olson was an "absent psychiatrist" or "absent principal investigator". To the contrary, in the opinion of Dr. Fawcett, Dr. Schulz appropriately reached the conclusion that Mr. Markingson was receiving reasonable and appropriate care in the clinical trial. There was absolutely no basis for Dr. Schulz to intervene into the care of Mr. Markingson nor discontinue his participation in the Study. Dr. Schulz satisfied the standard of care and did not cause or contribute to Mr. Markingson's death.

The only concerns about Mr. Markingson's care and treatment in the CAFÉ Study came from Ms. Weiss. Federal requirements indicate that an Institutional Review Board is to receive information about complaints received from investigators conducting the Study. However, those are the complaints registered by the participants. Ms. Weiss was not a participant in the CAFÉ Study. It was not required that either Dr. Olson or Dr. Schulz report this information to the Institutional Review Board, Astrazeneca or Quintiles. Their decision to not provide information to the Institutional Review Board, Astrazeneca or Quintiles about Ms. Weiss's concerns, did not violate the standard of care and was reasonable and appropriate.

One of the underlying assumptions of the Plaintiff's case is that if Ms. Weiss's concerns about her son had been related to either the Institutional Review Board or Astrazeneca Pharmaceuticals, an inquiry into Mr. Markingson's condition would have been conducted. Dr. Fawcett will testify that there is absolutely no way to know if such an investigation would have occurred. Further, there is no way to know if the IRB or Astrazeneca would have removed Mr. Markingson from the Study. Moreover, it would be sheer speculation to conclude that an investigation by the IRB or Astrazeneca would have prevented Mr. Markingson's suicide.

Dr. Fawcett will also opine that Dr. Schulz did not have a duty to disclose to Ms. Weiss that he was a co-investigator on the CAFÉ Study. It is affirmatively believed that that information was previously provided to Ms. Weiss when the CAFÉ Study was first introduced to

both her and Mr. Markingson. However, even if Ms. Weiss did not know that information, the standard of care did not require Dr. Schulz to disclose that information to her. Ms. Weiss was not a participant in the CAFÉ Study, was not a monitor of the CAFÉ Study, and was simply a person presenting concerns about a patient. The standard of care did not require that Dr. Schulz disclosed that information to Ms. Weiss. Further, in no way would the disclosure of that information have changed the facts or circumstances of this case. Thus, Dr. Schulz's care and treatment did not cause or contribute to Mr. Markingson's death.

Dr. Fawcett will also opine that the fact that the Office of the Ombudsman, the Department of Health and Human Services, and the FDA all conducted investigations and studies into the outcome of this case. In the opinion of Dr. Fawcett, each one of these investigating entities found that the standard of care had been satisfied and in no way did the care and treatment rendered by Dr. Olson, Dr. Schulz, or any person affiliated with the CAFÉ Study cause or contribute to Mr. Markingson's death.

Dr. Fawcett will also point out that in each one of these investigations conducted, Dr. Schulz was not named nor was he indicated as a person whose actions were being investigated. Dr. Fawcett will indicate that this information is striking because it demonstratively shows Dr. Schulz's role as both a co-investigator and the head of the Department of Psychiatry was not at any point in time questioned by these institutions. Further, not one entity believed that Dr. Schulz's role as a co-investigator, nor as the head of the Department of Psychiatry, caused or contributed to Mr. Markingson's death.

In the opinion of Dr. Fawcett, Dr. Schulz satisfied the standard of care both as a co-investigator of the CAFÉ Study and as the head of the Department of Psychiatry at the University of Minnesota. He provided reasonable and appropriate care to Mr. Markingson in both capacities. Further, there is not any evidence, in the opinion of Dr. Fawcett, that as either a co-investigator or as the head of the Department of Psychiatry Dr. Schulz in any way caused or contributed to Mr. Markingson's death.

Dr. Fawcett will also offer opinions about Mr. Markingson's employability as a schizophrenic. In his opinion, schizophrenia is a life long disease. In that regard, schizophrenic patients must be medicine compliant throughout their life in order to maintain mental stability. As a result of the disease process, the majority of schizophrenic patients have difficulty remaining medication compliant. Further, schizophrenic patients often experience several relapses throughout their life, and most are re-hospitalized on at least one occasion in their life. All of these factors truly inhibit a schizophrenic patients ability to garner and retain stable, full-time employment. In his experience, regardless of ideation level, most schizophrenic patients will be unable to maintain employment and are forced by their illness to rely upon social security disability benefits as their sole means of support.

CERTIFICATION

I certify that the foregoing statements and opinions are true and correct to the best of my knowledge and belief. I further certify that the above opinions are rendered to a reasonable degree of medical and psychiatric certainty. These opinions may be supplemented or revised should there be additional discovery and/or information submitted or brought to my attention for review.

Jan/Fawcett, M.D

Subscribed and sworn to before me this ____ day of <u>November</u>, 2007.

Notary Public

My comission expires: 11/29/2009

Dated: 11/12/07

David D. Alsop #120431

Angela M. Nelson #0306617 GISLASON & HUNTER LLP

Attorneys for Stephen Olson, M.D., and

Charles Schulz, M.D.

701 Xenia Avenue South, Suite 500

Minneapolis, MN 55416

Phone: 763-225-6000

MPLIB:307472.1

CURRICULUM VITAE Jan Fawcett, M.D.

Professor of Psychiatry
University of New Mexico School of Medicine
Department of Psychiatry MSC09 5030
1 University of New Mexico
Albuquerque, NM 87131-0001
505-272-1880 – office 505-490-3373 - cell
jfawcett@salud.unm.edu

CURRENT POSITION:

Professor of Psychiatry
Department of Psychiatry
University of New Mexico School of Medicine
Albuquerque, NM

Attending Psychiatrist

University Psychiatry Consultants – Albuquerque office University Psychiatry Consultants – Santa Fe office University Psychiatric Center General Clinic University Psychiatric Center Continuing Care Clinic

EDUCATION:

1952 - 1954	U.S. Naval Academy Annapolis, MD
1954 - 1956	BS University of Rochester Rochester NY
1956 - 1960	Yale University School of Medicine New Haven CT
1960 - 1961	Internship – U.S. Public Health Service Hospital San Francisco CA
1961 - 1963	Residency in Psychiatry Langley Porter Neuropsychiatric Institute San Francisco CA
1963 – 1964	Residency in Psychiatry University of Rochester Medical Center, Strong Memorial Hospital Rochester NY
1967	Board Certified – American Board of Psychiatry and Neurology

ACADEMIC AND PROFESSIONAL APPOINTMENTS:

Illinois State Psychiatric Institute Chicago IL



ACADEMIC AND PROFESSIONAL APPOINTMENTS (cont'd):

1968 - 1972 Associate Director of Research Illinois State Psychiatric Institute Chicago IL Stanley G. Harris Sr., Professor and Chairman 1972 - 2002 Rush Medical College and Presbyterian-St. Luke's Medical Center Chicago IL Professor of Psychiatry 2002 - present University of New Mexico School of Medicine Albuquerque NM 2007 - 2012Chair, DSM-V Mood Disorders Task Force American Psychiatric Association Washington DC

LICENSE:

Illinois No. 036-040712 New Mexico No. 2001-185

HONORS AND AWARDS

1973	Anna-Monika Award with James Mass, M.D. and Haroutune Dekimenjian, Ph.D. "Catecholamine Metabolism and Depression" Basel, Switzerland
1988	Cited in "Finding the Right Psychotherapist" Town and Country
1988	First Recipient, Dr. Jan Fawcett Humanitarian Award National Depressive and Manic Depressive Association
1991	Louis I. Dublin Award for "outstanding services and contributions to the field of suicide prevention as evidenced by leadership, devotion, and creativity." American Association of Suicidology
1993	Cited in "Top Doctors," Chicago Magazine
1993	Research Award honoring lifetime of research on the treatment of depression, and contribution to the knowledge of short-term risk factors for suicide. American Suicide Foundation
1993	ISSMP & D Executive Council Award of Distinction for "contributions to the treatment of Dissociation
1995	Cited in "The Best Medical Specialists in North America" Town and Country
1995	Distinguished Service Award Department of Religion, Health and Human Values Rush-Presbyterian-St. Luke's Medical Center
1997	Cited in "Top Doctors," Chicago Magazine
1999	Life Fellow American Psychiatric Association
1999	1999 William C. Menniger Award for distinguished contributions to the science of mental health American College of Physicians-American Society of Internal Medicine

Curriculum Vitae

HONORS AND AWARDS (cont'd)

ASSOCIATION:

American Association of Suicidology

1992 – 1995 Member at Large

American College of Neuropsychopharmacology

1983 Elected member
 1986 – 1990 Member, Ad-Hoc Committee on Relations with Advocacy Groups
 1990 – 1992 Chair, Committee on Relationships with Advocacy Groups
 1994 – 1996 Member, Task Force on Continuing Education
 1995 Co-Chair, Committee on Problems of Public Concern
 1996 – 1997 Chair, Committee on Problems of Public Concern

American Foundation for Suicide Prevention

1989 – present Member, Professional Advisory Committee
 1989 – present Board of Directors

1991 – 1994 President

American Medical Association

American Psychiatric Association

2001 – present Member, Work Group for the Practice Guidelines for the Treatment of Patients with Suicidal Behaviors.

American Society of Clinical Psychopharmacology

1992 – present National Board of Trustees

Association for Academic Psychiatry

Central Neuropsychiatric Society

Channel 2 WBBM-TV Health Team

1993 – 1994 Member

Chicago Consortium for Psychiatric Research

 1988
 Member

 1989 – 1991
 Secretary

 1991 – 1994
 President

1997 – 2001 Chairman, Board of Directors

Chicago Medical Society

Illinois Association of Suicidology

Illinois Hospital Association

1991 – 1994 Member, Mental Health and Chemical Dependency Steering Committee

Jan Fawcett, M.D. Curriculum Vitae ASSOCIATION(cont'd): Illinois Psychiatric Society 1974 - 1975President Institute of Medicine, National Academy of Sciences 2000 - 2002Member, Committee on Pathophysiology and Prevention of Adolescent and Adult Suicide National Advisory Council on Alcohol Abuse and Alcoholism 1995 - 1997Liaison representative National Alliance for Research on Schizophrenia and Depression 1987 – present Member, Scientific Council National Depressive and Manic Depressive Association 1986 - 1988Chairman, National Advisory Board 1989 – present Co-Chair, Clinical Committee, Scientific Advisory Board National Foundation for Depressive Illness, Inc. National Institute of Mental Health 1970 Member, Suicide Prevention Review Committee 1975 - 1977Psychopharmacology Review Committee 1977 - 1978Consultant, Psychiatry Education Branch Member, Science Advisors Committee - National Depression Awareness, 1985 - 1995Recognition and Treatment (D/ART) Program 1985 Speaker, Census Development Conference on Electroconvulsive Therapy 1988 - 1991Member, Research Scientific Development Review Committee 1990 - 1991Member, Special Review Committee – APA DSM-IV Field Trials Program 1991 - 1992Member, Treatment Assessment Review Committee 1992 - 1993Strategic Work Evaluation Group (SWEG) for the Psychotherapeutic Medications Development Program (PMDP). NIAA Board of Scientific Counselors Ad-hoc Member – Review of Laboratory of Clinical Studies Psychiatric Research Society 1970 Elected Member 1993 - 1994President Rush-Presbyterian-St. Luke's Medical Center - Chicago IL Grainger Director, Rush Institute for Mental Well-Being 1992 – present Suicide Awareness Voices of Education (SAVE) 2002 - present Member, Board of Reference Society of Biological Psychiatry 1990 Elected member ADVISORY COMMITTEES:

1978 - 1992	Chief Medical Advisor, Manic Depressive Association of Chicago
1986 - present	Member, Advisory Council and Honorary Board Member, Alliance for the Mentally Ill of Greater Chicago
1989 - present	Member, Scientific Advisory Committee, Neuropsychiatric Imaging Association
1995 – 2000	Member, Psychiatric Disease Expert Advisory Panel, United States Pharmacopeia (USP) Division of Information Development (DID)
2004	Member, VISN 7 MIRECC Advisory Board
2004	Consultant, Pharmacotherapists Fidelity and Pharmacotherapist-Patient Alliance as Factors in Patient Outcomes – University of Washington, Seattle WA

Jan Fawcett, M.D. Curriculum Vitae

ADVISORY COMMIT	
Pharmaceutical Compani	es
1983- 1988	Speaker, Visiting Faculty Program in Psychiatry, Mead Johnson Pharmaceutical Division
1987 - 1997	Member, National Advisory Panel, Psychiatrist Experience Program
	Dista Products Company, a Division of Eli Lilly and Company
1989 – 1991	Member, Academic Advisory Committee Visiting Professorship Program in
	Psychiatry, Pfizer, Inc.
1990 – present	Member, Research and Education Advisory Board for Anticonvulsants in Psychiatry, Abbott Laboratories
1990 - 2003	Speaker's Program on Anticonvulsants in Bipolar Disorder, Abbott Laboratories
1994 - 2000	Member, Serzone Advisory Board, Bristol-Myers Squibb
1997 - 2000	Member, National Advisory Panel, Glaxo Wellcome, Inc.
1998 – 1999	Member, Eli Lilly Bipolar Advisory Board, Eli Lilly and Company
2000 - 2004	Member, U.S. CNS Scientific Advisory Board, Wyeth-Ayerst Laboratories
EDITORIAL BOARD:	
1970 – 1980	Consulting Editor, Suicide and Life Threatening Behavior Journal of the American Association of Suicidology
1978 - 1986	Consulting Editor, U.S. Editorial Board Journal of Affective Disorders
1980 - 1988	Editor, Current Clinical Briefs
1981 - 1987	Associate Editor, Journal of Clinical Psychiatry
1983 - 1991	Editorial Board, Behavioral Sciences and the Law
1992 - 1993	Co-Editor, Psychiatric Annals
1992 – 1996	Editor, Psychiatry Volume, Current Practice of Medicine, pub by Current Medicine
1993 – present	Editor, Psychiatric Annals
1994 – present	Editorial Board, <u>Depression</u>
1995 – present	Editorial Board, Depression and Stress
2001 – present	Section Editor (Psychopharmacology), American Journal of Therapeutics
2002 – present	Executive Editor, Consumer Edition, Mental Fitness, MedWorks Media
RESEARCH:	
1969	Co-Investigator, NIMH Grant #1 RO1 MH15965 "MHPG Excretion, Catecholamine Metabolism, and Depression"
1969	Principal Investigator, NIMH Contract for the Midwest Regional Workshop on Suicide Prevention, sponsored by the Center for Studies of Suicide Prevention
1970	Principal Investigator, NIMH Grant #1 RO1 MH17974 "Psychobiological Studies of Suicide
1977 – present	Principal Investigator, NIMH Grant #1 R12 MH29957 "NIMH-CRB Psychobiology of Depression Collaborative Program"
1980 – 1984	Principal Investigator, NIAAA Grant #1 UO1 AA04240 'Study of Lithium Administration to Alcoholics'
1980 — 1987	Principal Investigator, NIMH Grant #1 UO1 MH35017 "Treatment of Depression Collaborative Research Program – Psychopharmacotherapy Component"
1980 – 1986	Principal Investigator, Antidepressant Efficacy of Alprazolam, Desipramine and Alprazolam-Desipramine Combination in the Treatment of Depressed Patients." The Upjohn Company

1980 – 1986	Principal Investigator, "Studies of Depression in the Elderly" The Retirement Research Foundation
1982 – 1986	Principal Investigator, "Long-Term Treatment of Depression with Wellbutrin" Burroughs-Wellcome Company
1983	Principal Investigator, "A Dose-Ranging Study for the Treatment of Depressive Disorder with LY139603 (Tomoxetine)." Eli Lilly and Company
1983 — 1986	Principal Investigator, "Phenylalanine Dietary Supplements in Elderly Patients with Low Energy" The Retirement Research Foundation
1984 – 1985	Principal Investigator, "Inderal ^R in the Treatment of Generalized Anxiety Disorder." Ayerst Laboratories
1985 — 1988	Principal Investigator, "Fluoxetine vs Amitriptyline in Depressed Adult Patients" Eli Lilly and Company
1985 — 1990	Principal Investigator, "A Multi-Center Double-Blind Comparison of 4 Fixed Doses of Nefazodone and Placebo in Patients with Moderate to Severe Depression." Bristol-Myers Company
1986 – 1987	Principal Investigator, "Tomoxetine vs Placebo: Fixed Dose Study in Depressed Outpatients." Eli Lilly and Company
1987 – 1988	Co-Investigator, "Humanitarian Use of Fluoxetine in Depressed Patients." Eli Lilly and Company
1987 – 1990	Principal Investigator, "Fluvoxamine vs Desipramine in Adult Depressed Outpatients: A Placebo-Controlled, Double-Blind Study." Reid-Rowell
1987 – 1990	Principal Investigator, NIMH Grant #1 RO1 MH 43045, "Psychobiology of Depression: Clinical Studies"
1988 – 1990	Principal Investigator, "Fluvoxamine in the Treatment of Panic Disorder: A Multicenter Double-Blind Placebo-Controlled Study in Outpatients." Reid-Rowell
1988 — 1990	Principal Investigator, "A Multicenter, Randomized, Double-Blind Parallel Group Dose Response Study of Milacemide in Patients with Mood Disorders Currently in a Major Depressive Episode." G.D. Searle & Company
1988 – 1995	Principal Investigator, "Compassionate Treatment with Fluvoxamine in Outpatients with Obsessive-Compulsive Disorder." Solvay Pharmaceuticals
1988 – 1990	Principal Investigator, "Double-Blind Parallel Comparison of SM-3997 (tandospirone) and Placebo in Outpatients with Depression." Pfizer Pharmaceuticals
1988	Principal Investigator, "Prospective Open Evaluation of the Seizure Incidence with Bupropion Hydrochloride (Wellbutrin)." Burroughs Wellcome
1988 – 1990	Co-Investigator, "Pilot Study for Evaluation of Milacemide in the Treament of Alzheimer's Disease." G.D. Searle & Company
1988 — 1994	Principal Investigator, "An Open-Label Evaluation of the Long-Term Safety and Clinical Acceptability of Oral Venlafazine Tablets in Depressed Outpatients" Wyeth-Ayerst Research
1988 – 1993	Principal Investigator, "Prospective Naturalistic Longitudinal Study of Anxiety/Panic Disorders." (In collaboration with Harvard University) The Upjohn Company

1989 – 1990	Principal Investigator, "Collaborative Fixed-Dose Study of the Efficacy and Safety of Deracyn-SR in Panic Disorder with Agoraphobia." The Upjohn Company
1989 – 1991	Principal Investigator, "An Open Multicenter Trial of Buspirone in the Long-Term Treatment of Depressed Outpatients." Bristol Myers Company
1989 – 1991	Principal Investigator, "Efficacy and Safety of a Combination of Fluoxetine (Prozac) and Deracyn/Domestic." The Upjohn Company
1989 – 1990	Co-Investigator, "Treatment Use of Anafranil in Obæssive-Compulsive Disorder." Ciba-Geigy
1990 – 1992	Principal Investigator, "A Double-Blind Trial of Nefazodone, Fluoxetine and Placebo in the Treatment of Depressed Outpatients." Bristol-Myers Company
1990 – 1992	Principal Investigator, "Fluoxetine vs. Placebo: Long-Term Treatment of MDD (Major Depressive Disorder)." Eli Lilly and Company
1990 – 1992	Principal Investigator, "A Multicenter, Randomized, Double-Blind Placebo-Controlled Comparison of Paroxetine and Fluoxetine in the Treatment of Major Depressive Disorder (Protocol #29060/115)." Bristol Myers Squibb
1990 – 1993	Co-Investigator, "A Triple-Blind Parallel Study Comparing Two Dose Ranges of Haloperidol in Hospitalized Patients with Schizophrenia." Merck, Sharp & Dohne
1990 – 1991	Co-Investigator, "Fixed Dose Double-Blind Study Comparing Efficacy and Safety of Xanax-SR Tablets vs Placebo in the Treatment of Panic Disorder Using Once Daily Dosing." The Upjohn Company
1990 – 1995	Principal Investigator, NIAAA Grant #1 RO1 AA07645 "Psychopharmacologic Treatment of Alcoholism"
1990 – 1993	Co-Investigator, "Remoxipride vs Haloperidol in Schizophrenia." Merk, Sharp & Dohme
1991 – 1992	Co-Investigator, "Paroxetine vs Fluoxetine in Outpatients With Major Depression." Smith Kline Beecham Pharmaceuticals
1991 – 1993	Co-Investigator, "Double-Blind Comparison of 3 Fixed Doses of Tandospirone and Placebo in Outpatients with Major Depression." Pfizer Pharmaceuticals
1991 – 1994	Efficacy and Side Effect Profile of Valproic Acid vs Placebo in Panic Disorder." Abbott Laboratories
1991 – 1992	Co-Investigator, "A Double-Blind Randomized Controlled Evaluation of the Effects of Venlafaxine on the Blood Pressure of Patients Being Treated for Major Depression." Wyeth-Ayerst
1991 – 1993	Principal Investigator, "Open Follow-Up Study of Tandospirone Administered with Major Depression (Protocol #N0513)." Pfizer Pharmaceuticals
1991 – 1992	Co-Investigator, "A Prospective Randomized, Double-Blind Placebo-Controlled Multi-Center, Parallel Groups Comparison of the Efficacy and Safety of Abecarnil (7.5-17.5mg) and Diazepam (15-35mg) in Outpatients with Generalized Anxiety Disorder." Sandoz Pharmaceuticals

1991 – 1992	Co-Investigator, "Fluoxetine vs Placebo in Major Depressive Influence of REM Sleep Latency." Eli Lilly
1991 – 1993	Co-Investigator, "Humanitarian Use of Sertraline in Depression." Roerig
1991 – 1993	Co-Investigator, "Double-Blind Comparison of Sertraline, Clomipramine and Placebo in Obsessive Compulsive Disorder." Pfizer Pharmaceuticals
1992 – 1994	Principal Investigator, "A Double-Blind Response Study to Determine the Safety and Efficacy of Fixed Doses (75-900mg/day) of Moclobemide in Patients with Panic Disorder With and Without Agoraphobia." Hoffman LaRoche
1992 – 1994	Co-Investigator, "Amesergide/Fluoxetine/Placebo in Major Depression." Eli Lilly
1992 – 1994	Principal Investigator, "An Open Multi-Center Trial of Nefazodone in the Treatment of Patients with Treatment Refractory Depression." Bristol Myers Squibb
1992 – 1994	Principal Investigator, "A Randomized, Double-Blind, Placebo-Controlled Study of the Safety and Efficacy of Two Doses of Ondasetron vs Placebo in the Treatment of Social Phobia." Glaxo, Inc.
1992 – 1994	Co-Investigator, "A Placebo-Controlled, Double-Blind, Parallel Group Efficacy, Safety and Tolerability Trial of Brofaromine Hydrochloride in Patients Having Panic Disorder with Agoraphobia." Ciba-Geigy
1992 – 1994	Principal Investigator, "A Phase II, Multi-Center, Randomized, Double-Blind, Dose-Finding Study of Three Different Doses of Roxindole EMD 62 100 vs Placebo in Outpatients Suffering From Depression, Protocol 62 100-004." EM Industries
1993 – 1994	Principal Investigator, "Double-Blind Parallel Comparison of Sertraline and Imipramine in Outpatients with Concurrent Major Depression and Dysthymia." Pfizer, Inc. (Roerig Division)
1994 – 1995	Principal Investigator, "A Double-Blind, Placebo-Controlled Comparison of Imipramine and Paroxetine in the Treatment of Bipolar Depression, Protocol No. 29060/352." SmithKline Beecham Pharmaceuticals
1994 – 1996	Co-Investigator, "Double-Blind Crossover Study of Sertraline and Imipramine in Outpatients with Chronic DSM-III-R Major Depression, Protocol R-0262." Pfizer, Inc. (Roerig Division)
1994 – 1995	Principal Investigator, "A Prospective, Multi-Center, Open-Label Study of Serzone (nefazodone) in the Management of Patients with Symptoms of Depression in General Psychiatric Practices." Bristol-Myers Squibb Company
1994 – 1995	Principal Investigator, "A Double-Blind, Placebo-Controlled Dose Escalation Study of the Safety and Efficacy of Oral Ondanseron in the Treatment of Patients with Panic Disorder." Glaxo
1995 – 1996	Co-Investigator, "A Multicenter, Placebo-Controlled Study of Relapse-Retention by Long-Term Treatment with High or Low Doses of ORG 4428 in Outpatients with Recurrent Major Depressive Episode." Organon, Inc.
1995 – 1996	Co-Investigator, "Gabapentin Adjunctive Treatment in Patients with Bipolar Disorder." Parke-Davis

1996 – present	Principal Investigator, "A Prospective, Multi-Center Study Comparing the Safety and Efficacy of Nefazodone HCl to Cognitive Behavioral Therapy-Chronic Depression (CBT-D) and Combined Nefazodone and CBT-CD for the Acute, Continuation and Maintenance Treatment of Chronic Major Depression and Double Depression." Protocol CN104-132, Bristol-Myers Squibb
1996 – 2000	Co-Investigator, "Advancing the Management of Depression in the Bipolar Patient" Stanley Foundation
1996 – present	Co-Investigator, "Fluoxetine vs Sertraline and Paroxetine in Major Depression: Comparison of Discontinuation-Emergent Signs and Symptoms." Protocol B1Y-MC-HCHJ, Lilly Research Labs
1997 – present	Principal Investigator, "The Efficacy and Safety of Rapid-Loading Depakote in the Treatment of Acutely Manic Patients with Bipolar Disorder." Protocol M95-305, Abbott Labs
1997	Principal Investigator, "Olanzepine vs Placebo in the Treatment of Mania Associated with Bipolar I Disorder." Protocol F1D-MC-HGEH, Eli Lilly
2002 – 2007	Principal Investigator, "Prevention of Recurrent Depression with Cognitive Therapy and Antidepressant Medication." RO1 MH 6076801A2

PUBLICATIONS:

Papers

- 1. Davis J, Morrill R, Fawcett J, Upton V, Bondy PK and Spiro HM: Apprehension and elevated serum cortisol levels. Journal of Psychosomatic Research 6:83, 1962.
- 2. Norris FH and Fawcett J: A sign of intracranial mass with impending uncal herniation. <u>Archives of Neurology</u> 12:381, 1965.
- 3. Bunney WE and Fawcett JA: Possibility of a biochemical test for suicidal potential: An analysis of endocrine findings prior to three studies. <u>Archives of General Psychiatry</u> 13:232-239, 1965.
- 4. Fawcett J and Bunney WE: Pituitary adrenal function and depression: An outline for research. <u>Archives of General Psychiatry</u> 16:517-535, 1967.
- 5. Bunney WE, Goodwin FK, Davis JM and Fawcett J: A behavioral-biochemical study of lithium treatment: Sensitivity of manic to temporary withdrawal of medication. <u>American Journal of Psychiatry</u> 125(4):91-104, 1968.
- 6. Maas JW, Fawcett J and Dekirmenjian H: 3-methoxy-4-hydroxy phenylglycol (MHPG) excretion in depressive states: A pilot study. <u>Archives of General Psychiatry</u> 19:129-134, 1968.
- 7. Fawcett J, Leff M and Bunney WE: Suicide: Clues from interpersonal communications. <u>Archives of General Psychiatry</u> 21:129-137, 1969.
- 8. Bunney WE, Fawcett JA, Davis JM and Gifford S: Further evaluation of urinary 17-hydroxycorticosteroids in suicidal patients. <u>Archives of General Psychiatry</u> 21:138-150, 1969.
- 9. Maas JW, Fawcett J, Dekirmenjian H and Landis H: Catecholamine metabolism and depressive states: Current studies. NIMH Workshop on Recent Advances in the Psychobiology of Depressive Illness pgs. 3-8, 1969.
- 10. Yufit RI, Benzies B. Fonte ME and Fawcett JA: Suicide potential and time perspective. <u>Archives of General Psychiatry</u> 23(2):158-163, 1970.

- 11. Fawcett J and Siomopoulos V: Dextroamphetamine response as a possible predictor of improvement with tricyclic therapy in depression. <u>Archives of General Psychiatry</u> 25:247-255, 1971.
- 12. Maas JW, Dekirmenjian H and Fawcett JA: Catecholamine metabolism, depression and stress. Nature 230:330-331, 1971.
- 13. Fawcett J, Maas JW and Dekirmenjian H: Depression and MHPG excretion: Response to dextroamphetamine and tricyclic antidepressants. <u>Archives of General Psychiatry</u> 26:246-251, 1972.
- 14. Fawcett J: Suicidal depression and physical illness. JAMA 219(10):1303-1306, March 6, 1972.
- 15. Maas JW, Fawcett JA, Dekirmenjian H: Catecholamine metabolism, depressive illness, and drug response. Archives of General Psychiatry 26;252-262, 1972.
- 16. Fawcett J: Explaining the stunning murder-suicide by "quiet family man." <u>JAMA</u> 221(2):200, July 10, 1972.
- 17. Jones FD, Maas JW, Dekirmenjian H and Fawcett JA: Urinary catecholamine metabolites during behavioral changes in a patient with manie-depressive cycles. <u>Science</u> 179:300-302, 1973.
- 18. Fawcett J: Seeing the skull beneath the skin: Recognition and management of the suicidal patient. <u>The Journal of Research and Training</u> 1(1):5-8, Summer, 1973.
- 19. Fawcett J: Clinical assessment of suicidal risk. Postgraduate Medicine 55(3):85-89, 1974.
- 20. Maas JW, Dekirmenjian H and Fawcett J: MHPG excretion by patients with affective disorders. International Pharmacopsychiatry 9:14-26, 1974.
- 21. Fawcett J, Susman P: The clinical assessment of acute suicidal potential: A review. <u>Rush-Presbyterian-St. Luke's Medical Bulletin</u> 14(2):86-104, 1975.
- 22. Epstein PS, Pisani V and Fawcett J: Alcoholism and cerebral atrophy. <u>Alcoholism: Clinical & Experimental Research</u> 1(1):61-65, 1977.
- 23. Fawcett J: Depression at the biochemical level. Psychiatric Annals 10(9):362-367, 1980.
- 24. Ward NG, Bloom VL, Dworkin S, Fawcett J, Narasimhachari N, Friedel RO: Psychobiological markers in coexisting pain and depression: Toward a unified theory. <u>Journal of Clinical Psychiatry</u> 43(8, Sec. 2):32-42, 1982.
- 25. Fawcett J, Kravitz H: Alprazolam: Pharmacokinetics, clinical efficacy, and mechanism of action. <u>Pharmacotherapy</u> 2(5):243-254, 1982.
- 26. Keller MB, Klerman GL, Lavori PW, Fawcett J, Coryell W, and Endicott J: Treatment received by depressed patients. <u>JAMA</u> 248(15):1848-1855, October 15, 1982.
- 27. Fawcett J, Clark D, Scheftner W, Gibbons R: Assessing anhedonia in psychiatric patients: The Pleasure Scale. Archives of General Psychiatry 40(1):79-84, 1983.
- 28. Ward NG, Bloom VL, Fawcett J, Friedel RO: Urinary 3-methoxy-4-hydroxyphenethylene glycol in the prediction of pain and depression relief with doxepin: Preliminary findings. The Journal of Nervous and Mental Disease 171(1):55-58, 1983.
- 29. Sabelli HC, Fawcett J, Javaid J, Bagri S: The methylphenidate test for differentiating desipramine responsive from nortriptyline-responsive depression. <u>American Journal of Psychiatry</u> 140(2):212-214, 1983.

- 30. Veith RC, Bielski RJ, Bloom V, Fawcett JA, Narasimhachari N, and Friedel RO: Urinary MHPG excretion and treatment with desipramine or amitriptyline: Prediction of response, effect of treatment, and methodological hazards. <u>Journal of Clinical Psychopharmacology</u> 3(1):18-27, 1983.
- 31. Sabelli HC, Fawcett J, Gusovsky F, Javaid J, Edwards J, Jeffriess H: Urinary phenylacetate: A diagnostic test for depression? Science 220(4602):1187-1188, June 10, 1983.
- 32. Prosen M, Clark D, Harrow M, Fawcett J: Guilt and conscience in major depressive disorders. <u>American Journal of Psychiatry</u> 140(7):839-844, 1983.
- 33. Fawcett J, Clark D, Scheftner W, Hedeker D: Differences between anhedonic and normally hedonic depressed patients. <u>American Journal of Psychiatry</u> 140(8):1027-1030, 1983.
- 34. Sabelli HC, Fawcett J, Gusovsky F, Edwards J, Jeffriess H, Javaid J: Phenylacetic acid as an indicator in bipolar affective disorders. <u>Journal of Clinical Psychopharmacology</u> 3(4):268-270, 1983.
- 35. Fawcett J, Kravitz H: Anxiety syndromes and their relationship to depressive illness. <u>Journal of Clinical Psychiatry</u> 44(8, Sec. 2):8-11, 1983.
- 36. Clark DC, Morrison DE, Fawcett J: Is capacity for pleasure associated with executive career success? <u>Journal of Occupational Medicine</u> 26(1):37-40, 1984.
- 37. Gusovsky F, Sabelli H, Fawcett J, Edwards J, Javaid J: Gas-liquid chromatographic determination of total phenylacetic acid in urine. Analytical Biochemistry 136:202-207, 1984.
- 38. Clark DC, Pisani VD, Aagesen CA, Sellers D, Fawcett J: Primary affective disorder, drug abuse, and neuropsychological impairment in sober alcoholics. <u>Alcoholism: Clinical and Experimental Research</u> 8(4):399-404, 1984.
- 39. Clark DC, Salazar-Grueso E, Grabler P, Fawcett J: Predictors of depression during the first six months of internship. American Journal of Psychiatry 141(9):1095-1098, 1984.
- 40. Kravitz HM, Sabelli HC, Fawcett J: Dietary supplements of phenylalanine and other amine acid precursors of brain neuroamines in the treatment of depressive disorders. <u>Journal of the American Osteopathic Association</u> 84(1, Suppl):119-123, 1984.
- 41. Clark DC, Fawcett J, Salazar-Grueso E, Fawcett E: Seven-month clinical outcome of anhedonic and normally hedonic depressed inpatients. <u>American Journal of Psychiatry</u> 141(10):1216-1220, 1984.
- 42. Sabelli HC, Fawcett J: Gut flora and urinary phenylacetic acid. Science 226(4677):996, 1984.
- 43. Fawcett J, Clark DC, Gibbons R, Aagesen C, Pisani VD, Tilkin JM, Sellers D, Stutzman D: Evaluation of lithium therapy for alcoholism. <u>Journal of Clinical Psychiatry</u> 45(12):494-499, 1984.
- 44. Fawcett J, Kravitz HM: The long-term management of bipolar disorders with lithium, carbamazepine, and antidepressants. <u>Journal of Clinical Psychiatry</u> 46(2):58-60, 1985.
- 45. Gusovsky F, Fawcett J, Javaid JI, Jeffriess H, Sabelli HC: A high pressure liquid chromatography method for plasma phenylacetic acid: A putative marker for depressive disorders. <u>Analytical Biochemistry</u> 145(1):101-105, 1985.
- 46. Clark DC, Clayton PJ, Andreasen NC, Lewis C, Fawcett J, Scheftner WA: Intellectual functioning and abstraction ability in major affective disorders. <u>Comprehensive Psychiatry</u> 26(4):313-325, 1985.
- 47. Clark DC, Gibbons RD, Fawcett J, Aagesen CA, Sellers D: Unbiased criteria for the severity of depression in alcoholics. <u>Journal of Nervous and Mental Disease</u> 173(8):482-487, 1985.

- 48. Sabelli H, Fawcett J, Gusovsky F, Javaid J, Wynn P, Edwards J, Jeffriess H, Kravitz H: Clinical studies on the phenylethylamine hypothesis of affective disorder: Urine and blood phenylacetic acid and phenylalanine dietary supplements. <u>Journal of Clinical Psychiatry</u> 47(2):66-70, 1986.
- 49. Keller MB, Lavori PW, Klerman GL, Andreasen NC, Endicott J, Coryell W, Fawcett J, Rice JP, Hirschfeld RMA: Low levels and lack of predictors of somatotherapy and psychotherapy received by depressed patients. Archives of General Psychiatry 43(5):458-466, 1986.
- 50. Fawcett J, Scheftner WA: Efficacy in depression: ECT versus antidepressants. <u>Psychopharmacology</u> <u>Bulletin</u> 22(2):468-469, 1986.
- 51. Fawcett J, Scheftner W, Clark D, Hedeker D, Gibbons R, Coryell W: Clinical predictors of suicide in patients with major affective disorders: A controlled prospective study. <u>American Journal of Psychiatry</u> 144(1):35-40, 1987.
- 52. Fawcett J, Clark DC, Aagesen CA, Pisani VD, Tilkin JM, Sellers D, McGuire M, Gibbons RD: A double-blind placebo-controlled trial of lithium carbonate therapy for alcoholism. <u>Archives of General Psychiatry</u> 44(3):248-256, 1987.
- 53. Kravitz HM, Fawcett J: Carbamazapine in the treatment of affective disorder. Medical Science Research 15(1):1-8, 1987.
- 54. Clark DC, Eckenfels EJ, Daugherty SR, Fawcett J: Alcohol-use patterns through medical school. <u>JAMA</u> 257(21):2921-2926, June 5, 1987.
- 55. Clark DC, Young MA, Scheftner WA, Fawcett J, Fogg L: A field test of Motto's risk estimator for suicide. American Journal of Psychiatry 144(7):923-926, 1987.
- 56. Fawcett J, Epstein P, Fiester SJ, Elkin I, Autry JH: Clinical management-imipramine/ placebo administration manual. NIMH Treatment of Depression Collaborative Research Program. Psychopharmacology Bulletin 23(2):309-324, 1987.
- 57. Fawcett J, Edwards JH, Kravitz HM, Jeffriess H: Alprazolam: An antidepressant? Alprazolam, desipramine, and an alprazolam-desipramine combination in the treatment of adult depressed outpatients. Journal of Clinical Psychopharmacology 7(5):295-310, 1987.
- 58. Young MA, Keller MB, Lavori PW, Scheftner WA, Fawcett JA, Endicott J, Hirschfeld RMA: Lack of stability of the RDC endogenous subtype in consecutive episodes of major depression. <u>Journal of Affective Disorders</u> 12:139-143, 1987.
- 59. Pandey G, Fawcett J, Gibbons RD, Clark DC, Davis JM: Platelet monoamine oxidase in alcoholism. Biological Psychiatry 24:;15-24, 1988.
- 60. Fawcett J: Predictors of early suicide: Identification and appropriate intervention. <u>Journal of Clinical Psychiatry</u> 49(10, Suppl):7-8, 1988.
- 61. Scheftner WA, Young MA, Endicott J, Coryell W, Fogg L, Clark DC, Fawcett J: Family history and five year suicide risk. <u>British Journal of Psychiatry</u> 153:805-809, 1988.
- 62. Clark DC, Gibbons RD, Fawcett J, Scheftner WA: What is the mechanism by which suicide attempts predispose to later suicide attempts? A mathematical model. <u>Journal of Abnormal Psychology</u> 98(1):42-49, 1989.
- 63. Fawcett J: Valproate use in acute mania and bipolar disorder: An international perspective. <u>Journal of Clinical Psychiatry</u> 50(Suppl 3):10-12, 1989.

- 64. Sabelli HC, Durai UNB, Javaid JI, Fawcett J: High phenylacetic acid differentiates schizophrenic from other psychoses. <u>Journal of Neuropsychiatry and Clinical Neurosciences</u> 1:37-39, 1989.
- 65. Rice J, Andreasen NC, Coryell W, Endicott J, Fawcett J, Hirschfeld RMA, Keller MB, Klerman GL, Lawri P, Reich T, Scheftner WA: NIMH Collaborative Program on the Psychobiology of Depression: Clinical. Genetic Epidemiology 6:179-181, 1989.
- 66. Fawcett J, Zajecka, JM, Kravitz HM, Edwards J, Jeffriess H, Scorza E: Fluoxetine versus amitriptyline in adult outpatients with major depression. <u>Current Therapeutic Research</u> 45(5):821-832, 1989.
- 67. Kravitz HM, Fogg L, Fawcett J, Edwards J: Antidepressant or antianxiety? A study of the efficacy of antidepressant medication. <u>Psychiatry Research</u> 32:141-149, 1990.
- 68. Gibbons RD, Clark DC, Fawcett J: A statistical method for evaluating suicide clusters and implementing cluster surveillance. American Journal of Epidemiology 132(suppl):S183-S191, 1990.
- 69. Fawcett J, Scheftner WA, Fogg L, Clark DC, Young MA, Hedeker D, Gibbons R: Time-related predictors of suicide in major affective disorder. <u>American Journal of Psychiatry</u> 147(9):1189-1194, 1990.
- 70. Young MA, Fogg LF, Scheftner WA, Keller MB, Fawcett JA: Sex differences in the lifetime prevalence of depression: Does varying the diagnostic criteria reduce the female/ male ratio? <u>Journal of Affective</u> Disorders 18:187-192, 1990.
- 71. Kravitz HM, Edwards JH, Fawcett J, Fogg L: Challenging the amphetamine challenge test: Report of an antidepressant treatment study. <u>Journal of Affective Disorders</u> 20:121-128, 1990.
- 72. Zajecka JM, Fawcett J, Easton MS: Treatment of psychotic affective disorders. <u>Current Opinion in Psychiatry</u> 3:43-47, 1990.
- 73. Zajecka JM, Fawcett J, Guy C: Coexisting major depression and obsessive-compulsive disorder treatment with venlafaxine. Journal of Clinical Psychopharmacology 10(2):152-153, 1990.
- 74. Fawcett J: Targeting treatment in patients with mixed symptoms of anxiety and depression. <u>Journal of Clinical Psychiatry</u> 51(11, suppl):40-43, 1990.
- 75. Zajecka J, Fawcett, Schaff M, Jeffriess H, Guy C: The role of serotonin in sexual dysfunction: Fluoxetine associated orgasm dysfunction. Journal of Clinical Psychiatry 52(2):66-68, 1991.
- 76. Zajecka JM, Fawcett J: Recent advances in the treatment of depression. <u>Current Opinion in Psychiatry</u> 4(1):70-72, 1991.
- 77. Fawcett J: The prediction of suicide in depressed patients: An interview with Jan Fawcett, M.D. <u>Currents in Affective Illness</u> X(3):5-13, 1991.
- 78. Fawcett J, Kravitz HM, Zajecka JM, Schaff MR: CNS stimulant potentiation of monoamine oxidase inhibitors in treatment refractory depression. <u>Journal of Clinical Psychopharmacology</u> 11(2):127-132, 1991.
- 79. Clayton PJ, Grove WM, Coryell W, Keller M, Hirschfeld R, Fawcett J: Follow-up and family study of anxious depression. <u>American Journal of Psychiatry</u> 148(11):1512-1517, 1991.
- 80. Fawcett J: Suicide risk factors in depressive disorders and in panic disorder. <u>Journal of Clinical Psychiatry</u> 53(suppl):9-13, 1992.

- 81. Kravitz HM, Katz R, Kot E, Helmke N, Fawcett J: Biochemical clues to a fibromyalgia-depression link: Imipramine binding in patients with fibromyalgia or depression and in healthy contols. <u>Journal of Rheumatology</u> 19(9):1428-1432, 1992.
- 82. Young MA, Halper IS, Clark DC, Scheftner W, Fawcett J: An item-response theory evaluation of the Beck Hopelessness Scale. Cognitive Therapy and Research 16(5):579-587, 1992.
- 83. Lazarus LW, Winemiller DR, Lingam VR, Neyman I, Hartman C, Abassian M, Kartan U, Groves L, Fawcett J: Efficacy and side effects of methylphenidate for poststroke depression. <u>Journal of Clinical Psychiatry</u> 53(12):447-449, 1992.
- 84. Pisani VD, Fawcett J, Clark DC, McGuire M: The relative contributions of medication adherence and AA meeting attendance to abstinent outcome for chronic alcoholics. <u>Journal of Studies on Alcohol</u> 54:115-119, 1993.
- 85. Fawcett J, Clark DC, Busch KA: Assessing and treating the patient at risk for suicide. <u>Psychiatric Annals</u> 23(5):244-255, 1993.
- 86. Busch KA, Clark DC, Fawcett J, Kravitz HM: Clinical features of inpatient suicide. <u>Psychiatric Annals</u> 23(5):256-262, 1993.
- 87. Fawcett J, Clark DC, Busch K: Assessing and treating the patient at risk for suicide. <u>Italian Journal of Suicidology</u> 3(1):9-23, 1993.
- 88. Kravitz HM, Fawcett J, Newman AJ: Alprazolam and depression: A review of risks and benefits. <u>Journal of Clinical Psychiatry</u> 54(suppl):78-84, 1993.
- 89. Fawcett J: The morbidity and mortality of clinical depression. <u>International Clinical Psychopharmacology</u> 8:217-220, 1993.
- 90. Tollefson GD, Fawcett J, Winokur G, Beasley CM, Potvin JH, Faries DE, Rampey AH, Sayler ME: Evaluation of suicidality during pharmacologic treatment of mood and ronmood disorders. <u>Annals of Clinical Psychiatry</u> 5:209-224, 1993.
- 91. Schaff MR, Fawcett J, Zajecka JM: Divalproex sodium in the treatment of refractory affective disorders. <u>Journal of Clinical Psychiatry</u> 54(10):380-384, 1993.
- 92. Fawcett J, Busch KA: The psychobiology of suicide. Clinical Neuroscience 1(2):101-107, 1993.
- 93. Young MA, Fogg LF, Scheftner WA, Fawcett JA: Interactions of risk factors in predicting suicide. American Journal Psychiatry 151(3):434-435, 1994.
- 94. Kravitz HM, Katz RS, Helmke N, Jeffriess H, Bukovsky J, Fawcett J: Alprazolam and ibuprofen in the treatment of fibromyalgia- report of a double-blind placebo-controlled study. <u>Journal of Muscu loskeletal Pain</u> 2(1):3-27, 1994.
- 95. Fawcett J: Overview of mood disorders: Diagnosis, classification and management. <u>Clinical Chemistry</u>, 49(2):273-278, 1994.
- 96. Kravitz HM, Fawcett J: Efficacy of divalproex vs. lithium and placebo in mania. <u>JAMA</u> 272(13):1005-1006, 1994.
- 97. Fawcett J: Antidepressants: Partial response in chronic depression. <u>British Journal of Psychiatry</u> 165(suppl 26):37-41, 1994.

- 98. Zajecka J, Fanelli J. Ross J, Kravitz H, Fawcett J: Efficacy of valproic acid vs. placebo in the treatment of panic disorder. <u>Psychopharmacology Bulletin</u> 330(4):735, 1994.
- 99. Lavori PW, Keller MB, Scheftner W, Fawcett J, Mueller TI, Coryell W: Recurrence after recovery in unipolar MDD: An observational follow-up study of clinical predictors and somatic treatment as a mediating factor. International Journal of Methods in Psychiatric Research, 4:211-229, 1994.
- 100. Hirschfeld RMA, Clayton P, Cohen I, Fawcett J, Keck P, McClellan J, McElroy S, Post R, Satloff A (work group): American Psychiatric Association Practice Guidelines for the Treatment of Patients with Bipolar Disorder. American Journal of Psychiatry, 151(12, suppl), December 1994.
- 101. Fawcett J: Compliance: Definitions and key issues. <u>Journal of Clinical Psychiatry</u> 56(suppl 1):4-8, 1995.
- 102. Zajecka JM, Jeffriess J, Fawcett J: The efficacy of fluoxetine combined with a heterocyclic antidepressant in treatment-resistant depression: A retrospective analysis. <u>Journal of Clinical Psychiatry</u> 56(8):338-343, 1995.
- 103. Fawcett J, Marcus RN, Anton SF, O'Brien K, Schwiderski U: Response of anxiety and agitation symptoms during nefazodone treatment of major depression. <u>Journal of Clinical Psychiatry</u> 56(suppl 6):37-42, 1995.
- 104. Carter CS, Fawcett J, Hertzman M, Papp LA, Jones W, Patterson WM, Swinson RP, Weise CC, Maddock RJ, Sheridan AQ, Liebowitz M: Adinazolam-SR in panic disorder with agoraphobia: Relationship of daily dose to efficacy. <u>Journal of Clinical Psychiatry</u> 56(5):202-210, 1995.
- 105. Young MA, Fogg LF, Scheftner W, Fawcett J, Akiskal H, Maser J: Stable trait components of hopelessness: Baseline and sensitivity to depression. <u>Journal of Abnormal Psychiatry</u> 105(2):155-165, 1996.
- 106. Fawcett J: Bipolar II disorder. Psychiatric Annals 26(suppl 7):S440-S443, 1996.
- 107. Fawcett J: The consequences of anxiety in clinical depression. Primary Psychiatry 4(5):35-42, 1997.
- 108. Amsterdam JD, Fawcett J, Quitkin FM, Reimherr FW, Rosenbaum JF, Michelsonn D, Hornig-Roham M, Beasley CM: Fluoxetine and norfluoxetine plasma concentrations in major depression: A multicenter study. American Journal of Psychiatry 154(7):963-969, 1997.
- 109. Fawcett J: The detection and consequences of anxiety in clinical depression. <u>Journal of Clinical Psychiatry</u> 58(suppl8):35-40, 1997.
- 110. .Fawcett J, Busch KA, Jacobs D, Kravitz HM, Fogg L: Suicide: A four-pathway clinical-biochemical model. <u>Annals of the New York Academy of Sciences</u> 836:288-301, 1997.
- 111. Stewart JW, Quitkin FM, McGrath PJ, Amsterdam J, Fava M, Fawcett J, Reimherr F, Rosenbaum J, Beasley C, Roback P: Use of pattern analysis to predict differential relapse of remitted patients with major depression during 1 year of treatment with fluoxetine or placebo. <u>Archives of General Psychiatry</u> 55(4):334-343, 1998.
- 112. Fawcett J, Barkin RL: A meta-analysis of eight randomized, double-blind, controlled clinical trials of mirtazapine for the treatment of patients with major depression and symptoms of anxiety. <u>Journal of Clinical Psychiatry</u> 59(3):123-127, 1998.

- 113. Keller MB, Kocsis JH, Thase ME, Gelenberg AJ, Rush AJ, Koran L, Schatzberg A, Russell J, Hirschfeld R, Klein D, McCullough JP, Fawcett JA, Kornstein S, LaVange L, Harrison W: Maintenance phase efficacy of sertraline for chronic depression. <u>JAMA</u> 280:1665-1672, 1998.
- 114. Trivedi MH, DeBattista C, Fawcett J, Nelson C, Osser DN, Stein D, Jobson K: Developing treatment algorithms for unipolar depression in cyberspace: International Psychopharmacology Algorithm Project (IPAP). Psychopharmacology Bulletin 34(3):355-359, 1998.
- 115. Rush AJ, Koran LM, Keller MB, Markowitz JC, Harrison WM, Miceli RJ, Fawcett JA, Gelenberg AJ, Hirschfeld RMA, Klein DN, Kocsis JH, McCullough JP, Schatzberg AF, Thase ME: The treatment of chronic depression, Part I: Study design and rationale for evaluating the comparative efficacy of sertraline and imipramine as acute, crossover, continuation, and maintenance phase therapies. <u>Journal of Clinical Psychiatry</u> 59(11):589-597, 1998.
- 116. Keller MB, Gelenberg AJ, Hirschfeld RMA, Rush AJ, Thase ME, Kocsis JH, Markowitz JC, Fawcett JA, Koran LM, Klein DN, Russell JM, Kornstein SG, McCullough JP, Davis SM, Harrison WM: The treatment of chronic depression, Part 2: A double-blind, randomized trial of sertraline and imipramine. Journal of Clinical Psychiatry 59(11):598-607, 1998.
- 117. Fawcett J, Barkin RL: Review of the results from clinical studies on the efficacy, safety andtolerability of mirtazapine for the treatment of patients with major depression. <u>Journal of Affective Disorders</u> 51:267-285, 1998.
- 118. Kravitz HM, Fawcett J, McGuire M, Kravitz G, Whitney M: Treatment attrition among alcohol-dependent men: Is it related to novelty seeking personality traits? <u>Journal of Clinical Psychopharmacology</u> 19(1):51-56, 1999.
- 119. Fawcett J, Sinioris ME: Using CQI to prevent the placebo effect from causing failed clinical trials.

 Quality Management in Health Care 7(3):1-6, 1999.
- 120. Amsterdam JD, Garcia-Espana F, Fawcett J, Quitkin FM, Reimherr FW, Rosenbaum JF, Beasley C: Blood pressure changes during short-term fluoxetine treatment. <u>Journal of Clinical Psychopharma-cology</u> 19(1):9-14, 1999.
- 121. Fawcett J, Hendin H: Suicide: Clinical/risk management issues. <u>TEN (The Economics of Neuroscience)</u> 2(3):33-39, 2000.
- 122. Fawcett J: Acute vs. chronic risk factors for suicide treatment implications. <u>TEN (The Economics of Neuroscience)</u> 2(3):57-59, 2000.
- 123. Jacobs DG, Jamison KR, Baldessarini RJ, Fawcett JA, Hendin H, Gutheil TG: Suicide: Clinical/risk management issues for psychiatrists. <u>CNS Spectrums</u> 5(2,suppl 1):32-48, 2000.
- 124. Fawcett J, Rosenblate R: Suicide within 24 hours after assessment in the emergency department: Look for and manage anxiety. Psychiatric Annals 30(4):228-231, 2000.
- 125. McGrath PJ, Stewart JW, Petkova E, Quitkin FM, Amsterdam JD, Fawcett J, Reimherr FW, Rosenbaum JF, Beasley CM: Predictors of relapse during fluoxetine continuation or maintenance treatment of major depression. <u>Journal of Clinical Psychiatry</u> 61(7):518-524, 2000.
- 126. Fawcett J, Kravitz HM, McGuire M, Easton M, Ross J, Pisani V, Fogg LF, Clark D, Whitney M, Kravitz G, Javaid J, Teas G: Pharmacological treatments for alcoholism: Revisiting lithium and considering buspirone. <u>Alcoholism: Clinical and Experimental Research</u> 24(5):666-674, 2000.

- 127. Kravitz HM, Bloom RW, Fawcett J: Recovery from a recurrent major depressive episode. <u>Depression</u> and Anxiety 12(1):40-43, 2000.
- 128. Fawcett J: Treating impulsivity and anxiety in the suicidal patient. <u>Annals of the New York Academy of Sciences 932:94-105, 2001.</u>
- 129. Thase ME, Rush AJ, Howland RH, Kornstein SG, Kocsis JH, Gelenberg AJ, Schatzberg AF, Koran LM, Keller MB, Russell JM, Hirschfeld RMA, LaVange LM, Klein DN, Fawcett J, Harrison W: Doubleblind switch study of imipramine or sertraline treatment of antidepressant chronic depression.

 Archives of General Psychiatry 59:233-239, 2002.
- 130. Brunswick DJ, Amsterdam JD, Fawcett J, Quitkin FM, Reimherr FW, Rosenbaum JF, Beasley CM Jr.: Fluoxetine and norfluoxetine plasma concentrations during relapse prevention treatment. <u>Journal of Affective Disorders</u> 68(2-3):243-9, Apr 2002
- Busch KA, Fawcett J, Jacobs D: Clinical correlates of inpatient suicide. <u>Journal of Clinical Psychiatry</u>, Jan 2003
- 132. Janowsky DS, Fawcett J, Meszaros K, Verheul R. Core heritable characteristics and relapse in alcoholics. Alcohol Clin Exp Rs 2001 May;25(5 Suppl ISBRA):94S-98S
- 133. Thase ME, Rush AJ, Howland RH, Kornstein SG, Kocsis JH, Gelenberg AJ, Schatzberg AF, Koran LM, Keller MB, Russell JM, Hirschfeld RMA, LaVange LM, Klein DN, Fawcett J, Harrison W: Doubleblind switch study of imipramine or sertraline treatment of antidepressant resistant chronic depression.

 <u>Archives of General Psychiatry</u> 59:233-239, 2002.
- 134. Brunswick DJ, Amsterdam JD, Fawcett J, Quitkin FM, Reimherr FW, Rosenbaum JF, Beasley CM Jr.: Fluoxetine and norfluoxetine plasma concentrations during relapse prevention treatment. <u>J Affect Disord</u>. 2002 Apr,68(2-3):243-9
- 135. Busch KA, Fawcett J, Jacobs D: Clinical correlates of inpatient suicide. <u>Journal of Clinical Psychiatry</u>, 64(1) January 2003.
- 136. Fawcett J, Busch KA: Drs Fawcett, Busch and Jacobs reply. J Clin Psychiatry. 2003 Dec; 64(12):1520
- 137. Fawcett J, Busch KA: Dr Fawcett, Busch and Jacobs reply. J Clin Psychiatry. 2003 Dec:64(12):1518-9
- 138. Busch KA, Fawcett J. Dr Busch and colleagues reply. J Clin Psychiatry. 2003 Dec;64(12):1517-8
- 139. Fawcett JA. Lithium combinations in acute and maintenance treatment of unipolar and bipolar depression. <u>J Clin Psychiatry</u>. 2003:64 Suppl 5:32-7
- 140. Quitkin FM, Petkova E., McGraph PJ, Taylor B, Beasley C., Stewart j, Amsterdam J, Fava M, Rosenbaum J, Reimherr F, Fawcett J, Chen Y, Klein D.: When should atrial of fluoxetine for major depression be declared failed? Am J Psychiatry, 2003 Apr;160(4):734-40.
- 141. Jacobs D, Conwell, Y, Fawcett, J, Horton, L, Meltzer, H, Pfeiffer, C, Simon, R. Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behavior, <u>American J Psychiatry</u>, Vol 160, No. 11, suppl. November 2003
- 142. Busch KA, Fawcett J: A fine-grained study of inpatients who commit suicide. Psychiatric Annals Vol 34 (5), May 2004
- 143. Fawcett J: Editorial: What do we know for sure about bipolar disorder Am J Psychiatry 162:1, Jan 2005

PUBLICATIONS (cont'd) Books:

- 1. Fawcett J (Editor): The Dynamics of Violence. Chicago, American Medical Association Press, 1971.
- 2. Clark DC, Fawcett J (Editors): Anhedonia and Affect Deficit States. New York, PMA Publishing, 1987.
- 3. Kahn A, Fawcett J (Editors): The Encyclopedia of Mental Health. Chicago, Facts on File, 1993.
- 4. Fawcett J, Stein D, Jobson K (Editors): <u>Textbook of Treatment Algorithms in Psychopharmacology</u>. John Wiley & Sons, Ltd., 1999.
- 5. Fawcett J, Golden B, Rosenfeld N: <u>New Hope for People with Bipolar Disorder: A Guide for Patients and Those Who Journey With Them.</u> Roseville, California: Prima Publishing, 2000
- 6. Collaborator, <u>Manic Depressive Illness, second edition</u> by Frederick Goodwin and Kay Redfield Jamison, Oxford University Press, 2007.
- 7. Fawcett J, Golden B, Rosenfeld N: <u>New Hope for People with Bipolar Disorder, Revsied Second Edition</u> (In Press)

Book Chapters:

- 1. Bunney WE and Fawcett J: Biochemical research in depression and suicide. In: <u>Suicidal Behaviors</u>: <u>Diagnosis and Management</u>. Edited by Resnik HLP. Boston, Little, Brown and Company, 1968.
- 2. Fawcett J: Suicide prevention in the seventies. In: <u>Priorities for Improved Treatment Approaches</u>. Edited by Resnik HLP. Washington DC, National Institute of Mental Health, Center for Studies of Suicide Prevention. DHEW Publication No. (HSM) 91-97, 1973.
- 3. Fawcett J: Schizophrenia. In: <u>1974 Britannica Yearbook of Science and the Future</u>. Edited by the University of Chicago Faculty. Encyclopedia Britannica, Inc., 1973.
- 4. Fawcett J, Marrs B: Suicide at the county jail. In: <u>Jail House Blues: Studies of Suicidal Behavior in Jail and Prison</u>. Edited by Danto BL. Orchard Lake, Michigan, Epic Publications, Inc., pp 84-106, 1973.
- 5. Fawcett J: Biochemical and neuropharmacological research in the affective disorders. In: <u>Depression and Human Existence</u>. Edited by Benedek T, and Anthony EJ. Boston, Little Brown and Company, Chapter 3, pp 21-52, 1975.
- 6. Fawcett J: Saving the suicidal patient -- the state of the art. In: Mood Disorders: The World's Major Public Health Problem. Edited by Ayd FJ. Ayd Medical Communication, Chapter 15, 226-243, 1978.
- 7. Fawcett J: Lithium carbonate in medicine and psychiatry. In: <u>Lithium Effects on Granulopoies is and Immune Function: Advances in Experimental Medicine and Biology</u> Vol. 127. Edited by Rossof AH and Robinson WA. New York, Plenum Press, Chapter 1, pp 1-13, 1980.
- 8. Fawcett J, Kravitz HM, Sabelli HC: CNS amine metabolites. In: <u>Handbook of Psychiatric Diagnostic Procedures</u>. Vol. 1. Edited by Hall RCW, Beresford TP. New York, Spectrum Publications, pp 49-108, 1984.
- 9. Fawcett J, Kravitz HM, Sabelli HC: Stimulant challenge tests. In: <u>Handbook of Psychiatric Diagnostic Procedures</u>. Vol. 1. Edited by Hall RCW, Beresford TP. New York, Spectrum Publications, pp 223-251, 1984.
- 10. Fawcett J, Kravitz HM: Treatment refractory depression. In: <u>Common Treatment Problems in Depression</u>. Edited by Schatzberg AF. Washington, DC, American Psychiatric Press, Chapter 1, pp 1-27, 1985.

PUBLICATIONS (cont'd) Book Chapters

- 11. Fawcett J, Kravitz HM: Current research in affective illness. In: <u>Nursing Intervention in Depression</u>. Edited by Rogers CA, Ulsafer-VanLanen J. New York, Grune & Stratton, Chapter 2, pp 13-38, 1985.
- 12. Fawcett J, Kravitz HM: New medical diagnostic procedures for depression. In: <u>Handbook of Depression:</u> <u>Treatment, Assessment, and Research.</u> Edited by Beckham EE, Leber WR. Homewood, Illinois, Dorsey Press, Chapter 14, pp 445-513, 1985.
- Kravitz HM, Fawcett J: Anti-epileptic agents. I. Carbamazapine. In: <u>Lithium Combination Treatment</u> (<u>Lithium Therapy Monographs</u>, Vol. 1). Edited by Johnson FN. Basel, Karger, Chapter 9, pp 133-155, 1987.
- 14. Clark DC, Fawcett J: Anhedonia, hypohedonia, and pleasure capacity in major depressive disorders. In: Anhedonia and Affect Deficit States. Edited by Clark DC, Fawcett J. New York, PMA Publishing, Chapter 5, pp 51-63, 1987.
- 15. Klerman GL, Hirschfeld RMA, Andreasen NC, Coryell W, Endicott J, Fawcett J, Keller MB, Scheftner WA: Major depression and related affective disorders. In: <u>Diagnosis and Classification in Psychiatry: A Critical Appraisal of DSM-III</u>. Edited by Tischler GL. Cambridge, Cambridge University Press, Chapter 1, pp 3-31, 1987.
- Fawcett J, Shaughnessy R: The suicidal patient. In: <u>Psychiatry: Diagnosis and Therapy</u>. Edited by Flaherty JA, Channon RA, Davis JM. Norwalk, Connecticut, Appleton & Lange, Chapter 4, pp 49-56, 1988.
- 17. Clark DC, Fawcett J: Does lithium carbonate therapy for alcoholism deter relapse drinking? In: <u>Recent Developments in Alcoholism: Treatment Issues, Volume 7.</u> Edited by Galanter M. New York, Plenum Publishing Company, pp 315-328, 1989.
- 18. Sherin KM, Fawcett J: Substance abuse: Controlled substances. In: <u>Textbook of Family Practice, Fourth Edition</u>. Edited by Rakel RE. Philadelphia, WB Saunders Company, pp 1623-1632, 1990.
- 19. Fawcett J: Classificazione clinica delle depressioni resistenti. In: <u>Psicofarmacoresistenza Problemi E Prospecttive</u>. Edited by Altamura C, Gnocchi G, Monteleone P, Muscettola G. Napoli, Idelson, pp 67-73, 1990.
- 20. Zajecka JM, Fawcett J: Antidepressant combination and potentiation. In: <u>Psychiatric Medicine</u>. Edited by Hall RCW. Longwood, Florida, Ryandic Publishing, Inc., pp 55-75, 1991.
- 21. Zajecka JM, Fawcett J: Innovative somatic treatments for depression. In: <u>Psychiatric Medicine</u>. Edited by Hall RCW. Longwood, Florida, Ryandic Publishing, Inc., pp 77-103, 1991.
- 22. Fawcett J, Clark DC, Scheftner WA: The assessment and management of the suicidal patient. In: <u>Psychiatric Medicine</u>. Edited by Hall RCW. Longwood, Florida, Ryandic Publishing, Inc., pp 299-311, 1991.
- 23. Clark DC, Fawcett J: An empirically-based model of suicide risk assessment for patients with affective disorder. In: <u>Suicide and Clinical Practice</u>: <u>Multiple Perspectives</u>. Edited by Jacobs D. Washington DC, American Psychiatric Press, pp 55-73, 1991.
- 24. Clark DC, Fawcett J: Review of empirical risk factors for evaluation of the suicidal patient. In: <u>Suicide:</u> <u>Guidelines for Assessment, Management and Treatment</u> Edited by Bongar B. New York, Oxford University Press, pp 16-48, 1992.

PUBLICATIONS (cont'd) Book Chapters

- 25. Fawcett J, Shaughnessy RA: The suicidal patient. In: <u>Psychiatry: Diagnosis and Therapy, Second Edition</u> Edited by Flaherty JA, Davis JM, Janicak PG. Norwalk, Connecticut, Appleton & Lange, pp 84-90, 1993.
- 26. Linnoila M, Fawcett J, Fuller RK, Harford TC, Martin PB, Meyer RE, Romach MK, Sellers EM: Evaluation of pharmacologic treatments for alcohol abuse, dependence, and their complications. In: Clinical Evaluation of Psychotropic Drugs: Principles and Guidelines Edited by Prien RF, Robinson DS. New York, Raven Press, pp 625-649, 1994.
- 27. Fawcett J, Busch KA: Stimulants in psychiatry. In: <u>The American Psychiatric Press Textbook of Psychopharmacology</u>. Edited by Schatzberg AF, Nemeroff CB. Washington, DC, American Psychiatric Press, pp 417-435, 1995.
- Hollon SD, Fawcett J: Combined medication and psychotherapy. In: <u>Treatments of Psychiatric Disorders</u>, <u>Second Edition</u>. Edited by Gabbard GO. Washington, DC, American Psychiatric Press, pp 1221-1236, 1995.
- 29. Fawcett J, Busch KA: Depressive disorders. In: <u>Current Practice of Medicine</u>, <u>Volume 3</u>. Edited by Bone RC. Philadelphia, Current Medicine, pp X:1.1-1.10, 1996.
- 30. Easton MS, Fawcett J: Treatment outcomes for addictive disorders in psychiatric settings. In: <u>The Principles and Practice of Addictions in Psychiatry</u>. Edited by Miller NS. Philadelphia, WB Saunders Company, pp 407-415, 1997.
- 31. Fawcett J: Psychopharmacotherapy and psychotherapy: Treating target symptoms and learning. In: The Annual of Psychoanalysis. Edited by Winer JA. Hillsdale, New Jersey, The Analytic Press, Vol. XXV, pp 17-25, 1997.
- 32. Fawcett J: Profiles of completed suicides. In: <u>The Harvard Medical School Guide to Suicide Assessment</u> and Intervention. Edited by Jacobs DG. San Francisco, Jossey-Bass Publishers, pp 115-124, 1999.
- 33. Fawcett J: The anxiety disorders, anxiety symptoms and suicide. In: <u>Suicide An Unnecessary Death.</u> Edited by Wasserman D. London, Martin Dunitz, pp 59-63, 2001.
- 34. Fawcett J, Busch KA: Stimulants in psychiatry. In: <u>Essentials of Clinical Psychopharmacology</u>. Edited by Schatzberg, AF, Nemeroff CB. Washington, DC, American Psychiatric Publishing, Inc., pp 303-325, 2001.
- 35. Fawcett J: Suicide in treatment-refractory depression. In: <u>Treatment-Resistant Mood Disorders.</u> Edited by Amsterdam JD, Hornig M, Nierenberg AA. United Kingdom, Cambridge University Press, pp 479488, 2001.
- 36. Fawcett J, Conwell Y, Jamison K, Baldessarini R, May P, <u>Reducing Suicide</u>, Edited by Goldsmith SK, Pellmar, TC, Kleinman, AM, Bunney WE, The National Academies Press, Washington, D.C. 2002
- 37. Fawcett, J, contributor The Dana Guide to Brain Health, Edited by Bloom ,FE, Beal, MF, Kupfer, DJ, The Free Press, New York, NY, 2003
- 38. Fawcett, J: Sympathomimetics and Dopamine Receptor Agonists. In: Comprehensive Textbook of Psychiatry, Eighth Edition. Edited by Saddock, BJ and Saddock, VA. Lipincott William & Wilkins, pp 2938-2945, 2005
- Fawcett, J Mood Disorders In <u>The Merck Manual of Diagnosis and Therapy</u>, 18th <u>Edition</u>, Edited by Beers, MH, Porter, RS, Jones, TV, Kaplan, JL, Berkwits, M. Merck Research Laboratories, Whitehouse Station, NJ pp 1703-1716, 2006

PUBLICATIONS (cont'd) Book Chapters

- 40. Fawcett, J Depressive Disorders In <u>The Textbook of Suicide Assessment and Management</u>, Edited by Simon RI, Hales RE, American Psychiatric Publishing Inc, Washington DC, London, England, pp 25-276, 2006.
- 41 Hollon, SD, Fawcett J Combined Medication and Psychotherapy in <u>Gabbard's Treatments of Psychiatric Disorders, Fourth Edition</u>, Edited by Gabbard GO, American Psychiatric Publishing Inc, Washington DC, London, England, pp 439-448, 2007
- Fawcett J Acute Risk Factors for Suicide: Anxiety Severity as a Treatment Modifiable Risk Factor in Suicide in Psychiatric Disorders, Edited by Tatarelli R, Pompili M, Girardi P, (In Press)