UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY
LOUISVILLE DIVISION

UNITED STATES OF AMERICA,	)	Case No. 3:13-CR-173-JHM
Plaintiff,	)	
vs.	)	
GEORGE KUDMANI,	)	
Defendant.	)	January 23, 2017 Louisville, Kentucky

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TRANSCRIPT OF TESTIMONY OF DR. TIMOTHY KING
FROM JURY TRIAL
BEFORE HONORABLE JOSEPH H. McKINLEY, JR.
UNITED STATES CHIEF DISTRICT JUDGE

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APPEARANCES:

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[Defendant present.]

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Proceedings recorded by mechanical stenography, transcript produced by computer.

(Begin testimony in open court at 11:01 a.m. Jury present.)

(DR. TIMOTHY KING, called by the Government, sworn.)

DIRECT EXAMINATION

BY MR. ANSARI:

Q. Good morning, Dr. King. Can you please introduce yourself to the ladies and gentlemen of the jury, please?

A. Good morning. My name is Timothy King. I'm a pain management/anesthesiologist physician.

Q. Sir, why did you become an anesthesiologist?

A. As far as I can remember back, I've always wanted to be a physician. The specialty field of anesthesiology was attractive to me in the early days of my schooling. I have an aptitude, I have a talent in science and math. That combined with the gifts of an inquiring mind and a passionate heart actually led me into the study of medicine and anesthesiology specifically. Anesthesia and chronic pain management essentially are studies in pharmacology and chemistry, and that worked out well with regard to my talents and gifts.

Q. Did I provide you patient files in this case to review?

A. Yes, sir, you did.

Q. Okay. Hospital records?

A. Yes.

Q. And KASPER reports?

A. Yes.

Q. And autopsies?

A. Yes.
Q. And I guess a whole lot of other hospital and practitioner records dealing with patients; is that correct?
A. That's correct.
Q. Okay. And did you review those files before today?
A. I did review them, yes.
Q. And did you prepare a report?
A. Yes. I prepared multiple reports.
Q. Okay. And are you prepared to testify to those reports today?
A. I am prepared, yes.
Q. All right, sir. Have I compensated you for this case?
A. Yes, you have.
Q. And did I pay you $350 an hour?
A. That's correct.
Q. We've paid you approximately $16,000?
A. That's correct.
Q. Okay. And you're being paid to be here today?
A. I am being paid to be here today, yes.
Q. And you have consulted on other cases in the past?
A. I've consulted on multiple cases over the years. I've consulted on criminal cases, civil cases, malpractice cases, medical board and administrative cases, and malpractice review panels.
Q. And have you been accepted as an anesthesiologist expert by

other courts?
A. Yes, I have.
Q. I know this is going way back, but you went to medical school in like 1970?
A. It is going way back, yes. It was in the 1970s I was in medical school.
Q. And where did you go to medical school?
A. I attended medical school at Indiana University School of Medicine in Indianapolis.
Q. Where did you do your residency?
A. I left Indiana for my residency. I attended residency in anesthesiology at the University of Washington in Seattle.
Q. And just briefly describe your residency program.
A. The anesthesia residency program is about three years in duration. It's a little bit longer these days as we have added some additional courses and course content. My training involved an internship and then two years of specific training in anesthesiology and pain management. I attended training with Dr. John Bonica, who at the time was alive and eventually became known as the father of pain management. So I had the honor of training and being mentored by him.
Q. So you're board certified in anesthesiology?
A. Yes, sir, I'm board certified in anesthesiology.
Q. Okay. And is that the highest certification recognized in your field?

A. It is. It's recognized as the gold standard.
Q. Now, you also became, I guess, board certified in pain medicine?
A. Yes. The board examination for pain medicine was not available during the time when I was undergoing my training in anesthesiology. I had some small part to play in putting together the board exam and some of the topics of interest as we developed this specialty of pain management. I subsequently went on to take the board exam in pain management via two different board agencies. At the time we weren't sure who was going to be the ultimate board certifying agency, so I took both exams not knowing which direction it was going to go.
But, yes, I'm board certified by both agencies in pain management.
Q. Did you also obtain a board certification in addiction medicine?
A. Yes. Within the last several years, I attained board certification in addiction medicine.
Q. So why does an expert like yourself obtain three different board certifications?
A. Anesthesiology can be considered the study of pain management in an acute setting. We obviously take care of pain needs when someone is having an operation. As we began to understand our tools in the operating room and brought those into the clinic to deal with acute pain management and chronic

pain management, it became necessary to evolve and then become certified in pain management.

As we followed the course of chronic pain management over the years, we became aware that that particular specialty was deeply tied into and integrated with issues regarding substance abuse and addiction. It was appropriate to proceed with an in-depth study and certification of addiction medicine if one were to call oneself a pain management physician.

Q. Have you also been associated with or taught at medical schools?

A. I have always been in private practice, I'm a private practice doctor, but I have had association with several medical schools over the years. I initially was on staff at the University of Washington in Seattle for some years. Then I became an associate staff member of Indiana University School of Medicine when we moved back to the Midwest.

My practice currently -- clinical practice is currently in Northwest Indiana. So over the last decade I've had clinical appointments with Rush University and currently have a clinical appointment with the University of Chicago.

Q. So you've also been in a clinical setting, you said, for many years?

A. I primarily am a private practice clinical physician, yes.

Q. And you've been, I guess, practicing medicine now for 40 years?

A. Forty years is a long time, but I think that's correct.
Q. Okay. Can you just kind of give us an overview of what's your general practice and how you've practiced over the last 40 years? What kind of practice have you been in?
A. I participate in a pain management practice, a chronic pain management practice, in Northwest Indiana. We also have a large footprint in the Chicagoland area. So approximately 50 percent of our practice is in Illinois, 50 percent in Indiana. For the last -- and I'm not really sure. I'm embarrassed I don't know how long our organization has been in effect, but it's been for well over a decade.

My partner and I were the founders of the organization. Our intent was to put together a specialty practice in chronic pain management. We see patients on a private practice setting. My typical day would be to go in and see between 20 to 30 patients. On some days I would be in the outpatient surgery suite doing various procedures, interventional pain management procedures, on our patients, but for the most part about 80 to 90 percent of my work is in the clinic day to day seeing patients one by one.

As the years have gone on, and particularly over the last couple years as I have attained semi-retirement status, I have been mentoring a lot of our doctors. I also see patients on the days that I'm in the clinic, but I also do a lot of mentoring and a lot of out-of-the-clinic teaching for various medical groups.

Q. And, sir, when you -- in private practice, do you also treat Medicaid patients?
A. Yes. They are a large part of our practice.
Q. Have you also served on credentialing boards?
A. Yes. I've served on multiple credentialing boards over the years.
Q. What does a credentialing board do?
A. The credentialing board is the hospital agency, the hospital board, that reviews the application, the certification of applying physicians. In my case, when physicians would come in and apply for pain management status, pain management privileges at the local hospital, I would review those records, along with several other colleagues, to make sure the credentials were appropriate.
Q. Just give us an example of the types of patients you treat and the ailments that they have.
A. That's a big spectrum. Essentially anyone complaining of pain is welcome and encouraged to come into the clinic. I would estimate that approximately 70 to 80 percent of our patients are complaining of some sort of spine problem. Typically it's low back pain. It could be neck pain. The remaining 25 to perhaps 30 percent -- that doesn't quite add up mathematically, but perhaps a quarter to a third of our patients are complaining of pain issues that are not related to the spine.
I see patients with abdominal pain, chest pain, myofascial

pain, fibromyalgia complaints. We see patients coming in with various somatic complaints that have a mental health etiology, so we do practice some psychology and psychiatry in the evaluation of our patients for their specific pain complaints.

Q. What type of treatments do you offer? Is it opiate-based? Injections? Surgery? What's your general treatment options?

A. Pain management, by definition and by standard of care, is a multidisciplinary practice. It would be inappropriate to label myself or any practice as an opiate-only practice. We have many options available to evaluate and treat chronic pain. We market ourselves as a multidisciplinary pain management practice.

I have specialty training in interventional pain management, so I can additionally perform specialty injections under x-ray guidance. That is a part of what I do, but the majority of what I do involves medicine management, physical therapy management, psychological management, and referral to appropriate physicians and specialties to deal with the particular pain problem that we might be dealing with.

Q. In your 40 years of service, have you also given seminars and presentations on chronic pain?

A. Yes, sir. I have given many.

Q. What about responsible use of opiates?

A. Yes. I've lectured frequently on the responsible use of opiates.

Q. Opiate addiction and drug diversion?

A. I've lectured on opiate addiction and drug diversion.
Q. And where are you and have you been licensed to practice medicine?
A. I'm foundationally licensed in the state of Indiana since I graduated from medical school in Indiana, but I am also licensed in the state of Washington, where I did my residency program. At the time I wasn't sure we would be living on the West Coast, so I was at that time also licensed in Oregon, California, but have never practiced in those two states. We did for a short time move up to Alaska, where our last child was born, so I do have an Alaskan license. And from there we came back to Indiana. My practice in Indiana, being along the border, ultimately required adjacent licensure in Illinois and Michigan.
So I have a number of state licenses, but essentially that's the story of how they came about.
Q. All right. So is the basic practice of medicine different in Indiana, Michigan, California, Alaska, Oregon, Illinois?
A. No. The standard of care for the practice of medicine, the basic way medicine is practiced, is the same in this country regardless of which state we're practicing in.
Q. So can you please tell the jury what the basics are for treating a patient in any one of those states in this country?
A. Foundationally as medical students, regardless of whether one is being trained in the 1970s or today, we as a physician, when we practice medicine, are held accountable for four -- what

I call four basic tenants, four basic bullet points that we must perform.

Our job description as a physician includes examination of the patient, using appropriate history and physical exam techniques. After we examine the patient, we formulate a diagnosis. That diagnosis, particularly in the field of pain management, is required to be individualized and multidisciplinary, has to be appropriate to the patient and their condition. And then, thirdly, we monitor the patient for compliance and then monitor the patient for success.

So essentially we go through the steps as a physician, essentially in any specialty, of examination, diagnosis, treatment plan, and then follow up on the treatment plan, so those four elements. And that's an iterative process. So I send you home, I see you back in a month or two months or three months, I re-examine you, I re-question the diagnosis, I evaluate the treatment plan once again, and then monitor that treatment plan until the next visit. Those are the four elements, becomes an iterative process in the practice -- defining the practice of medicine.

Q. Does that make a difference if you're an anesthesiologist, an OB/GYN, a pediatrician, or a family practitioner?

A. No. It makes no difference what your specialty is. As an anesthesiologist in the operating room, I don't operate quite that way, of course. But when we're taking care of patients in

the clinic, it makes no difference what specialty you are.
Q. And how do you chart your progress? How do you chart your notes, your patient records?
A. Patient records are not allowed to be charted in a random manner. Our medical record is not something that we as individual physicians are allowed to extemporaneize and document in a manner that suits us best.
We are taught as physicians foundationally in medical school to document according to a specific series of entries: A chief complaint, a history, a physical, a diagnosis, a treatment plan, and then monitor that treatment plan. Those are very specific entities. They're very specifically defined. It's uniform across all medical schools, all time, and all teaching. So our medical record is expected to be the same or pretty close to similar in all cases regardless of specialty, regardless of location.
Q. And based on your review of Dr. Kudmani's files and all the records you've looked at, did Dr. Kudmani follow the basic practice of medicine?
A. He did not. He did not follow the basic practice of medicine. I can be more specific if you like and tell you why I am opining that, why I'm coming to that conclusion.
Q. Yeah. If you can just give us some bullet points, because I'm sure we're going to hit it throughout.
A. Let's begin with the medical record. The medical record

does not put forth any of the basic tenants that I just put forth. The medical record is not a legitimate medical record. It's simply a compilation of a date, the medication prescribed, and in some cases the money owed. There is scant presentation of any exam for the most part. In the vast majority of the entries, there is no entry with regard to physical exam or history or diagnosis.

So I would say that the medical record is indeed not a medical record. It's more of an accounting.

Secondly, the patients are not examined. A diagnosis is not defined with regard to pain management. Therefore, the drugs are being prescribed without a legitimate medical purpose, and, therefore, the drugs are being prescribed outside the usual course of medical practice.

So we have the record. We have the prescription of the medications. We have a failure to examine the patient, a failure to monitor the patient, a failure to do what is correct for the patient.

Dr. Kudmani's charts represent one of the worst things that we are concerned about in medical practice, and that is doing harm. Our primary concern when practicing medicine is to do no harm. But, yet, we see nothing in the medical chart of the patients that I reviewed that there was any improvement, that there was any help, that there was any aid to the patient, that there was any true addressing of the medical problem.

Dr. Kudmani did harm.

His entire practice was outside the usual course of medical practice. This was really not the practice of medicine.

Q. Let me ask you: When a patient comes in with a complaint of pain -- back pain, knee pain, whatever it is -- why can't we just give them narcotics? They're asking for them. Why can't we just give them to them?

A. That's a reasonable question, and certainly it's one that I'm asked several times each day by some of my patients. To answer that in the way I respond to my patients is I say, "Well you have to understand what pain is."

I think we would all agree that pain is an expression of suffering, it's an unpleasant sensation, but that unpleasant sensation, that suffering has two components to it that we as physicians, whether we're strictly pain management or whether we're general physicians, have to understand. Suffering can be caused by emotion. Suffering can be caused by something broken. We refer to that something broken as a somatic pain.

When someone comes in and complains to me of pain and says, "I want some narcotics," it's up to me, it is imperative that I address and evaluate that patient as a physician. And if I determine that a large part of their pain is emotional, it might be an expression of depression. It might be an expression of PTSD. In today's world it might be a result of a young adolescent female or male having been sexually or emotionally

abused as a child and now being manifested as a chronic pain syndrome.

If I treat that patient with their required -- requested treatment of narcotics, I will make the patient worse. Narcotics have a negative impact on emotional or psychiatric pain.

If I really believe the patient has something broken, if I really believe it's a somatic pain, then I will define that somatic pain. Is there a herniated disk? Is there a fracture that hasn't healed? Is there something that should be addressed by appropriate physical therapy, by non-opioid pain management, or by psychologic treatment to help them cope with something that I can't do anything about?

But to immediately give them narcotics is the wrong thing to do. That's one tool in a large tool chest, but it is potentially dangerous, it has side effects, and needs to be carefully considered before it's used.

Q. If it's one tool, what are the other tools?

A. There are multiple other tools. And, again, the way I present it to the patients when we have this discussion is we have four areas that we can choose from.

We can choose physical therapy, and sometimes physical therapy means aerobic conditioning. A lot of the pain that we see is a reflection of lifestyle choice. Maybe the patient isn't eating healthy or maintained their weight appropriately or

exercise. So we deal with physical therapy, TENS unit, acupuncture, massage. Those are elements of one large choice that we can use to treat chronic pain.

The second large area of choices to treat pain would be on the interventional end. Maybe the individual has an acute herniated disk, a sciatica, a radiculopathy and might be a good candidate for an epidural injection or an injection to address the arthritic facet joints in their low back. Those are all very excellent choices from the interventional pain management end.

The third area that we would look at in terms of treatment choices would be the non-opioid medications. We have a host of medications that we know are not nearly as dangerous and are oftentimes very much more effective over the long term than narcotics.

We have antidepressants. We have medications that we borrow from the anti-epilepsy field -- the gapapentins, the pregabalins -- that are very common and very effective. We have Tylenol. We have aspirin. We have a whole host of anti-inflammatories that we can choose from to try to match to the patient. And it is imperative that we look at those before we reach for the very potentially dangerous and unproven narcotics for long term.

And the last thing I actually should have included with the interventional -- and we sometimes have surgery, but rarely surgery. But mostly it's physical therapy, it's the psychologic

assessment and assistance with depression or coping, it's the non-interventional ends with shots, and then it's the medications with an emphasis on the non-opioid choices.

Q. How do people that either aren't insured or underinsured, how do they afford those procedures?

A. We're rarely talking about procedures. The majority of time when I talk with our patients we're talking about lifestyle changes, we're talking about nutrition, we're talking about conditioning, we're talking about getting up off the couch and doing things, we're talking -- it is imperative that I as a physician take care of the entire patient.

Sometimes patients say, "Why are you talking to me about this or that?" I say, "Because I'm taking care of you as an entire patient. You come to me with suffering, with pain, but we have to look at the total picture."

It is well known and it has been for decades that family practice doctors, who are usually the first people to encounter people complaining of pain, have the imperative and have the skills to interact with the patient and to counsel them with what we call a brief intervention, to counsel them on their lifestyle choices and on things that they can do from a physical therapy standpoint, from a conditioning standpoint, from a non-opioid medication standpoint to get better. Rarely do we talk about procedures.

Even though I participate and specialize in some degree to

interventional pain medicine, that's a very small part of what I actually treat the patients with.

Q. So all those kind of tools that you talked about, are those the basic options in any state you practiced?

A. They are the standard of care options. They are the options that would be expected to be presented to a patient in chronic pain.

Q. And were those the standard of care options in 2009 through 2012?

A. Yes. They were standard even then.

Q. And from your review of the records, the records of Dr. Kudmani's records and for the specific sort of date ranges that we gave you, did you find that Dr. Kudmani's prescribing narcotics were for a legitimate medical purpose and within the usual course of professional practice?

A. I did not find that they were prescribed for a legitimate medical practice purpose. I did not find that they were prescribed within the usual course of medical practice.

Q. And what is the potential harm to a patient if you fail to prescribe within the usual course of professional practice?

A. There's a great deal of potential harm associated with narcotics. We all live in a world today where we see it on the news. It's a reflection of the world we live in, that I suspect in discussion with each one of you, you would have a story to tell about somebody you know or perhaps a family member who has

fallen prey to the opioid epidemic.

The two major issues that we worry about as physicians, that we deal with on a day-to-day basis are, number one, death as a result of the opiates, sometimes the opiates in combination with other medications, and the second one is either maintenance of addiction or causing addiction. Those are the two big ones. Those are the two that we read about in the news every day. There are a host of others that are not quite as significant. Opiates can worsen -- well, it is significant. Opiates we know worsen depression, cause mood instability, induce panic attacks, cause insomnia.

There's a host of concerns that we have about the use of narcotics, and, thus, it is never the first tool and sometimes not even considered as a last tool as we deal with our complex patients complaining of chronic pain.

Q. What are some tools that can be used or employed by a physician to stop the diversion of those drugs on the street?

A. In the early 2000s, particularly family practice became aware they had to marshal the troops, that they had to figure out a way to address the diversion of the drugs and the ongoing abuse of the drugs. So there began a push towards what we call universal precautions. And although we as physicians don't like to be detectives, we just want to take the patient at face value and give them what's appropriate, we do have to be careful about how we use some of these treatment choices.

As a result, some of the objective options that we have as part of our universal precautions is to do a urine drug test. If the patient comes in and tells me they're on this drug and this one, I'll do a urine drug test to see if I can confirm that -- it's all believe but confirm, believe but confirm -- to see if they're on perhaps any illegal drugs that they didn't tell me about. So one option is a urine drug test.

The second option, which at the time was not required but was still available as an objective test, was to do a prescription drug monitoring program, that is to say the KASPER. I'm not sure if you're familiar with the KASPER. But the KASPER, of course, is a list of all the prescribed medications that a -- controlled medications that a patient is receiving by all doctors. So we look for doctor shopping. We look for doctor shopping, and we try to see if the patient is maybe getting controlled medications in a deadly combination or in a greater quantity from multiple doctors.

In addition, we talk to the patient, we interview the patient. That's something that we sometimes forget. Maybe I won't get all my information on the first visit. Maybe it'll take me a second visit. Maybe it'll take me a third visit. But if I don't ask you about your background, whether alcohol plays a part in your background or whether your family history has an addiction associated with your mother or your father or your brother, if I don't ask you quietly and gently, if I'm sensing

there's an abuse history that might be foundational, if I don't ask these questions, then we won't know. Then I as a physician will not be doing my job pulling together an appropriate history.

So there's some objective things and there's some that we learn by a detailed and careful and thoughtful history.

Q. What about police reports? Do those show potential for addiction or substance abuse issues?

A. If someone comes in with a history of having their medication stolen, that's a major red flag. If they've had their medication stolen twice, three times, or four times, then we've got more red flags coming up. Police reports objectify the fact that the medications were stolen but don't justify it. If the patient's having their medication stolen, we unfortunately have to be concerned that the medication is being sold, being diverted, or it's being traded. It's a trade commodity. Controlled substances are trade commodities these days.

But police reports are important as one of the risk factors that we look at.

Q. Now, those tools you talked about for stopping diversion, were those considered the standard of care in the medical community from 2009 to 2012?

A. Yes. They've always been standard of care. And certainly during this time frame we've had KASPER available to look at as

well.

Q. Did Dr. Kudmani use any of those tools in his practice?

A. To my knowledge, he did no urine drug tests and he did no KASPER reviews.

Q. Now, we've kind of talked about red flags, but are there certain risk behaviors or red flags that a physician should look for to see if a patient is addicted or potentially abusing a substance?

A. There are multiple red flags that we look for, and this is part of doing a careful history. It's part of what's required of every physician. The red flags can be divided into two areas, two categories.

Mental illness is a large part of what we look for because we know that drug abuse and addiction is associated with mental illness. So if we have an individual who has a history of anxiety, depression, post-traumatic stress disorder, OCD, or a history of abuse or past history of addiction -- past history of addiction, we do need to ask that -- or if the individual has a history of being raised in a family who abuse drugs or had alcoholic issues, we know statistically -- these are not judgment issues. We just know statistically. And when we look at the numbers, these individuals, these patients, are at higher risk of abuse and diversion. So we have to consider that a red flag, a risk factor.

Also, there are health issues, somatic health issues, that

we have to look at in terms of risk factors. If the individual has cardiac disease, if the individual has hepatitis or cirrhosis or if they have asthma or chronic obstructive pulmonary disease or if they have sleep apnea, all these become important in terms of the safety of whether or not we should prescribe opiates.

Q. In the files that you reviewed, did Dr. Kudmani make any effort to look for those risk factors or red flags?

A. There were occasional times when he would treat an apparent depression or anxiety with an inappropriate medication, an inappropriate workup, but by and large there was no documentation of review with regard to looking at risk factors in the chart on any of those patients.

Q. How does a simple physical or physical exam of a patient help spot some of those risk factors?

A. It has sometimes been said, "What are you going to see on physical exam if the patient's addicted?" But the reality is there's no system in the body, not one system in the body, that's not affected by dependency on drugs and addiction.

So we have to do a complete physical exam. We have to look at the patient to see if there are any needle marks or pockmarks. We have to examine the patient with regard to their general body habitus. Are they sleeping? Are they not sleeping? Is their liver enlarged? Is their heart abnormal? Do they have a murmur, suggesting they may have an endocarditis

from an infection as a result of drugs? We look at their skin color. Do they have jaundice? We look at their muscles. Is there muscle wasting?

Each drug has its own sort of unique presentation in the body. Some of the illegal drugs present as skin breakout -- methamphetamine -- deterioration of the teeth that we sometimes see with a lot of drugs, an erosion of the nasal septum in the nose with cocaine and other types of inhaled stimulants.

But by and large, if we don't do, as physicians, as we are taught, a complete physical exam, then we will miss indications of abuse or diversion. And, indeed, the Kentucky Board of Medical Licensure requires us to do that as early as 1996 and then reaffirming again in 2001 that the physician is required to do a complete physical exam.

Q. Let me ask you: What if patients came in and lied to Dr. Kudmani? What if you're a physician and they come in and say, "I have all this pain"? Isn't the physician the victim, they're being lied to?

A. The physician is never a victim. We are out there putting ourselves forth as a physician, as a purveyor of an individual who can help with health issues. We open our doors and we say, "Come on in, and we'll treat your medical condition." So the physician is never a victim.

And, again, to reiterate what I said, in the early 2000s, in the mid-2000s, we instituted universal precautions, and there

was a very specific set of parameters that each physician is called upon to do to prevent diversion and to prevent abuse. By the way, abuse is when the patient uses that medication for an inappropriate medical use to get high. Diversion is if the patient sells it to a neighbor. So when we use "abuse" and "diversion," they have separate issues.

But we are required as part of the universal precautions to go through the various elements listed to prevent that, to minimize it, to make what the Kentucky Board of Medical Licensure calls a diligent -- a diligent -- effort to prevent abuse and diversion.

Q. Do drug addicts make rational decisions? Do they always tell you the truth?

A. No. No. Drug addicts will not always tell you the truth. The very definition of the disease of addiction or drug dependency is that the patient will lose common sense, will lose logic, will lose self-preservation. They will continue with their abuse of the drug despite consequences. Despite losing their spouse, despite losing their job, despite losing their life, they will continue to get the drugs. They will steal for the drugs.

They will certainly tell me as a physician, "Hey, I'm sorry. Yes, I overuse my Xanax, but if you prescribe it for me again just this one time, I promise I will use it appropriately." I would like to believe them, but I can't. I would like to trust,

but verification indicates they don't have the ability because of the nature of what the drugs do to the brain.

It's not that they're not good people. It's just you cannot believe them because of the very definition of what addiction is. You've lost the ability to control. You've lost what we call the executive function that allows us to function reasonably and logically on a daily basis. You cannot believe an addict.

Q. Now, Doctor, have you reviewed the -- you kind of referenced the 1996 Kentucky guidelines.

A. Yes, sir.

Q. And then were those later amended?

A. Those were later amended and put forth in terms of the 2001 edition and I believe later amended in 2003 as well.

Q. Okay. And are you basing in part your testimony today based on those guidelines?

A. Yes, I am.

Q. And those guidelines are pretty specific about what a physician should do -- take history, a physical exam, all the stuff you talked about, monitor, treatment plan, that type of stuff?

A. Yes. They're well written, they're common sense, and they're consistent.

Q. Now, when you went to medical school in the 1970s, is that the last time that you learned what the standard of care is?

A. No. The standard of care to some extent will evolve over time, but there are fundamentals in the standard of care that never change.

For instance, we didn't just learn in the 1970s or in the 1960s that opiates were addictive. We have always been taught as physicians that there is a particular way to treat a patient, there's a particular way to trial medications. We may give a patient a trial on a medication that might be an antibiotic or a blood pressure pill or a pain medicine, and we are taught, if we decide to go that route, to monitor the response to that patient. So in that sense, those standards have not changed over the years.

To the extent that we have new medications and we have a better understanding of what addiction is, we have a better understanding of the pharmacology of how our medications work, our standards of care evolve as we have new tools and new understandings. But there is a fundamental part of the standard of care in terms of how we operate as a physician and how we prescribe, how we examine, how we document. Those have not changed.

Q. How do physicians keep up with changing times?

A. When I was given my medical degree, it was emphasized to me that I am not allowed to stop learning. I was sent out into the world at graduation with the admonition that this is my advanced degree to keep learning.

So I read journals, and we are all told to read journals. We are told to keep up with scientific advancements not only through the journals but through our professional agencies. In the case of Dr. Kudmani, he was specialized and did a residency in OB/GYN. All of our specialty organizations, whether it's anesthesia, the American Pain Society, or the American College of Obstetrics and Gynecology, all of them have a stance on the use of opiates. So we learn through peer-reviewed literature.

We learn through our professional organizations. We learn by attending meetings. Most of us, because of our licensure, are required to have continuing medical education, so many hours per year.

So there's really no excuse for us to say we didn't know. As a matter of fact, we're constrained, we're told, we're expected to know as the years go on.

Q. We're going to turn -- we're going to look at a few photographs, and then from there we're going to move into the heart of your testimony about specific patients.

MR. ANSARI: Can we bring up Exhibit 34, page 19?

Q. And, Doctor, I've given you numerous photographs. We're not going to go through them all because we went through them a lot this week. But did you use these photographs when making your determination of Dr. Kudmani's practice?

A. These photographs reinforce my opinion and reinforce the reports that I wrote.

Q. Just briefly describe what you see here.
A. This is a chaotic medical shelf. Of course, I know it was taken from Dr. Kudmani's office. But on the top shelf -- and I've had a chance to look at this photograph very carefully and to magnify it. But on the top shelf there are multiple bottles of poison interspersed with multiple vials of local anesthetics and injectables interspersed with other items, such as blood draw tubes and labeled bottles that I'm not quite sure what are in them. That's on the top shelf.

On the bottom shelf we see a chaotic combination of sprays that are used, I presume, for glass slides to put maybe swabs on from Pap smears. And there's -- right between those two bottles, there's a bottle of ultrasound gel. And off to the left there's a hand sanitizer and a mirror. And I think on some subsequent photographs we identified that there might be a sink there, but the sink was non-utilizable because it was full of junk.

Q. So is that the standard of care in 2009 to 2012 that a medical practice should conduct themselves as?
A. No. This is non-standard care at any time frame.

MR. ANSARI: Can we go to page 16, please?

Q. And what do you see here, sir?
A. This is a drawer of medical instruments, inclusive of vaginal speculums, staple remover, tools, cotton swabs, forceps, tape, tubes of something. It's a chaotic, unsanitary drawer of

medical stuff.

MR. ANSARI: Can we go to page 28, please?

Q. What do you see in this photograph?

A. I think this is an under-the-sink view with who knows what dripping down into that left lower corner. I don't know whether that's rust from water leaking. I don't know whether that's biological material that has leaked out of some sort of a specimen container.

Additionally, on the right-hand side I see a tube of what I think is lube with what appears to be a gauze package on top of it that appears to be stained, appears to have lost its sterility. That circular black thing with the silver base in the center is a foot pump, a soap foot pump, which is obviously stashed out of the way so it can't be used. This looks like an unsanitary, non-standard collection of biological materials under the sink.

MR. ANSARI: Can we go to page 33, please?

Q. What do you see in this picture?

A. I never did figure out exactly what that wooden apparatus was. I thought it might have been a puzzle to begin with, but I really don't know what it is.

But, of course, what grabs the eye here is that you've got a needle disposal box, the red box there, with lengthy needles spilling out of the top with their points protruding. And down at the bottom there I see multiple TB syringes that are all

used, that are all unsterile, that look to have at least in the one perhaps some residual material in it.

Then I see wrappers that were discarded presumably when the needles were opened, along with maybe a Steri-Wipe or Kleenex that was thrown in there. And everything is adjacent to swabs and speculums there in that package that are used for uterine -- for cervical swabbing.

Q. Is that over the sink?

A. And it is over the sink, yes. It's in a cardboard box over the sink.

MR. ANSARI: And, lastly, could we go to page 36, please?

36 I think is the next -- yes, yes.

Q. 36, right here. So what does *CPT 2004* mean?

A. "CPT" refers to the coding manual that we use, as required by insurance companies, to code our various diagnoses and procedures. That comes out on a yearly basis. This one, of course, is labeled 2004. But the non sequitur here is the fact that this picture was taken in 2012. So this coding book is clearly out of date but obviously is sitting on the copy machine here and obviously is still in current use.

Q. From the photographs that we've just seen, does this office appear to be a normal doctor's office where legitimate medical treatment is taking place?

A. This does not appear to be a doctor's office at all.

Q. I'm going to turn to the specific patient files now, but in case I forget to ask you -- the questions I'm asking you, I'm looking for answers that are within the standard of care during 2009 and 2012, and then we're going to talk about specifically were these drugs for legitimate medical purpose and within the usual course of professional practice, okay?

A. Yes, sir.

Q. All between 2009 and 2012.

And so we don't have to go through each specific -- all the files for each patient -- we did that the other day -- let me just hit some high points first, and that is: For any of the Kudmani patient files you reviewed for the dates of service listed in the indictment, did any of them contain an adequate patient history?

A. None of them contained an adequate patient history.

Q. What about an adequate physical exam?

A. None of them contained either a targeted or an adequate physical exam.

Q. What about a diagnosis, an adequate diagnosis?

A. A legitimate diagnosis, an objective legitimate diagnosis, was not formulated in any of the cases.

Q. What about a treatment plan?

A. The treatment plan was never delineated. The closest we got to a treatment plan indication was a simple listing of the narcotic.

Q. What about a follow-up on that absent treatment plan?
A. That was no follow-up, no follow-up commentary at all.
Q. And generally was there a height, weight, and blood pressure taken of these patients?
A. Vital signs were absent pretty much throughout. There were a couple times when I saw what I assumed to be a body weight, but it was very rare. There was one time when I saw one blood pressure. But by and large, vital signs were not taken or recorded.
MR. ANSARI: Can we go to Exhibit 1, page 2, please?
Q. This is Count 1, Kim Forbes. Her date of service, roughly March 2011 through September of 2011. We're looking at this top one, which is the first date of service, March 11, 2011.
And tell me if I'm right, but it looks like, "Adhesion pain. Back pain. To get MRI. Refer to Dr. Nazar." Am I reading that correctly?
A. Yes, sir, that's what it says.
Q. When you looked at this patient file, did you see any medical records obtained from Dr. Nazar or from anybody else?
A. I saw no medical records from anyone.
Q. And did -- and in this file did you see where Dr. Kudmani ever asked his patient about an abuse history, drug abuse history?
A. There was no indication that he inquired about drug abuse history.

Q. Did this patient exhibit risk behaviors like you talked about before?
A. Yes. She exhibited multiple risk behaviors. Did you want me to name them or ...
Q. If you can name a few of them.
A. A few of them? She was doctor shopping. The KASPER clearly showed that she was doctor shopping. She also had some physical comorbidities of concern, including obesity and asthma, and she was a chronic smoker.
Q. And I think we see -- I don't know if it's on this page but -- oh, yeah. Down here in the lower left, "Stolen." Stolen medication, would that be a risk factor?
A. That would be a risk factor.
Q. And you kind of said this earlier, but on the left-hand side do you see where it says "owes 15," "owes 15"?
A. Yes.
Q. Did you see those throughout Dr. Kudmani's patient files?
A. I did, yes.
Q. And what did you think those meant?
A. They are consistent with dollars, and the reason I say that is because it showed up throughout the various charts. Sometimes they're crossed off. They're also consistent with some of the pictures that we saw, some of the photos of the office, where apparently lists or scores were kept posted on the wall with regard to this sort of thing. But this appeared to be

owes $15.
Q. Is that the standard of care in the medical community for tracking how much patients owe?
A. No. Well, at least not on the medical chart.
Q. And in this file did you see any objective testing done?
A. There was no objective testing done, no urine drug tests, no KASPERs.
Q. From an anesthesiologist's point of view, did Dr. Kudmani ever attempt to get to the alleged back pain issue?
A. No. He never did a targeted investigation or exam.
Q. Now, I guess she came in. She was there for approximately seven months. She got medication, she got Percocet and Xanax, and the risk behaviors were disregarded.
What was the point of Xanax? How does Xanax fix back pain?
A. Xanax does not fix back pain. Xanax is indicated for short-term sedative use. It might be used for breakthrough anxiety. It's not even appropriate for long-term treatment of anxiety. But it clearly has no indication and no part to play in the treatment of long-term back pain.
Q. She was also given Klonopin at some point. How does Klonopin affect back pain?
A. Klonopin and Xanax are both what we call benzodiazepines. They're part of that tranquilizer, sedative/hypnotic class. They relax patients. They make them sedate. Klonopin is longer acting than Xanax, but Klonopin is not a medication that we use

to treat back pain. It's more of a psychiatric medication to use for the -- as an adjunct in the treatment of long-term anxiety, but in and of itself it has nothing to do and is not an appropriate treatment option for back pain.

Q. Now, you had mentioned comorbidity. She was a smoker, asthma, obesity. So how does oxycodone, Klonopin, and Xanax affect a person with these types of comorbidities?

A. We're particularly concerned by what I referred to earlier as the polypharmacy, when we start mixing these. When we mix a potent opiate, like oxycodone or Percocet, with a benzodiazepine, whether it's Xanax or Klonopin, that opiate-benzo combo is a red flag polypharmacy. It has a disproportionate sedation associated with it. It will cause respiratory depression, among other things.

But we're particularly concerned in this case about respiratory depression on top of the fact that we know she's respiratory compromised. She's been a pack-a-day smoker for at least 15 years. She's got a history of asthma. I'm going to assume she's got COPD because of that history of smoking. So she's got asthma, COPD, a heavy smoker, and she's obese.

Why are we concerned about obesity? Because her body morphology predicts that she will also have chronic sleep apnea, obstructive sleep apnea. When we sedate our patients, when we oversedate our patients, when we respiratory drive them down with this combination of benzos and opiates, we worsen the sleep

apnea on top of the asthma and COPD, and we kill patients because of respiratory depression.

MR. ANSARI: Can we go to Exhibit 21A, page 6?

Q. I had given you also Norton Hospital records to review; is that correct?

A. Correct.

Q. We've already had someone testify to this. We're not going to get deep into this, but I just want to bring up one thing and ask you a question, and that is: On here it talks about "severe hypothermia. Toxic dose of sedative and narcotic medications could produce this picture."

What is severe hypothermia?

A. Hypothermia is loss of body temperature.

Q. And are benzodiazepines a sedative?

A. They are a sedative, correct.

Q. Okay. So, Doctor, let me ask you this: Were the drugs that Dr. Kudmani gave Ms. Forbes from March 11, 2011, to September 6, 2011, one, for legitimate medical purpose?

A. They were not administered for legitimate medical purpose.

Q. And, two, were they written within the usual course of professional practice?

A. They were not administered within the usual course of medical practice.

MR. ANSARI: Can we go to Count 2, Sommer Stinnett, Exhibit 2, page 4?

Q. She was roughly there for 11 months, but I want to point out on this top part, on September 7th, 2011, "Pelvic pain. Back pain. Hit by ambulance. Adhesion. Percocet. Xanax."

Am I reading that correctly?

A. That's correct, yes.

Q. Now, did this patient exhibit any sort of high-risk behaviors?

A. I'm going to refer to my notebook here just a moment. This is Ms. Stinnett?

Q. Yes, sir.

A. Yes. She had significant high-risk behaviors, the worst of -- well, the most significant of which is the fact that she was under treatment in 2009 for drug addiction. She was being treated in what we call a medication-assisted treatment facility, MAT, with Suboxone. She was participating in a Suboxone treatment program for addiction, and that in and of itself should have been the reason why she should receive no further opiates.

But she had additional risk factors as well. She had a lengthy history of doctor shopping, as shown by the KASPER. She received multiple substances -- multiple substances -- from multiple doctors over a lengthy period of time. And in spite of all of that, she was prescribed what we call a prescriptive speedball by Dr. Kudmani, combination of narcotic plus a stimulant.

Q. And that was the Adipex?
A. That was the Adipex, yes.
Q. Okay. What's Adipex used for?
A. Adipex typically is used for weight reduction. It's an amphetamine-like drug that can help with weight reduction for short periods of time, but we refrain from prescribing it in combination with opiates and benzodiazepines because of the combo upper-and-downer effects that we see.

So when you combine Adipex, in her case, with the Percocet, we get what we call a prescriptive speedball that is sought after by a number of patients -- by a number of individuals who are seeking the drugs for euphoric reasons.

Q. And, again, did Xanax or Adipex go to the initial complaint, which is pelvic pain or back pain?
A. No. None of them effectively or appropriately pharmacologically addressed her diagnoses of pelvic pain, back pain, or adhesions.
Q. From an anesthesiologist's point of view, did Dr. Kudmani ever attempt to treat that alleged back pain?
A. He neither evaluated it nor treated it appropriately.
Q. So were the drugs that Dr. Kudmani gave Ms. Stinnett from March 5th, 2012, to August 15th, 2012, one, for legitimate medical purpose?
A. They were not for a legitimate medical purpose.
Q. And, two, were they written within the usual course of

professional practice?
A. They were not.
MR. ANSARI: Can we go to Count 3, Anna Prewitt, Exhibit 3, page 7, please?
Q. It looks like that date of service of 2/14/11, initial. Dyspareunia and dysme- -- I've already forgotten how to say the term -- dysmenorrhea, what do those mean?
A. Dysmenorrhea is basically a painful menstrual period, and dyspareunia means pain with sex.
Q. And does oxycodone or Klonopin help either of those two issues?
A. No. Those two drugs are not indicated for menstrual pain or sexual-related pain. They have no relationship to them whatsoever.
Q. Did Dr. Kudmani -- and I know sometimes you talk about an exit strategy. Does Dr. Kudmani employ an opiate exit strategy with this patient?
A. No, he does not. And the fact she had been on opiates for some time prior to seeing him -- multiple opiates for a long period of time -- is essentially fulfilling what we are asked to do as physicians if we decide to use opiates to do a trial. She's had her trial. She had her trial for a long time prior. So there was really no legitimate medical reason for Dr. Kudmani to continue prescribing the medications to which she had not responded appropriately to.

Q. Now, we can go through her KASPER. I'm sure you've looked at her KASPER. She had other providers providing her medication; am I right?

A. Yes. She had multiple other providers, yes.

Q. And what's the difference between some of those providers and Dr. Kudmani prescribing?

A. I, of course, haven't reviewed the records for these other prescribers. I haven't -- presumably they're not under investigation. I don't know that.

But certainly it's required when a physician takes on a new patient that the physician do an independent medical exam. In other words, I don't just accept somebody who is sent to me on narcotics and just continue those narcotics. I have to independently examine and come to a diagnosis and determine that that medication may or may not be appropriate.

But we don't have the past medical records, so we don't know exactly what went on or what the rationale was or what the diagnoses were that the previous physicians were using to rationalize the use of opiates.

Q. Well, can a doctor just take a KASPER look back and say, "Hey, Dr. A and B prescribed these same opiates. I can do the same"? Is that okay to do?

A. That's not okay, and that's not standard of care. And, again, at the risk of reemphasizing here, but we are constrained as physicians to do an independent medical exam.

I'm not a vending machine. I mean, that's sometimes the way -- I feel like patients are coming to me, they say, "Hey, look, I want to continue," in her case, "my hydrocodone. I want to continue my clonazepam." I'm not a vending machine. I'm not somebody you put in a quarter, pull the lever, and out comes your drugs.

If you're coming to me as a physician, I will be a physician. We are constrained to be a physician. We are constrained to examine the patient, come to a diagnosis, and appropriately decide what is their treatment option, not just continue de facto. I don't want to be a vending machine. It's inappropriate. It's outside the standard of care to act like that.

Q. So that brings me to the point of Ms. Prewitt. Were the drugs that Dr. Kudmani gave Ms. Prewitt from July 1st, 2011, to August 17th, 2012, one, for legitimate medical purpose?

A. No, they were not.

Q. And were they written within the usual course of professional practice?

A. They were not.

MR. ANSARI: Can we go to Count 4, Corey Reuber, Exhibit 4, page 3, please?

Q. And his initial chief complaint on 10/3, it says, "Had MRI. Showed bulging disk, L5-S1. He'll be seeing orthopaedic surgeon in two weeks. He is in severe pain and through his wife

requested one RX Lortab until he gets in."

Did you see in this patient's file any indication of any other records from an orthopaedic surgeon?

A. No. There were no other records, no workup, no evaluation, no imaging.

Q. Did you see an indication of an MRI in this gentleman's file?

A. There was no MRI in the file.

Q. Well, this one -- let me -- there's an MRI in this file; correct? This is the --

A. Well, not of the back. Well, I'm sorry. Let me -- I just turned to my notes here. There is an MRI of the lumbar spine dated 10/07, so there is -- and that would correlate with this date of 10/3/07.

MR. ANSARI: Can we go to page 6, please?

Q. Is it the standard of care in the medical community for an MRI to have a handwritten patient's name, date of birth, and date at the top of it?

A. That would be suspicious. That would not be standard of care. That would not be acceptable from a -- what we refer to in the clinic as a legal standpoint, but it would not be usual.

MR. ANSARI: What about page 7? Can we go to page 7?

Q. Now, that note referred to the L5-S1. And I guess as an anesthesiologist, you review and send people off for MRIs frequently?

A. Yes.
Q. Can you tell the ladies and gentlemen of the jury what this MRI says?
A. Translating, what this says -- I'll read it verbatim, and then I'll explain it. "At the L5-S1 level, there's a 2-millimeter broad-based disk bulge which appears to just touch but not efface or displace the S1 nerve roots." Then it defines which images that's shown on.

Essentially that's normal. As we age, we sometimes -- I get a lot of patients say, "Well, I'm suffering from disk bulges." Well, welcome to the living. At age 18 we have the most ideal backs, and every year after that we tend to degenerate a little bit. Bulging is a normal part of that degenerative process. A 2-millimeter bulge at L5-S1 -- and L5-S1 is the lowest disk in our spine, so it takes the most weight, it takes the most wear and tear. So we would expect -- we would expect -- we would anticipate there would be bulging.

Is this Mr. Reuber? Is that who it refers to?
Q. This is Count 4, Mr. Reuber.
A. Mr. Reuber is 43 years old. This is actually a very good MRI for somebody -- for a male who is 43 years old. Typically if we live long enough, our L5-S1 disks are going to go away entirely and be bone on bone. This is normal for age. I would look at this, and I would say, "Good job. You've got a healthy back."

Q. So did this individual need opiates?
A. He did not need opiates.
Q. Well, from an anesthesiologist's point of view, then, did Dr. Kudmani do anything to improve his alleged pain in his back?
A. There's no indication, there's no chart documentation that suggests that the pain was improved or the patient's function was improved or the quality of life was improved, which are the three parameters that we look at in pain management to mark and measure progress.
Q. Was it -- the basic practice of medicine, do you see that in this case?
A. This case fails to meet the parameters of the basic practice of medicine. In this particular case, or this particular individual, the care was outside the usual course of medical practice. This is not pain management. This is not medical practice. This is drug dealing.

MR. ANSARI: Can we go to page 2, please?

MR. LAMBERTUS: Your Honor, can we approach the bench for a second?

THE COURT: Uh-huh.

(Bench conference on the record outside the hearing of the jury.)

MR. LAMBERTUS: Judge, I object to that last comment and ask the court to discharge the panel. I think we've been through what we're supposed to say and not say, and I don't

think he's supposed to say -- or any witness is supposed to say -- what is unlawful and what is lawful and things like that.

THE COURT: Meaning --

MR. LAMBERTUS: Calling him a -- yes, sir. I'm sorry. Yes, that's the particular comment. I have not objected to anything else because I don't think it's been objectionable, and he's certainly said some very uncomplimentary things. But to invade the province of the court and the jury in the same remark, and that's what this trial is all about. So that's my objection.

THE COURT: All right. I'm going to overrule your objection.

MR. ANSARI: Thank you, Judge.

(End of bench conference.)

BY MR. ANSARI:

Q. Doctor, you've kind of hit it, but I'm going to just ask you again for the purposes of the jury. The drugs that Dr. Kudmani gave Mr. Reuber from August 1st, 2010, to September 6th, 2012, were they, one, for a legitimate medical purpose?

A. They were not for legitimate medical purpose.

Q. And, two, were they prescribed in the usual course of professional practice?

A. They were not.

MR. ANSARI: Can we look at Count 5, Nicole Phillips, Exhibit 5, page 8?

Q. Specifically at the top we see the first date of service. It looks like, "Manic depressive. On Celexa, Seroquel, and Klonopin. Discharge odor and back pain."

Can you please tell us what Celexa is?

A. Celexa is an antidepressant.

Q. What is Seroquel?

A. Seroquel is also an antidepressant.

Q. What about Klonopin?

A. Klonopin, as we talked, is a benzodiazepine similar to Xanax or Valium. It's what we would call a sedative/hypnotic.

Q. And it looks like Lortab was prescribed on this date. How does Lortab interact with Celexa, Seroquel, and Klonopin?

A. They're all sedating medications, and I can't overemphasize the concern we have as physicians about polypharmacy. When we start mixing potent neuromodulating medications like multiple antidepressants -- in this case, Seroquel plus Celexa plus the long-acting sedative Klonopin, the benzodiazepine -- along with the Lortabs, we've not only got the narcotic-benzo combo that we talked about earlier, but we've got the additional sedation coming from the antidepressant. So that's of concern because of the sedative interactions.

Q. Does Lortab go to the "discharge odor" complaint?

A. No.

Q. And how does Lortab -- she's got a back pain complaint. Why can't you just give Lortab for the back pain?

A. Well, as we discussed, the back pain is actually her chief complaint. It's what she came in and said she was having. She says, "My back hurts."

It's up to me as a physician, it's up to Dr. Kudmani as a physician, to say, "Okay. That's your complaint. Why does your back hurt?" So he has to do an exam, and he has to come up with a diagnosis. Back pain is not a diagnosis. It's a complaint. It's a subjective complaint. It's a chief complaint. But there's no diagnosis.

So we would not give -- and, indeed, the Kentucky Board of Medical Licensure in their rules indicates refrain from just treating functional disorders, as they call it. In other words, if somebody comes in and says, "My back hurts," don't just give them narcotics until you come to an actual diagnosis.

MR. ANSARI: Can we go to page 12, please?

Q. And you've reviewed these. But you see on this page, 2/17, "Purse stolen." Again, 3/8/10, "RX stolen by boyfriend." And then down another line, there's another RX stolen.

Are those what you consider to be risk behaviors?

A. Those are clearly risk behaviors and red flags. In total, she had her drugs, quote, stolen four different times.

Q. Was this patient also on Suboxone at some point?

A. Yes. She's another example of the fact that because she was under treatment for addiction with Suboxone, clearly -- clearly -- controlled substances and narcotics should not have

been prescribed.

MR. ANSARI: And can we go to page 19?

Q. This letter from Our Lady of Peace, what would be the standard of care in the medical community when a physician receives a letter like this from a psychiatric hospital?

A. This is a very well-presented letter from the psychiatric hospital inviting Dr. Kudmani to participate in the care of their patient who is being treated currently for addiction purposes. So if I received this, I would say, "Wow, okay. One of my patients who I'm prescribing to is addicted." So the next thing I would do is I would call the individual here, the mental health worker, and say, "Thank you very much for letting me know. Let's coordinate our care, and I will quit prescribing narcotics going forward."

So the standard of care would be to make a connection with and optimize the care so as to do no harm to the patient.

Q. From an anesthesiologist's point of view, did Dr. Kudmani attempt to treat her alleged back pain?

A. No, he did not.

Q. And were the drugs Dr. Kudmani gave Ms. Phillips from February 17th, 2010, to August 3rd, 2011, one, for legitimate medical purpose?

A. No, they were not.

Q. And, two, written within the usual course of professional practice?

A. They were not.

MR. ANSARI: Can we go to Count 6, Joyce Hook, Exhibit 6, page 6, please?

And can we go to -- I guess we're going to go to page 7 and look at 4/16/08 as the chief complaint.

Q. "Annual physical exam," is that the only notation you see besides some gynecological things going on there?

A. That would be the only indication of what we would call a chief complaint. The reason why they're there would be an annual physical exam.

Q. Is it within the standard of care to provide oxycodone to someone for an annual exam?

A. No, it is not.

Q. And on 4/28, right below that, it says, "Still in pain. Joints and hip." And then it's Klonopin and oxycodone.

Is that the appropriate treatment for joint and hip pain?

A. Klonopin is certainly not indicated. Percocet is likely not indicated, but we don't know because, again, this is just a chief complaint, what we call a functional complaint, by the patient. We have no evaluation, no exam, no documentation. So given this only, the Percocet also is not indicated.

Q. Now, I don't have it here, but Ms. Hook's KASPER -- you went through Ms. Hook's KASPER?

A. Yes, I did.

Q. And it was -- I believe it was all Dr. Kudmani's

prescribing?
A. I'm reviewing it briefly here. Yes. There was no indication it was other than Dr. Kudmani.
Q. And at some point does the Klonopin abruptly stop?
I've got a note that's October 2011.
A. Yes. The last Klonopin was 4/27/11. It was abruptly stopped. She was on a modestly high dose at that point, but it was abruptly stopped, and from there on she received a combination -- I'm sorry. 6/9/11, she -- no. Wait a minute. I take that back. Klonopin -- there are several additional prescriptions of Klonopin. There's an additional one on 6/9/11 and then 10/10/11.
Did you say 10/10/11?
Q. Yes.
A. I'm sorry. I was misreading this.
Yes. At 10/10/11, that was the last prescription for Klonopin. Again, a modestly high dose, and it appeared to have been summarily stopped at that point.
Q. What can happen if you stop someone on Klonopin cold turkey?
A. We have great concern about stopping any of the benzodiazepines like Klonopin or Xanax or Valium cold turkey. Those are the sorts of medication weans that typically would have to be done in a hospital because we worry about convulsions, we worry about death. We can wean down on a lot of medications, but the benzodiazepines are a very dangerous subset

in terms of weaning. We cannot stop safely those medications cold turkey.

Q. So the proper there is to wean her down until she finally is off them?

A. Even I would not wean somebody down on this modest -- relatively high dose of Klonopin. I would get a mental health worker or psychiatrist to do the weaning because of the concern and the individual variability of how patients respond when doing it.

Q. But I guess her KASPER continues to show oxycodone being prescribed all the way, I think, until August or September of 2012?

A. Yeah. She continued receiving Percocet on a regular basis.

Q. And so for the approximately four and a half years she saw Dr. Kudmani, was there any substantiation in the file to show that those Lortabs or Klonopin, for that matter, were for legitimate medical purpose?

A. No.

Q. And were any of those drugs prescribed in the usual course of professional practice?

A. They were not.

MR. ANSARI: Can we go to Count 7, please, Robin Alvey, which is Exhibit 7, page 4?

Q. And the initial date of service, 11/4/09. Again, it looks like, "Diabetic. On insulin. Methadone, 80 milligrams a day,

by Dr. Amin. On Neurontin, methadone."

Dr. Kudmani prescribes Percocet and Xanax. How do Percocet, Xanax, methadone, and Neurontin interact?

A. They're all sedating medications. And as we've talked, there's a significant concern about respiratory depression and death. Percocet is a significant respiratory depressant, Xanax is a significant respiratory depressant, and methadone is of great concern because of its unpredictability and its extreme long-acting half-life. When we put methadone into the equation, it is a major, major red flag with regard to concern of overdose and respiratory depression. Neurontin is a sedative agent as well.

So this combination is a particularly concerning combination of polypharmacy. It's a major safety issue.

Q. And the chief complaint or -- there's no diagnosis. Anything else that would lead to substantiate the need for Xanax and Percocet on this day?

A. There's no indication of a pain complaint here at all.

MR. ANSARI: Can we go to page 12, please?

Q. I won't go through this whole letter, but you've read this letter in the file?

A. Yes.

Q. And this is essentially a letter Dr. Kudmani wrote to a police officer?

A. Oh, yes. Correct.

Q. Can you just -- just general overview, what does it kind of -- to the point, what does it say?
A. Well, it indicates that Dr. Kudmani's rationale for prescribing medication to Ms. Alvey was for back injury and neuropathy and Xanax was prescribed because she had been on it in the past for anxiety attacks, and he indicates that if he had known that she was doctor shopping and receiving medication from multiple doctors that he would have denied the medication and he would have refused to give her Percocet. And he sums by indicating, "As of this minute, she is no longer my patient." And then he signs his name.
Q. And that was August the 18th, 2010. Did you see prescriptions written to Ms. Alvey by Dr. Kudmani after August the 18th, 2010?
A. Five days later he began writing for Percocet and Xanax again.
MR. ANSARI: And can we go to page 5, please?
Q. And on this one it appears that the patient wrote in her medical records. Is that the standard of care in the medical community?
A. No. That would be very unusual to have the patient actually write in the medical record.
Q. And so Dr. Kudmani wrote the officer, says he's no longer prescribing. The patient then writes in here that she admits to falsifying the prescription.

What would be the standard of care in the medical community after these two things occurred?

A. To protect the patient, to do no harm, the standard of care would be to not continue prescribing controlled substances to this patient. One should just not write them. She's just too high a risk. The standard of care would be to stop that medication and perhaps look at other choices of pain management as we previously discussed.

MR. ANSARI: Can we go to page 3?

Q. Did she also exhibit risk factors like her medication being stolen?

A. Yes. Yes, she did. She -- yes, she did.

Q. Specifically based on all of what we've covered on this patient, were the drugs that Dr. Kudmani gave Ms. Alvey from August 23rd, 2010, to July 13th, 2012, one, for legitimate medical purpose?

A. They were not.

Q. And, two, written within the usual course of professional practice?

A. They were not.

MR. ANSARI: Go to Count 8, Michelle Cornwell, Exhibit 8, page 22, please.

Q. It looked like her initial date of service was 6/20/07. She was obviously a long-term patient. She had some surgeries.

Did you note specifically in this patient's file that she

had medical comorbidities?
A. She had several. She was very obese. She was 350 pounds. She was a diabetic. She suffered from hypertension. She was a smoker, a heavy smoker, quote/unquote. I don't know how many a day. She had COPD. She had reactive airway disease. So she had a number of factors that would be of concern to any physician, any reasonable, any prudent physician, prescribing respiratory depressants like narcotics or narcotics plus benzodiazepines.
Q. And did Dr. Kudmani prescribe oxycodone, diazepam, and Xanax at some point during this patient's history?
A. Yes.
Q. And how do those three drugs interact with those comorbidities you spoke about?
A. As we've previously discussed, they're significant respiratory depressants, so that polypharmacy of narcotic plus sedative/hypnotics, benzodiazepines, would be expected to depress respiration and facilitate death.
MR. ANSARI: Can we go to page 15, please?
Q. Lower left-hand corner, it says, "Police report." Is that one of those risk behaviors you talked about?
A. Yes.
Q. On page 17 there's a letter from Anthem in here. What is this letter? What's the purpose of this letter?
A. Typically if the insurance carrier notices concerns

regarding the prescription or the polypharmacy that's being administered to a patient, if it goes on for a while, they'll notify the doctor to make sure the doctor is aware that some potentially bad things are about to happen. This is a letter from Anthem indicating that this individual was taking Valium, or diazepam, for insomnia for a chronic time frame and that's inappropriate and also indicated that this patient was taking gabapentin and expressed the reasonable concern that gabapentin increases the risk of suicidal thoughts and suicidal behaviors, and the form asks Dr. Kudmani to respond accordingly.

Q. Did Dr. Kudmani respond?

A. He checked the box which says, in both cases, "Patient will not likely comply with this suggestion."

Q. Now, were the drugs that Dr. Kudmani gave Ms. Cornwell from August 26th, 2011, to February 20th, 2012, one, for legitimate medical purpose?

A. They were not.

Q. And, two, written within the usual course of professional practice?

A. They were not.

MR. ANSARI: Can we go to Count 9, Terri Keith? And that's Exhibit 9, page 24.

Q. And, Doctor, you've reviewed this file, and I think we can all agree that she's had multiple back surgeries; am I correct?

A. That's correct.

Q. Elbow surgery?
A. We assume that's correct. We don't have any past medical records delineating it, but Dr. Kudmani puts it in the record several times.
Q. He also noted some knee surgery and tubal ligation and a hysterectomy and gallbladder. Multiple surgeries, long-time patient. Shouldn't this patient be receiving opiates?
A. The case has not been made for a chronic pain condition that would reasonably be expected to respond to opiates. In other words, based on the fact that somebody's had multiple back operations, we can't automatically assume that chronic pain exists.

Any given time today there are hundreds of patients across the country who are having back operations, and the vast, vast majority of them are not going to have chronic pain problems. Some of them will be having their second or third operation, but that in and of itself does not make the case to use opiates. So what we have to do is examine the patient and determine whether or not there is an issue there that would be appropriately treated with opiates.

So the pain condition here has not been defined is what I'm saying. The fact that she has a history of back operation does not in and of itself make her a reasonable candidate for opiates.
Q. Were there any sort of historical records in there from

these other physicians or these other surgeries?
A. There were no past medical records in the chart.
Q. At some point Soma and oxycodone is prescribed by Dr. Kudmani. How does Soma and oxycodone interact with each other?
A. Dr. Kudmani completes the medications necessary for what we call the holy trinity. You may have heard about that before. But the holy trinity is the combination of a narcotic, usually hydrocodone or Percocet, plus a benzodiazepine, usually Xanax but it could be Klonopin, with Soma. Soma tends to be the anchoring medication of those three. Soma is a muscle relaxant that's highly addictive and was abused and fairly popular multiple decades ago. It really does not have a legitimate medical use during this time frame in today's world.
But the combination of the narcotic plus the benzodiazepine plus the addictive medication Soma is what we call the holy trinity, is highly sought after on the streets and by addicted individuals. Because until heroin was as available as it is today, that combo, the holy trinity, was known for its heroin-like effects, its heroin-like euphoric effects. So we kind of looked at it as a heroin-type combination and as a result did not prescribe it and were always very careful to make sure that we were perhaps not one participant in prescribing the medication the patient needed to complete the holy trinity.
MR. ANSARI: Can we go to page 41, please?

Q. And you've seen this letter; am I correct?
A. Yes.
Q. Okay.
MR. ANSARI: Can we go to page 42?
Q. I won't go back through this letter. We've seen it a couple times specifically. But when you -- when a physician receives a letter like this from a family member, what's the standard of care in the medical community when you receive something like this?
A. If we get a third-party notification of concern about a patient's drug usage -- in this case it came from her sister -- we pay a great deal of attention to that. We pay a great deal of attention to that. It could come from other sources, of course, but in this case it came from a close family member. It was typed, it was well presented, it was well written, and it left her name and her number and her address, her home phone, her cell phone.
The standard of care would be to contact this individual or at least acknowledge that there is a concern with regard to medication abuse or possible diversion going on and to discuss with the patient what her take on it is, but it is definitely something to be acted on. It is a red flag that we pay particular attention to if it's coming from a family member and presented in as formal a manner as this was.
MR. ANSARI: Can we go to page 43, please?

Q. Another letter from the sister. Same question.
A. Same question. The sister was obviously concerned in this letter about the fact that the patient might forge her signature, and so this letter was well written to Dr. Kudmani saying, I'm not giving you -- "I'm not giving my permission for my sister to proceed with my approval at all. Just letting you know." So, again, well presented and should be paid attention to by the doctor.

MR. ANSARI: Can we go to page 13, please?

Q. July the 1st, 2009, it states, "Jennifer Reynolds, Terri's daughter, agrees to administer her pain medications."

At this point, if her daughter takes over the administration of that pain medication, does that relieve Dr. Kudmani of his responsibility to monitor his patient?
A. No, not at all. Dr. Kudmani is still required to monitor the patient for compliance and response.
Q. Does it relieve him of any of his duties if he has a daughter who's a nurse prescribe medication -- or administer the medication for eight, nine months?
A. No, no. It does not relieve him at all. In the end, as we discussed, universal precautions are required of all of us as we do this, and we can at no time ignore red flags or other conditions. We still, as physicians, maintain the responsibility to exercise due diligence.

MR. ANSARI: Can we go to page 38, please?

Q. And this letter is showing adult treatment services, chemical dependency aftercare, NA meetings from Jewish Hospital in Dr. Kudmani's file. What is the standard of care when a physician receives a letter like this?

A. Dr. Kudmani should have been aware and I'm pretty sure was aware of the fact that Ms. Keith had significant mental health abuse and overdose issues in her history. This confirms that yet again, and it indicates that she's attending or hopefully going to be attending Narcotics Anonymous.

If I was the prescribing physician -- and standard of care would dictate that -- I look at the medications to make sure I'm doing no harm. He was doing harm. He continued to maintain the medications in spite of the fact that she had OD'd several times, she had abused her medications, and was unlikely to change that behavior going forward. Standard of care would be to stop the medications.

MR. ANSARI: Can we please go to Exhibit 20C, page 1115?

And kind of blow up the top half, "Reason for Admissions."

Q. And so this talks about her. It says, "Hospitalized after 9/2009 after a suicide attempt. This was her third attempt. The patient has a history of major depression; dysthymia, recurrent, severe; polysubstance abuse, dependent on pain medication."

Essentially how do these reasons for admission -- how is

Soma and opiates -- how do they affect these reasons for admissions, her co-mental health morbidities, I guess?

A. She's addicted, and she's overdosed. She's tried to commit suicide. Soma, as we've talked about, is a very addictive sedative and respiratory depressant which when combined with her benzodiazepine plus narcotic gives her an effect like heroin.

We can't give these. We can't give these medications to people who have this sort of demonstrated history. That's outside the standard of care.

We also are aware, as I indicated earlier, that our opiates have other side effects, including worsening of depression. Worsening of depression. It tends towards panic attacks and causes mood instability.

So when we give her narcotics, when we give her benzos, when we give her Somas, it makes her problem worse. Specifically she already has a diagnosis of severe, recurrent dysthymia, which is a mood, depression-type disorder, and she's been hospitalized about it. We're essentially throwing gasoline on the fire. I don't know how else to say it. We're throwing gasoline on the fire.

MR. ANSARI: Can we go to page 1157, please?

This is -- I need 1157. Sorry.

Q. "Patient was able to hear. Appears concerned. Patient was defensive about her pain pills from her doctor due to her severe pain. Patient reported that her drug of choice were Soma, Xanax

pills, and she is taking pain pills. Can lead her right back to her drug of choice, which is not very removed from what she is doing."

Is this what you're -- is this also what you're talking about with the adding gasoline to fire?

A. It's -- yes. It's unreasonable to assume that her behavior is going to change. We like to think that, but multiple examples have shown that it's not. It's unreasonable to continue treating her with the same things that she's been receiving and have gotten her into trouble on a repeated basis.

Q. And so these are documented by Our Lady of Peace. Is that showing that they acknowledge the concern?

A. They acknowledge the concern.

MR. ANSARI: Can we go to page 1214, please?

Q. And can you just explain what this is and interpret it for us, please?

A. This is a list of medications that the patient was on as she was discharged from the hospital. Of course, in this case it's Terri Keith. She was discharged on the antidepressant Wellbutrin as well as Neurontin and the benzodiazepine Klonopin. She was also discharged with the understanding that her primary care doctor was providing Topamax; hydrocodone, the narcotic; and Detrol.

Q. Does it look like Our Lady of Peace was weaning her down off of some of her narcotics?

A. Yes. I went back and reviewed her course prior to this. She actually came in on a fairly high dose of Percocet, so they weaned her off the Percocet and are discharging her on a lower dose and a less potent medication, hydrocodone. Still significant, but, yes, they did wean her down significantly. Additionally, they have decreased the amount of Klonopin that she was taking. Wait a minute. I'm not sure about the Klonopin on that.

But they definitely attempted to wean her down on the narcotic. They stopped the oxycodone, the Percocets, altogether.

Q. What about the Soma? Did they discontinue the Soma?

A. By virtue of the fact that it's not listed here, I presume they stopped the Soma altogether, which would be entirely appropriate.

Q. And they had her for -- I think we saw on the discharge summary they had had her for a few weeks?

A. Many weeks, yes.

Q. All right. And obviously Dr. Kudmani had received a letter from Jewish. So these records weren't hidden from him; am I right?

A. No, they were not hidden from him. It would be standard of care for the physician to receive copies of the summary discharge.

Q. Now, were there any drug risk behaviors noted in Ms. Keith's

file?
A. There were a lot of drug risk behaviors. Do you want me to just list them in rapid fashion here?
Q. Yes, sir.
A. But very critically, first of all, she had a history of doctor shopping, extensive doctor shopping. She had a history of holy trinity combinations with different narcotics but still holy trinity combos.
At one point she tested positive for methamphetamine. When asked about that later, to explain it she indicated she didn't mean to take it, she thought it was cocaine. So there's that concern. There's at least one urine drug screen that was done that was negative for benzodiazepines. Benzodiazepines didn't show up, and she was supposed to be on them. So it was an inconsistent urine drug test.
Additionally, she was hospitalized multiple times. And I won't go through the dates and the specifics, but she was hospitalized for polysubstance overdose, depression and overdose. She was involuntarily held psychiatrically for overdose. She was admitted again for overdose, depression, and suicide ideation. And she was admitted for her third suicide attempt, which we just saw here, which also included diagnoses of depression and polysubstance abuse.
So she has a very, very unfortunate, very bad history of abusing drugs and of mental health issues. And, again, as we

talked, those two are tightly entwined. So we've got multiple red flags, multiple risk factors.

In addition to that, she also has a history of alcohol abuse, and she comes from -- and a history that finally came out in the chart that she was -- as an unfortunate recognition of our society today, she was abused as an adolescent female, which explains to a great deal why she had lifestyle choices that turned out to be the way they are.

But those are all red flags, all risk factors that any prudent, any reasonable physician would look at and say, "No controlled substances at all."

Q. So was it within the standard of care to prescribe Soma and opiates to someone with these mental health issues?

A. It was egregiously outside the standard of care.

Q. Do you know people who have died from pain?

A. No one has died from pain.

Q. Do people die from addiction?

A. People definitely die from addiction.

Q. What's more important to treat, the addiction or the pain?

A. We can treat them both. We can't cure them. We're not sure we can cure addiction, we're not sure we can cure pain, but we can treat them both simultaneously without aggravating the other.

Q. And can you tell me what happens on -- it's page 14. May the 3rd, 2010, were there again opiates and Klonopin prescribed?

A. We are talking about Ms. Keith?
Q. Yes. And I'm sorry. I'm at page 14, Exhibit 9.
A. I'm sorry. Would you repeat the question?
Q. Yes. What occurs on this day?
A. Yeah. On this day she comes in complaining of -- "CO," complains of -- pelvic pain, anxiety -- anxiety attacks. On Wellbutrin. It has the one blood pressure that I saw in the chart. Breasts is normal limit. Mammogram ordered. UA, urinalysis, negative. Pap, wet, negative. I assume he did a Pap smear. TVS, vaginal sonogram, negative. And prescribes Klonopin three times a day, which is a pretty hefty dose, and Percocet 10 -- Percocet 10 milligrams is the high-potency Percocet -- three times a day -- I'm sorry, four times a day.
Q. And it's not in this record, but the KASPER -- like a week before this, did he also prescribe Soma?
A. That's correct.
Q. So now is he prescribing the three-drug cocktail you talked about?
A. He continues -- even after her discharge from the hospital as we noted there where Soma was stopped, he continues to prescribe the Soma. So she continues to receive the holy trinity cocktail.
Q. Now, we know from past testimony and all the KASPERs and the records we just saw that Klonopin was prescribed for long periods of time by Dr. Chhibber; am I right?

A. That's correct.
Q. And so why can't Dr. Kudmani -- well, let me put it this way: Did Dr. Kudmani ever prescribe Klonopin to this patient before this date?
A. Before this date, no. This appears to be the first time that Dr. Kudmani prescribed the Klonopin.
Q. Why can't Dr. Kudmani, then, just continue what Dr. Chhibber's already done?
A. As we've discussed, if one physician is going to take over the prescribing or the treatment of any sort of another physician, an independent medical assessment must be done. At the very least I would expect a conversation between her psychiatry doctor, Dr. Chhibber, and Dr. Kudmani as to -- you know, and this question is asked to me fairly frequently. If I'm prescribing some medications for a patient and the family doctor or sometimes even the psychiatrist says, "Look, the patient's stable. Why don't you take over all the medications?" I'll examine it, I'll see if it's appropriate, and I may assume those medications.

So sometimes it occurs that one doctor to prescribe all the medications is appropriate, but that would have to be a documented conversation, which it's not. It would have to be based on an independent medical evaluation by Dr. Kudmani that in this case Klonopin was appropriate, and that's not here. So in the end we shrug our shoulders, and we say, "I don't know why

the Klonopin was suddenly picked up by Dr. Kudmani to complete the holy trinity combo."

Q. Now, they're not listed in the records that we've seen today either in Our Lady of Peace or on the KASPERs, but we saw in some insurance records prior to today that she had also filled trazodone and gabapentin on May the 3rd, written by Dr. Chhibber.

Can you explain what trazodone and gabapentin are?

A. We talked a little bit earlier. Trazodone is an antidepressant, and gabapentin in our world is used for treatment of nerve pain. It's technically an anti-epileptic medicine, but we use it for chronic sciatica or neuropathy. So the combination of trazodone and gabapentin that was previously prescribed would have been presumably for nerve pain and depression treatment.

Q. And I also provided you with the autopsy of Terri Keith?

A. Yes.

Q. Okay. And I guess the lab results. So did the M.E. conclude that this person died of opiates and benzodiazepines?

A. He concluded that she died of benzodiazepines and opiates, and I concur with that conclusion.

Q. Now, from an anesthesiologist's point of view, did Dr. Kudmani ever attempt to treat her back pain?

A. No, he did not.

Q. Did he improve her quality of life?

A. He did not.
Q. Were the drugs that Dr. Kudmani gave Ms. Keith from July 29th, 2009, to May 3rd, 2010, one, for legitimate medical purpose?
A. They were not.
Q. And, two, written within the usual course of professional practice?
A. They were not.
MR. ANSARI: Can we go to Count 10, Samantha Green, Exhibit 10, page 24?
Q. Did you note -- and I brought this up only because she's a long-term patient. This is 1990, and obviously she goes all the way to 2012. In her file did you note drug risk behaviors for her?
A. Yes. There were multiple drug risk behaviors.
Q. What were those?
A. She was overusing her medications. There are several behavioral things that we look for when we start prescribing. We look for overuse of the medications, and she was overusing. We look for early refills, and she was early refilling. We look for early out medications, and she was early out. We look for doctor shopping behaviors, and she was doctor shopping.
So essentially she hit all the high points of abuse and diversion behavior that we, again, are called upon to be diligent for. She displayed that.

Q. Did he -- did Dr. Kudmani employ an exit strategy for opiates since he had prescribed for so many years opiates?
A. No, he did not. He kept prescribing.
MR. ANSARI: Can we go to page 8, please?
Q. There's a notation on June the 1st, 2011, "Patient was in car accident. Neck pain. Thoracic/lumbar pain."
Did you note any sort of objective testing -- x-rays, MRIs, CT scans -- in this patient's file?
A. No. There were none.
Q. Did you note any other type of medical records from any other providers regarding this alleged car accident?
A. There were none.
Q. And so I ask you: Were the drugs that Dr. Kudmani gave Ms. Green from December 30th, 2011, to August 22nd, 2012, one, for legitimate medical purpose?
A. No, they weren't.
Q. And, two, within the usual course of professional practice?
A. They were not.
MR. ANSARI: Can we go to Count 11, Amber Donahue? And that's Exhibit 11, page 5.
Q. And her -- looks like her initial date of service was 8/26/09. "Pelvic adhesion," and then it looks like "dyspareunia" maybe.
MR. ANSARI: Can we go to page 3?
Q. And there's a note in here about "my own father, Steve

Donahue, has accused me of selling my medication, which is a false statement. Refill at Cox early. Only this time." And then again the next time, "Call Cox. Donahue refill."

What would be the standard of care in the medical community when someone's father comes in and accuses you of stealing -- or, I mean, selling your medication?

A. I must admit, when I read this, I found this highly unusual. First, as we've talked, the patient wrote the note and signed it in the medical chart, which is pretty unusual in and of itself. But the larger question is, Why did it come up? You know, I don't know why it's in here, because there's no other entry here that would suggest that, you know, this was an issue.

But certainly if it came up in discussion -- and it obviously did or it wouldn't be written in this manner in the chart. If the patient -- again, third party indicating that there was abuse or diversion going on, I would certainly have a more in-depth review of the situation. I would certainly look at the KASPER. I would certainly stop early refills and would think seriously about stopping the medication altogether.

In this case there was never a legitimate diagnosis put together, so the medications in this case, as in frankly all the others, should never have had narcotics started. But certainly at this point I would have -- the standard of care would indicate that they would be stopped.

Q. And so were the drugs that Dr. Kudmani gave Ms. Donahue from

September 2nd, 2011, to September 30th, 2012, one, for legitimate medical purpose?

A. No.

Q. And, two, written within the usual course of professional practice?

A. No.

MR. ANSARI: Can we go to Count 12, Brandy Casanova? That's Exhibit 12, page 3.

Q. Initial date of 10/28/11. It says, "Valium by Ten Broeck. Pelvic pain, dyspareunia, and dysmenorrhea." And then he prescribes Norco.

So what is Valium?

A. Valium is a sister drug to Xanax and to Klonopin, so it's in the sedative/hypnotic class of benzodiazepines that we've spoken of.

Q. And Dr. Kudmani on that date prescribes, I'm sorry, hydrocodone and -- Norco, hydrocodone, and Xanax. How does hydrocodone, Xanax, and Valium all work together?

A. As we've discussed, they're all very potent respiratory depressants. They work together to present a certain euphoria, a popular polypharmacy if the individual is looking for euphoric or high effect from the medication.

MR. ANSARI: If we go to page 5, please.

Q. And this obviously is a letter from the Methadone/Opiate Rehabilitation and Education Center here in Louisville. As

well, it says, "She is pregnant. Our recommendation is continued methadone maintenance along with ongoing counseling. We are aware that she has received regular prescriptions from you for both opiates as well as benzodiazepines. These would be dangerous and contraindicated, and we ask that you no longer prescribe for her."

Did you note in the patient's file and the pharmacy records and KASPER that Dr. Kudmani actually did continue to write opiates and benzodiazepines after being warned by Dr. Jorrisch?

A. Incredibly he continued to prescribe hydrocodone and Xanax despite this letter.

Q. And if she's on methadone, how dangerous is hydrocodone, Xanax, and methadone at the same time?

A. Methadone is an unpredictable drug, particularly when put together with other controlled substances such as the benzodiazepines. There's a disproportionate death and respiratory depression that results when we combine methadone with Valium or any benzo. It is highly dangerous. It is highly dangerous not only to add the benzo to the methadone but also to add an additional narcotic, that is to say Norco.

Q. Was there a -- you know, the complaint that she gave, any diagnosis or anything to substantiate the need for the benzodiazepines and the opiates to be given to her?

A. Her chief complaints were all regarding pelvic pain, pain with intercourse, pain with menstrual periods. There was

nothing to suggest an objective or reasonable diagnosis for pain to be treated with any kind of narcotics.

Q. So I ask you: Were the drugs that Dr. Kudmani gave Ms. Casanova from October 28th, 2011, to August 15th, 2012, one, for a legitimate medical purpose?

A. No.

Q. And, two, written within the usual course of professional practice?

A. No.

MR. ANSARI: Go to Count 13, Angela Morgan, which is Exhibit 13, Page 4.

THE COURT: Let's take a 15-minute break before we go there. Been at it for about two hours.

Ladies and gentlemen, don't make up your mind about this case. Don't discuss it with anybody. We'll be back.

(Jury left the courtroom at 12:58 p.m.)

(Recess at 12:58 p.m. until 1:21 p.m. Jury present.)

BY MR. ANSARI:

Q. Doctor, we're going to talk about Count 13, Angela Morgan, which is Exhibit 13, page 4. 11/13/09 is the initial appearance. Her chief complaint, "Has been on Lortab, Xanax for anxiety attack, and scoliosis by Dr. Allen."

Is that the chief complaint that you get out of that?

A. It could be construed to be the chief complaint, yes.

Q. Okay. How does -- I guess on 3/19, "Still hurting, back."

Should this person have received the Lortab and Xanax on 11/13/09?

A. No. There was no foundation to begin or continue the prescription of opiates.

MR. ANSARI: Could we go to page 10, please?

Q. We have another letter from Dr. Jorrisch from the MORE Clinic. Here she'll be -- or, "Here she will receive methadone maintenance along with ongoing counseling. We are aware that she has received prescriptions from you, including both hydrocodone, alprazolam. These would be contraindicated and dangerous with her current treatment. The patient has been informed as not to seek these prescriptions from you. She has been cautioned about the dangers of benzodiazepine withdrawal and is to seek medical help if this becomes a more significant problem."

So, again, I ask the same question. After October 11th, 2011, did you see that Dr. Kudmani prescribed opiates and benzodiazepines again?

A. Yes. He continued prescribing opioids and benzodiazepines as soon as two weeks after this letter.

Q. And how dangerous is it to take hydrocodone, Xanax, and methadone together?

A. Very dangerous. As we discussed, methadone has unpredictable effects, and to mix that specifically with alprazolam or Xanax and then to add an additional hydrocodone or

opiate to that is extremely dangerous.
Q. What's the standard of care in the medical community when a doctor receives a letter from the methadone maintenance clinic from another physician warning him of prescribing?
A. This is pretty pointed. If I read this, if any reasonable, if any prudent physician read this, he would stop prescribing immediately. And it would call for, I think, reasonably a contact to acknowledge, yes, I received this and, yes, I agree and I will not prescribe any further.
Q. What happens if Ms. Morgan came in and told Dr. Kudmani, "Hey, I'm no longer enrolled in the methadone clinic. You can continue to prescribe to me"? What would a doctor do in that situation?
A. Well, that scenario would be outside the usual practice of medicine if he decided to continue prescribing. So regardless of whether she elected to stay in or not in the program, she essentially has admitted that she has an addiction issue. So regardless of whether she stayed in the program, Dr. Kudmani would not be within standard of care to continue to prescribe controlled substances to an addict.
Q. Were the drugs Dr. Kudmani gave Ms. Morgan from March 9th, 2011, to September 5th, 2012, one, for legitimate medical purpose?
A. No.
Q. And, two, written within the usual course of professional

practice?
A. No.
MR. ANSARI: Go to Count 14, Jessica Dichiara, and that's Exhibit 14, page 13.
Q. She has -- she'd been there for a while. She had, I guess, some history of hysterectomies and other surgeries.
Did you note specifically any drug risk behaviors with this patient?
A. Yes. Specifically, she, like so many of the others, had on KASPER an indication of doctor shopping. So she had been seeking from multiple providers multiple medications, and that was evident on KASPER. Additionally, she was prescribed the holy trinity combination again, which, as we've talked about, produces a heroin-like effect, which is very dangerous, very euphoric, and not medically indicated.
MR. ANSARI: Now, can we go to page 33?
Q. This is another letter from Our Lady of Peace. Would this also be one of the risk behaviors, drug risk behaviors?
A. Yes. This would be an indication that this particular patient was being treated for drug abuse and addiction issues, and, of course, it would be a very significant red flag that in and of itself would certainly speak towards the cessation of continued prescription of controlled substances by Dr. Kudmani.
MR. ANSARI: Can we go to page 34, please?
Q. Another letter from another psychiatric institution, slash,

rehab. Would this also be a risk behavior?
A. Yes. Her primary reason for hospitalization, as we see there, is unstable mood and anxiety. And as we have so often talked here this morning, the treatment of major depression or, as it puts -- it also has here PTSD. To treat an individual with particularly the holy trinity combination, an individual suffering from major depression and PTSD and unstable mood, would be clearly outside the standard of care.
Q. At the bottom it shows discharged February 3rd, 2011.
MR. ANSARI: Can we go to page 27, please?
Q. Is there a narcotic prescription written after February 3rd, 2011?
A. Yes. There's prescriptions written for this -- indicates there are prescriptions written for Xanax and Lortab.
Q. It looks like Xanax was before that, but the Lortab was after?
On this --
A. Yes, correct.
Q. On this one. We're going to see in a minute that you are correct.
Does this appear to be -- in the notes in the records, does this appear to be the last prescription in the medical record written but not actually prescribed?
A. That's correct.
Q. So if we go to Exhibit 12B, which is the pharmacy records --

MR. ANSARI: I'm sorry. This is the -- I meant 14B.
Q. -- we see numerous dates where alprazolam and hydrocodone are written after that February 5th, 2011, date but do not appear in Dr. Kudmani's patient file; am I correct?
A. That's correct. Medications are prescribed without any apparent exam or entry into the patient record.
Q. And so I'll ask you: Were the drugs that Dr. Kudmani gave Ms. Dichiara from February 5th, 2011, to July 4th, 2011, one, for legitimate medical purpose?
A. No.
Q. And, two, written in the usual course of professional practice?
A. No.
MR. ANSARI: Count 15, Janis Sulzer, Exhibit 15, page 107.
Q. This kind of sets the date, December the 8th, 2006. She was a long-term patient. But I'm going to jump to page 48, and this is a letter from a urologist. I assume you've read this in the patient file?
A. Yes.
Q. And essentially, "She is inappropriate in her complaints of pain and request for pain medication. I explained to her that we will not prescribe her narcotics unless an obstruction stone can be demonstrated. She and her sister were found to be rummaging through the drawers and cabinets in the exam room as

they were waiting for my evaluation. I explained to her that she may require multiple ESWL treatments in order to render her stone-free. She was demanding and unhappy with my explanation. We will schedule a procedure in the near future."

Now, this is dated February 21st, 2007. Do you see that Dr. Kudmani prescribed to her after this date?

A. Yes. He continued to prescribe controlled substances and narcotics.

Q. And what would be the standard of care in the medical community when you receive a letter like this from a specialist?

A. As we've indicated previously, this is a third-party observation, direct observation, from a physician colleague. I would take this very seriously, any prudent physician would take this very seriously, and consider stopping all opiates, particularly since there was not a foundation to begin them initially.

MR. ANSARI: And can we go to page 65, please?

Q. There's a note in the upper right here. It says, "On home incarceration."

Would that also be one of your risk behavior factors you look at?

A. That would be -- yes. It would be behavioral indication that perhaps this individual cannot be trusted to use the medications in a responsible manner.

Q. Do you note any other type of risk behaviors with this

patient?
A. There were several. She had a history of seizures of unknown origin, and one has to consider that the seizures might have been related, as we talked about, with regard to variable use of drugs. As we've talked, the benzodiazepines sometimes can cause seizures. We often statistically see people having seizures if they're inappropriately using controlled substances. So that would be a risk factor we would look at and question as to whether that was suggesting inappropriate use.
Additionally, she was doctor shopping as well. The record, the KASPER record, shows doctor shopping behavior for oxycodone, hydrocodone, codeine.
Q. Did she also have overdoses at hospitals?
A. She was admitted for overdose on Xanax and Lortab two days after last having been prescribed them by Dr. Kudmani.
Q. And so I ask you: Were the drugs that Dr. Kudmani gave Ms. Sulzer from September 7th, 2011, to April 6, 2012, one, for legitimate medical purpose?
A. They were not.
Q. And, two, written within the usual course of professional practice?
A. They were not.
MR. ANSARI: Go to Count 17, Tonya Woolsey, Exhibit 17, page 12.
Q. Roughly her first visit, 4/23/2010. She had said, I guess

up here, "Back surgery. Fusion T2-T12. Lortab. Xanax." Then complaint, "Pelvic pain, dyspareunia, and dysmenorrhea." And then Dr. Kudmani prescribed Lortab and Xanax on that date.

On your review of the file, did you ever see where there was any sort of medical documentation for the back surgery?

A. No. There was no imaging, past medical records, or other documentation.

MR. ANSARI: Now, can we go to page 11, please?

Q. On 3/18/11, it says, "Admitted herself to Lady of Peace." We've been seeing those letters from Our Lady of Peace. "She is allowed to take Lortab."

Is that standard of care in the medical community, for a patient to tell you what you can and cannot take?

A. No. As we discussed earlier, this individual obviously has some drug abuse issues and may be addicted. But certainly because of the whole addiction and drug abuse scenario, we cannot take her word for it. It would need to be independently verified. Therefore, it's not appropriate, it's not within the standard of care to simply accept without verification that she is continuing to take her Lortab with their approval. That would be highly irregular and unusual.

Q. And the next entry down, 8/8/11, it states, "On Seroquel, trazodone from Lady of Peace." And then he gave her Lortab on that day.

Again, is there any sort of chief complaint or diagnosis to

substantiate the need for Lortab on any of these days?
A. No. There's no legitimate diagnosis that would support the use of Lortab.
Q. And as it indicates, since she's on Seroquel and trazodone from Our Lady of Peace, there may be some mental health issues?
A. Yes.
Q. Was there any sort of documentation where there was a conversation between Our Lady of Peace and Dr. Kudmani?
A. No. Except for this one entry, there's no indication that Dr. Kudmani followed up, explored, or interviewed the patient or tried to secure past medical records. There was nothing further. He did not follow up on it.
Q. Were the drugs that Dr. Kudmani gave Ms. Woolsey from March 31st, 2011, to September 3rd, 2012, one, for legitimate medical purpose?
A. No, they were not.
Q. And, two, written within the usual course of professional practice?
A. No.
MR. ANSARI: Can we go to Count 18, Amanda Fehribach? And it's Exhibit 18, page 18.
Q. It looks like April 21st was her initial visit. Did you notice any drug risk behaviors with this patient?
A. She had been on opiates and benzodiazepines for quite some time prior to Dr. Kudmani with no improvement. Additionally,

she -- as we learned, she had a long-standing history of opiate abuse that apparently began when she broke her collarbone at age 27. She was age 31 at this presentation, I believe. But historically that was not followed up on or examined or inquired about by Dr. Kudmani as it should have been.

MR. ANSARI: Now, can we go to Exhibit 18I, page 2?

Q. Did I supply you with these records from the hospital?

A. Yes, you did.

Q. And can you -- this is the discharge summary. Can you just briefly explain what this is?

A. The key issue here in terms of discharge medications indicates on Number 4 there that she's Suboxone weaning, which indicates that, as indicated in the brief history, she has a long-standing history of opiate abuse and presented to the hospital in acute withdrawal. So she was at some point started on Suboxone because of her addiction. Based on this, one assumes reasonably that she has a true medical diagnosis of addiction and is being weaned off the Suboxone as she is discharged to home. She is also instructed to follow up with Narcotics Anonymous.

Q. Now, this is September of 2012. This is roughly the time where Dr. Kudmani stops practicing; am I correct?

A. I'm sorry. Was that a question?

Q. Yes.

A. Yes, that's correct.

Q. Okay. So I ask you: Were the drugs that Dr. Kudmani gave Ms. Fehribach from December 31st, 2010, to August 29th, 2012, one, for legitimate medical purpose?

A. No.

Q. And, two, written within the usual course of professional practice?

A. They were not.

MR. ANSARI: Can we go to Count 19, Lindsay Panter? And that's Exhibit 19, page 21.

And let me start on page 20. I'm sorry. That's the initial date, but let me go to page 20.

Q. There's a reference here to "stolen RXs" and "police report obtained." Did you note risk factors or behaviors with this patient?

A. Yes, and that clearly is one of them. There were additional ones in terms of the context in which the pills were stolen. It was in the context of being with her boyfriend negotiating for purchase of ecstasy, and it was during that time frame that the pills were apparently stolen out of her purse. The social aspects of this suggests that we're dealing with more of an abuse issue as opposed to a legitimate pain issue.

Q. And so also -- and based on your review of the records, was there any medical indication for the need of these long-lasting and potent narcotics?

A. No. There was no indication that they were being prescribed

for a legitimate medical purpose.
Q. So were the drugs that Dr. Kudmani gave Ms. Panter from June 13th, 2011, to August 31st, 2012, one, for legitimate medical purpose?
A. No.
Q. And, two, written in the usual course of professional practice?
A. No.
Q. Let me get into just a few general questions. Do most medical practices charge patients cash?
A. It would be unusual. It would not be the usual way of doing medical practice to charge cash. Most people have insurances. There are times, of course, when we as a medical office collect a co-pay, but that would be typically the extent of the actual cash collection.
Q. Is it the standard of care in the medical community to charge a patient cash for simply picking up a prescription?
A. No. That would be definitely outside the standard of care. We charge for being a physician, for doing an examination, for coming to a diagnosis, and putting together a treatment plan, but per se we do not charge for writing a prescription. That would be inappropriate and outside the standard of care.
Q. Do most medical practices deposit their cash intake in a business bank account?
A. Typically, yes.

Q. From your review of all the records, did it ever appear that Dr. Kudmani attempted to get to the root cause of any of these patients' underlying complaints?

A. There was no indication that he did. There was no indication that he was practicing legitimate medicine in the manner that I described earlier in terms of doing an examination and coming up with a legitimate diagnosis.

Q. Well, from your review of the patient medical records and the photographs that we've went through here today, does it appear that Dr. Kudmani was actually practicing medicine?

A. I would have to conclude that after reviewing the photographs of the office, after reviewing the reports, after reviewing the medical records that Dr. Kudmani was not practicing what we would interpret as legitimate medicine. He was not making a diagnosis. He was not examining the patients. He was not formulating an individualized treatment plan. He was not monitoring the treatment of the patient for outcome or compliance. He simply was not practicing medicine.

His office did not appear in the form that we would all expect a medical office to present as. There were significant issues with regard to his disorganization of the medical office. That was reflected in the disorganization and the lack of standard documentation in the chart and his complete lack of acting like a physician and discharging the duties of a physician.

I do not see that he was acting under the auspices of being a legitimate physician or a legitimate medical practice.

MR. ANSARI: Thank you very much, sir. I appreciate it.

THE COURT: Okay. Mr. Lambertus?

MR. LAMBERTUS: Thank you, Judge.

CROSS-EXAMINATION

BY MR. LAMBERTUS:

Q. Dr. King, I assure you I won't go through everything. I just want to go through some things with you to make it clear in my mind and maybe the jury's mind.

First of all, sir, you are a -- correct me if I'm wrong. You have your own medical-legal company for analyzing cases and expert testimony; is that right?

A. I operate separate from our clinic. There's a separate corporate organization. That's correct.

Q. Okay. And so that is a substantial part of your business, I presume?

A. It is, depending on the amount of work, typically half or less than half of my income.

Q. Would half be an average year in, year out?

A. I would say it varies between 30 to 50 percent.

Q. All right. And what would be an average year of how much you charge or are paid for analysis of cases?

A. I'm not sure I can give you an average because it really

over the last decade has varied so considerably, but on the high end I may earn as much as 150,000, and in other years it would be less or considerably less than that.

Q. All right. And as the prosecutor asked you and you said, you charged the prosecutor $350 an hour and so far have made about $16,000 on this case; is that right?

A. That's correct.

Q. And it looks as if from your testimony and your website and so on that you work with the police in various forms -- FBI, DEA, sheriff's offices, metro police departments, and so on -- is that right?

A. That's correct.

Q. And so what you're doing today is absolutely your line of work, which is to testify for the prosecution in medical cases; is that right?

A. Not necessarily for the prosecution. Typically when I am testifying for criminal cases it ends up being for the prosecution, but with all the other venues that I reviewed, it ends up being a lot of testifying or at least giving expert opinion or consultation for the defendant as well.

Q. Have you ever testified in a criminal case for the defendant?

A. One time.

Q. Okay.

A. For criminal cases, one time.

Q. For criminal cases.

All right. And the rest of the time, then, obviously it's been for the prosecution?

A. In criminal cases, correct.

Q. Yeah, in criminal. Yes, right.

A. Yes.

Q. And in this case in particular, you were given the information on September 23rd of -- I mean, September 3rd of 2016; is that right?

A. I'll accept that as correct. I don't have an independent recollection.

Q. Within a day or two, it's not a problem, but I think I just read that. So September-ish of 2016, is that about right?

A. That would be about right, yes.

Q. Okay. And that's the first time you ever came in contact with this case; is that right?

A. That's correct.

Q. In other words, you hadn't worked on it before, been part of the process, or anything like that?

A. That's correct. I had not seen or been involved with it prior.

Q. Okay. And what you analyzed is what you were given by the prosecutor?

A. Correct.

Q. And you didn't testify about it, so let me just go through

the list. You did not meet with any of the patients in person?
A. I did not meet with any patients, correct.
Q. You did not meet with Dr. Kudmani?
A. I did not meet with Dr. Kudmani.
Q. You did not meet with any of the other doctors whose names appear in these patients' files or on their KASPER reports?
A. That's correct.
Q. And you told us that you are licensed in quite a few states but not Kentucky; is that correct?
A. Correct.
Q. And it sounds as if to practice medicine in a state, a doctor needs to get licensed in that state; is that correct?
A. If one is to practice medicine, one must be licensed in the state, correct.
Q. Right. Have you ever been licensed in Kentucky?
A. No.
Q. All right. Is it fair to say that the rules of medical practice are state by state?
A. No.
Q. All right.
A. As we talked earlier, the standards of care, the general rules of medicine, do not respect individual state boundaries. Standards of care for the U.S. are the standards of care. So regardless of where one practices, one would expect to have the standards of care be the same.

Q. Am I correct, though, that each state sets its own particular rules on different things?
A. It is true that states may emphasize or more specifically define concerns with regard to the practice of one type of medical specialty or another. In other words, the Kentucky Board of Medical Licensure saw fit to put out specific clinical guidelines for the use of opiates and the treatment of chronic pain. Those are specific to the state of Kentucky. But in general the consensus, the culture, that is put forth with regard to opiates would be consistent state to state, albeit the Kentucky guidelines are defined by the medical board.
Q. All right. If you know, were you a part of Kentucky's rules, guidelines, and things that have been published recently over drug prescribing and addiction and so on?
A. I had no participation in that, no.
Q. All right. Did you participate, though, in Indiana's, where you live?
A. I did participate in Indiana's rulemaking, yes.
Q. All right. And let me --
MR. LAMBERTUS: Judge, can I approach the witness for a second?
THE COURT: Uh-huh.
Q. And in no way am I saying flip through this other than just to make sure that's what you participated in.
THE COURT: He's through.

MR. LAMBERTUS: All right. I'm sorry. Thank you, Judge.

Q. Is that what you participated in?

A. Yes. Yes.

Q. All right. And would you tell members of the jury exactly how this came about, how this task force, which included you, produced this and what's this all about?

A. The forms, the book that you gave me, as entitled the "First Do No Harm" product that was put forth by the state of Indiana, it was put forth by the attorney general's office in an effort to present practitioners in Indiana with opiate use guidelines. The opiate epidemic, of course, is quite severe, and although Kentucky in some sense has beat Indiana to it by putting together their guidelines, in 2013 the attorney general's task force in Indiana started the same process and ended up in 2014 with this rather large volume.

There were several committees. There were several sub-groups. I was a participant in the educational committee. So as one of a couple pain physicians, I worked with a lot of our family practice doctors talking over various proposals for guidelines, various limits, various concerns, various ways to address and work up the patient and document the findings. In the end I was a pretty modest player, I did not have a large part to do with this, but I like to think that I was helpful to our family practice colleagues, helping them see things from a

chronic pain management full-time perspective.
Q. And what you just said was that a large part of the purpose of this was to help your doctors who were prescribing pain medication to review these things, follow these rules, learn, and so on?
A. These are concepts that we always knew. There was nothing new put forth here. But given the magnitude of the opioid epidemic, particularly in Kentucky, as you well know -- and Indiana shares that because of our Ohio border concerns about practice on the two sides -- our thought was to formalize these a little more. Again, nothing new, but we thought it necessary to put into more of an objective format for our physicians specific guidelines that they could follow and keep our patients safe.
Q. Right. And would you agree that -- this is a quote from Attorney General Zoeller. "The Indiana Prescription Drug Abuse Task Force," which is what you have in your hand there, "in partnership with the Indiana State Medical Association developed the tool kit titled 'First Do No Harm: The Indiana Healthcare Providers Guide to the Safe, Effective Management of Chronic Non-Terminal Pain.'"
Would you agree that --
A. I agree to that, yes.
Q. Okay. So that's what that was, the tool kit for providers, doctors for the prescribing of effective management of chronic

pain?
A. Correct.
MR. LAMBERTUS: Judge, I'd ask that we be allowed to mark that and introduce that, please.
THE COURT: Any objection?
MR. ANSARI: I couldn't hear you, David.
MR. LAMBERTUS: Move this into evidence, please.
MR. ANSARI: No objection.
(Defendant Exhibit 6 admitted in evidence.)
BY MR. LAMBERTUS:
Q. And it looks as if you continued to speak to law enforcement groups about prescribing and pain management and addiction and all those things; is that correct?
A. Medical groups and law enforcement, correct.
Q. All right. And obviously medical groups. Sorry to leave that out. Because that's really what the big document was for, for providers, doctors, was it not?
A. It was put together as a guideline for doctors, yes.
Q. Right. And that was -- in other words, that one is not law enforcement. When you speak to law enforcement, you are speaking, I presume, as here's what to think about, here's what to do, I suggest this, and so on, and that's for breaking the law or not breaking the law.
Here, am I right, that this is for doctors, to tell them think about this, do this, don't do that, and so on?

A. It was put together primarily as a guideline for providers -- doctors and nurse practitioners and others -- who might be prescribing controlled substances.

Q. Okay. And as a result of that, were there some really specific factual things delineated; for example, how long you can prescribe something, what kind of dosage, things like that?

A. There were specific guidelines, parameters put forth of a specific nature -- the number of pills, the monthly distributing amount, the monthly amount above which it would trigger certain evaluations or referrals -- yes.

MR. LAMBERTUS: Judge, may I approach the witness?

THE COURT: Uh-huh.

Q. Dr. King, would this look like what we just talked about and you were just answering?

A. What you've handed me is the Indiana State Medical Association of what we call the "Pain Management Prescribing Final Rule." So it was our state medical association's summary of that large tome that we just referenced.

Q. All right. So this is -- this is the Cliffs Notes version, kind of, of the large one we started with here?

A. Yes.

Q. Okay. And in this one, again, we get really specific on various things -- how many months, how many milligrams, all that kind of stuff. And so now that's been published as of the day that this was announced?

A. Correct.
Q. All right.
MR. LAMBERTUS: Judge, we would ask also to mark that and put that into evidence, please.
THE COURT: All right.
(Defendant Exhibit 7 admitted in evidence.)
Q. I think a few minutes ago you said that Kentucky basically did the same -- roughly the same thing, they actually just got started on it a little before Indiana did; is that fair to say?
A. The state got involved in pulling together specific guidelines earlier, yes.
Q. By "earlier" we mean like about a year before? Does that sound about right?
A. No. It was actually much earlier. The first guidelines published by the Kentucky Medical Board was 1996.
Q. For example, we've heard testimony from other doctors that said the use of KASPER -- KASPER I'm sure has another name in Indiana. Are you familiar with the KASPER service?
A. Yes.
Q. Okay. Although it's been around for a long time, it became mandatory by rule of Kentucky Board of Medical Licensure in early 2013 in Kentucky. Does that sound right to you?
A. Yes.
Q. Okay. And by "mandatory" I mean there was a written rule that said, "Doctors, you must use KASPER in these enumerated

situations."
A. It became required at that point, as you correctly say, in 2013, but KASPER was available here as early as 2009 and was one of the few objective tools that we have as physicians to see if doctor shopping or aberrant behaviors are going on. So like so many of our other tools, even though it wasn't required until 2013, it was really one of the only two objective ways we had of monitoring abuse and diversion in our patients, and it definitely was available in 2009.
Q. So in 2009 it was available and '10, '11, and '12. And certainly a good idea, the reason that they made it up. And it became mandatory in 2013?
A. Correct.
THE COURT: Well, I just don't want the jury to -- come up, counsel.
(Bench conference on the record outside the hearing of the jury.)
THE COURT: I'm not going to say anything. You're going to redirect him --
MR. ANSARI: Yes.
THE COURT: -- on this?
MR. ANSARI: Yes.
THE COURT: All right. I mean, I thought I'd get an objection about all this but ...
MR. ANSARI: I'm going to come back and ask him

specifically that Kentucky was '96, 2001, 2003, way ahead of Indiana. And I haven't objected yet because he hasn't -- I think it's fine right now, but any more I would object.

MR. LAMBERTUS: Well, Judge --

THE COURT: You know, it's just all this talk about KASPER not being mandatory and all that kind of stuff, you know, we need to relate it to the standard of care. And I'm going to trust you to do that.

MR. ANSARI: All right, sir.

MR. LAMBERTUS: Judge, can I just tell you my thought on it? I mean --

THE COURT: I thought you probably already had.

MR. LAMBERTUS: Okay. Well, my point is that that is reflective of the standard of care. I might be wrong, but I think a doctor could think that that is what the standard of care is, what he's told he must do.

THE COURT: Well, that's why I'm going to trust him to get this doctor's opinion about it.

MR. LAMBERTUS: Okay. But I'm not trying to -- well, okay. All right.

(End of bench conference.)

BY MR. LAMBERTUS:

Q. Doctor, one of -- I believe one previous doctor mentioned that, as we would expect, KASPER has gotten better and more functional as time has gone on. Would you agree with that?

A. I'm not sure what you mean by "better and more functional."
Q. Well, the apparatus works better, that the website is better, it's quicker response, and like a lot of technology continues to improve, it's a lot easier for a doctor to use now than it was before?
A. My understanding is it was pretty straightforward beginning about 2009. I mean, does it become more push button? Perhaps. But that's not to say that it was awkward or difficult or impossible to use back in the beginning.
Q. And are you aware that to start with you had to fax your request up and it took some number of days to get a response back and they weren't always sure about the accuracy at the beginning?
A. I am aware that in the early stages some of that went on, but by and large it was obtainable without too much difficulty.
Q. And let me go to another topic here. As a general proposition, you went through the different counts and said Dr. Kudmani didn't do this, didn't do this, didn't do this.
When you say he did not do, for example, a medical exam, certainly you were not there at the time obviously; is that true?
A. Well, I was certainly not there at the time.
Q. Exactly. So I think is it possible that what you're saying is if he did any kind of exam, he didn't write it down?
A. We have a general convention in medicine -- and, again, we

are taught this as medical students -- and that is if we don't write it down, it didn't happen, it doesn't exist. So when we deal with critical issues like opioids or a critical exam to help us make a specific diagnosis, if we don't write it down, whether we did it and just decided not to write it down or not, it can generally be assumed that it did not occur.

So given the fact that whether he decided not to write it down or not, the fact is it wasn't written down, and there was nothing written down time after time after time. So I think it's reasonable to assume that it just didn't occur.

Q. And, Doctor, as you just said, that's your assumption. Number one, you weren't there; is that right?

A. Well, that's conventional thinking. That's the way that we are taught as physicians.

Q. I understand. But let's take little, tiny steps. If you weren't there, you didn't see whether there was any exam or not?

A. True.

Q. And if there was any type of exam and it wasn't written down, I understand that that doesn't count in your score card, but in the actual practice of medicine at that moment with that patient, would that be an exam?

A. The exam is not valid, it's not legitimate unless it's documented. And our conventional form, the way we are taught as physicians, is to document it, as I said earlier, by standard format. We are taught from the beginning as medical students to

document things according to standard format so that when the chart is reviewed by another individual, another doctor, there's a standard format.

There is nothing here. There's nothing here.

Q. Right.

A. That's not only a non-standard format, it's just nothing.

Q. All right. Let me try a very simple, basic example. A person comes in to Dr. Kudmani or any doctor, they've got a sharp board sticking out of their arm. Doctor, "Oh, my God," grabs it, pulls it out, starts sewing up and doing the wound, doesn't write a thing down. Did the doctor do the right thing and practice medicine by doing that?

A. Well, he did Part A perhaps correctly, but that's not the kind of patient we're talking about. These patients don't have boards sticking out their arms. These patients are coming in with chronic illness, and they've got a long past medical history. Most of them have been on narcotics before, sometimes for long periods of time. This isn't a "board sticking out of your arm" situation. These are chronic diseases that should have the time to document something at some point along their multiple years of care.

Q. And let me ask you about some specific people. Do you have your notes or --

A. I do. Yes.

Q. All right. You talked about an Angela Morgan. Do you

remember talking about Angela Morgan?
A. Yes.
Q. And you said -- that's a letter from the MORE Center. Do you recall?
A. I'm sorry?
Q. Do you recall that?
A. Yes.
Q. Okay. Now, and the MORE Center is a methadone center giving a different type or style of opioid; correct?
A. Correct.
Q. All right. And when you looked at her KASPER, you noticed that she never got any of that methadone. Can I show it to you, or do you have it?
A. The KASPER did not list methadone. That's correct.
Q. Okay. So if you didn't talk to the doctor at the MORE Center and you didn't talk to Angela Morgan, is there any reason to believe that Angela Morgan showed up any other time other than the first time and then went away?
A. Well, two points. Your question, if I may, had two parts to it.
Q. Go ahead.
A. You indicated correctly that there's no indication on KASPER that the methadone was filled by way of KASPER.
Q. Right.
A. But that's not unusual. Most methadone clinics will

dispense the methadone there and the patient will not be given a prescription, so at this time frame those would not be expected to show up on KASPER. And that has been a source of concern with regard to our care of patients who are being treated for addiction that are still coming to see us for pain medicine. So that in and of itself is not unusual.

The second part to your question indicates that why do I assume that that's correct. Well, we have a letter from the Methadone/Opiate and Rehabilitation Education Center for treatment of opiate dependence, and it's very specific, indicating that the patient is being treated. It makes no difference to me whether the patient was attending that MORE facility once, twice, or ten times. The fact that we have in the chart a formal letter saying, from the agency, that we have an addicted patient and she's going to enter into the program, that tells me we're dealing with a patient who is addicted.

So we have to be concerned if, as Dr. Kudmani did, in terms of the continuation of narcotics after he has formally been made aware that the patient was being treated for addiction.

Q. Doctor, if Dr. Kudmani was curious to see is she really getting her methadone now and he used KASPER, he would not have seen it on there; correct?

A. If he were curious would not be the term I would use. It is an inappropriate term. He is the treating physician.

Q. All right.

A. We are called upon to use due diligence --
Q. All right.
A. -- when being concerned about abuse and addiction. He was given a formal letter from the agency. Whether the patient actually took -- and this is where I'm a little confused in terms of what you're asking.
It's immaterial to me, to a certain degree, whether the patient had one or more or perhaps no methadone. The fact that she was addicted and admitted to a program is the key issue. We are dealing with an addicted patient. And the treating doctor, Dr. Kudmani, having been formally made aware of that should not continue his narcotics regardless of whether methadone was actually given or not.
Q. All right. So we say that had he been doing due diligence and looked at KASPER, he would not have seen methadone? That's number one?
A. Not on the KASPER, correct.
Q. All right. And, number two, none of us know, other than Ms. Morgan and Dr. Kudmani, what was discussed between the two of them anytime she went in to see him?
A. Well, in terms of Dr. Kudmani's discussion, you're talking about, or with the MORE Clinic?
Q. No. Between Angela Morgan and Dr. Kudmani.
A. Beyond what's documented briefly in the chart, we don't know what that discussion was about.

Q. Right.

Okay. And we have another patient. Here we go. Can you remember or look up Brandy Casanova?

A. Yes, I have the records.

Q. Same issue on her. MORE Center with nothing on the KASPER report. So, again, due diligence by Dr. Kudmani, KASPER wouldn't have told him whether she was taking methadone or not; is that correct?

A. Well, the KASPER would not, but, again, he received a formal letter and presumably read it, because it was in the chart, indicating that she was under treatment for addiction. At that point, whether the KASPER showed anything or not, is totally immaterial because he has a formal letter from the addiction clinic saying, I am treating -- "We are treating her for addiction. Please stop prescribing controlled substances."

Q. Well, I guess my question relates to, he is not prescribing on top of someone else's prescription?

A. No. We have to reasonably assume he is, because it is standard, it is usual for us not to see the methadone show up. But, again, that seems to be an argument about a very small point, because we know for a fact that she was addicted, was admitted to an addiction treatment program.

So for him to continue prescribing narcotics knowing officially -- not due diligence. He has it in the chart. It's in black and white. The letter says, Please stop -- it says,

"Please cease her prescriptions of opiates and benzodiazepines." So it's a specific documentation that is easily read and understood and ignored on Dr. Kudmani's part.

Q. And you also testified, I believe, that on 10/28 that Dr. Kudmani prescribed three different drugs -- Xanax, hydrocodone, and diazepam. Do you recognize that?

A. On 10/28/11, he filled -- she filled prescriptions for hydrocodone and alprazolam as prescribed by Dr. Kudmani. And if I said three -- if I said he prescribed three drugs, that was an error. It appears he prescribed two drugs, Xanax and hydrocodone. Prior to that she had, of course, been on other drugs, including Valium.

And while under Dr. Kudmani's care, she doctor shopped for additional medications, including Ambien and Percocet. So during that time frame, although he did not prescribe the Ambien and Percocet, she was doctor shopping and receiving them on top of his Xanax and hydrocodone and Norco.

Q. And which prescriptions are you saying -- are you talking about there?

A. Well, I'm looking at the KASPER, and the KASPER indicates that the initial prescriptions for Xanax and hydrocodone by Dr. Kudmani were on 10/28/11.

Q. Right.

A. And then subsequently, over the course of time, over the course of 2012, she was receiving Ambien and Percocet from

another physician, and she was receiving after that additional hydrocodone from another physician.

Q. All right. So Dr. Kudmani's prescriptions show up on the KASPER. The other doctor's prescriptions show up on the KASPER. Would that lead you to believe that -- I guess you're talking about Dr. Penta?

A. Dr. John Penta prescribed multiple scripts for Ambien and Percocet and a fairly reasonable number as well.

Q. And when Ms. Casanova went in to see Dr. Penta, is it safe to assume that she told him, "I'm in pain. I need this," and Dr. Penta said, "All right," and prescribed it for her?

A. It's not safe to assume. I don't want to assume at all, actually. We don't have the medical records for Dr. Penta. Again, the worth of the KASPER is to find out what other physician players are involved.

And if you see it as a physician, as a provider, doing due diligence, then I have to ask in a person, in a patient, who we know 100 percent is being treated for addiction and then I see she's getting very potent additional Percocets and Ambiens -- Ambien is sort of a form of benzo, so it's a very potent sedative agent in and of itself -- when we see this sort of polypharmacy going on, we have to assume that she's doctor shopping for reasons of abuse and diversion. That would be the logical conclusion.

Q. Would you say, then, that Dr. Penta would have seen that as

well or should have?
A. I can't comment on Dr. Penta. I haven't reviewed his records.
Q. All right. But certainly when Brandy Casanova went in to see Dr. Penta, if he had looked, he would have seen that previously, about four or five months prior, she was getting prescriptions from Dr. Kudmani?
A. I presume he would have. I'm not judging Dr. Penta. I haven't seen his records. I don't know his rationale for treating her.
Q. Okay.
A. I don't know what specialty he may or may not be. I just don't know anything about him.
Q. All right. Let's talk about Kim Forbes for a second. Do you have it?
A. Oh, I'm sorry. Yes, I do have it. I was not watching. I apologize.
Q. No problem.
And really the thing I'm concerned about with Ms. Forbes, did you analyze medically and scientifically the death of Ms. Forbes?
A. I'm not sure what you mean by "medically and scientifically."
Q. Well, do you -- have you issued an opinion or can you issue an opinion today on what caused her death?

A. I read the review and the toxicology prepared by the pathologist and I concur with the conclusion, but I did not do an independent evaluation or assessment.
Q. All right. Let me take you one step at a time. Are you aware that there was no autopsy?
A. Yes.
Q. Are you aware that there was no blood test?
A. Yes.
Q. Are you aware --
A. I'm sorry. Let me back up for a moment. There was a blood test -- excuse me. There was a urine drug test that was done in the hospital.
Q. All right. Let's be clear. There was no -- are you aware there was no blood test?
A. Yes.
Q. Okay. So no autopsy, no blood test. We agree on that?
A. Correct.
Q. And in the urinalysis that was done, there was a trace amount of benzodiazepine. Do we agree on that?
A. Well, there was benzodiazepine.
Q. Right.
A. Again, I hesitate to start commenting on the amounts because that gets into a toxicological analysis that would require more information to determine how critical it might be.
Q. All right. You've seen the lab report?

A. Yes.
Q. And there is no amount determined. Do we agree on that?
A. The presence of benzodiazepine was confirmed.
Q. Right. Without an amount?
A. Yes.
Q. Okay. Knowing those things -- and by the way, when you look at the urinalysis, the urinalysis doesn't even distinguish what type of benzodiazepine there was discovered; is that right?
A. And that would be consistent, that would be expected with the type of urinalysis that was done. That would be what we refer to as a qualitative study. It's a quick and dirty study, so to speak, where it tells us what classes of medicines were present. So we don't know whether it was alprazolam or Klonopin. It just tells us there was a benzodiazepine there. Further analysis would be required to get the specific medication. But that would be usual.
Q. But no further analysis was done, so this is all we have?
A. Correct.
Q. And is it accurate to say that the alprazolam that Dr. Kudmani had prescribed about three weeks prior might not be the benzo that's in her urine because it was not tested?
A. It's more likely than not that it was.
Q. Why is it more likely it was alprazolam and not clonazepam?
A. When we review patient histories, when we try to determine a cause of death, when we try to decide as a physician was I

contributory to the death, what we do is we go back and we look at patient behaviors. We look at the track record. We look and see does the patient have a history of abuse, does the patient have a history of early refill, does the person have a predilection towards one or another set of drugs.

So when we look at what I call the 30,000-foot view on this patient, we know that she has a history of drug abuse, we know that she has been on drugs for a long period of years, and we know what her drug predilection is. So when we add all those behaviors and past history up and then we add to it the observation that when she was admitted to the hospital overdosed, comatose, and unresponsive with her history of abuse and we know that she was on benzodiazepine, specifically alprazolam, and that has been her drug of choice for a long time, it's reasonable to assume that's what it is.

Q. All right. Doctor, I'd ask you not to make a reasonable assumption or a possible assumption but to the proper medical, scientific standard. Would you issue a definitive opinion on the cause of death for Kimberly Forbes knowing that there's no autopsy, no blood test, and there's no amount of the benzodiazepine in her urine?

A. I'm not a toxicologist, so I will not be rendering a medical opinion on her cause of death.

Q. Okay.

A. As I initially said, I agree with and I think the opinion by

the medical examiner is correct. I would agree with it.
Q. Okay. But you feel -- don't let me put words in your mouth. You feel that because of your lack of training and experience in this area that you should not give the definitive medical opinion on what the cause of death was here?
A. That's correct. I'm not rendering a specific opinion on the cause of death.
Q. All right.
A. But clinically I agree with the medical examiner.
Q. Had there been no opinion from the medical examiner and you were presented with the facts -- again, no autopsy, no blood test, no amount of the benzodiazepine, plus it's in her urine, meaning not in her actual body system at the time -- would you have issued an opinion under those circumstances?
A. I would not at any point render an opinion because I am not a toxicologist.
Q. Okay. That's fine. We'll leave that one there. Thank you.
Now I would like to ask you about Terri Keith. Can you find Terri Keith there?
A. Yes, sir. I have it.
Q. Okay. Now, you went through what records to determine your thoughts on Terri Keith?
And by the way, I only want to ask you about the death, okay?
A. I had quite a number of records presented for Ms. Keith,

including her medical record from Dr. Kudmani as well as the hospital records, so I have a lot of pages here of review and report. I also have reports from Our Lady of Peace from the mental health workers who saw her both as an inpatient and an outpatient. I have reports from the social workers. And as I indicated, I have reports from the hospitalizations. So I don't know if that's specifically what you're asking for.

Q. Sure. Yes. There's quite a few of these records, as you can imagine, as you know.

Did you get all of the ones from Hendersonville, Tennessee? Or tell me what you got from Hendersonville, Tennessee. Hospitals.

A. Yes. Again, I've got 23 pages of notes here. So if you can give me a date, I might more efficiently be able to get to it.

Q. Okay. It looks like two particular admissions. May 17, 2006. June 7, 2006.

A. Yes, I have notes on that emergency room visit and hospitalization.

Q. All right. Is it possible for you to give an overview of what you consider her -- by "her" I mean Terri Keith's -- health records as it relates to her health care?

A. I'm not sure what you're asking.

Q. All right. Well, maybe we'll go a little piece at a time, all right?

We agree that she was a patient of Dr. Kudmani for some

years?
A. Correct. Yes.
Q. All right. And during her time as a Dr. Kudmani patient, he did various OB/GYN surgeries on her?
A. Correct.
Q. Starting, it looks like, back in about the year 2000? Does that seem right to you?
A. The initial records I have date back to November of 2000, yes.
Q. All right. And I'm trying to work off your chart, if that helps you any.
A. Thank you.
Q. And then she also had various surgeries from other doctors along the way. Do you find all that?
A. She had additional surgeries with Dr. Kudmani, and I don't see any other indications that she had surgeries from other doctors documented in the medical record.
Q. All right. Let me see if I can get some of those real quick for you.
Dr. King, it looks like you have noticed and written down a variety of things, including surgeries. L5-S1 fusion in 1989. I'm working off your chart. Do you see?
A. Yes, I do.
Q. Okay. Another possible cervical fusion, 1997. A third back surgery, unspecified time. Then a fourth back surgery,

unspecified time.

Does that -- when you look through, I mean, you wrote that down because you think that she had those back surgeries?

A. Actually -- and just to make sure I'm not misinterpreting what you're asking -- I thought you had asked me if she had after that any surgeries.

Q. I'm sorry. I'm sorry. No. My fault. I'm just talking about surgeries in general.

A. Surgeries in general, yes. A larger picture.

Q. I'm trying to get a scope of her medical situation.

A. Yeah. There were several indications in Dr. Kudmani's record that she had undergone multiple back surgeries, the earliest of which was mentioned as 1989, so it was obviously many years prior. But we don't know the nature of that surgery. The first one was indicated as an L5-S1 single-level fusion, but beyond that we don't know what or even if the other surgeries were performed. They're non-specific. There are no dates. We have no medical records. We simply have an unfortunate young woman who clearly is addicted looking for pain medication.

So as we've talked, I don't have any independent verification based on review of the record that she actually had all the surgeries that she claimed. It just isn't documented.

Q. Did you take a look at the autopsy report?

A. I briefly looked at the autopsy report.

Q. When the coroner testified, Dr. Weakley-Jones, she mentioned

that there were, you know, scars on her back from, she denoted, a surgery. Would that lead you to believe she probably did have surgeries?

A. I believe she had a surgery or surgeries. I just don't know how many or what was actually done.

Q. Okay.

A. I mean, I will grant that she had surgery.

Q. Okay.

A. I just don't know the nature of it and how many.

Q. All right. And you also mention other surgeries, and it looks like you mention them from other records as well. She had hip replacement, knee surgery, and so on.

Is that accurate?

A. That's correct, yes.

Q. And this information also came to you from other hospital records, like Our Lady of Peace, Jewish Hospital records?

A. Yes. A lot of this information lacking in Dr. Kudmani's chart was drawn from the various hospital records that I was able to review.

Q. All right. So is a quick summary that this lady had at some point, I believe you said, between 18 and 20 surgeries over her lifetime as a health issue, let's call it? She required a lot of surgery?

A. I don't know about that particular number, I didn't add them up, but certainly she's had a number of areas apparently

addressed surgically.
Q. Yeah. And as we said, they go back into the '80s. It goes back to 1989, it looks like, the first surgery.
And then she started with Dr. Kudmani in November of 2000. That's when he started being her OB/GYN. Does that look like --
A. Certainly the first entry we have is 2000.
Q. All right. And his note at that time, "Leakage." What's that mean, do you think?
A. That's a very reasonable question. Again, as I've talked, we have to standardize as physicians our documentation, and he writes "CO," which means "complains of" --
Q. Okay.
A. -- and then "leakage," and then, comma, "chronic smoker." And that is a non-standard statement in terms of presenting for chronic pain.
Q. All right. So she complains of leakage. We're not sure about that. Probably gynecological issue. She's a chronic smoker.
"TVS," he gave her a transvaginal ultrasound. Is that what that would mean to you?
A. Yes.
Q. Okay. "T&A"?
A. Tonsils and adenoids.
Q. Okay. She's had an appendectomy, had her gallbladder taken out. At this time -- this is in November of 2000 -- she's had

three back surgeries, a tubal ligation, elbow surgery, and she complains of hot flashes, night sweats.

"Surgery if" -- what's all that?

A. My interpretation -- and, again, the handwriting is horrible, so there's a lot of interpretation on this. But my interpretation of that is, "Surgery if D/C," meaning D/C, stop, "if stop smoking."

Q. All right. Then the summary of three back surgeries. "Rods and bolts," meaning she's got rods and bolts in her back?

A. Pretty crude way of putting it, but yes.

Q. Okay. And I definitely don't want to go through all of this, but she is in to see Dr. Kudmani on a fairly regular basis with a variety of complaints, and he does some more surgeries on her. There's one in, looks like, 2001. Then 2003 at Norton Southwest Hospital, a laparotomy, which is a ...

A. An abdominal procedure where we put a scope in the abdomen to view the inside of the pelvis or abdomen.

Q. Okay. Diagnosis: "Recurrent stress incontinence, pelvic pain, bilateral benign ovarian cysts, and pelvic adhesions. She complains of" --

Are you with me? Do you see where I am?

A. Yes.

Q. -- "pelvic pain, bilateral ovarian cysts, strong family history of ovarian and breast cancer, recurrent stress incontinence."

So he is -- not to your satisfaction, but he's making notes and he's doing things with her, and she's coming in to see him on a fairly regular basis.

"Recent MRI." And, also, a cholecystectomy, Doctor, is a ...

A. I'm not sure where you are.

Q. Okay. Your first -- page 3, December 17th, 2003, first little box there at the bottom.

A. Yes. Okay.

Q. And what's --

A. Well, I note here that it's illegible. But the note, to the extent I can read it, says, "Recent MRI" -- I don't know what the MRI was of -- "C4-C5, cholecystectomy, hysterectomy, tubal ligation."

Q. All right. So those were surgeries that he had either done or planned to do with her?

A. And, again, that's unclear, because back in the beginning it had indicated that she'd had her gallbladder out. Cholecystectomy is having your gallbladder out. So I don't know what he's planning or intending with this note.

Q. And mitral valve prolapse, that's heart condition, isn't it?

A. Correct. It is.

Q. All right. And then we go to OB/GYN surgery at Norton Southwest Hospital, laparoscopy, the adhesions. And then we go to Tennessee; Hendersonville, Tennessee. Do you see that?

A. Yes.
Q. May 17, 2006. And you've gone through those records, have you not?
A. Yes.
Q. All right. And she went in -- do you have your sheet in front of you there? It's your Bates Number 3:0846.
A. I don't have my tagged record on those.
Q. All right. Can I put it up on the thing here, and we'll see if this works. Can you see that okay?
A. Yes.
Q. So she goes in to the Hendersonville, Tennessee, medical center. Chief complaint, "Chest heaviness, short of breath." She tells them past medical history. Back problems, hypertension, high cholesterol, had her gallbladder removed, appendectomy, bilateral elbow surgery, hysterectomy. She's on Percocet, baclofen, Toprol --
THE COURT: Mr. Lambertus, why don't you just ask a question about all this?
MR. LAMBERTUS: I'm sorry.
Q. You've read the medical history?
A. Yes.
Q. Okay. And that's what it was?
A. Yes.
Q. Okay. And then she was discharged, it looks like.
THE COURT: Is that a question?

Q. Did she get discharged?
A. Yes.
Q. Thank you.
Can I show you the next one? Does this look like she's back on June 7th of '06?
At the top.
A. Yes. I was checking my record. Yes.
Q. All right. And when she came in, do you see that -- oh, this is what she is signed out with. Would you read those drugs there? Tell us what they are, please.
A. She was discharged on baclofen, Percocet, oxycodone, Lunesta, Valium, Motrin, chewable vitamins, and Prozac. And it appears that on all those, except for Motrin, those were prescribed, quote, per prescribing M.D., which I assume is Dr. Kudmani.
Q. Actually it was not, and we'll show that in a second.
But at any rate, those are what she was listed as to take. And you notice that there's one scratch out and a check mark over to the side --
A. Yes.
Q. -- "Do not order"?
Would that mean to you that take everything that's checked and then, whoops, don't take that one and we checked it to the side to say --
A. I would assume that's what it means.

Q. All right. This is still June 7. So she was, by your notes and what we've seen, in there on -- in May, and she was back in June. Is that the way you read it all?
A. Yes.
Q. And then she -- you've listed that she has continuing treatments with Dr. Kudmani. And then in July of 2007, she is inpatient in a psychiatric hospital, Ten Broeck Hospital. Do you see that?
A. Yes.
Q. Excuse me, Doctor. I want to go back for a second and show you more Hendersonville.
Down toward the bottom, primary care physician, the Amin Family Medical. That's where you had asked who was her physician at that time, and she -- do you see where she had advised it was the Amin Family Medical?
A. Yes, I see where that's written.
Q. Okay. And then she starts going to Our Lady of Peace, which is a Jewish Hospital psychiatric hospital. Are you familiar with that here in Louisville?
A. Yes.
Q. And to try to summarize it quickly, it looks like she starts going -- or you tell me. When does it look to you like she starts going into Our Lady of Peace Hospital?
A. I'm a little unsure as to where you are. You skipped back and forth. So what date are we at?

Q. Well, it looks like to me like September 9th of 2008.
A. Okay. She was treated as an inpatient on 7/7/07 at Ten Broeck for depression and overdose, and then she was sent for outpatient care. But she had -- that was her second overdose, her first one being in Hendersonville that we just reviewed.
Q. Right.
A. So then she went to Ten Broeck, and then she went to Jewish Hospital on 9/9/08, which was essentially a year later. And, again, that was another issue related to Xanax overdose.
Q. And so we've got a Hendersonville admission in '06 where she is complaining of all kinds of things and then the second admission in Hendersonville for an overdose; is that correct?
A. That's correct.
Q. And then she comes back to Louisville, and a year later she's admitted to Ten Broeck psychiatric hospital. Roughly the same thing as Hendersonville; is that fair?
A. For depression and overdose.
Q. All right. And now we're at -- it looks like I'm at 9/9/2008 for Our Lady of Peace. Does that look right to you?
A. For depression and overdose again.
Q. All right. And --
A. That's an involuntary hold. They held her against her will.
Q. So however she got there, they determined she needed to stay there; is that fair to say?
A. Correct.

Q. So on the next day, September 10th, your pages 149 through 151, and she is making comments to her therapist and so on. Do you have those notes in front of you?

A. I do, yes.

Q. And what did she say about her overdose there? "Ingested," et cetera, what's all that?

A. There were several things that were said in that entry. She indicated, she admitted she had taken 30 Xanax as an overdose, and she said, "Well, I did that because I had a tooth extracted and I lost my pain medicine." So she said she took 30 Xanax, which doesn't make sense.

But she also indicated as part of the history here -- and this is critical, as we talked about earlier with regard to abuse in adolescent females. She indicated that her first child had been born when she was 16 and unmarried. Again, this is the same admission, same entry here. And it indicated that she was a child of an alcoholic and was currently in a relationship with an active alcoholic, and we know that these are extremely high-risk historical notes and will tend towards addiction in an individual. So she's basically got almost every high-risk comorbidity checked.

Q. And also, as you said, being abused in some way as a youth, at that point she still was in denial about that. Do you see that right above?

You made the note, "Denies physical, sexual, emotional

abuse."
A. Yeah. She opened up about that in a later admission and admitted to it, but the point is she's got significant factors for abuse.
Q. Sure. Absolutely.
And then she does get out on September 12, 2008. Do you see that? Is that right?
A. Yes, correct. Well, she was discharged from the inpatient program but was maintained on what they call the intensive outpatient program. So they were maintaining continuity because of her high-risk behavior.
Q. And on her discharge, her psychiatrist, am I right, Dr. Chhibber, gave her prescriptions for Cymbalta? Which is what, sir?
A. Cymbalta is an antidepressant.
Q. All right. Trazodone?
A. Trazodone is an antidepressant, sometimes a sleep-assist medication.
Q. And referred to Dr. David Rouben for what?
A. For Soma and Lortab.
Q. All right. So obviously that is under the auspices and recommendation of Our Lady of Peace Hospital?
A. And I don't know who Dr. David Rouben is, because they clearly -- she clearly was under the care of Dr. Kudmani prior to the admission and afterwards.

Q. And she's, looks like, out of the hospital for five days and comes back in. Do you see that?
A. What date are you referring to?
Q. 9/17. She was discharged on 9/12, and she's readmitted on 9/17?
A. Correct.
Q. And what does she say about why she's in there this time?
A. The social worker notes, not surprisingly, that the patient was essentially depressed and indicated that she, the patient, had overdosed on pills because she was, quote, worn out, which is unfortunately no surprise. This poor woman was not treated well with her continued use of controlled substances.
Q. And does she also state to the social worker that she has a large, close family and has had 23 family deaths in her lifetime?
A. That's what she states, yes.
Q. And does she appear to continue over the next, what, month or so to go back and forth to Our Lady of Peace as required?
A. Well, not necessarily as required. She's non-participatory in a lot of the recommendations. She refuses to participate in smoking cessation, which in the scheme of things isn't that big a deal for her list of problems, but then shortly thereafter, in October of 2008, she requests, quote, immediate discharge from the program. And her discharge diagnosis at that time was major depressive disorder, recurrent, severe; panic disorder with

agoraphobia. So she clearly was not doing well at all from a psychiatric standpoint but requested discharge.

So she was discharged from the intensive outpatient program and went back to see, within a week or two of that discharge, Dr. Kudmani, who indicates in his notes he prescribed Percocet and Soma.

Q. And let's go back for a second to September 29th, if we would. Do you see that note?

A. September 29?

Q. Yeah, September 29th.

A. Of what year?

Q. 2008, where we are.

A. I don't see a 29. I see a 9/17/08. Is that what you mean?

MR. LAMBERTUS: Judge, may I approach the witness?

THE COURT: Uh-huh.

A. Yes, I have it.

Q. Okay.

A. That was on the -- yes. Okay. That was much earlier. Okay. I see.

Q. And did she talk about having a surgery at that point?

A. Yes. And one of the major issues here that we haven't talked about but now is a good time, she has a very unstable social life in the sense that she is essentially homeless. On that entry that you're referring to here, it says, quote, "Patient still looking for housing. Needs hip surgery but can't

until housing settled."

And just prior to that, the week prior, she was noted by the social worker to be, quote, "Patient pays daughter's bills so grandchildren don't suffer while patient herself is technically homeless," end of quote. So she has a very unstable social life.

Q. Doctor, let me put this up for you. Can you see that?

A. Yes.

Q. All right. This is -- do you see -- is that the date we talked about a minute ago, 9/12/08, for her discharge from that admission?

A. We're going backwards in time again.

Q. Yes.

A. It is one of her many overdose admission discharge summaries, yes.

Q. All right. And you see, do you, that in the middle the order is to follow up with Dr. David Rouben?

A. That was the Dr. Rouben we referred to earlier, and I don't know who he is.

Q. And it's Toprol, Crestor, Soma, and Lortab --

A. Correct.

Q. -- is that right?

A. Yes.

Q. Earlier you had said, I believe, that Crestor, Soma, and Lortab was not recommended by you, certainly. Is that accurate,

fair to say?
A. I had no comments on Crestor, which is a cholesterol medication.
Q. Toprol, excuse me.
A. Toprol is not a pain or a sedative medication. It's more of a hypertensive blood pressure medicine, so I would have no opinion on that.
Q. All right. And, Dr. King, do you see this date of 10/8 up in the corner there?
A. 10/8. Okay. Yes, I see it.
Q. All right. Now, it's another discharge, and what does the hospital say Dr. Chhibber is prescribing for her? And tell us what they are too, please.
A. Cymbalta and trazodone, both of which are antidepressants; BusPar, which is an antidepressant; and Klonopin, which, as we know, is a sedative/hypnotic benzodiazepine.
Q. All right. Is that correct, that's what Dr. Chhibber is giving her?
A. Well, actually what it says is, "Follow up with Dr. Chhibber for the below medications."
Q. All right. So that's what the hospital is saying she should do; is that correct?
A. Yes. She was being discharged -- she was requesting immediate discharge against -- presumably against medical advice, so the best they could do is say follow up with

Dr. Chhibber for these medications as we just talked about, which presumably Dr. Chhibber had been prescribing prior.

Q. All right. And then a little further down, what is she to do with Dr. Kudmani?

A. She's instructed, since she was requesting immediate discharge, to follow up with Dr. Kudmani regarding the medications that he had been prescribing previously.

Q. So would you agree that the -- the previous follow up with Dr. Rouben and those drugs. Now we have follow up with Dr. Kudmani. Does it appear to be the same drugs that Dr. Rouben was to give her?

A. Well, again, this is not the same as saying, "Give her these drugs." But in a sense, yes, they are -- not in a sense. They are the same drugs. But it's indicating that she should, quote, follow up with, not necessarily continue taking. But obviously there has to be continuity, so she's being reasonably instructed to follow up with since she's discharging herself.

Q. All right. And were you aware from looking in the Dr. Kudmani file about Terri Keith's daughter signing for her medications? Did you talk about that? Did you analyze that?

A. We reviewed that at time of examination, yes.

Q. All right. And so you agree that Jennifer Reynolds, daughter of Terri Keith, presented herself and signed to be responsible for administering the medications?

A. Yes.

Q. And did that in her medical chart?
A. Yes.
Q. She identified herself as a nurse?
A. Yes. She was -- historically, by her statement -- we don't have any independent verification -- she was an LPN, who was currently out of work. There was -- there were issues with regard to care of the grandchildren that apparently were of some significance, mixed with the social problems of being homeless, and it appears that the living situation eventually evolved into the daughter and the mother living together, which lasted for a while and then broke apart. So there appears to be chaos in that household.
Q. And I'm just going to go a little faster here. You saw and you talked about a letter from the sister of Terri Keith; is that correct?
A. Yes.
Q. And that preceded the Jennifer Reynolds, daughter, note. Do you see that?
A. Yes, by approximately four weeks.
Q. And Ms. Harrod's note was also sent to Dr. Chhibber. Do you see that?
A. It was cc'd to Dr. Chhibber, correct.
Q. Can we just -- we'll go quickly that she went again back and forth to Our Lady of Peace?
A. Well, I will agree that she did, but it's a very serious and

very dramatic issue. She was in and out of the hospital for overdose and severe mental problems, so not to be taken lightly, but yes.

Q. No, no. I didn't mean to hint at that. There's just so many notes, we'll be here forever if we go through all of them. I was trying to go fast. I'm sorry.

Does it appear that she is participating and following the advice of all the folks in the therapy sessions?

A. There are multiple problems that are occurring, so I don't know what you mean by "following the advice." She's arrested for driving without a license and -- I'm sorry, not she. Her daughter was arrested for driving without a license and was put in jail, presumably the one that wanted to dispense her medications.

The patient herself, Terri Keith, had significant dizziness and mental status changes which are attributed to overdose and, quote, clearing. She resumed her medications. She's unsteady. She falls and goes to get treated because of falling.

There's a note on 9/15/09 from the doctor overseeing Our Lady of Peace care. He says, quote, "Patient lying about attending groups." Quote, "Difficult to engage and non-compliant with psychotherapeutic interventions of her treatment." So, no, she does not participate in any meaningful fashion. She continues to be out of bounds in her behaviors.

Q. Could you go to October 8 at the bottom? The note that you

made says, "Progress note, Our Lady of Peace, from Dr. Angela Brock."

A. If you give me the exact date.

Q. 10/8.

A. 10/8 which year?

Q. Your page 17.

A. No. I mean which year. 10/8 ...

Q. '09.

A. '09, okay.

Q. Sorry. Your page 17, bottom note.

A. 10/8/09. Yes, okay. And your question?

Q. What was all that about? What did Dr. Brock ...

A. As part of the inpa- -- excuse me, the intensive outpatient program, the patient was given transportation. They sent a van to pick her up. On the way in to her group therapy, she tried to solicit Klonopin.

Now, having said that, this may not be the entry that says that. Yes. No, that is the one.

And she was advised that it was inappropriate to try to get diverted drugs off her fellow patients as she was being brought in a van for treatment. She apologized and said that she, quote, didn't take her morning medication and, quote, knows better. But as we talked about, we're dealing with somebody who is addicted, and there is no control. There is no control.

And she also reported as part of that same note that you

just asked me to review that she has been, quote, depressed since five years old and admitted that her drug of choice was pain medication with increasing amounts, quote, end of quote.

Q. And so am I right on 10/8 she admits to trying to get Klonopin from other sources than the doctor? Is that true?

A. Correct.

Q. And two days before, am I right, she said to one of the therapists, "History of alcohol abuse but denies recent use and denies the use of street drugs"? Do you see that?

A. That's what she indicates, yes.

Q. And previously you had said that at one point she admitted she thought she had done cocaine the night before but it turned out it was methamphetamine instead of cocaine?

A. Correct.

Q. So clearly, am I correct, that on one day she'll say one thing to one therapist and two days later she'll say something else different to another therapist?

A. Well, I think it's established that she's lying about her compliance and care and she's lying about her history of drugs and she is refusing to admit that her -- and she doesn't realize, I think, herself. Clinically we would expect she would not realize that her early childhood history of abuse and pregnancy and other issues was really the reason why she was having chronic pain. That was the reason, not because of all her surgeries. She was emotionally, mentally suffering from

psychosomatic pain that needed to be treated with other than narcotics.

Q. Nevertheless, every time -- we've gone through the discharge. Have you seen the note we've read that says, "Follow up with your primary care physician for your pain medications"?

A. Which is appropriate. The hospital was sending her to follow up with a doctor. Presumably any reasonable, any prudent physician after seeing that hospitalization would have stopped those medications. Dr. Kudmani did not.

Q. And, also, do you see on 10/8 the prescriptions or the medications given by Our Lady of Peace Hospital?

A. Yes.

Q. And what are those?

A. Klonopin, trazodone, Neurontin, and Wellbutrin. In other words, three antidepressants and the benzodiazepine, Klonopin.

Q. Is there another name for Neurontin?

A. Gabapentin.

Q. All right. Am I right that trazodone and Neurontin, also known as gabapentin, do not show up on a KASPER report?

A. That's correct. They're not controlled substances.

Q. And do we agree that throughout Dr. Chhibber was prescribing Neurontin, also known as gabapentin, trazodone, and clonazepam?

A. That's correct.

Q. All right.

THE COURT: Let's take a 15-minute break and come

back. Don't make up your mind about this case, ladies and gentlemen. Don't discuss it with each other.

We'll be back in session in 15 minutes.

(Jury left the courtroom at 3:13 p.m.)

(Recess at 3:13 p.m. until 3:35 p.m. Jury present.)

THE COURT: Okay.

BY MR. LAMBERTUS:

Q. Dr. King, I'm going to show you this. Does that look familiar to you?

A. Yes, it does. And I'm referencing it in my chart here.

Q. It's absolutely at the very end of everything.

A. This represents the last note in the chart written by Dr. Kudmani.

Q. All right. And if you would, give us a brief summary of what you see there and what he did and so on.

A. This is a follow-up visit from -- well, allegedly it is a follow-up visit. But it says, "Complains of pelvic pain, anxiety attacks. On Wellbutrin. Blood pressure, 128/72. Breasts, normal limits. Mammogram ordered 5/6/10. UA," urinalysis, "negative. Pap" -- I'm not sure what that next word is, "culture" maybe -- "negative. TVS," transvaginal sonography, "see photo," probably.

And then there's a note indicating that he's prescribing Klonopin and Percocet. Percocet is being prescribed at four per day of the high-potency 10-milligram dose, and the Klonopin is

being prescribed at the relatively high dose of 1 milligram three times a day.

Q. All right. Thank you.

And when you review the records, do you note that the clonazepam prescription has previously been given for the past year or so at Our Lady of Peace through Dr. Chhibber?

A. Dr. Chhibber was the prior prescriber of Klonopin. This is the first time Dr. Kudmani has prescribed Klonopin.

Q. Right. And as to the amount, dosage, and everything, am I right Dr. Kudmani's prescription is exactly like what Dr. Chhibber's was?

A. Dr. Kudmani prescribed the same amount without variation, yes.

Q. Okay. And at the time you did your chart, is this correct, that you were not aware that Ms. Keith had picked up a trazodone prescription and a gabapentin prescription on May 3rd when she picked up her other two prescriptions?

A. From Dr. Kudmani, you mean?

Q. Yeah. The two prescriptions from Dr. Kudmani, we've talked about those, have we not?

A. I'm confused. Are you talking about the trazodone and the Neurontin?

Q. Yes. I'm calling it gabapentin.

A. Or gabapentin, yeah.

Q. Am I right that that's the same thing though?

A. They are the same thing, yes. Correct.

I'm not aware of who or when they were written. They were not documented in the medical record.

Q. Okay. So you were not given that information?

A. I'm not aware that it existed.

Q. Okay. Well, hang on one second.

MR. LAMBERTUS: Judge, may I approach the witness?

THE COURT: Yes.

Q. I believe this is an exhibit already. I'll show you this.

All right. Doctor, I'm going to put another copy of that up here. Doctor, can you see it on the screen --

A. Yes.

Q. -- better now?

All right. What I'm referring to is the very, very bottom. Do you see the dates on here?

Let me give you some help. At the bottom, do you see those three dates?

A. I do, yes.

Q. All right. And you see at the bottom Dr. Kudmani for the oxycodone? Do you see that one?

A. Yes.

Q. And then right above it for the drugs trazodone and gabapentin, which I now know is also Neurontin?

A. Correct.

Q. Go back to the date. Same date, May 3rd, May 3rd. Do you

see that?
A. Yes.
Q. And also the same pharmacy, Rite Aid Pharmacy. Do you see that?
A. Yes.
Q. And see the three Receipt Numbers 888, 889, and 890 for the receipt of those that day? Do you see those numbers as well?
A. I do.
Q. All right. And you've not seen this before; is that correct?
A. Correct.
Q. Okay. Oh, and I'm sorry. One more thing. And you see that those two prescriptions -- I'm talking about, again, gabapentin/Neurontin and trazodone -- the prescribing physician is Dr. Chhibber from Our Lady of Peace?
A. Yes.
Q. Okay. Thank you.
My question to you on those two prescriptions: Is there a safety issue or danger issue with abusing those two drugs?
A. Those two drugs, like any drug, are of concern. They're not controlled substances, so they're not in the same ballpark that we would consider the Norco or the benzodiazepines, but they are prescribed substances. So even though they're not controlled, they do require a doctor's signature.
Q. True. Which is why they appear on this chart like we have

them on there?
A. Yes.
Q. If a person, patient, or whatever took an excessive amount of the trazodone, is that a serious health risk?
A. It's a health risk. Trazodone is not known to be a commonly abused substance. I can't recall when I've seen it taken as an overdose or an abused medication.
Q. All right. But if it is taken as an overdose, would it serve the same bad function on a human being?
A. I don't -- I've had no experience with a trazodone overdose. It would be so rare that I am unfamiliar with it.
Q. All right. What about trazodone with Neurontin with oxycodone with clonazepam taken excessively?
A. And we might include Soma with that, because she had -- within the last week or two of her death, she filled a prescription for Soma as well.

But I would say if you're asking me to rate the concerns on that, I would put the -- in terms of the most danger of overdose and death and respiratory depression specifically, I would rate Percocet the worst followed by the benzodiazepine -- it would be that combination -- followed by the Soma, which we have talked about in terms of the holy trinity, the heroin-like effect that that trilogy gives -- trinity gives to you. And way far behind I would put the gabapentin and the trazodone.

Gabapentin specifically has a huge therapeutic safe range.

I didn't see what the dose was. Could you maybe tell me what the dose was on the gabapentin?

Q. Yes, sir. That is not listed as far as I can see. I'm sorry.

A. Gabapentin typically would be prescribed on a one or a three a day of a modest 100 to 300 milligrams, but we know that we can go up to 3,000, 4,000, 5,000 milligrams of gabapentin and still be safe. It's an inherently safe drug.

So, again, in the scheme of the drugs that she was taking, the finger points pretty specifically to the holy trinity as causing her overdose death.

Q. Are you aware that the lab test as part of the death investigation, the lab did not test for Neurontin or trazodone either one?

A. I'm aware of that, yes.

Q. So it's, I presume, very difficult to issue an opinion on what effect that had since we don't know what the reading effect would be?

A. Well, I think we're dealing statistically with concerns regarding the holy trinity. That is well known to cause death by respiratory depression, and we know that she was taking it and we know that she was unfortunately severely mentally unstable with a lengthy history of overdoses. More than likely, just statistically based on her history and her medical issues, it was the holy trinity that caused her to have respiratory

depression and die. I am not concerned particularly about the trazodone or the gabapentin.

Q. Do you think you might be more concerned if they had been tested for and you could see the lab result?

A. No, it would not concern me.

Again, I harken back to the fact that the holy trinity is well known as a heroin-like euphoria and respiratory depression side effect. We are all aware of what heroin does to people in terms of death and respiratory depression. Before heroin became as easily accessed and as cheap as it is today, the holy trinity was what people would go for. So it's very understandable to me and very -- I think very likely, highly, highly likely that it was the holy trinity that caused her death.

Q. Do you have the lab report in front of you, sir?

A. I do not.

Q. All right. Doctor, can you see this?

A. I can, yes.

Q. All right. So it's all clear. Do you see this is the Terri Keith case and AIT laboratory report?

A. Yes.

Q. And do you see any Soma result here?

A. I don't believe it was tested for. If we reference the top part there where it says "Date Collected" and, of course, has 5/6/2010 and then it says "Tests" and then it gives two codes there, the 70530 is listed as drugs of abuse panel in the blood.

Typically drugs of abuse panel does not include Soma, nor does it include trazodone or Neurontin. So I don't believe based on this it was tested for.

Q. All right. So based on the lab report, you cannot issue an opinion, of course, on Soma, trazodone, or Neurontin because they weren't tested for?

A. I'm not issuing an opinion on the cause of death at all, as you and I discussed.

Q. I'm sorry. That's what I was asking you for. So if you're not issuing an opinion on it, then we're finished.

Thank you, sir.

A. And in answer to your question -- I'm sorry. In answer to your question, the opinion from the medical examiner was, "Death in this case is attributed to multiple drug toxicity." I concur with that.

Q. But on your --

A. But I'm not issuing an independent medical opinion on it.

Q. Okay. Pardon me. That was my question.

Based on the science, based on the test, what was tested for, what was not tested for, you're not going to issue a medical opinion on what the cause of death was?

A. No. I'm just saying her behaviors over the years prior were consistent with the M.E.'s opinion, that she died secondary to multiple drug toxicity.

Q. Am I right, the answer to the question are you issuing an

opinion on the cause of death medically and scientifically, your answer is no?

A. Correct.

MR. LAMBERTUS: Thank you, sir.

THE COURT: All right. Mr. Ansari?

REDIRECT EXAMINATION

BY MR. ANSARI:

Q. Dr. King, you were asked about the -- specifically about the guidelines and some of the ones that you kind of helped prepare for Indiana; is that right?

A. Correct. Yes.

Q. And you made the comment that although yours -- I guess Indiana's started to come around between 2013 and I guess were ultimately published in 2015?

A. Correct. Yes. Well, they were 2014, and then there were some addendums. So, yes, between 2013 and '15.

Q. Okay. Now, to be clear, there were already guidelines in place by the Kentucky Medical Licensure Board in 1996; is that right?

A. That's correct, yes.

Q. And those were amended in 2001?

A. Yes.

Q. And again amended in 2003?

A. Correct.

Q. And those -- well, specifically -- and I'm looking at the

2001 modified by 2003. Here's the actual 2001 version. "Model Guidelines for the Use of Controlled Substances in Pain Treatment"; am I correct?

A. Yes, that's correct.

Q. Okay. And the 2003 is called the "Guidelines for the Use of Controlled Substances in Pain Treatment"?

A. Correct.

Q. Okay. And both these guidelines set out specific things that physicians should do. We won't go through all of them, but I'm just going to touch a couple of them.

One is, "Evaluation of the patient"; am I right?

A. That has always been a consistent part of the foundation, yes.

Q. "A complete medical history and physical examination must be conducted and documented in the medical record"?

A. Yes.

Could I ask which one you're reading from there?

Q. I'm looking at the --

A. I think --

Q. -- the modification in 2003.

A. Okay. Thank you.

Q. And we're not going to read this whole thing but just to make a point.

The second thing is, "Treatment plan. A written treatment plan should state objectives that will be used to determine

treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations, consultations, or other treatments are planned"; is that right?

A. That's correct, yes.

Q. A third one is, "Informed consents and treatment agreements." They're talking about -- what are those, informed consents and treatment agreements?

A. Essentially every patient is able to choose their own destiny, as it were, but we have to, particularly when it comes to opiates, inform the patients about the ups and the downs. There's a risk-benefit ratio, so we have to educate, we have to do an informed consent, and tell the patients, "Look, here are the risks." So we have to be very explicit about that, and as part of that we would talk about an exit strategy and withdrawing the medicine if it doesn't work. So those two would go together as part of the informed consent.

Q. Exactly right. They talk about high risk, and they say for some high-risk patients "a written agreement between patient [sic] and patient outlining patient responsibilities, including: One prescribing doctor and one designated pharmacy."

What does that mean?

A. Essentially if we're going to prescribe controlled, dangerous substances, there has to be one pharmacy and one prescriber. If I'm going to be the guy prescribing, then you

don't get it from anybody else. We don't want doctor shopping. And we only want one pharmacy because there can be pharmacy shopping too. Particularly in the past when the pharmacies didn't talk to each other, you could get patients going and getting medications filled here, here, and here without being discovered that they were pharmacy shopping. So one pharmacy, one doctor.

Q. "Urine/serum drug screening when requested."

A. We're talking about urine drug screens, and we talked about that. Want to make sure the patient's taking what's prescribed, not taking what's not prescribed, and also looking for the presence of illegal substances, like methamphetamine, cocaine, heroin, that sort of thing.

Q. "No early refills and no medications called in. If medications are lost or stolen, then a police report could be required before considering additional prescriptions."

What does that mean?

A. No medications called in. If we're going to prescribe potentially dangerous controlled substances, I want to see you. I want to see you. I want to make sure that you're making progress. I want to make sure you're not having adverse effects. I want to make sure that you're not becoming apneic at night and on the verge of dying from respiratory depression. So each refill, each follow-up has to be predicated on an exam and an update in terms of progress and potential adverse effects.

Q. "The reasons for which drug therapy may be discontinued, such as violation of a documented doctor-patient agreement."
A. If you are only in it for the drugs, then the drugs are not appropriate, and it's up to me, in terms of exercising discretion as the prescriber, to make sure that the patient is not doing it for the drugs only. So I have to make sure that the patient is compliant. And we have other choices. We don't fire patients, necessarily, if they're aberrant in their behaviors, but we will take the drugs off the table, the controlled substances, and we will make other choices to treat their pain.
Q. The number four is, "Periodic review." What does "periodic review" mean?
A. "Periodic review" basically means I need to know what's going on. I need to make sure that as a patient you're compliant. I need to know as a patient are you making progress based on one of those three things: Pain improvement and function improvement and quality of life improvement. Those are three parameters that we look at to judge success.
Q. Under that same heading, "Periodic requests for a KASPER report could be utilized."
A. Yes. Again, this was before, as we talked earlier, that albeit KASPER are not required during this time frame, it was online, it was available. In 2009 it could be easily accessed online. So we want to make sure that KASPER, being one of the

only two objective ways that we as pain management physicians have to monitor a patient compliance, that we use it. It's free. We can do it. It's web-based. We can access it.

Q. "Consultation. The physician should be willing to refer the patient as clinically indicated for additional evaluation and in order to achieve treatment objectives."

A. It doesn't necessarily mean that I'm the end all. There are some things that I don't do. Certainly I have patients referred to me for interventions because that's what I do, but if I have somebody who I think is addicted or is getting into problems with regard to out-of-control depression or PTSD, I'll refer that patient for psychiatric consultation, or I'll refer them for an orthopaedic consultation if I really think there's a back issue that needs to be structurally addressed.

But we need to be aware that we work together. So referrals are appropriate, indicated, and necessary -- frankly necessary in these complicated patients who we work with.

Q. "Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangement pose a risk for medication misuse or diversion."

A. We're talking about what we call -- and we didn't talk about this, but it's called the biopsychosocial component of pain -- biologically, psychologically, and socially -- depending on the living condition, like the one patient was essentially homeless.

When we've got conditions like that, we have to consider the whole situation to see if adherence, to see if psychological issues, to see if things beyond just the biological problem of something potentially being broken can be addressed safely with opiates. So we look, based on that, at the entire biopsychosocial aspect of the patient.

Q. "The management of pain in patients with a history of substance abuse or with a coexisting psychiatric disorder may require extra care, monitoring, documentation, and consultation with or referral to an expert in the management of such patients."

A. And essentially that was the case in almost each patient that we reviewed. If we were to choose one risk factor, one major issue that causes us problems across the board in terms of abuse and overprescribing and diversion, it's mental health and addiction. If we have patients who have overdosed -- who have overdosed -- have tried to commit suicide, either intentionally or unintentionally, why would I want to give them medications that they could do the same thing again, especially if they were suffering from severe depression and weren't making good judgments? Mental health is the reason, one of the major risk factors that we look at, particularly when it's a long-cited history of overdose, let alone multiple overdoses, such as it was with our one patient.

Those patients should not have controlled substances. They

are not able to control it. It is egregiously, egregiously outside the standard of care to continue putting dangerous substances in the hands of people with that sort of history.

Q. The next big thing is, "Medical records. The physician should keep accurate and complete records to include," and then it goes through a litany of different things.

A. Which were not obviously seen in this case at any time.

Q. "The medical history and physical examination; diagnostic, therapeutic, and laboratory results; evaluations."

Those ring a bell?

A. Of course, those are all required as part of a standard examination, standard documentation, almost none of which were done in Dr. Kudmani's workup and treatment of these patients.

Q. And the last big heading, this one was, "Compliance with controlled substances laws and regulations."

A. Well, I would summarize by saying, as you've asked me repeatedly, these controlled substances were not issued for legitimate medical purpose and they were issued outside the usual course of medical practice for all the reasons that I've been putting forth. Those are the legal requirements that I as a physician voluntarily sign and agree to on my DEA certificate, which allows me to prescribe controlled substances. I am told that I must prescribe for a legitimate medical purpose and in the usual course of medical practice.

I'm not allowed to run a pill mill. I'm not allowed to

write outside of the practice of medicine. I'm not allowed to write medications just without a medical foundation and examination and appropriate diagnosis.

MR. ANSARI: May I approach the witness, Your Honor?

THE COURT: Yes, sir.

Q. Just so we're clear, I want to make sure that these are the '03 guidelines that you referenced when performing this evaluation.

A. You, of course, didn't go through all the details, but the answer is, yes, this is the set of guidelines that I referenced.

MR. ANSARI: Your Honor, we would move to admit Exhibit Number 46.

THE COURT: Okay.

(Government Exhibit 46 admitted in evidence.)

Q. I won't go through the '96 and '01, but those kind of summarize those; am I correct?

A. They are representative, yes. The verbiage and the concepts are the same.

Q. And so Kentucky was truly ahead of Indiana?

A. I'm happy to pass on the compliment that Kentucky was well ahead of Indiana in this area. Of course, the bad news on that is that it had to be because Kentucky was suffering more than most states, including Indiana, because of the drug diversion issue. So the problem that Kentucky was having was horrible and continues to be very, very bad. But that's what necessitated

the early start by your medical board, and they did a good job.
Q. Let me ask you this: He went to Angela Morgan next, and specifically, you know, she was the one that went to the MORE Clinic and that there was no methadone on the KASPER. And so are you telling us that when you go to a methadone clinic, because they dispense it in-house, it does not show up on KASPER?
A. That's exactly right.
Q. Okay. So if you're a practitioner and you receive a letter from that clinic, it's upon you to call the clinic and find out what's going on?
A. It is. It is absolutely. But I will tell you that that would be the standard. Methadone is typically not dispensed as a prescription for treatment of addiction. Because of the addiction issues, they require the patient to come in, and they give the methadone to drink right there. So they have to show up on a daily basis. It's very onerous, but no prescriptions are written.
So we assume if the patient is being treated in a methadone clinic for addiction and we assume with validity and as a standard that they're getting it there, no scripts are written, it would not show up in the KASPER.
Q. And you didn't see any reference or materials in Dr. Kudmani's file that would indicate that he contacted the MORE Clinic?

A. I saw no indication of contact.
Q. Before I move on to the next patient, which is Brandy Casanova and that clinic, I just want to clear -- I don't think I did this with those guidelines. But those '01, '03 guidelines, those were in place between 2009 and 2012 in Kentucky; am I right?
A. Clearly they were, yes.
Q. All right. And the Indiana guidelines don't play a part in Kentucky, and they came after?
A. They came after, yes.
Q. Let's go to Brandy Casanova. Same thing with Ms. Casanova. If she went in-house to the methadone clinic, those are not going to show up in KASPER?
A. That's correct.
Q. But he received a letter from the MORE Clinic?
A. Correct. And made no response that I could discern.
Q. Right. There was no documentation that there was any kind of communication from Dr. Kudmani to the MORE Clinic?
A. No documentation, correct.
Q. And some things came up about other -- I think a Dr. Penta prescribing some oxycodone.
MR. ANSARI: So can we bring up Exhibit 24E, page 195, please?
A. Could I ask which patient that was?
Q. This is Brandy Casanova.

MR. ANSARI: And 24E are Brandy Casanova's MORE records.

You know what? I'm wrong. It's 12E, 12E. 12E, page 195. Thank you.

MR. LAMBERTUS: Judge, can we approach the bench for a second?

THE COURT: Uh-huh.

(Bench conference on the record outside the hearing of the jury.)

MR. LAMBERTUS: Are these in evidence?

MR. ANSARI: I think they are. They were all the certifieds. They came in under stipulation.

MR. LAMBERTUS: Okay. If you tell me they were all in there.

MR. ANSARI: I'm correct?

MS. JEFFERSON-WEBB: That's correct. That was the long list of records that I read in early in the case.

MR. ANSARI: These are all certified records.

MR. LAMBERTUS: Well, I understand that. I just didn't know if they'd been admitted.

THE COURT: Okay.

MR. LAMBERTUS: I took care of that, apparently.

(End of bench conference.)

BY MR. ANSARI:

Q. So on this specific page -- I don't know if you've had time

to read it. But, "Dose with admission. Get KASPER. Note: 29-year-old female referred from JDAC. Presented to JDAC 1/27 addicted to opiates and pregnant."

And within here somewhere -- I think it's EDC. Halfway down, "Denies medical issues except pregnancy." I assume that's "expected delivery" -- I don't know what "C" stands for -- "at 7/15/12 and plans to see Penta with delivery at Suburban. Is working with Project Link. Is getting RXs, Dr. Kudmani. Patient is separated 12 years, in relationship." And it kind of goes on.

Now, if I pull up the KASPER which the defense attorney went over with you and pull up Penta, we see Dr. Penta July the 12th, July the 12th, July the 17th, July the 30th, August the 13th, and those were for various small amounts; am I right? Six, 4 days, 3 days, 10 days, 15 days?

A. Yes.

Q. And only -- I'm sorry. And only two of those drugs I read off were oxycodone?

A. Correct.

Q. Okay. And we see now from the MORE records Dr. Penta was the OB/GYN delivering the baby. Does that make sense now?

A. It certainly defines who he is and, yes, clarifies the situation.

Q. And so without looking, indicative of an OB/GYN who is giving a couple days of medication after a birth?

A. Yes.
Q. Okay. Now, with concern to Ms. Forbes --
MR. ANSARI: Can we bring up Exhibit 21A, page 6, please?
Q. I think you ultimately said you're not opining on specifically as to the degree of medical certainty whether she had died based on the benzodiazepine, but you were asked quite a bit of questions on this, so I just want to clear it up.
You reviewed these records; am I right?
A. I did, yes.
Q. Okay. And I think you agreed there was a urine test; am I right?
A. Yes. Correct.
Q. And did that urine test show positive for benzodiazepines?
A. Yes, it did.
Q. Did the internist here list drug overdose as one of the final diagnoses?
A. The specific indication here -- two references -- "Patient found to have benzodiazepines in the drug screen," and then it goes on a little bit more. And then it says, "No discernible electrocerebral activity was identified. Severe hypothermia. Toxic dose of sedative and narcotic medications."
Q. And severe hypothermia we talked about earlier. It's the body's cold?
A. The body is cold, yes. Well below -- yeah. Basically the

body -- the individual had been dead for some time is what this suggests.

Q. "Toxic dose of sedative and narcotic medications could also produce this picture." What does he mean by that?

A. I'm not sure exactly what he's stating here. The grammar perhaps could be a little clearer. But from a medical perspective, when I read that as a physician dictating, I read that as saying it was an overdose of sedative and narcotics.

Q. So specifically is a benzodiazepine a sedative?

A. It is, yes.

Q. And a benzodiazepine as a sedative, can it cause respiratory arrest?

A. Yes, it can.

Q. And respiratory arrest will lead to a heart attack?

A. Correct. Yes.

Q. And both those together, I guess eventually oxygen is cut off to the brain?

A. Correct.

Q. And does that cause global anoxic encephalopathy?

A. Yes. Those terms, just, again, to be clear, means brain death.

Q. Okay. And so although you're not saying, because you're not a pathologist or a toxicologist -- this picture that's painted here, is that also a picture that is painted when someone overdoses and dies on benzodiazepines?

A. Yes, it's very consistent with that. This is a consistent picture of drug overdose with no recovery.

Q. Okay. All right. Thank you.

The next thing that you-all talked about was Ms. Keith, and a point was made -- you went through a lot of medical records. And correct me if I'm wrong, but when you're talking about there's no indication for medical records of surgeries, you mean the people that conducted those surgeries, those medical records are not found in Dr. Kudmani's patient records?

A. That's correct.

Q. Okay. There was a lot of anecdotal history listed in all the patient records, whether it be hospital or Dr. Kudmani, that came from somebody, but they're not the actual records for the surgeries?

A. That's correct.

Q. Okay. And why is it different -- why is anecdotal history different from actual documentation of surgeries?

A. Our patients will typically come in with their perception of what has happened in their past. Sometimes they're right; sometimes they're wrong; sometimes they don't remember. It's incumbent upon me as the diagnosing and treating physician to document the past medical history.

These are chronic pain patients. They have a long history. Things get distorted. If we ask any of us what happened ten years ago, we're likely to distort the facts a little bit. But

we can't distort the facts when I'm prescribing potent polypharmacy. We have to know the score.

So it's vital that we know the past medical history in terms of what worked, what didn't work, what the legitimate diagnoses were in the past so we don't have to reinvent the wheel, so we don't have to assume things that aren't true, so that we can maintain a safety profile when we put together the appropriate treatment plan.

MR. ANSARI: And if we could go to Exhibit 20D, page 4, please.

Q. You were asked about the autopsy specifically. If you see Picture Number 2, it says, "Six-inch scar." Is that a reference to a possible back surgery?

A. Yes, it is.

Q. Okay. But it's referenced to one scar on the back; am I right?

A. Correct.

Q. Okay. A lot of talk went back and forth about records and surgeries. Now, all those surgeries were prior to 2009; am I right?

A. Correct.

Q. Okay. And so because the surgery happens years before, that doesn't mean that years later you would still need chronic pain medicine?

A. No. Typically our operations don't result in chronic pain;

otherwise, none of us would have operations. It occasionally happens, but it's not because of the surgery. It's because of something else going on. Maybe the right diagnosis wasn't made, or maybe the surgery was inappropriate, or maybe a screw is fractured or a non-union has occurred, but the surgery per se doesn't mean that the patient is going to have chronic pain.

Q. I'm not going to bring them all up, but you went through a couple medical reconciliation, slash, discharge orders; am I right?

A. Correct.

Q. One was from Dr. Johnson, who was the ER doctor at Hendersonville?

A. Yes.

Q. And then the rest were from Our Lady of Peace?

A. Yes.

Q. Okay. And so when I go to the hospital or anyone goes to the hospital, do they note the medications that I'm on when I get to the hospital?

A. And that's part of standard procedure, yes.

Q. Okay. And when I'm discharged from that visit, do they note again what medications I came in on?

A. They do, yes.

Q. And do they usually say, "Hey, we either gave these or we didn't to you while you were here, but if you want any more, you've got to go see the person that's prescribed them to you"?

A. That's exactly what it means, yes.
Q. All right. So all those we saw, that's exactly what those are saying?
A. Correct.
Q. All right. The doctor isn't saying, "I specifically want you to go take" X, Y, and Z?
A. No. He appropriately leaves that up to the family doctor or the prescribing doctor to take care of. The hospital is there for acute care, not for long-term management. So the patients are sent back to their prescribing doctors to address the medications.
Q. And a couple times Dr. Rouben was the prescribing doctor on the Our Lady of Peace discharge for Soma and it might have been oxycodone. I don't know. But definitely Soma; am I right?
A. I believe that was correct.
Q. Okay. But you reviewed the KASPER in this case, and the KASPER goes back to January of 2009; am I right?
A. Correct.
Q. And you don't see a Dr. Rouben on the KASPER?
A. I do not.
Q. Okay. And so if Dr. Rouben was prescribing those in '08, he wasn't in '09 or '10?
A. Correct.
Q. And we don't know why, but it could be any reason why?
A. But it's not on the KASPER. Correct.

Q. Okay. You were asked specifically about a July 1st, 2009, date when Jennifer Reynolds, the daughter of Terri Keith, comes in and signs and starts taking over her medication, I guess distributing or dispensing. And you made reference I think a few times in the notes that that appears to be the same daughter who is having some issues, either driving on suspended license or Terri Keith's taking care of her kids; am I right?

A. Yes.

Q. And so is Ms. Reynolds the best person to put in charge of someone's medication, of narcotic medication?

A. No. No, she's not, for all the reasons we talked about with all the social chaos going on.

Q. And if she's an LPN, do LPNs have prescription-writing authority?

A. They do not.

Q. Okay. So she can't write those prescriptions?

A. No.

Q. You were asked about the alleged street drug use. You-all talked about it, where she said, "I thought it was cocaine, but it ended up being methamphetamine."

Now, if Dr. Kudmani had been using urinary drug screens, would he have caught the use of those illegal narcotics?

A. In all likelihood, yes.

Q. And that would have been helpful why?

A. We have one instance here where we know she admitted to

taking methamphetamine while trying and thinking she was taking cocaine, but we don't know what else she may have been taking that she didn't tell us about or that wasn't documented in the record. A urine drug screen is, as I've said many times, one of the two objective things we have to absolutely validate what's going on, KASPER being one objective thing, urine drug screen being the other. So for us as physicians to not take advantage of those two objective tools is not good. It's not standard of care.

So we need to know what she's taking, what she's not taking, and what illegal substances she may be taking. Urine drug screen is really the only "trust but verify" way of doing that.

Q. You were also asked about trazodone and Neurontin. Those did not show up on the KASPER; am I right?

A. Correct.

Q. And that's because they're not controlled substances back then?

A. Correct.

Q. Okay.

A. They still aren't.

Q. Okay.

MR. ANSARI: Can we bring up page -- I mean, Exhibit 20D, page 1?

Q. You also agree that you're not giving independent medical opinion as to the cause of death of Ms. Keith?

A. Correct.
Q. But you agree --
MR. ANSARI: And maybe page 4.
Q. But you agree with the medical examiner --
A. I do.
Q. -- Dr. Barbara Weakley-Jones?
MR. ANSARI: Try 5, please. We're going to get it right.
There we go.
Q. All right. And trazodone, Neurontin, and Soma are not listed on this drug abuse panel?
A. That's correct.
Q. But the Klonopin and oxycodone are?
A. Yes.
Q. And those concentrations and therapeutic levels are in the lethal doses; am I right?
A. On this particular visual that we're looking at, it has concentration, but it doesn't have therapeutic range.
Q. Okay. Are you familiar with the therapeutic range of either of those narcotics?
A. Not offhand, no.
Q. Okay. So we'd have to rely on the M.E.'s testimony when she testified this past week?
A. Yes.
Q. All right. And last question. The Klonopin, although

prescribed previously by Dr. Chhibber, on this specific day, on May the 3rd, it's the first time that Dr. Kudmani has ever prescribed this medication?

A. Correct.

Q. And on that date you do not see any specific charted patient history or complaint or diagnosis or treatment plan that would substantiate Dr. Kudmani prescribing Klonopin or opiates?

A. That's correct.

Q. Okay. And according to the M.E. in her report, both drugs, either the opiates or the Klonopin, were enough to kill her?

A. Yes. And I would agree with that.

MR. ANSARI: Okay. All right. I appreciate your time. Thank you, sir.

MR. LAMBERTUS: Just one or two questions.

THE COURT: All right.

RECROSS-EXAMINATION

BY MR. LAMBERTUS:

Q. Dr. King, the prosecutor asked you about the incident where Ms. Keith apparently attempted to take cocaine and ended up taking methamphetamine. Do you recall that?

A. Yes.

Q. And she revealed that at Our Lady of Peace Hospital, did she not?

A. I don't have -- I'd have to look it up, but it certainly was in conversation with one of her caregivers.

Q. Okay. Well, I mean --
A. I will agree if you stipulate that's what it is.
Q. Oh, yes. Absolutely.
And the prosecutor asked you if it would have been a good idea if Dr. Kudmani had taken a urine test, and you said yes; is that correct?
A. Yes.
Q. Well, similarly, would it have been a good idea for Our Lady of Peace Hospital, who was the one told about taking the drugs, to take a urine sample of her too?
A. I don't know what their protocols are, and certainly I didn't review their -- all the caregivers' records that were involved. In other words, I didn't see Dr. Chhibber's records on things. So I can't comment on that. Certainly it's a tool available to the hospitals, just as it is the doctors.
Q. All right. So it would be an equally good idea for the hospital as it would be for Dr. Kudmani to do that?
A. I don't have all the information for the hospital, so I don't know what went into their decision-making on that. I don't know what their protocols are. I don't know what their admission guidelines are.
Q. Let's make a generality. If someone tells you -- a patient tells you they're snorting cocaine or methamphetamine, do you do drug tests?
A. The differential is this: If the patient is under --

Q. Well, first of all, is that a yes or no?
A. Well, because there's a difference here, because the patient here was in the hospital. So we know that she's in all likelihood not taking any medications other than what's being given to her.

But when the patient is outside the hospital being followed by Dr. Kudmani or another doctor, it's the outside-the-hospital routine "trust but verify" the use of urine drug screen becomes important. In the hospital it becomes important, as we have seen, if the patient comes in in an overdose scenario. And in the case of Ms. Keith, we found that she had benzodiazepines and narcotics.

But we don't follow a patient in the hospital with urine drug screens. That doesn't make sense. We follow the patient outside the hospital on a routine basis, trusting and verifying by taking urine drug screens.

Q. Did we not talk about Ms. Keith trying to get Klonopin off a fellow patient while she was in the hospital?
A. On the way to -- actually she was on the way to an outpatient program.

MR. LAMBERTUS: Okay. That's all. Thank you.

THE COURT: Anything?

All right, Doctor. You may step down. Thank you very much for your testimony.

(Testimony concluded at 4:25 p.m.)

C E R T I F I C A T E

I CERTIFY THAT THE FOREGOING IS A CORRECT TRANSCRIPT FROM THE RECORD OF THE PROCEEDINGS IN THE ABOVE-ENTITLED MATTER.

s/Terri L. Turner
Terri L. Turner, RMR, CRR
Official Court Reporter

March 9, 2017
Date

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GOVERNMENT EXHIBITS ADMITTED:

Exhibit 46 - "Guidelines for the Use of Controlled Substances in Pain Treatment" 155

DEFENDANT EXHIBITS ADMITTED:

Exhibit 6 - "First Do No Harm: The Indiana Healthcare Providers Guide to the Safe, Effective Management of Chronic Non-Terminal Pain" 97
Exhibit 7 - "Pain Management Prescribing Final Rule" 99

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