UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF WISCONSIN

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	Case No. 18-CR-145
	)	Milwaukee, Wisconsin
vs.	)	
	)	August 6, 2021
LISA HOFSCHULZ & ROBERT	)	
HOFSCHULZ,	)	(Excerpt transcript)
	)	
Defendants.	)	
	)	

TRANSCRIPT OF DR. TIMOTHY KING
BEFORE THE HONORABLE PAMELA PEPPER
UNITED STATES CHIEF DISTRICT JUDGE, and a jury.

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Dr. Timothy King

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1 P R O C E E D I N G S
2 THE CLERK: The Court calls criminal case, Case
3 No. 18-CR-145, United States of America v. Lisa Hofschulz &
4 Robert Hofschulz. Please state your appearances for the record
5 starting with counsel for the Government.
6 MS. STEWART: Good morning, Your Honor. Julie Stewart
7 and Laura Kwaterski on behalf of the United States along with
8 Laura Reid.
9 MR. BRINDLEY: Good morning, Your Honor. Beau
10 Brindley and Michael Thompson and Vadmir Glozman on behalf of
11 Lisa Hofschulz, who is present.
12 MR. SMITH: Morning, Your Honor. Jonathan Smith
13 appears on behalf of Bob Hofschulz, who is present.
14 THE COURT: Morning. In the never-ending saga that is
15 the jury, one of the jurors has informed our CSO that they
16 misunderstood the instructions about how long the trial would
17 take, and they have a family vacation starting a week from
18 today. I propose for the moment we do nothing about that. I
19 don't know what we can do about that. I don't know how much
20 more clear I could have made it that ten business days through
21 the end of next Friday.
22 At some point, we can discuss whether or not we want
23 to talk to this person. I think the answer to the person is I'm
24 sorry, but we made clear what was happening. If things move
25 more quickly and get finished before then, great. I don't think

1 we can tell a juror we will let you go because you didn't
2 listen. So I throw that out there for you to think about. I
3 think we were quite clear. We had a number of people tell us
4 when they had vacation starting. We had the one young man that
5 says my vacation starts on the 16th. We told them, yeah, that's
6 after. I don't -- I don't know. I don't know how much more
7 clear we could have been. I don't think this is anything that
8 any of us could have done anything about, but I wanted to let
9 you all know that that is out there. I don't propose we do
10 anything about it right now. I propose that you all think about
11 it, and I will think about it. My view is at the end of the
12 day, we will go as quickly as we can. But if we are still here
13 on Friday, I'm sorry, you're here. Anything from the Government
14 before we bring the jury in?
15 MS. STEWART: No, Your Honor. Thank you.
16 THE COURT: Mr. Brindley.
17 MR. BRINDLEY: No, Your Honor.
18 THE COURT: Mr. Smith.
19 MR. SMITH: No.
20 THE COURT: We should get Dr. King back in and get the
21 jury.
22 (Jury enters.)
23 THE COURT: Have a seat. Welcome back. Dr. King, you
24 are still of course under oath.
25 THE WITNESS: Yes, ma'am.

1 THE COURT: Mr. Brindley.
2 MR. BRINDLEY: Thank you, Your Honor.
3 **CONTINUED CROSS EXAMINATION BY MR. BRINDLEY:**
4 Q. Dr. King, good morning, sir.
5 A. Good morning, sir.
6 Q. I'd like to start with talking about patient Ron Michalski.
7 With respect to patient Ron Michalski, you referenced a period
8 of multiple months without a record of a visit, correct?
9 A. If that's what the record reflected, yes. I'd have to
10 review it to be specific. If it is in my accounting, yes.
11 Q. You did not observe obviously whether Ms. Hofschulz met with
12 Ron Michalski outside of normal office settings, did you?
13 A. No, I reviewed the medical record and the information that
14 it portrayed and nothing beyond that.
15 Q. Okay. And so with respect to patient Amber Taylor, I will
16 ask you a similar question. You did not know whether Amber
17 Taylor ever met with Ms. Hofschulz outside the normal office
18 setting, do you?
19 A. I only know what was in the chart in terms of official
20 medical and office settings.
21 Q. Now, you were also not present for any of the interviews
22 that were done with patients Hirschfeld or Klunk, were you?
23 A. I don't know what you mean by interviews.
24 Q. You weren't present with the investigator over here when she
25 interviewed folks, were you?

1 A. That's correct, I was not present for interviews by the
2 investigator.
3 Q. So you do not know what these patients may have said about
4 lies that they told to Ms. Hofschulz, do you?
5 A. I was not privy to any of those conversations.
6 Q. Okay. Now Frank Eberl, were you provided with any hospital
7 records from the VA for Frank Eberl?
8 A. I don't believe I was provided with any outside hospital
9 records. If they were in the medical chart for Ms. Hofschulz, I
10 saw them. But as I reviewed my chart here, I don't see any
11 indication that I had any hospital records specifically.
12 Q. If Frank Eberl had been in and out of the VA Hospital
13 getting medicated there, you won't have that information, right?
14 A. If it was not in the medical chart, I would not have it.
15 Q. Now, you talked yesterday with respect to Mr. Eberl. You
16 talked to -- about I think a difference in his weight at one
17 point, right?
18 A. I don't believe so.
19 Q. The Government asked you how much he weighed on his driver's
20 license image. Do you remember that?
21 A. That question was asked.
22 Q. Did you have information how much he weighed during his last
23 visit with Ms. Hofschulz?
24 A. I don't believe that was documented in the medical record.
25 Q. All right. It is correct based on that, the records you had

1 for Mr. Eberl, that he did suffer from diabetes, correct?
2 A. He did have a -- he had a current and past medical history
3 of diabetes, that's correct.
4 Q. He had a current and past medical history of pancreatitis?
5 A. Correct.
6 Q. He had a current and past medical history of hypertension,
7 correct?
8 A. Correct.
9 Q. He had a current and past history of hypothyroidism,
10 correct?
11 A. Yes.
12 Q. And if not properly managed, this combination of medical
13 problems could cause someone's health to decline. You won't
14 disagree with me about that?
15 A. That would be correct.
16 Q. Okay. You were not given access to any of the photos that
17 were taken at the scene where Mr. Eberl died, were you?
18 A. I was not.
19 Q. So you don't know what pill bottles were present at the time
20 that he died and didn't get to see them, did you?
21 A. I am reviewing my chart here for just a moment. Bear with
22 me if you would, please. I did not see any of the photographs
23 that were taken of the death scene. I was however provided with
24 an investigation report that was dated 11-21-15, which did give
25 a description of the death scene.

1 Q. But you did not -- You didn't have the photographs then.
2 You didn't see how many bottles of medication were depicted in
3 the photos taken, am I right?
4 A. I did not see any photographs.
5 Q. Okay. You were also -- We spoke earlier about not being
6 present for interviews done with patients Hirschfeld and Klunk.
7 I take it you were also not present for any interviews that the
8 investigator did with patients Graves and Moore, were you?
9 A. That's correct. I was not present for those.
10 Q. And so at no time did you ever hear patients Graves or Moore
11 describe the quality of care that they believed they received
12 from Ms. Hofschulz, did you?
13 A. I was not present for any of those interviews.
14 Q. When we talked yesterday about presuming that someone may be
15 an addict with respect to cocaine testifies, this morning I'd
16 like to talk a little bit about alcohol. Now, would a urine
17 drug screen indicate that there's something positive for
18 alcohol, obviously that means there's alcohol present in the
19 urine specimen, right, or evidence of alcohol I should say to be
20 more clear?
21 A. That would be correct. There would be evidence of alcohol
22 consumption, correct.
23 Q. Now, obviously, you'd agree with me I think that everyone
24 who has a drink is not automatically an alcoholic, right?
25 A. I think that would be fair to say of course.

1 Q. And it's also true that people -- even people that might
2 have one drink at the end of the day, that really doesn't
3 necessarily make them alcoholics either, does it?
4 A. It doesn't necessarily make them an alcoholic, correct.
5 Q. And the only thing you could see in the patient charts were
6 indications that alcohol was present in a person's urine drug
7 screen tests, right, in terms of alcohol. Let me rephrase the
8 question. In terms of alcohol, the only information you had to
9 indicate that any of these patients were using alcohol were the
10 urine drug screen analysis, right?
11 A. There were occasional mentions in the medical chart with
12 regard to whether the patient imbibed alcohol. And if so, they
13 were in some cases there was an estimation of how frequently.
14 So the medical history was also reflective to some degree
15 although in very incomplete fashion the alcohol consumption
16 history of the patient.
17 Q. But none of these patients had a situation where there was
18 something recorded in the history where they reported actually
19 being alcoholics or going to alcohol treatment, did they?
20 A. There actually was. I can give you some examples if you'd
21 like.
22 Q. Which patient?
23 A. Well, the example I will offer is for Mr. Eberl. There were
24 a number of -- Stand by a second while I review my record for a
25 moment.

1 Q. Sure.
2 A. I may have to go back and look at each patient separately.
3 What I mean to say is that there were some intake forms known as
4 the Cage, c-a-g-e, or the Audit, a-u-d-i-t, which were forms
5 filled out by the patient which are indicative of alcohol
6 consumption or alcoholism or Alcohol Use Disorder as we call it.
7 And I actually will have to go back and find out which patients
8 those tests were offered to, but there were at least -- There
9 was at least one patient who filled out those -- those risk
10 assessment tests, and that's how we refer to it, risk assessment
11 tests, that were quite positive for the overuse of alcohol.
12 I mention Mr. Eberl. I'd have to go back and check
13 each patient. I know there was at least one where there was a
14 significant indication of alcohol abuse based on that.
15 Q. In fact, with Mr. Eberl, isn't it true there's actually in
16 the medical charts and if you don't remember you don't remember.
17 But in Mr. Eberl's chart, isn't it indicated that he spoke to
18 Ms. Hofschulz and indicated he did not have a problem with
19 alcohol or you don't recall?
20 A. I don't recall. Well, actually I do note in my notes here
21 that he denied an alcohol history.
22 Q. Yes.
23 A. But --
24 Q. That's my question.
25 A. Yes.

1 MR. BRINDLEY: If we could publish for Dr. King and
2 the jury Government Exhibit 63, page 42, please.
3 THE COURT: Okay. I think the witness has it. Jurors
4 have it too.
5 Q. All right. Dr. King, what you see before you is a page from
6 Frank Eberl's chart, correct?
7 A. That's correct.
8 Q. And this is the Cage Questionnaire that when you -- that you
9 mentioned a minute ago. When you said Cage, you're talking
10 about this?
11 A. I was, yes. This is that example.
12 Q. And I'm going to go through a little bit of what Mr. Eberl
13 filled out with you here. With respect to the question of if
14 you ever felt like you wanted to cut down on your drinking or
15 drug use, he indicated no, correct?
16 A. Correct.
17 Q. When the question have people annoyed you by criticizing
18 your drinking or drug use? He indicated no, right?
19 A. Correct.
20 Q. Have you ever felt bad or guilty about your drinking or drug
21 use? Indication no, right?
22 A. Correct.
23 Q. Have you ever had a drink or used drugs first thing in the
24 morning to steady your nerves or get rid of a hangover? And he
25 answered no, right?

1 A. Correct.
2 Q. Under recent experiences, he indicates in the last three
3 months, have you felt you should cut down or stop drinking or
4 using drugs? He indicated no, correct?
5 A. Correct.
6 Q. And then in the last three months, has anyone gotten on your
7 nerves by telling you to cut down or stop drinking? He
8 indicated no, right?
9 A. Right.
10 Q. And then in the last three months, have you felt guilty
11 about how much you are drinking, and he indicated no, right?
12 A. Correct.
13 Q. And in the last three months, have you been waking up
14 wanting a drink, alcoholic drink? He indicated no, right?
15 A. Correct.
16 Q. Okay. If we can go on to the next. That's it. So that's
17 the Cage Questionnaire on alcohol as it related to Frank Eberl,
18 correct?
19 A. Correct.
20 Q. Now, when you were giving your testimony yesterday,
21 Dr. King, you indicated that beginning back in the 1990s, there
22 was a much different view about what quantity of opiates ought
23 to be prescribed, am I right?
24 A. Well, the proposition was put forth that there was no
25 ceiling limit for the opiates. The conventional thinking up to

1 that point was opiates should be used marginally. That is when
2 the discussion began. That would be the way I would phrase it.
3 Q. Fair enough. So starting in the 1990s, there were some
4 people in the pain management field that were advocating the
5 idea that there was no ceiling on how much opiates could be
6 prescribed for a chronic pain patient, right?
7 A. I would phrase that slightly different. Based on the
8 experience in terminal end-of-life cancer patient care, it was
9 -- it was generally regarded that there was no ceiling effect.
10 In other words, in an end-of-life situation, an oncologist can
11 use whatever narcotics were appropriate to keep the patient
12 under good pain control.
13 The proposition was then made if it weren't for the
14 cancer patients, perhaps we could take that same philosophy and
15 practice and apply it to chronic pain patients. So the genesis
16 of the use of the no ceiling thought process in chronic pain was
17 not proven and not generally accepted, but it was proposed
18 because it worked in cancer. Some people thought that it should
19 be able to be effective in chronic pain and thus began the
20 decade where that was tried.
21 Q. Okay. So there were people in the pain management field
22 that believed that you could treat chronic pain just like you
23 treat end-of-life cancer with no upper boundary on what opiates
24 could be prescribed for the chronic pain patients. That is the
25 idea that some people proposed, is that true?

1 A. And I think you phrased that correctly. Some people did
2 propose that, yes.
3 Q. And that theory was previously advocated by a doctor named
4 Russell Portenoy at one point, wasn't it?
5 A. Dr. Russell Portenoy was a palliative care end-of-life
6 specialist out of New York. And, yes, he did propose that.
7 Q. And it was also advocated by an individual named Dr. Steven
8 Passik; is that right?
9 A. Dr. Steven Passik was a psychologist. He's not a medical
10 doctor, but he concurred with Dr. Portenoy and generally
11 referenced Dr. Portenoy as his mentor, so he reflected the same
12 beliefs that Dr. Portenoy did.
13 Q. Okay. Those similar beliefs were advocated by a
14 doctor named Forest Tennant. You're familiar with him too,
15 right?
16 A. Yes.
17 Q. Now, ultimately, you said these theories caused a lot of
18 problems because opiates were being prescribed in too high of
19 numbers in a lot of situations; is that true?
20 A. Too high a dose, yes.
21 Q. And the advocates of these no ceiling high-does opiate
22 theories, you understand that those people did hold seminars
23 proposing these theories, right?
24 A. Seminars by and large hosted by the drug companies, yes.
25 There was significant bias in that regard.

1 Q. There may have been bias, but it is a fact that seminars
2 were hosted by these theorists that we were just talking about
3 where they advocated this no ceiling high-dose opiate theory,
4 right?
5 A. Yes. They did push their agenda, yes.
6 Q. When they were out pushing their agenda, they were
7 presenting themselves as if they were experts in their field,
8 correct?
9 A. Correct.
10 Q. Even though as you've said, the majority of people did not
11 join that view. I think that is what you were saying?
12 A. Correct, yes.
13 Q. However these guys when they presented themselves as if they
14 were experts and this really worked, right?
15 A. Self proclaimed experts, that's correct.
16 Q. Now, you know that many doctors and practitioners attended
17 the seminars put on by these advocates for their position?
18 MS. STEWART: Objection, lack of foundation.
19 THE COURT: Overruled.
20 Q. You know that happened, right?
21 A. Well, to the extent that many seminars were produced by
22 these individuals hosted by these individuals and underwritten
23 by the drug companies, yes. There were understandably a number
24 of physician and healthcare providers who attended.
25 Q. And you would agree with me that physicians and healthcare

1 providers can be influenced by what they hear at seminars they
2 attend. That's true, isn't it?
3 A. I think we've shown that that is true. And the bias
4 associated with the drug companies who host these things does
5 have an influence on the practice, whether it is medically
6 founded or sound or not. So yes, I would agree with that.
7 Q. Okay. So then it's fair to say that there were a lot of
8 practitioners and providers who may have been influenced or
9 taken in by these theories, right?
10 A. Well, there were some but not all for sure.
11 Q. Right. Certainly not everybody, but there was a number of
12 people that were influenced by this, right?
13 A. Yes.
14 Q. And it started to influence the practice, right?
15 A. It started to influence individual practices, that's true.
16 Q. Yes. Individual practitioners, right?
17 A. Correct.
18 Q. Okay. Now, it turns out, as you've stated here, it turns
19 out that these high dose no ceiling theorists in your view or
20 maybe in the view of the majority, they were wrong, correct?
21 A. They were definitely proved to be wrong, that is correct.
22 There was no scientific foundation that came forth after the
23 studies were looked at to support the use of opiates for chronic
24 pain therapy.
25 Q. Okay. But you would agree with me that people who followed

1 these proposed self proclaimed experts and followed the theories
2 that they presented, if someone was basing their practice on one
3 of these theories, you would agree with me that that person
4 could act in good faith while trying to follow that theory and
5 end up doing something that turned out to be wrong, correct?
6 A. I would not agree with the way you phrased that question.
7 Q. Okay.
8 A. Here is how I would modify that. Assuming the individual
9 has engaged in the practice of medicine and all the basic
10 pillars that we discussed in detail and assuming then that
11 within the sphere of practicing medicine, the individual, the
12 practitioner, is practicing within the standard of care. The
13 standard of care would dictate that if the individual were to
14 use the philosophy of high dose opiates, standard of care would
15 require that the results would demonstrate an improvement in the
16 patient's condition without significant adverse side effects.
17 And that's where things fell apart because in good faith, that
18 would imply the practice of medicine was being performed and the
19 patients were getting better, and patients were not getting
20 better. There was no demonstration of improvement of pain and
21 function, and there was a significant increase in the incidents
22 of addiction and overdose death. So the good faith use of these
23 medications was not demonstrated.
24 Q. Okay. Dr. King, in fact in a prior proceeding, do you
25 recall that you and I had a discussion about this topic in the

1 past?
2 A. I do.
3 Q. Okay. And that was under oath in another situation, was it
4 not?
5 A. Correct.
6 Q. And under oath in that circumstance --
7 MS. STEWART: Objection, Your Honor. Can we be heard
8 at sidebar, please?
9 THE COURT: Okay.
10 (Sidebar discussion.)
11 MS. STEWART: This is an improper impeachment, Your
12 Honor. He asked the witness a question about whether good faith
13 and the witness said it depends on the context, and he answered
14 it within the context of this case. Now, he's trying to impeach
15 him with prior testimony, which is a different context. It is
16 not appropriate to do so. He hasn't demonstrated any lie and so
17 bringing in a prior proceeding and prior testimony is hearsay or
18 because it is his prior statement, Dr. King's prior statement,
19 so it is hearsay or it is improper impeachment.
20 THE COURT: I don't know what he said at the prior
21 proceedings. I don't have any way of knowing it is impeachment.
22 MR. BRINDLEY: Judge, here is what it is. I also
23 didn't ask him in terms of Ms. Hofschulz in particular in this
24 instance. I asked him whether practitioners could act in good
25 faith based on these high-dose theories, and he gave me an

1 indication I think at the end that he could not. And at the
2 other hearing, I asked him also in general terms the same thing,
3 and he gave a different kind of response. So I am going to read
4 him the question and answer. I believe it is arguably
5 inconsistent. They can redirect it. I will ask did you give
6 this answer, and he can say yes or no.
7 THE COURT: I don't -- I think he can do that.
8 MS. STEWART: That isn't impeachment, Your Honor. He
9 is saying something now that is inconsistent with what he said
10 before, and he is impeaching him. But he didn't say anything
11 inconsistent. He answered the question in a context.
12 If he wants to get him down to the same question and
13 same question and answer, then he can impeach him if it is a
14 lie. That is not what is happening here.
15 THE COURT: You can raise your objection again after
16 he reads it if it turns out it is not the same thing.
17 MS. STEWART: Okay.
18 (Back on the record.)
19 THE COURT: I overrule the objection. Go ahead,
20 Mr. Brindley.
21 Q. Dr. King, during that prior proceedings when testifying
22 under oath with respect to high-dose opiate therapy, were you
23 asked the following question and did you give the following
24 answer. Question: "Okay. And those doctors could be
25 following that protocol trying to act in

1 good faith even though they don't meet the
2 standard of care that you are describing?
3 Answer: They didn't meet the overall standard of
4 care, and they could have acted accordingly,
5 yes."
6 MS. STEWART: Objection, improper impeachment.
7 THE COURT: Sustained.
8 Q. So Dr. King, with respect to the advocates of the high-dose
9 opiate therapy, you said that they had conducted seminars and a
10 lot of people attended them. What you're ultimately saying
11 those people should have realized at some point that this was
12 not working for patients, correct?
13 A. And they actually did. By 2012, there was a major
14 abdication of those stances by both Dr. Portenoy and
15 commensurate with Steve Passik, and they realized and they
16 stated in national publications no less than the Wall Street
17 Journal and other medical journals something to the effect of if
18 we had known what we know now, we never would have followed that
19 path. And that was put forth and totally abdicated in terms of
20 their previous position by 2012.
21 Q. Dr. Portenoy certainly did that explicitly, right?
22 A. Yeah. In that same article in the Wall Street Journal.
23 Dr. Passik, who again is a psychologist, also indicated that
24 Dr. Portenoy was his mentor and basically he followed the same
25 things. So two of those individuals we discussed really gave up

1 their previous thoughts that no controlling effects were
2 appropriate.
3 Q. Two of them you said gave up some previous thoughts. Some
4 other individuals maintained them longer obviously and were in
5 the minority, true?
6 A. There became an extreme minority at that point, and I don't
7 know if you want to discuss individual personages at this point,
8 but the main lead and the main thought leader at that point was
9 Dr. Portenoy. And his decision to say, no, we were wrong, we
10 caused a lot of problems, a lot of deaths, a lot of addiction,
11 that carried a lot of weight. And the individuals who were left
12 behind who may have decided that that philosophy was still
13 appropriate were in a very distinct minority.
14 Q. But in-between the 1990s and the early 2000, 2010, 2011, you
15 would agree with me that there were multiple practitioners out
16 there following this high-dose, no ceiling opiate philosophy,
17 right?
18 A. You're asking for numbers?
19 Q. I'm not asking for numbers. I'm just asking if there were
20 people that were doing it?
21 A. There were some people during the '90s and early 2000s who
22 were doing that, yes. We've discussed that.
23 Q. Okay. You do not know, Dr. King, what kind of training
24 regarding pain management philosophy Ms. Hofschulz received or
25 who it was from, do you?

1 A. That's correct. I don't know her training background.
2 Q. So you do not know whether she was impacted by this
3 high-dose opiate therapy idea or not, do you?
4 A. I do not.
5 Q. Dr. King, you issued your opinions or provided your opinions
6 regarding Ms. Hofschulz on certain patients. You did not
7 consult with any other expert in pain management regarding the
8 opinion you are presenting in this case, did you?
9 A. I did not consult with any other experts, that's correct.
10 Q. So there was no peer review of the opinions that you're
11 presenting here about Ms. Hofschulz, was there?
12 A. Well, technically that's probably not correct. In the sense
13 that I provided you with a great deal of the literature that
14 supports my opinion and to the extent that those pieces of
15 literature involve peer-reviewed articles, my opinion was
16 founded on peer-reviewed foundation.
17 Q. Obviously, you believe your opinion is founded on peer
18 reviewed. You believe your opinion is correct. But my question
19 is no other expert in the field of pain management reviewed it
20 at all to say whether they agreed with you or not, right?
21 MS. STEWART: Objection, asked and answered.
22 THE COURT: Overruled.
23 THE WITNESS: I certainly did not present my final
24 opinion to any colleagues or any other individuals for review.
25 That would have been inappropriate.

1 Q. Okay. So then the only person as far as you know did the
2 review and provided opinions about Ms. Hofschulz was you who
3 were retained by the Government and have been so retained in
4 many occasions in the past, right?
5 A. Based on my training and qualifications, the Government
6 asked me to offer an opinion and to render the sources upon
7 which I rendered my opinion, which I did do.
8 Q. As far as you know, the Government did not engage any other
9 pain management expert that has had less affiliation in law
10 enforcement in the past. You're not familiar with them engaging
11 anyone else like that, are you?
12 A. I am not aware if they did or did not engage anyone else.
13 MR. BRINDLEY: Your Honor, no further questions.
14 THE COURT: Thank you, Mr. Brindley. Mr. Smith.
15 MR. SMITH: Thank you, Your Honor. No questions.
16 THE COURT: Thank you, Mr. Smith. Redirect,
17 Ms. Stewart.
18 MS. STEWART: Thank you, Your Honor.
19 **REDIRECT EXAMINATION BY MS. STEWART:**
20 Q. Dr. King, you were asked several questions about the
21 high-dose opiate theorists of the 1990s and going into the early
22 2000s. Do you recall that discussion?
23 A. I do, yes.
24 Q. Did those theorists ever indicate that it was unnecessary to
25 perform medical evaluations of patients prior to prescribing

1 high doses of opiates?
2 A. Quite the contrary. Starting as early as the 1990s, it was
3 reaffirmed that if practitioners are going to use high-dose
4 opiate therapy, they reaffirmed that a complete and thorough
5 medical exam must be performed, diagnosis must be established,
6 and improvement of pain and function must be demonstrated as a
7 result of a short-term trial opiate therapy.
8 So in answer to your question, it was reaffirmed that
9 medicine must be practiced, and it must be accompanied by all
10 the facets of the things we talked about earlier that define the
11 practice of medicine.
12 Q. Did Dr. Portenoy or Dr. Passik or any of other -- other
13 theorists opine that it was ever appropriate to prescribe high
14 doses of opiates to patients not seen by a medical provider?
15 A. Never. It was also reaffirmed that the high-dose opiates
16 were being put forth as a treatment option, and it is important
17 to understand that's what was being done. It was being put
18 forth as a treatment option, which previously had been off the
19 table. It was never put forth as the way to do it or the way to
20 treat chronic pain regardless of what the diagnosis or any exam
21 showed.
22 It was also reaffirmed that the patient still needed
23 to be examined, diagnosis still needed to be defined, and a
24 treatment plan that was multi-disciplinary needed to be put
25 forth and improvement had to be demonstrated to support the

1 continued use of opiates. That was always foundation.
2 Q. In those four tenants that you discussed, the four pillars
3 I'm sorry you call them that define the practice of medicine,
4 are there different philosophies on whether those apply?
5 A. No, that's the way medicine is practiced. Sometimes it's
6 expressed differently in state statutes, but essentially that's
7 the core foundation of how medicine is defined.
8 So we may differ with regard to how to define the
9 standard of care, but we do not differ with regard to how to
10 practice medicine.
11 Q. When you are talking about different treatment options and
12 the high-dose opiate therapy being one treatment option proposed
13 in the 1990s, which pillar are we in, which group?
14 A. It is in the treatment plan, the treatment plan formulation
15 pillar.
16 Q. So is it the case that in the '90s, there were different
17 opinions about options for treatment that could happen in that
18 third group?
19 A. That would be correct.
20 Q. But even the differences of opinions within that group,
21 there was always agreement about doing the first, second and
22 fourth step; is that right?
23 MR. BRINDLEY: Objection leading, Your Honor.
24 THE COURT: Sustained.
25 Q. So can you explain to me where the differences of opinion

1 lie or lied in the '90s? I'm sorry.
2 A. In the '90s, it was put forth as I indicated that opiates at
3 a large dose might be reasonably considered as a treatment
4 option but then in no way impacted the necessity that I
5 discussed many times that a complete patient evaluation must be
6 performed, a diagnosis must be established and amongst the
7 multi-disciplinary treatment options for a patient, it was
8 suggested we could now consider the use of high-dose opiates.
9 That's where that concept came in.
10 But then the fourth pillar was also still in effect
11 that it is imperative, based on the practice of medicine, to
12 demonstrate an improvement in the patient's pain and function is
13 what you heard me say all the time, a lack or at least minimal
14 adverse side effects, and patient compliance. And of course,
15 that's where it all fell apart because none of those things
16 occurred. The patients never got better with opiate therapy.
17 Addiction and overdose death became major issues that were
18 promulgated into this very day with regard to the opiate crisis.
19 But those other three pillars always remained intact. All we
20 did was add an option to the treatment pillar.
21 Q. When did Dr. Portenoy change his position on whether
22 high-dose opiate therapy was appropriate?
23 A. He completely advocated that position in 2012.
24 Q. Did that make a big splash in the pain management community?
25 A. It made a huge splash in the pain management community

1 because it was put forth not as an opinion piece or as a subtle
2 article on an obscure professional journal. It made the front
3 pages of the Wall Street Journal, and it was subsequently
4 published in multiple medical journals.
5 Q. Were the changing opinions of Dr. Portenoy and his maybe
6 disciples isn't the right word. That is the only one coming to
7 mind. So did the change of opinion of Dr. Portenoy and his
8 disciples make it into the generally understood lexicon of the
9 pain management community by 2012?
10 A. It absolutely did, yes.
11 Q. How much of your opinion -- You've testified that
12 Ms. Hofschulz wasn't practicing medicine for these eight
13 patients that you reviewed, and you testified that the
14 prescriptions were not for the legitimate medical reason and not
15 within the usual course of professional practice. Do those
16 opinions rely solely on the dosages of narcotics prescribed
17 here?
18 A. No, no, not at all. As I said many times, the dosages is
19 one red flag risk factor that we look at, but it is not
20 determinative. It is taken in the context of the other parts of
21 the evaluation and treatment and response.
22 Q. You were asked by Mr. Brindley and he showed you pages from
23 your CV and he walked you through several presentations you
24 provided to law enforcement. Do you recall that?
25 A. I do.

1 Q. Did Mr. Brindley skip over many presentations you provided
2 at hospitals?
3 A. Yes, he did.
4 Q. And I won't read all of those, but did you among the
5 hospitals that you've presented to, did that include Activate
6 Healthcare, Indiana University, St. Margaret Hospital, Sisters
7 of St. Francis, St. Anthony, St. Catherine's Hospital, the
8 American Academy of Family Practitioners, the Master Spine
9 Course, Lumber Injections and the Centers for Pain Management
10 among others?
11 A. Yes.
12 Q. Did Mr. Brindley also skip over the presentation you gave to
13 the annual meeting of defense counsels?
14 A. Yes, he did skip over that one.
15 Q. Mr. Brindley focused a lot on the multiple times that you've
16 been hired by government entities and prosecutors. Do you
17 recall that?
18 A. I do.
19 Q. Were all of those engagements for the purpose of providing
20 testimony or do you sometimes do consulting work as well?
21 A. I do a great deal of consulting work. I am not sure what
22 percentage, but maybe it approaches a third of what I do is
23 consulting and never requires testimony.
24 Q. And when you've been engaged by prosecutors' offices or
25 governmental entities, have you been asked to provide your

1 opinion about whether something is within the usual course of
2 professional practice?
3 A. Yes, I have. And if I understand you correctly and correct
4 me here if I go off in the wrong direction. When I am consulted
5 by the Government, whether it is the Attorney General's Office
6 or the Department of Justice or one of the other governmental
7 agencies, the question is always posed as to whether my
8 evaluation of the material they give me is within the usual
9 course of medical practice and if controlled substances are
10 prescribed for a legitimate medical purpose.
11 I'm asked to give a fair judgment, and there are times
12 when I say the findings are okay and within bounds and other
13 times when they are not within bounds. But in all cases,
14 particularly when I give the lectures, I educate our law
15 enforcement officials who of course are not doctors and they are
16 legitimately asking me as an expert to help them sort out the
17 legitimacy of the medical practice.
18 They are really asking me to educate them. So I go in
19 not with a bias, but with an understanding here are the criteria
20 that we as physicians understand, the criteria that define the
21 practice of medicine, and the legitimate use of opiates. I
22 educate law enforcement on those points, and then we use those
23 points to go forth to compare the case that they may have in
24 mind to see whether that case falls within or without those
25 criteria. That's the process.

1 Q. When you've educated prosecutors, for example, on a case
2 that you have found to be within the usual course of
3 professional practice, do you still get paid for the time you've
4 spent reviewing and educating those prosecutors?
5 A. Most of the time, yes.
6 Q. And has there ever been a time you felt forced to say -- to
7 give a particular conclusion to any prosecutor's office?
8 A. No, that has never occurred.
9 Q. Did you feel compelled to give a particular opinion here?
10 A. No, I was not compelled to give a particular opinion here.
11 My opinions here are based on the facts and the foundations that
12 I've put forth.
13 Q. Mr. Brindley focussed a lot on the CDC guidelines that were
14 issued in 2016. Do you recall that?
15 A. I do.
16 Q. And around the same time, did the Wisconsin -- did
17 Wisconsin issue any guidance on MMEs?
18 A. Yes, and we talked about that. The Wisconsin Medical Board
19 as well as the State of Wisconsin and the University of
20 Wisconsin were all consistent in their recommendations that were
21 accepted by the Wisconsin Medical Board to define, as we've
22 talked about, 50 Morphine Equivalents. As I would say to as a
23 stop, look and listen dose. And then the 90 Morphine
24 Equivalents as a pretty much thou shall not go beyond here
25 without significant demonstration of improvement and lack of

1 adverse side effects.
2 Q. Is there any limitation in those Wisconsin regulations or
3 guidelines that those only applied to family practitioners and
4 not those specializing in pain management?
5 A. There was no limitation to whom those should apply.
6 Q. And based on your views and your opinions, does the CDC
7 guidance apply to anyone treating chronic pain patients?
8 A. It applies to anyone treating chronic pain patients as we
9 laboriously discussed in the first paragraph yesterday of the
10 section on the audience. It applies equally to MDs, DOs, nurse
11 practitioners, PAs and anyone practicing pain management.
12 Q. Is that generally understood and accepted in the medical
13 community?
14 A. It is.
15 Q. Mr. Brindley asked you a lot of questions about your
16 background and your experience. When you've been providing
17 opinions in this case about whether Ms. Hofschulz complied with
18 the usual course of professional practice or whether she
19 practiced medicine, are you holding her to the standard of your
20 knowledge and experience?
21 A. No. I think I explicitly stated that earlier yesterday.
22 The opinions I put forth in my recommendations or my opinions
23 regarding Ms. Hofschulz are not based on what I would do or on
24 my personal opinions. They are based on what the standards of
25 care are relative to the CDC or professional organizations,

1 peer-reviewed literature and those things. That's the
2 foundation of my opinions, and those are the standards to which
3 I am holding her.
4 Q. Mr. Brindley asked you a lot of questions about whether it
5 would be appropriate to take away a patient's pain medication
6 because they are abusing them or because they are using other
7 substances and whether it would be appropriate to leave them in
8 pain. My question is, are there other ways to treat or lessen
9 pain besides narcotic medications?
10 A. There definitely are, and it's I think misrepresented when
11 we phrase it in terms of "taking away somebody's pain pills."
12 The reality is we have multiple other treatment options. And by
13 the way, they all work best in combination, and that's why we do
14 a multi-disciplinary or multi-model approach.
15 Yes, we use physical medicine modalities, which
16 include physical therapy, massage, weight loss, aerobic
17 conditioning, sorts of things that involve work but have been
18 shown to be the most helpful in terms of chronic pain.
19 We look at psychologic modalities, which might be
20 treatment for addiction or Substance Use Disorder or mental
21 illness because and psychosocial problems that all contribute to
22 the worsening and sometimes the genesis of chronic pain.
23 We look at things like cognitive behavioral therapy,
24 mindfulness. There are a host of psychological modalities.
25 Yes, they in involve work, but they have shown to be more

1 effective than opiates in the same manner that physical medicine
2 options have been shown to being more effective than opiates.
3 We will use other non-opiate medications and interventions.
4 Sometimes a surgical intervention might be appropriate.
5 Sometimes various pain injections or implantations like epidural
6 or spinal cord stimulators might be appropriate, and certainly
7 there are a host of non-opiate medications like
8 anti-inflammatories, antidepressants, anti-epileptic drugs and
9 some others that can be brought to bare.
10 Q. It sounds like if a provider determines that opiate
11 medications present too much risk for a particular patient, that
12 doesn't mean that the patient is left to suffer in pain. Is
13 that a fair statement?
14 A. Not at all, not at all.
15 MS. STEWART: No further questions.
16 THE COURT: Anything else for Dr. King?
17 MR. BRINDLEY: Yes, Judge.
18 **RECROSS EXAMINATION BY MR. BRINDLEY:**
19 Q. Dr. King, you were talking about who the CDC guidelines are
20 written for, who they apply to.
21 MR. BRINDLEY: First of all, Your Honor, with respect
22 to the CDC guidelines, at this point, the defense would offer
23 into evidence Exhibit 204, which is those guidelines and we've
24 been reading from repeatedly, Dr. King and I.
25 THE COURT: 204?

1 MR. BRINDLEY: Yes.
2 MS. STEWART: No objection.
3 THE COURT: Without objection, I will admit
4 Exhibit 204. Did you want to publish anything?
5 MR. BRINDLEY: No, Judge. We did that yesterday for
6 Dr. King. I want it to be admitted.
7 Q. Dr. King, you would agree with me that there are primary
8 care doctors out there who end up dealing with chronic pain in
9 their practice. That's a fact isn't it?
10 A. That is true.
11 Q. Those primary care doctors sometimes when they are dealing
12 with that situation, they will actually refer the patient out to
13 a pain management clinic that specializes in that, correct?
14 A. That occurs frequently, yes.
15 Q. So there's primary care doctors on the one hand and people
16 that specialize in pain management on the other. And sometimes
17 primary care will refer the patients to that second category of
18 doctor?
19 A. Right. For various reasons, primary care may feel it's
20 better if the patient were in the hands of a specialist, so that
21 does occur, yes.
22 Q. And in the field of pain management, pain management offices
23 or pain management specialties, you can have doctors or nurse
24 practitioners that work solely in pain management, right?
25 A. That's correct, yes.

1 Q. Now, you talked about the list of your seminars which we
2 went through in some detail. In sum, sir, between 2012 and
3 today, 2021, would you agree with me that 19 out of 32 lectures
4 or seminars were all involving law enforcement or investigation.
5 Does that sound right?
6 A. In terms of the actual seminars, that's probably correct.
7 Q. Between 2012 and today 2021, during that time period, you
8 have not published any peer-reviewed articles on the subject of
9 pain management or opiates, correct?
10 A. I am not involved in pain management research so it is
11 correct, I don't publish peer-reviewed articles. I might add --
12 I'm sorry, counselor. I might add of the seminars that you
13 referenced and the numbers you put forth are correct don't take
14 into consideration I do a great deal of consulting with medical
15 groups, medical group audits, and I work with doctors in various
16 practices in terms of instruction. Those for obvious reasons
17 are not put on my seminar list.
18 Q. Okay. So then to come back around to my question, I think
19 you agree with me that during the time period I have discussed
20 in the last ten years, you've published no peer-reviewed
21 articles on the subject of pain management at all. And you said
22 no because you are not doing research, right?
23 A. That's correct.
24 Q. In fact, during that time period, you have no published
25 articles, non peer-reviewed articles on the subject of opiate

1 prescription or prescribing either, do you?
2 A. That's correct.
3 Q. Is the reason for that because of your close affiliation
4 with law enforcement leads you to be viewed as less than
5 objective in the field?
6 A. Well, I take offense to that characterization, but the
7 answer is this. I'm a good instructor. I'm a good teacher, and
8 I have a great deal of experience in the field of pain
9 management, more than 40 years.
10 As a result of my desire and reasonable facility to
11 present, talk and teach, I've put the majority of my time in
12 that area. So I make a lot of presentations, I talk to doctors,
13 I audit their practice when I am invited in to review cases.
14 And the majority of my time has been put into that area. It
15 makes little difference whether I am educating law enforcement
16 or medical providers or the public for that matter as I do a
17 number of public presentations to include such venues as the
18 YMCA and other places.
19 I'm a good instructor, and that's where I choose to
20 invest my time. I do not choose to invest my time in research
21 because I don't have enough time.
22 Q. Okay. Dr. King, earlier you were describing Dr. Portenoy
23 and Dr. Passik and some others. You used the term self
24 proclaimed experts. Do you recall using that term?
25 A. I do.

1 MR. BRINDLEY: No further questions.
2 THE COURT: Anything else, Mr. Smith?
3 **RECROSS EXAMINATION BY MR. SMITH:**
4 MR. SMITH: I do have a question.
5 Q. Doctor, Ms. Stewart on her redirect discussed with you some
6 additional seminars and what not where you were brought in to
7 speak to law enforcement investigators and the like, correct?
8 A. Correct.
9 Q. And I think your answer was that you go in to educate these
10 individuals about what I would believe to be your understanding
11 of medical matters because those were things they do not
12 possess, right?
13 A. They are not as fluent as they might like, and there are
14 certain points that they may not have any other obvious sources
15 to ask the questions. So, yes, I service that source.
16 Q. Certainly because there are matters which you talk that
17 would be beyond the knowledge of the lay individual; that is,
18 the non-medical professional, fair?
19 A. I think you've just given the correct definition of an
20 expert, to make complex things better understood to either the
21 court or to law enforcement. So yes.
22 MR. SMITH: Nothing further.
23 THE COURT: Anything else, Ms. Stewart?
24 MS. STEWART: No, Your Honor. Thank you.
25 THE COURT: So may Dr. King be excused?

1 MR. BRINDLEY: Yes, Your Honor. We will not be
2 recalling Dr. King.
3 THE COURT: All right. Thank you, Dr. King. You are
4 excused.
5 (Witness excused.)
6 (Excerpt concluded.)
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1 C E R T I F I C A T E

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3 I, SUSAN ARMBRUSTER, RMR, Official Court Reporter and
4 Transcriptionist for the United States District Court for the
5 Eastern District of Wisconsin, do hereby certify that the
6 foregoing pages are a true and accurate transcription of the
7 audio file provided in the aforementioned matter to the best of
8 my skill and ability.

9

10 Signed and Certified February 8, 2022.
11 /s/Susan Armbruster
12 Susan Armbruster

13

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