UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
WESTERN DIVISION

UNITED STATES OF AMERICA, Docket No.: 3:19CR490

Plaintiff, July 12, 2021

v Toledo, Ohio

WILLIAM R. BAUER,

Defendant.

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TRANSCRIPT OF JURY TRIAL, VOLUME 4
BEFORE THE HONORABLE JACK ZOUHARY
UNITED STATES DISTRICT JUDGE

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THE COURT: Good morning. We're back on the record with counsel only. The jury will be coming in shortly. I thought I would place on the record a discussion that I held with counsel last Friday.

We reviewed a number of exhibits that were offered by the government, and we had some rulings. And I will now recite into the record the results of that conversation.

Exhibits 101 through 208 were admitted without objection.

Exhibits 401 through 414, again, admitted without objection.

Exhibits 501 through 630 admitted without objection.

Exhibits 701 through 703 admitted without objection.

Exhibits 712 through 725 admitted. There were -- there was only one objection to that series, and that was to Exhibit 721. Defendant objected, I overruled and admitted it, along with the other photos in that series.

801, the government offered to admit, defendant objected, and I sustained that objection. So 801 is not admitted.

804 admitted without objection.

The government also offered 805 and 806. I held

off a final decision on those two exhibits until the government was ready to rest.

And I believe that concludes the exhibit discussion that we had, and counsel may take their notes and advise if I have been accurate or not at some point, doesn't have to be right now, in my summary of those exhibits.

When the jury comes in this morning shortly, I will be giving them the limiting instruction that we also discussed Friday afternoon. There was some back and forth and revisions that were made to an initial draft, and I will read, what I believe is the consensus by all, the language that the final draft ended up with. And that's how we'll start.

And if the government's first witness -- you may bring that person in the courtroom so that we may start quickly once the jury arrives. Thank you.

(Jury present in courtroom.)

THE COURT: Welcome back, ladies and gentlemen. You all may be seated. Give the jury a little to get settled in. Hopefully everyone had a good weekend. Certainly the weather Saturday was very nice. Sunday, not so nice.

Before we call the first witness, sometimes, during the course of a trial, ladies and gentlemen, I will

give additional instructions, also known as limiting instructions. And that's what I'm going to do for you to start off this week, and to start off today.

Ladies and gentlemen, last week you heard testimony from coroners Jeffrey Hudson and Daniel Cadigan about Melody, a patient of the defendant. You also heard testimony on Friday about the death of Rodney. Those deaths themselves are not at issue in this case. Also not at issue is whether any medications prescribed by defendant were a cause or a contributing cause in those deaths. Rather, such testimony is relevant in the context of whether defendant knowingly and intentionally distributed and dispensed Controlled Substances by issuing prescriptions outside the usual course of professional practice and not for a legitimate medical purpose.

With that, the government may call its next witness.

MS. DUSTIN: We call James Cipiti.

JAMES CIPITI,

was herein, called as if upon examination, was first duly sworn, as hereinafter certified, and said as follows:

DIRECT EXAMINATION

BY MS. DUSTIN:

Q. Would you introduce yourself to the jury, please?

A. Pardon me?

Q. Would you introduce yourself to the jury?
A. Good morning. My name is James Robert Cipiti.
Q. And tell us where are you employed.
A. I'm employed with the Port Clinton Police Department.
Q. What is your position?
A. I'm a patrolman.
Q. And how long have you been with the Port Clinton Police Department?
A. Seventeen years.
Q. And what community are you from?
A. Port Clinton.
Q. Tell us about your employment background prior to joining the police department in Port Clinton.
A. I graduated high school in 1988. From there I joined the United States Army. I left the Army in 1997, I stayed out in The State of Washington for a little while, worked in the wood products industry.

From there, my father was getting sick, and he owned an appliance repair business back in Port Clinton. That's when I decided to come home. My wife and I both moved back here in the year 2000. I took over the business for a little while up until his death, and then I decided to go to the police academy and become a police officer.

Q. Are you currently married?

A. No.
Q. And were you married?
A. I was married, I'm a widower now.
Q. And what was your wife's name?
A. Melody Anne Cipiti.
Q. And did you and Melody have any children?
A. No, we did not.
Q. And tell us how you and Melody met.
A. Stationed down at Fort Polk, Louisiana, year was 1990. Her brother was my roommate, and she came down to visit him, and there's the story.
Q. Eventually you moved back to Port Clinton?
A. Yes.
Q. And when you moved back here, did Melody work anyplace?
A. Yes.
Q. Where did she work?
A. She worked at Magruder Hospital.
Q. Tell us about Melody's education.
A. She went to -- I can't remember the name of the college, college in Louisiana when I was stationed down there, and then she finished up -- I think it was Pierce Community College (Phonetic) in Killeen, Texas when I got transferred to Fort Hood Texas.
Q. What did Melody do at Magruder Hospital?

A. She was a phlebotomist.
Q. What did she do as a phlebotomist?
A. Draw blood, test blood, look for stuff. Not really sure what.
Q. Just, in general, tell us about things that you and Melody did while you were living in Port Clinton shortly after moving there.
A. We would go on a lot of trips down south, Hocking Hills, rent cabins, camping somewhere. Outgoing, we had did a lot of family stuffy, have a big family in Port Clinton. Just out, normal couple stuff.
Q. At some point did she have an accident?
A. Yes.
Q. And when was that accident?
A. It was, I want to say 2008.
Q. And tell us the circumstances of the accident.
A. We were going to Outback Restaurant, and she slipped and fell on some ice. And when she fell back, I heard her head bounce twice on the pavement, and then she was out. And that's when I dialed 911.
Q. So this would have been winter?
A. Wintertime, yes.
Q. Was it early 2008, 2007, late, do you recall?
A. I want to say late 2007. That's what I want to say. I also want to say 2008.

Q. You know it was winter?
A. Yeah, it was around there.
Q. And you called 9111?
A. Yes.
Q. And did she sustain an injury?
A. Yes.
Q. And what was her injury?
A. She had a fracture in her neck, she had hip pain, lower back pain.
Q. After that injury did Melody have any discomfort?
A. Any discomfort?
Q. Yes, did she suffer from any discomfort?
A. Yeah, she had pain.
Q. Did she have pain in the areas you just described, her neck, where else?
A. Lower back.
Q. Lower back. As a result of her pain, did she see a doctor?
A. Did she see a doctor?
Q. Yes.
A. Yes.
Q. And tell us, was she treated long term by a doctor?
A. Yes.
Q. And who was that?

A. Dr. Bauer.
Q. And do you know his first name?
A. William.
Q. Do you remember when she started to see Dr. Bauer approximately?
A. 2008.
Q. And did she see Dr. Bauer until her death?
A. Yes.
Q. And when did she die?
A. She died September 13th, 2015.
Q. Was she seeing any other -- was she being treated for any other disorders during that time period?
A. She had bipolar disorder, and she was seeing, I don't remember who that was.
Q. Okay. Some type of mental health services provider?
A. Yes.
Q. And can you explain to us how Melody progressed in terms of her pain? Let's start from the time she started to see Dr. Bauer until her death.
A. Well, she was in a lot of pain, and she was using pain medications to help the pain. But throughout this process I kept asking her about surgeries and stuff like that. I mean, are they going to offer you any kind of surgery to fix the back, you know, what are they going to

do, you can't stay on this forever. We never really got a clear answer. She never gave me a clear answer on anything.

Q. Did Melody go through any -- was any physical therapy ordered by Dr. Bauer that she -- she went through?

A. No.

Q. Do you recall her going for periodic diagnostic tests?

A. I remember her going to see Dr. Bauer, her appointments.

Q. Do you remember her having any type of tests like MRIs or any type of diagnostic --

A. I don't remember at this point, no, I don't.

Q. Was she prescribed -- what type of drugs was she prescribed from Dr. Bauer?

A. The Hydrocodone, Percocet, some other narcotics, I can't really name them all. I think there was Methadone in there.

Q. And did she take these medications the entire time she saw Dr. Bauer until approximately the time of her death?

A. Yes, she's been taking medications for -- 2008 until her death in 2015.

Q. Did they -- medications improve her pain from what you could see?

A. No.

Q. And can you tell us any observations you made of Melody while she was on the medications?

A. There was several times where I -- back in those days I was kind of young on the department so I worked a lot of overtime. And I also worked a lot of overtime just to get away from the home sometimes. I would come home from work, working a 12-hour shift, and I'd see my wife sitting in the chair with her head laying back, mouth wide open, basically gasping for air. I would wake her up and get her to bed. I will say this, she did have sleep apnea. But there was several occasions where I would come home, even early on when I want to come home, let's go out to supper, let's go see a movie. Couldn't take her anywhere. She didn't want to go anywhere.

As this progressed in our relationship, it just seems that the person that I married, which was Melody Cipiti, I don't know who that was in the middle of this going until the end. I have no idea who that was. All I ever wanted was my wife back. I don't know who that was. I would talk until I'm blue in the face. Her mother would talk to her until she was blue in the face trying to get her off this crap, get surgery. There was just a lot I had to deal with those years. I just felt like I didn't get any help from -- from any other -- anybody else. Maybe,

you know, I don't know if Dr. Bauer had tried to talk to her because she never told me anything about that, about surgery. All I wanted her to do was have the surgery, get the back fixed, get your job back, and let's go on with our life, and I didn't get that.

Q. Tell us about -- you said get her job back. Did she have a job this entire time?

A. No, she did not.

Q. What happened?

A. She was in and out of jobs. She would go -- she would go to work. They released her from Magruder because she wasn't working, and, of course, they had to hire somebody because they needed somebody to work.

So she got a job over in Fremont. There was a new clinic that opened, it was owned by Dr. Matag (Phonetic) I can't remember what the name of the clinic was. While she was there -- she did good for awhile, but then she was falling asleep a lot. She was falling asleep a lot because she was taking those pain medications when she was at work. She just couldn't get off the pain medication.

And then that place closed down due to a sale of ProMedica. It's all business stuff from there on, but she didn't get fired. They were all let go because that building was bought by another hospital.

Q. Did her falling asleep affect her abilities to do anything else?
A. It affected her ability to draw blood. I remember her specifically telling me that she had people come in to help her, what she called a stick, because she was missing it all the time, and she never knew why. I knew why. She couldn't drive. I don't know how the hell -- excuse me, I don't know how she made it back and forth to work.
Q. Was there ever an incident where she couldn't drive herself someplace?
A. I'm sorry?
Q. Was there an incident when she couldn't drive herself someplace?
A. Drive herself someplace?
Q. Yes.
A. I was coming back from Pennsylvania from a Homeland Security briefing we had there, and I got a phone call from my Sergeant at the time, who's since retired --
MR. GIBBONS: Objection.
THE COURT: He objected.
MR. GIBBONS: Objection.
MS. DUSTIN: I'll ask you a different question.
THE COURT: Thank you.
BY MS. DUSTIN:

Q. While you were in Pennsylvania, did you learn something that caused you to come back?
A. Yes.
Q. What happened?
A. My wife was getting her hair and nails done, she couldn't keep her eyes open. And we had to come back because another cop was called there to go pick her up and take her home.
Q. Did Melody's body appearance change over this time period?
A. She's gained a ton of weight, a lot of weight. She was always kind of a heavier girl, but with the inactivity, the sitting around, the odd hours of, well, not even eating correctly, you know she gained a lot of weight, a lot.
Q. Did the medications, the Controlled Substance medications that Melody was taking, did they increase or decrease during the time -- this time period, do you recall?
A. I can't recall. I think it just stayed the same. There was just a lot of pill bottles laying around.
Q. Did the medications enable Melody to do more activities?
A. No. No.
Q. Did the pain medications, the Controlled

Substances, improve her pain?

A. I -- I wouldn't know. I don't really know.

Q. Did she have a hard time walking?

A. Yes.

Q. And did you ever see her lose her balance?

A. Yes.

Q. What would happen?

A. She would fall, or she'd fall into a couch or a wall or whatever was available that she could catch herself on.

Q. Did you ever go to an appointment with Dr. Bauer and Melody?

A. I did once.

Q. Tell us about that.

A. We went there, and we pulled in, we went inside, there was absolutely no place to sit down. The office was packed full of people. I think I waited in there maybe five minutes just standing up, and then I just went outside.

Q. How long did you wait before she was able to see Dr. Bauer?

A. Oh, maybe 20, 25 minutes, maybe 30 minutes, something -- I really don't remember. We were there for a little while.

Q. How long was her appointment?

A. When she went in, it seems like she came out in maybe 15 minutes after that.
Q. You didn't actually go in with her?
A. I did not go in, no.
Q. Did she have any concerns with respect to her medication? Did she ever talk to you about whether she ran out early, or had to get more?
A. I know she ran out early and tried to get more. And I remember her having arguments with the pharmacist at Rite Aid about I really need this, you need to fill it, and the pharmacist saying, no, I can't, it's too early.
Q. Do you remember the day that Melody passed away?
A. Yes.
Q. And what was the date?
A. September 13th, 2015.
Q. And tell us about when you -- your day that morning. What did you do that day?
A. I was working harbor patrol, and when I --
Q. Harbor patrol?
A. Harbor. How do I explain that? Harbor patrol -- in Port Clinton we have a police boat, and we patrol our harbors, and we patrol certain areas of the lake and look for safety violations, or help boaters if they're in distress or if they have any questions.
When my shift ended, I went home, and I walked

into the bedroom and changed in the closet, had a big walk-in closet at the time. I was in there changing clothes, I was tired, went to go lay down, laid down, and Melody was still in bed. I just felt like there was something wrong, and then I reached over, and being a cop and showing up on a lot of dead body calls, I knew she was gone. So I immediately got up, I ran over to try to -- I was going to pull her off the bed, but it -- she was rigid. So it was too far, there was just no -- I could not do any life -- life-saving techniques at all, so I just called 911 and had everybody come.

Q. Approximately what time did you go to work that morning?

A. I'm sorry?

Q. What time did you go to work that morning?

A. I think I left the house at maybe 9:30.

Q. A.m.?

A. A.m.

Q. And what time did you get home, approximately?

A. 2:00.

Q. Around 2:00 p.m.?

A. Around 2:00 I think.

Q. And did Melody have any difficulty breathing in terms of at night when she slept?

A. Yeah.

Q. And so tell us about -- if she used anything to help her breathe.
A. She used the breathing machine, the Cpap I think they call that. It was a machine --
Q. Do you recall when you came home whether she was wearing her Cpap machine?
A. I think she was wearing it at the time.
Q. At that time did you find any evidence, or did you suspect a suicide?
A. No.
Q. Why not?
A. Well, there was nothing ever really to indicate that she wanted to hurt herself. Another thing is I was kind of, you know, after our conversations, I told her, and we talked about this, you continue taking this medication the way you take it, you're going -- it's going to kill you, you're not going to wake up from this.

Yes, I was surprised that she was dead, but I wasn't surprised either because I knew that she was just taking this medication, and a lot of it.

Q. So there was, you know, no suicide note?
A. No.
Q. Did you see any, you know, empty pill bottles laying around?
A. I don't remember if I saw empty pill bottles.

Q. Do you know where she normally kept her pill bottles?
A. In the kitchen.
Q. In the kitchen. You did say that Melody had some mental health treatment that she sought. Was she ever suicidal?
A. She would always -- sometimes she would say, you know, if she -- a lot of times if she didn't get her way, she was mad about something, she was going to kill herself, but she would never, you know -- sometimes I think a lot of people say that, and they just don't do it. You know, hell, I may have said it at one time in my life, you know, you get mad.
Q. Let me show you what's been marked as Government's Trial Exhibit 802. It's going to be on the screen in front of you.
And do you recognize 802?
A. Yes.
Q. And what is that?
A. That's a picture of my wife and I.
Q. And when was that taken?
A. That was taken 1992 down in Louisiana.
Q. While you were still --
A. I was still in the service. I looked better.
Q. Go ahead.

A. Never mind. I looked better.
Q. And Exhibit 721, what is that a picture of?
A. Looks like her driver's license picture.
Q. Melody's?
A. Melody, yeah.
Q. Do you remember what year that was from?
A. Pardon me?
Q. What year?
A. No, I don't remember what year.
Q. Thank you.
MS. DUSTIN: If I just may have a moment, Your Honor?
BY MS. DUSTIN:
Q. Do you recall if Melody ever was called, like, randomly into Dr. Bauer's office to do pill counts?
A. I've -- no, I've don't remember anything like that.
Q. Do you recall if Melody was ever called in to Dr. Bauer's office to do urine screens?
A. Not that I recall, no.
Q. And did the medications improve Melody's function and daily activities at all?
A. No, she was still having a hard time walking.
Q. Could she do the things she used to do?
A. No, we never did anything more after that.

Q. Thank you. Nothing further.

THE COURT: Cross examine?

MR. GIBBONS: Thanks, Judge.

CROSS-EXAMINATION

BY MR. GIBBONS:

Q. How are you today, sir?

A. I'm fine. Thank you.

Q. Sir, I'm just going to ask you a couple questions about your wife's overall situation. Do you recognize the names of Dr. Briede, B-R-I-E-D-E and Dr. Evans?

A. Dr. Briede, yeah, and Mrs. Evans.

Q. Who is Dr. Briede and Dr. Evans?

A. I think Dr. Evans was her mental doctor. Dr. Briede was family doctor at the time.

Q. Okay. And I take it that your wife started treating with Dr. Bauer in about 2008, is that accurate?

A. Yes.

Q. Dr. Briede was a psychiatrist?

A. No, Dr. Briede was -- I want to say the family doctor. I think Cindy Evans was the mental doctor.

Q. Psychiatrist, if you know?

A. Psychiatrist, yes.

Q. Okay. So was it Dr. Briede and/or Dr. Evans who referred your wife to Dr. Bauer's office?

A. I don't know. I would say it was -- I don't know

who referred.

Q. And the psychiatrist, had your wife been treating with that person prior to 2008?

A. Yes.

Q. And did she have a diagnosis?

A. At that time I don't think she had a diagnosis. I don't think she told me about the bipolar stuff until after the accident that she had when she fell.

Q. I see. So at some point in time before she was being treated by Dr. Bauer, she was diagnosed with bipolar, is that accurate?

A. Yes.

Q. Okay. And that bipolar had been in existence for how long in 2008?

A. I don't know.

Q. Okay. Do you know if she was being treated by a mental health doctor prior to 2008 for any other conditions?

A. I don't know how she was being treated, but she was seeing a psychiatrist for depression.

Q. Okay. And for how many years back in 2008 had she been seeing or been treated by a psychiatrist?

A. At least a year.

Q. Okay. And were those issues obvious to you in 2008, those mental health issues?

A. Yes.
Q. Okay. And when was her slip and fall or injury at the Outback?
A. It was in the winter of 2007. I want to say either December or January she slipped and fell.
Q. Was that during the winter months?
A. It was during the winter months. The parking lot was icy.
Q. And she slipped in the parking lot?
A. Yes, right outside of Outback Steakhouse in Sandusky, Ohio.
Q. You were with her, were you not?
A. Yes, I was.
Q. And she hit the pavement, or the snow and the ice pretty hard, did she not?
A. She did.
Q. I see. And was she conveyed to a local hospital at that time?
A. Yes. She was transported by ambulance to the local hospital. I think it was Fireland's.
Q. And for how long was she in the hospital after that fall in the Outback Steakhouse parking lot?
A. She was released that night.
Q. I see. And she sustained injuries as a result of that fall, did she not?

A. Yes.
Q. And was it a traumatic brain injury that she sustained as a result of that fall?
A. That was one of the diagnosis, yes.
Q. I see. And was she hospitalized any further after that fall at the Outback Steakhouse?
A. No.
Q. Okay. And who is -- which doctor was treating her for the traumatic brain injury?
A. I don't -- I don't remember who.
Q. And you retained an attorney, did you not?
A. Yes, we did.
Q. And you instituted some form of claim against Outback or some other entity?
A. Yes.
Q. And your attorney was Mike Kinney in Rocky River?
A. Yes.
Q. Okay. I know Mike.
And did you resolve that claim with a settlement from Outback or someone else?
A. Yes, we did.
Q. Okay. And that was in 2007 or --
THE COURT: What was in 2007?
MR. GIBBONS: I'll rephrase it.
THE COURT: Thank you.

BY MR. GIBBONS:

Q. The Outback incident was in 2007?

A. Yes.

Q. And which doctor diagnosed her with the traumatic brain injury?

A. I don't know. I don't remember who.

Q. Okay. And was there a doctor who referred her to see Dr. Bauer?

A. I don't know who that doctor would have been --

Q. I see.

A. -- at the time. I don't remember that.

Q. And you were married to her, did she experience pain as a result of that injury?

A. Yes.

Q. I see. And can you describe the pain that you observed, or became aware of, that your wife suffered from?

A. She had a lot of pain in her neck. She wore the neck brace, and she always complained about lower back and hip pain.

Q. I see. So she had also back and hip pain?

A. Yes.

Q. And she went to see Dr. Bauer for pain relief, correct?

A. Yes.

Q. And during the time frame that you -- or she was

being treated, you went to his office on one occasion?
A. Just one occasion.
Q. I see. And how often did your wife go to see Dr. Bauer, if you know?
A. I don't know how often that was.
Q. I see. And did she have any surgeries between the time where she first went to see Dr. Bauer and the date of her death?
A. No, there was no surgery.
Q. And the date of her death was in 2015 sometime?
A. Yes.
Q. And was she awaiting surgery at the time of her death?
A. No.
Q. Okay. Did she -- or was she contemplating surgery?
A. No.
Q. Okay. And did she continue to work at Magruder Hospital even after she went to be treated by Dr. Bauer?
A. She only worked there for a short time after that.
Q. Can you give us a better idea of how long she worked there?
A. You know, I really honestly don't remember. I don't want to give you something I can't back up.

Q. That's fair. But during the time period that she was being treated by Dr. Bauer, she held other employment, did she not?
A. She did.
Q. And was that that medical clinic, at that medical clinic in Fremont?
A. Yes.
Q. And what type of work did she do there?
A. Phlebotomy.
Q. And for how long did she work at the clinic?
A. I want to say before that place sold, I want to say at least two years, two-and-a-half, maybe three.
Q. As long as three years?
A. As long as three.
Q. Okay. And for whatever reason she lost that employment?
A. Right.
Q. And what was that reasons other than -- well, did the business close, or was it sold?
A. The business was sold, and every employee got their last check and had to leave. It was --
Q. Can you tell us the years that she worked at the clinic in Fremont?
A. No.
Q. Okay. And it was -- but it was during that time

frame that she was being treated by Dr. Bauer?
A. Yes.
Q. Okay. Did she have any other employment other than the medical clinic in Fremont?
A. No.
Q. Okay. Did she drive?
A. She did drive.
Q. Did she drive herself to Dr. Bauer's location?
A. Yes.
Q. Did you have a problem with that?
A. I always had a problem. After awhile she was taking all these medications and driving.
Q. But nonetheless, you didn't prohibit her from driving, did you?
A. No.
Q. Okay. And was she driving up until roughly the time of her death?
A. Yes.
Q. And you mentioned that you became concerned about the medication?
A. Uh-huh.
Q. And you brought that concern to the attention of your mother, is it, or was it her mother?
A. No, it was her mother.
Q. Was she living up in Ohio at that time?

A. Yes.
Q. And did her mother live with you?
A. Yes.
Q. And did you ever go to see Dr. Bauer and express your concern about what was going on with your wife?
A. No.
Q. Okay. Did you -- did you or your mother in law ever go to any other doctors to seek any other form of treatment?
A. No.
Q. So your wife was being treated by Dr. Bauer from roughly 2017 -- I'm sorry, 2008 until 2015?
A. Yes.
Q. And at no time during that time frame did you complain to Dr. Bauer's office or try to switch doctors or do anything like that?
A. No.
Q. Now, your wife continued to be treated for mental health issues while she was being treated by Dr. Bauer?
A. Yes.
Q. And how many years from 2008 until 2015 did she regularly see a psychiatrist?
A. She saw them pretty regularly, excuse me, up until her death, from about 2007 until her death.
Q. Would that have been Dr. Gary Bishop?

A. Yes.
Q. And where was Dr. Gary Bishop's office located?
A. Honestly, I don't know. I want to say Fremont.
Q. Was there a doctor or psychiatrist that she treated with prior to Dr. Bishop?
A. It was -- it was Dr. Evans.
Q. Dr. Evans. So did the treatment by Dr. Evans and Dr. Bishop coincide with the treatment that she was being given by Dr. Bauer?
A. That I don't know.
Q. Okay. How often would she go see the psychiatrist?
A. I would say maybe once every couple months.
Q. I see. And did she drive herself there?
A. Yes.
Q. And even though you had concerns about that, you did not prohibit her from driving to her other doctors' appointments?
A. No.
Q. And you did not make any alternative arrangements to get her to her other medical appointments?
A. No.
Q. And does your mother-in-law drive, or did your mother-in-law drive?
A. She did drive, or, yes, she drives.

Q. And did your mother-in-law drive Melody to her doctors' appointments?
A. I'm sure she did every -- every now and again because they would stop and have lunch somewhere.
Q. And you mentioned earlier that she, Melody, used a walker at some point in time?
A. I don't think I mentioned that, but she did use a walker.
Q. She did use a walker?
A. Yeah.
Q. At what point in time did she use a walker?
A. In the house when she would get up from her chair, maybe use the bathroom or go to the bedroom she would use that.
Q. Okay. Did she do any other activities other than go see her doctors?
A. No.
Q. Do you know the specific date that was her last appointment with Dr. Bauer?
A. No, I do not.
Q. Do you know what the date was for her last appointment with Dr. Bishop?
A. No, I do not.
Q. Was that at or near the time of her death?
A. I don't know.

Q. Do you know if Dr. Bishop had her on any type of prescribed Controlled Substance medications?
A. I don't know if he did or did not.
Q. Did you ever ask your wife back in 2008 if she was being prescribed Controlled Substances other than by Dr. Bauer?
A. No, I've never asked her anything like that back then.
Q. After her death, did you examine the pill bottles?
A. No, I did not.
Q. Okay. So you have no knowledge about whether he -- she was taking Controlled Substances from any other provider other than Dr. Bauer at the time of her death?
A. Yes, correct.
Q. Okay. So there's no question that she suffered from a traumatic brain injury?
A. Right.
Q. Okay. And did she suffer from headaches during the time frame that Dr. Bauer treated her?
A. I don't remember.
Q. Okay. And we know that she had bipolar disease, and was she -- how many years was she under the care of a psychiatrist looking back from her date of death?
A. I'd say about five or six years.

Q. Okay. Did she also have thyroid cancer?
A. A long time ago, yeah.
Q. Okay. Was she being treated by any doctor for thyroid cancer?
A. At the time she was until then, she had surgery and had all that removed.
Q. Okay. And when was that roughly, if you know?
A. Oh, jeez. 2005. I mean, I don't really remember. It was awhile back.
Q. And obviously she had the lower back pain?
A. Yes.
Q. And did she suffer from anxiety and depression?
A. Depression.
Q. Okay. And would you characterize her pain from the time frame where she was being treated by Dr. Bauer as being constant or persistent?
A. I don't -- I don't know.
Q. Okay.
A. She would always say she was in pain --
Q. Okay.
A. -- you know.
Q. On a daily basis or periodically?
A. Just periodically.
Q. Okay. You also spoke about, she made some stray comments about wanting to kill herself?

A. Uh-huh.
Q. And with respect to the date of her death, can you place those in terms of time?
A. No, I can't.
Q. Okay. So do you know if Dr. Bauer permitted her to have early refills?
A. That, I don't know.
Q. Okay. But apparently she had, on occasion, tried to get early refills, but she was turned away --
A. She has, yes.
Q. -- by the pharmacist?
A. Right.
Q. Did she have a regular pharmacy that she went to?
A. We usually went to Rite Aid in Port Clinton.
Q. Okay. And so you allowed her to drive, even though you had some concerns?
A. Yes.
Q. And you did not interfere with or her treatment by Dr. Bauer?
A. No, I did not.
Q. And you did not put your foot down, so to speak, and complain to Dr. Bauer or his office about what you saw with your spouse?
MS. DUSTIN: Objection, asked and answer.
THE COURT: Sustained.

MR. GIBBONS: Okay. Judge, just a moment.
Thank you, sir.
THE COURT: Any redirect?
MS. DUSTIN: Just a couple questions.

REDIRECT EXAMINATION

BY MS. DUSTIN:

Q. Just to kind of clarify in terms of Melody's work history, after the Fremont Medical Clinic closed and she was no longer working there, when was the last time she held a job?

A. I don't think she did.

Q. So she passed away September of 2015?

A. Right.

Q. Prior to that when did she last hold a job?

A. I think she tried to take one of those traveling jobs, and it just -- it just fell through.

Q. Why was she not able to get employed again?

A. She just didn't put forth any effort to try to get employed anywhere, stayed home.

Q. And what did she do at home?

A. Nothing. Just sat there and passed out.

Q. Was there any evidence that the medications that Melody was taking alleviated her pain to make her more functional?

A. No. She walked, you know, with that walker from

then until her death. She didn't -- we didn't go anywhere or do anything.

Q. Thank you. Nothing further.

A. You're welcome.

THE COURT: You may step down. Thank you.

THE WITNESS: Thank you.

THE COURT: Next witness?

MS. DUSTIN: We call Timothy King.

TIMOTHY KING, M.D.

was herein, called as if upon examination, was first duly sworn, as hereinafter certified, and said as follows:

DIRECT EXAMINATION

BY MS. DUSTIN:

Q. Good morning.

A. Good morning.

Q. I'll let you set yourself up there.

A. Thank you. I feel like I brought in a library. I'm not going to reference the printed material unless there's a need to do so. I believe I can access everything in expedient fashion on my computer.

Q. Perfect. Would you introduce yourself to the jury, please?

A. Good morning. My name is Tim King. I'm an anesthesiologist, pain management addiction specialist.

I practice out of Indiana, Northwest Indiana.

I've been in practice for about 43 years.

So that's a good start.

Q. What's the name of your practice?

A. The name of my practice is a APEC, stands for Anesthesia -- and what's it stand for? Anesthesia and Pain -- APEC is the name of it. I've kind of forgotten what it stood for.

Q. That happens to people once in awhile when they sit in that chair.

Tell us, where do you live? What community are you from?

A. I'm from Indiana, an Indiana boy, Midwest boy all my life. Currently I live in Indianapolis.

My practice, which I do, or have been doing part time over the last couple years, is up in Northwest Indiana, in Chicago. For all the multiple decades of practice, are all -- our organization has straddled the Chicago/Northwest Indiana area, so for the vast majority of that several decades I practiced both in the Chicago area and the Northwest Indiana area.

Q. Let's talk about your education and training.

Where did you go to medical school?

A. I went to medical school, I attended medical school at Indiana University School of Medicine in Indianapolis.

And then the next question you'll ask is where I did my specialty training.

Q. When did you graduate from medical school?

A. I graduated from medical school in 1975, back in the olden days.

Q. And then tell us about your residency program.

A. My residency program, again, for the jury, the residency program is the specialty training that physicians undergo after they finish with their foundational medical training, medical school.

So I did my residency training in anesthesiology and pain management at the University of Washington in Seattle, Washington.

Q. And your residency was in anesthesiology?

A. Anesthesiology and pain medicine, yes.

Q. Who did you train under?

A. I trained under an individual by the name of Dr. John Bonica. Again, the jury would not know who Dr. Bonica is, but Dr. Bonica is commonly regarded as the father of pain medicine. There's way more to it than that, but I have extreme regard for him, and he was one of the authors, one of the pioneers that began to look at the understanding of the physiology and pathology associated with chronic pain, so I was very honored to have worked and been mentored by him.

Q. Would you describe your residency program at the hospital?

A. Again, a residency program generally consists of a minimum of a couple years. Back in the olden days when I did it, there was a year of internship where I would rotate through various hospitals and learn how to take care of general medical issues on the ward.

And then the second two years of the three-year program, at that time, were invested actually in the operating room and in the pain clinic actually taking care of patients, administering anesthesia, learning how to do various type of injections for anesthetic and pain purposes. And approximately, I'm just guessing, it's been a long time, but approximately maybe about 10 percent of that time, or 15 percent of that time, was actually spent in what, at the time, was a novel clinic. We referred to it as the pain clinic, multi-disciplinary pain clinic. But we rotated through the pain clinic to better understand how to take care of patients suffering from chronic pain and how to perform various diagnostic injections, procedures, and look at various treatment options.

Q. And when did you complete your residency program?

A. Residency program was completed in 19 -- 1978.

Q. Are you board certified in anesthesiology or any other areas?

A. Yes.

Q. And describe your certifications and when you were certified.

A. Well, I don't know if I remember the exact dates of certification, maybe some of them. But I am board certified in anesthesiology. I'm lifetime board certified in anesthesiology. And that I don't know the date of that, but it was shortly after graduation from the residency training program in the 1970s, maybe early 1980s, sometime in that time frame. I went on to practice anesthesia and pain management in a private setting and private clinics at various hospitals.

And it became very clear that there was a need and an interest in the treatment of chronic pain. And as an anesthesiologist, I had had significant training in that regard. So approximately 1992, '93, pain medicine had evolved into a separate specialty. It had not been a separate specialty prior to that. But in approximately the early 1990s, and then by 1992 there were board qualifications, board certification available for chronic pain.

So in 1992 I became board certified in the specialty -- the new specialty of pain management under the auspices of the American Society of Anesthesiologists. It was a sub-board, as it were. So I became boarded in pain

medicine then.

In that same year I also became boarded in pain medicine by the American -- American Board of Pain Medicine. I get these terms mixed up sometimes. But at the time, because pain medicine was a new specialty, there were several agencies that were vying for the provision of board certification, have to take an exam for it, have to have certain qualifications. At that time I wasn't quite sure who was going to be dominant in terms of board certification for the long-term, so I took the board certification exam through that agency as well, and now have a lifetime board certification in pain management through the American -- American Pain -- American -- I don't remember the name, but it's American Academy of Pain Medicine.

And then thirdly, I'm -- or fourthly, I guess, I'm board certified in addiction medicine. And I became board certified in addiction medicine in approximately 2015.

Q. And is a board certification the highest certification recognized by the field?

A. It is, yes. It's the gold standard for statement of specialization and competency in a particular area.

Q. Why seek board certification in three areas, anesthesiology, pain medicine and addiction medicine?

A. That's a fair question. The times change. When I started in anesthesiology, of course we were aware that there were very -- various mechanisms of pain management for when we had to make patients, in a sense, pain for operations, but we also recognized there was a big need in the chronic pain world. But we understood that there were different diagnosis and therapies that had to be applied.

So as I transcended from -- transitioned from pain -- from anesthesiology to pain medicine, and I did eventually go fully into pain medicine, I became aware of the problems that we are all aware of, and that is that the use of Controlled Substances, specifically narcotics, can lead to addiction and all the problems therein.

And it became very evident early that to really do a good job in pain medicine, one needed to understand the psychiatry involved in addiction and in the use of long-term Controlled Substances, not only just opioids or narcotics, but other medications that are classified as Controlled Substances, like Xanax and Valium and that sort of thing. So it became obvious to me that in order to do a good job in pain medicine, it was necessary to fully understand the concepts for diagnosis and treatment of addiction as well. And thus I made that transition as well.

Q. Have you had associations with teaching at

medical schools?

A. I have. I -- I'm going to use a term here which is, well, it's descriptive. I'm basically an in-the-trenches doctor. Yes, I do have associations, and have had over the years, with several universities, but I'm not the guy at the university that publishes papers and oversees the residents. I actually see patients on a daily basis and wrestle with their problems, their diagnosis and their treatments and the long-term issues involved with the disease process of chronic pain.

I have been associated over time with Indiana University School of Medicine, with the University of Chicago, and the University of Washington in Seattle as associate professor. That really meant that I would be invited, from time to time, to give lectures to the residents, to the medical students, and sometimes would participate, perhaps, in some of the teaching in the clinics. So I did do that from time to time, maintain an association with academia, as it were. But the majority of my time was spent actually in the clinic taking care of patients.

Q. Let's talk about your actual experience as a pain management physician over the last approximately 40 years.

Tell us about your practices.

A. About what goes on in the clinic?

Q. Just, in general, what practices have you been associated with?
A. You mean as in geographically where I've been?
Q. Yes.
A. When I graduated from the residency program in Seattle, I went into practice in Spokane Washington with a number of my colleagues, and we participated in providing anesthesia and pain management services in that town for quite a number of years.

After -- after that we moved up to Alaska. That's another story, but they had a need of anesthesia services up there. They were starting some new programs in cardiovascular, open heart, and they wanted someone who was competent in regional anesthesia, that is to, say, giving shots, you might say, and pain management. So we moved up to Anchorage, Alaska and were up there for quite a number of years. Very much enjoined that experience, working at one of the major hospitals in Anchorage and doing some work at the native hospital, which was also located in Anchorage.

So we adopted our last child in Anchorage, and then we came back down to Indiana again where my parents were aging and needed some help.

So my next practice was in Elkhart, Indiana which very quickly -- because at that point I was very much

involved in the -- in the practice of pain management, very quickly expanded to include several hospitals over in South Bend and Northwest Indiana. And ultimately ended up, as our group grew a little bit larger and we had to separate out our duties because you can't be all places at one time. So I took up stand in Northwest Indiana, which is where I have been for a couple decades.

Q. And for the last couple decades, have you actually practiced in a clinic?

A. I have, yes. We have a -- a surgery center -- well, we manage a -- we manage actually a couple of surgery centers, and then we have several clinics.

The majority of my time has been invested in taking care of patients up in the Northwest Indiana corridor. Although, as senior physician, I frequently would go over to Chicago and mentor some of our younger physicians on more difficult cases and help them out with diagnosis and treatment options in the Chicago area. But primarily I was founded and grounded in Northwest Indiana.

Q. So you have experience with the proper prescription of opioids and other pain relief medications?

A. Yes, correct.

Q. And with -- with also with respect to injections, do you have experience administering injections for pain relief?

A. Yes. The injections are what we refer to as an interventional approach to pain management, shots, but we term it a little bit nicer and say the interventional approach. There's a host of requirements and skills necessary for that, the majority of which actually come from the field of anesthesia. And no surprise, as an anesthesiologist I was taught to put needles in various locations accurately, carefully and meticulously. And then over the years that developed into a set of skills that were very necessary and applicable for both treatment and diagnosis of chronic pain conditions. So, yes, that was a large part of what I did and what I still do.

Q. Well, tell us about the type of patients and the conditions you treat.

A. Chronic pain involves a lot. Statistically the majority of problems we treat are represented by spinal disorders. Majority of people come in with various back pain or neck pain, or perhaps what we call radicular pain, sciatica radiates into the leg, or the pain radiates into the arm. So I would say the majority of what we treat, and majority of pain patients that present are complaining of some sort of spine pain, with or without radiating or radicular qualities.

But pain is more than that. Pain can be any sort of nerve disorder or muscle or joint disorder and includes

everything from rheumatoid arthritis and fibromyalgia to post-injury pain or post-surgical pain, or pain associated with herpes zoster or shingles. We don't limit ourselves in our clinic. And I -- some clinics do, but we don't limit ourselves. If a patient is complaining of chronic pain, from whatever source, we invite them in and we evaluate things to see what we may have to offer.

Sometimes if it's not an area where we have the special tools to address the pain, we may refer them out to colleagues who do have specialty skills in certain areas. But basically we take all comers.

Q. And are you currently active in your clinic?

A. Okay. So that's a two-part question. Covid hit, as we all know, and that, like, threw an atom bomb into the middle of things. So we had to very quickly transition to Telehealth like a lot of practices did. So during the year of Covid I backed off a little bit, and from -- well, I backed off entirely from direct patient care, and I practiced Telehealth.

And then I would come into the clinic periodically, again, as senior physician, to mentor some of our younger physicians and our Nurse Practitioner and to help out with cases that they needed a little assistance on.

Beginning in the spring, late spring, I elected

to go on Sabbatical for a year, so, as we speak, I'm not actively involved in the clinic. I'm on Sabbatical pursuing other professional interests and endeavors.

Q. Have you given seminars or presentations on chronic pain, the responsible use of opioids, opioid addiction and drug diversion?

A. I have given those lectures many times to many audiences.

Q. Where are you licensed to practice medicine?

A. Currently I have active licenses in the states of Indiana, Illinois and Michigan, which makes sense. That's the nuclear area where I practice.

Over the years, depending on where I have lived or other professional obligations, I -- I have had licenses which are currently inactive, in Alaska, Washington State, Oregon, California, Arizona, Florida. I think that's the list.

Q. Michigan?

A. Well, Michigan I have an active license in currently.

Q. And then do you serve on any credentialing boards?

A. I have, over the years, served on the credentialing boards of the -- occasionally the hospitals that -- that were in the community that I practice in.

Most of that was in Northwest Indiana, so I served on the credentialing board at St. Anthony's Hospital in Northwest Indiana. Currently I'm not on any boards.

Q. And do you perform consulting work in terms of court cases?

A. I do. I do. Approximately -- and, again, I'm just dealing in approximation, but approximately, let's say, five to ten, maybe closer to 10 percent of the work that I do these days in consultation have to do with what you might term audits, where a medical practice may call me up and say we're concerned about the opioid crisis. We have 20 doctors or ten doctors, and we want to make sure we're all following the appropriate standards of care and protocols. King, would you mind coming in and doing a chart review and sort of auditing our doctors to make sure everything is fine so we don't get into trouble.

So, yes, I participate in that. I do consultations with specific medical groups.

There's a sort of a part two to that, in the sense that back -- well, I've spent a lot of time with the Attorney General's Office, State of Indiana, where they asked me to come in back in the early part of 2012, 2013 to assist in the states putting together of appropriate opioid protocols. Most of the state boards did, Ohio did it as well. But they asked me to participate on -- on the

committee for Indiana.

As part of that, I also worked with the Attorney General's Office on specific cases. Cases that they brought, were bringing to the medical board for overprescribing or pill mill type operations. And I guess that's a long way of saying as I worked there, and I had a little niche place in the back office, the investigators would sometimes bring me cases that had not actually been brought to maturity, but ones that they were concerned about and would ask me my opinions. So I did a fair amount of consulting in that regard on cases that the state was not sure whether it merited proceeding to medical board action.

Q. So you've consulted in criminal prosecutions?

A. I've consulted in criminal prosecutions, yes.

Q. Civil suits?

A. Civil suits, yes.

Q. And both in federal and state court?

A. Yes.

Q. And I think you mentioned your administrative cases with respect to the medical board.

A. Correct.

Q. Have you been accepted as an expert in pain management by courts?

A. By?

Q. By courts, in federal and state jurisdictions.
A. I have, yes.
Q. Do you know how many times you have testified as an expert?
A. Total testifying, including over -- participating in suits that involved my patients that were, say, Work Comp cases, I've testified maybe approaching 55 times.
With regard to what you just asked in terms of state and federal expertise in pain management, approximately 35 of those cases have been involved in asking for my expertise.
Q. How many times have you been asked to be an expert and review a doctor's patient charts to determine if the doctor wrote prescriptions within the usual course of professional medical practice?
A. That would be the majority of those -- beyond just the ones I testified for?
Q. Yes.
A. Well, I don't keep exact track, so it would be greater than 35 because those cases all involved those questions, as does the one today.
And beyond that, I've testified maybe -- not testified, I've been involved and have served as an expert in maybe an additional, I don't know, five to ten cases that were settled prior to coming to court in which case I

did not need to testify.

But the foundational question was still, were medically Controlled Substances prescribed for legitimate medical purpose and in the usual course of medical practice.

Q. Have you ever been asked to be an expert and review a doctor's patient charts and found that the doctor acted appropriately?

A. No. If the question is have I testified in favor of the doctor --

Q. No, I asked you if you just asked to review the charts.

A. Yes, I've reviewed several charts where I have found there's no foundation for pursuing, you know, further prosecution.

Q. And maybe that was with respect to state, federal courts or your work with the Indiana Attorney General's Office?

A. That's correct. The majority, if not all that, was through the Attorney General's Office, correct.

Q. Now, do you have a separate business aside from your medical practice?

A. I do. The -- yes, I do.

Q. And why did you establish that business?

A. Well, in the business you're referring to, so the

jury understands, is my consulting practice. In the beginning, and by in the beginning I mean around 2012 or so, or prior to 2012 I had been involved in offering my expertise to the federal government from time to time, but generally not frequently. It was perhaps once a year or once every other year.

And I participated in that using the -- using the personnel in our medical practice to assist me because there's a lot of clerical work that needs to be done in these cases. But it wasn't very frequent, and I didn't need to establish a separate corporation one might say.

However, when I began work with the Attorney General's Office, all of a sudden that kind of went like that, and the time involved, and then the requirements for record keeping and assembling of documents and putting together various types of reports mushroomed. The time requirement became so great that at that point I incorporated and brought on some staff because I couldn't just use the staff at the clinic when they had a little bit of spare time.

So the name of my consulting organization was at that time, and still is, Midwest Medical Legal Consultants, and that's a corporation.

Q. And do you have employees?

A. I'm sorry?

Q. Do you have employees?
A. Yes, I do have employees. I have -- I have two nurses, two registered nurses and an office manager.
Q. Are you related to your employees?
A. I am related to them. The two registered nurses are -- well, one registered nurse is my wife. She is a -- is a registered nurse. She has background expertise and certification in pain management, so she has been very helpful in that regard.

The other registered nurse is my daughter, who has had training in critical care and worked at the University of Chicago for many years. And I brought her in to assist with some of the work as well.

The third employee, the office director, is my daughter as well. She is a teacher with expertise in computer technology, and she has been invaluable as well with regard to record keeping and organization of various things. So, yes.
Q. And how do your -- the nurses assist you in your consulting work?
A. They perform the clerical work. For instance, in this case, the patient charts were extremely lengthy. When they came in, they were anywhere from 1,000 to 1,500 pages. As a matter of fact, in total for this case I reviewed pretty close to 30,000 pages. That's a lot of pages.

That's a lot of -- I don't even read books that long.

But these came in and needed to be organized, and they needed to be organized in a very specific way. So the office manager and the two nurses would work with organizing the material as it came in, such that we could work with it in a very straight forward and objective way.

Would you like me to describe how we do that? Is that the question you're asking?

Q. Sure.

A. In terms of the forensic chronology --

Q. We can get to that a little bit later. Let's talk a little bit more about your background.

You've practiced in several states, is the --

BY THE COURT REPORTER: Excuse me --

BY MS. DUSTIN:

Q. Oh, I'm sorry. I said, Dr. King, you've practiced in several states. Is the basic practice of medicine different depending on the state?

A. No. The -- the practice medicine, the standard of care for medicine is the same throughout the country.

Q. Is it similar in Ohio?

A. It is similar in Ohio, as it is in Indiana, yes.

Q. Can you explain the basics of treating a patient in a medical practice in any medical field in any state of the country?

A. I'm going to rephrase that question a little bit if it serves your purpose. The question can be phrased what is the practice of medicine, what constitutes the practice of medicine, and I'm going to make it very simple for you here.

Regardless of what specialty a physician is, whether it's oncology or OB/GYN or pain medicine or anesthesiology or neurology, doesn't make a difference. There's four basic bullet points as I often use as my example here.

The first thing a physician must do to participate in the legitimate practice of medicine is a patient evaluation. And that patient evaluation makes sense. You know that, you go into the doctor, you get examined, you have a history taken, you have past x-rays or MRIs obtained, or past medical history, past medical records reviewed. So the first point is in the practice of medicine an evaluation is performed.

The second thing is, based on that evaluation, a diagnosis is determined. So the diagnosis has to have foundation, it has to be objective. It can't be just, you know, a thought process. It has to be based on objective findings in the evaluation. So number two would be a diagnosis.

Number three would be, okay, now we have a

diagnosis, what do we do? We formulate a treatment plan. So the third bullet point in the practice of medicine is a treatment plan.

And then the fourth -- and that treatment plan, by the way, is unique to the patient. You can't have, like, the same treatment plan for everybody. It might be similar if you're a specialist, but they can't be the same. Pain medicine, it has to be multi disciplinary, and it has to be unique. And I know we'll go back to discussing that another time.

But the fourth thing is then after you initiated the treatment plan, you have to follow up with the patient, right, and that makes common sense. You have to evaluate the patient over time to see if they're responding appropriately to the treatment plan, to see if they're compliant with the treatment plan. In the case of pain medicine, make sure there's no abuse, diversion or addiction going on. But that becomes an iterative process, then you come around and start again to see the patient back again, reevaluate them, you reaffirm or change the diagnosis as appropriate, you reaffirm or change the treatment plan as appropriate, and then you send them out and follow up with them to see if it's working.

So those four things constitute a very appropriate and simple and objective definition of what

medical practice is.

Q. Does morality play any role in that?

A. Morality plays a big role, yes. Thank you for asking that. You've all heard that, you know, we all take a vow when we graduate from medical school that we will do no harm. Well, that -- that is true. There are actually two -- two things that, as physicians, we are expected, from a morality or ethics standpoint, to maintain.

One is to do no harm, and the other is to do good. I'm not going to use all the fancy Latin phrases for that, but the point is, yes, as part of our process of evaluation, diagnosis, treatment and follow up, we have to make sure that we're serving the patients' best interests, and that we are doing no harm, and are, in fact, doing good. And that's where sort of the risk and benefit ratio conversation starts to come in as well, but, yes.

Q. Does the --

THE COURT: We might be doing good if we took our mid-morning break unless you want to --

MS. DUSTIN: No, sounds like a good time.

THE COURT: Let's take our mid-morning break, 15 to 20 minutes, whatever you may need in that range.

Please remember all the rules. We're in recess.

(A brief recess was taken.)

THE COURT: Before you continue with your direct

examination, I need to remind all spectators, and, counsel, you might help me in that regard. Anyone who is visiting during the course of this trial is, of course, welcome. However, you should refrain from any type of gestures or reaction to testimony that you're hearing, whether it be favorable or unfavorable. Thank you very much.

BY MS. DUSTIN:

Q. Thanks, Judge. I think we were talking about standard of care, is that right, Dr. King?

A. I -- well, that's a good place to start.

Q. We talked about how you take care of a patient?

A. Yes.

Q. And is that the standard of care essentially?

A. The standard of care, okay, so let me offer a, sort of a working definition of standard of care. Standard of care is -- are the actions of a prudent practitioner acting according to generally accepted medical and scientific principles as practiced in the United States. That's a little bit of a formal definition, but, basically, one might say a way to translate that would be it's the generally accepted way to treat a patient for a given condition.

Q. So you went to medical school, I think you said it was about in the 1970s?

A. That's correct, yes.

Q. And Dr. Bauer went to medical school in the late '60s?
A. I believe, recollection looking at his CV, it was in the late '60s, I was in the early '70s, so we maybe overlapped a year or so, something in that regard. We're basically old doctors, yes.
Q. Is that the last time you, or any doctor, should have been educated about the standard of care?
A. No, not at all. The standard of care is something that evolves over time, and this makes common sense, you would -- you would understand this. The standard of care responds to changes in our understanding of disease, in terms of what causes it, the best way to treat it, and -- and the medications that are available, techniques that are available.

So as medical and science proceeds and we have more tools and more understanding of particularities of medicine, the standard of care would reflect those -- those items so that we can always, in the end, have the patient's best interest in mind, and provide a -- a baseline set of diagnostics and therapeutics of patients for their best interest. So the standard of care evolves over time as techniques and understanding evolves.
Q. How do doctors ensure they keep up with the times as they change?

A. There are many ways as a physician that we can keep up with the times as they change, as you put it. A couple examples, you've probably heard of continuing medical education, or what we call CME's. It's necessary for most state licenses. In order to renew your license in any given state at any time, you have to have fulfilled so many hours of CMEs, which is one way of keeping up.

We all subscribe to various journals that are appropriate to our specialty. I subscribe to a number of journals that have to do with anesthesiology and pain management journals. There are quite a number of pain management journals. So reading journals is another generally accepted way to keep up with the standard of care.

Another example of how to keep up would be through our professional organizations. Just as we read, and are expected to read, medical journals to keep up on scientific and medical advancement, we also belong to various professional organizations that hold meetings, seminars and sometimes put forth various position papers telling us how to act with regard to certain things, like how to use opioids for the treatment of chronic non-cancer pain.

But those -- those organizations would be organizations like the American Academy of Neurology or the

American Society of Anesthesiologists or the American Academy of Pain Medicine, or the American Pain Society. So we have a number of those, and we keep up with regard to advancements through them. And then we go to meetings, and we go to meetings and we talk with people, and we interchange ideas of successes and failures to understand what's working and what's not working. So there are many ways to do that.

And I would just simply add board certification. Board certification, except for back in the olden days when I started anesthesiology and was given a lifetime certification in anesthesia, my board certification in pain management in not a lifetime certification. It has to be renewed every ten years. And during that ten year time period, I'm expected to read so many hours, to go to so many meetings, to get involved in so many projects so that I understand what the standard of care is and I'm up to speed and up to date on that. So the ten-year renewal for board certification is another mechanism, a very good mechanism, where, objectively, where we're presented with current scientific and medical advancements so we can continue to understand the standard of care.

Q. And do also medical boards for each state send out guidance and -- with respect to the standard of care relative in that state?

A. Yes. Each state sometimes has a certain bias towards asking their physicians, perhaps, to invest a certain number of their required hours to learn about, let's say, HIV and AIDS. That happened about a decade ago in Washington state where I had a license at the time. So part of my CMEs had to be in that area.

Other states, in response to the opioid crisis, have required that some of our CMEs be in the area of opioid prescribing. So that's -- and I'm -- I'm not 100 percent sure which states have required that, but I know some have, so that's another mechanism.

Q. Are you familiar with the statute that regulates manufacture, importation, possession, use and distribution of controlled substances?

A. Yes, what you're referring to is what we call the Controlled Substances Act of 1970.

Q. When did you become familiar with that act?

A. Well, 1970 was the year I started medical school, so I'm very familiar with that because I was brought up at the time that I remember clearly. President Nixon was president, and the Controlled Substances Act was being brought into being to address the use of Controlled Substances, meaning narcotics and sedatives and some other things.

And as part of that act, we had to -- well, as

part of that act, the Drug Enforcement Administration, the DEA, was brought into being. I'm not an expert on the timing on all this, but that was part of the process that I was being taught in medical school at that time. And as part of that process, and as a physician, as a young student physician, I was -- I was prescribing opioids, from time to time, when we approached our third and fourth medical school years.

But in order to do that, I had to apply to the DEA, the Drug Enforcement Administration for a certificate, a Controlled Substance certificate, that would register me and allow me to be a provider, in the sense that I would write prescriptions. So I was very familiar with it because it occurred during the time frame when I was in medical school.

Q. And what are Controlled Substances?

A. Controlled Substances is the larger term for medications that physicians and other providers can prescribe. That's because of their potential danger and because of their addictiveness, the Drug Enforcement Administration and Congress has put those drugs into a separate category saying you have to have special certification to prescribe these, again, because of the danger and because of the addictiveness. And -- and there are -- there are five classifications starting --

Q. If I can interrupt you. I'm going to maybe help you present your answer with the use of an exhibit and a demonstrative exhibit that we've blown up.

Let me show you what's been marked as trial Exhibit 804.

THE COURT: I would assume the chart is the same as what's on our screens?

MS. DUSTIN: Yes.

BY MS. DUSTIN:

Q. Does that look the same as what's on our screen?

A. It is, yes.

MS. DUSTIN: With The Court's permission, may I have Dr. King step down and explain what Controlled Substances are utilizing this exhibit?

THE COURT: He'll need to be mic'd to do that. If he needs a portable mic we can do that, or he can stand.

MS. DUSTIN: You can do this right here. I'll step away and let you into the mic here.

THE COURT: You'll need a portable mic if you ask a question.

BY MS. DUSTIN:

Q. All right. Looking at trial Exhibit 804, and it has some categories of Controlled Substances, and explain to us what these are.

A. So, again, Controlled Substances are those

medications that -- that generally have some sort of medical use associated with them, but are structured into different schedules, depending how dangerous they are and how addictive they are.

But just as a reference here, we don't have Schedule I, but Schedule I medications would be medications like heroin or LSD, where there's no medical usage for it. There would be no reason why, as a practitioner, would have to prescribe or could prescribe those. They're very dangerous and have no medical applicability. So that's Schedule I.

On this chart we go through Schedule II, Schedule III -- Schedule II, Schedule IV and Schedule V Controlled Substances. These are the medications that typically would be part of my moratorium in the clinic that I might, from time to time, prescribe to patients, so that's why we're talking about these three particularly scheduled categories.

So Schedule I -- sorry, the first list of Schedule II Controlled Substances, and these are the ones that you've heard of that are sort of headliners in terms of the opioid crisis. These are the Dextroamphetamine or Amphetamine medications. Brand name on that would be Adderall. And that's used for various psychiatric conditions like attention deficit disorder.

Oxycodone and Acetaminophen is Percocet. And there are different formulations of Oxycodone. You've got pure Oxycodone that is -- actually, this isn't quite correct here. Well, Oxycodone ER, which is extended release, is -- so Oxycodone ER, Oxycontin and Percocet all have the active component Oxycodone in it. So they're all different formulations. Some of them are time released, some are in combination with Tylenol, but the active component is the Oxycodone, the narcotic Oxycodone.

And then next you have here, I'm going to skip around a little bit, buy you have the Hydrocodone, which is the Norco type medications you've heard of, that's in combination with Tylenol. Vicodin is an older name which had a different concentration of Tylenol in it. But Hydrocodone is the main component of that particular pill. Of course you all know Morphine, Morphine comes in different formulations, controlled release or ER, extended release or time release, but it's still Morphine.

And, additionally, you all know about methadone. You may not know about Oxymorphone. Oxymorphone is in the formulation called Opana, but Oxymorphone is very -- well, it's actually a breakdown product in the body of Morphine, so it's very much related to Morphine.

Some of these you've heard of, some you haven't, but these compose the Schedule II. And the Schedule II is

the highest schedule because of concern about the safety of the medications, but they are medications that are used, from time to time legitimately, in the practice of medicine, so they're Schedule II.

Are there any questions you want to ask me on that?

Q. Did you indicate that you wanted to clarify something on the chart?

A. Yeah, the clarification was Oxycodone -- Oxycontin is continuous release, contin for continuous. Oxycontin is listed here as a common brand name. Actually, Oxycontin is a brand name for Oxycodone ER. It's not a big deal because we're dealing with sort of the same medicines. Just one's time released, the other is not, still the same medicine. Because technically we have Oxycodone as a freestanding brand name as well. It's been around, it's a generic name. But, otherwise, it's completely accurate.

Q. Maybe explain to us what it means to have an extended release formulation of a drug.

A. In the beginning it seemed to make common sense that if an individual was needing narcotics, let's say three or four times a day, that it might make sense to have an extended-release formulation that would maybe last eight hours, or maybe 12 hours, or maybe even 24 hours. So with that sort of common sense thought -- by the way, this

turned out not to be a good idea, just in case you were wondering. But it seemed common sense at the time in the late '80s and early '90s. And Purdue Pharma was the company that started producing controlled-release Morphine first, and then controlled-release Oxycontin after that. They started marketing -- the drug companies started marketing these medications as, you know, this will cover the pain needs for eight hours or 12 hours. Turned out that's not the case. Turned out that there were problems associated with that, and that's a separate lecture, but the situation was in the beginning it seemed to make sense to look for various additives to these medications that would allow it to dissolve slowly in the stomach and provide the body with a controlled release. But it never turned out like the drug companies said to be a blood level like this, it was like this. So you'd start out and you get a high dose, and then it would taper off so it was never an even schedule.

So, for various reasons, that ended up supporting addiction and diversion. You know, if -- if an addict could get ahold of a 30-milligram Oxycontin, he'd have a lot of medication that he could grind up and shoot intravenously. So it added to the diversion and abuse issue, as well as not proving itself to be helpful from a medical standpoint. But we still have some of these ER

formulations in our formula, and they can be used. They're not used all that much these days.

Q. And then the last category, the class, could you tell us about the class?

A. Oh, okay. Yes, I'm sorry, I -- I totally neglected that, that was behind my right shoulder here. There are multiple types of Controlled Substances, right. They aren't all narcotics. We have Controlled Substances -- well, okay, so the -- well, the three or four major ones that you would do well to understand.

Number one are the opioids or the narcotics. And that includes the action Oxycodones, the Norcos and the Methadones we've been talking about. You understand what narcotics are, they're the actual pain relievers.

The second class of Controlled Substances are what we call the sedative hypnotics or the sleeping pills or the tranquilizers. And that would include things that we call Benzodiazepines, which would be Xanax, Valium, Clonazepam, Ativan, things of that sort. And they typically will show up here on the Schedule IVs as Clonazepam, Diazapam. Diazapam is Valium. Clonazepam is Klonopin. They are Benzodiazepines, so they're the class of medications called Benzodiazepines. Think of them as the sedatives or as the tranquilizers.

There's a third class that we refer to as

stimulants. And that's, as represented here by Adderall, or -- and Adderall, by the way, is pure Amphetamine. It's in the class of stimulants. There are different types of stimulants, but Adderall tends to be one of the common ones. If you remember that, that's adequate.

So we have the opioids, we have the sedatives, and we have the stimulants. The fourth class, and we mention this fourth class because we do see it as a combination poly pharmacy medicine that comes into play, and I'll describe that later. That would include things like Pregabalin or Lyrica. You may have heard of Lyrica, or you may have heard of Gabapentin or Neurontin. Those medications are not opioids, they're not sedatives, but they do have addictive qualities. And they particularly have addictive qualities when they're combined with some of the other narcotics or sedatives. And we'll talk more about that later.

But the fourth class would be the non-opioid, non-sedative, non-stimulants, that would include not only the Pregabalin or Lyrica, but it would also include Carisoprodol. You'll never remember how to pronounce that. It's called Soma. Soma is a muscle relaxer. You may have had heard of that. Soma is an addictive muscle relaxer, and there's really no medical need to use that in a pain management scenario these days. But historically it has

been used and abused, so we include it here because we do see it, and we'll see it in some of the patients that we'll talk about today. So the fourth class would be the other, which should be the Somas and the Lyricas.

Q. Are there concerns with combinations of certain of these Controlled Substances?

A. You never wanted to come and have jury duty and learn chemistry, but you're having to do so today.

So here's the deal, I just gave you a whole bunch with regard to how we classify the Controlled Substances. Again, we've got the opioids, the sedatives, the stimulants and the other. We can combine those, and we can cause further mischief by combining them. And I'm going to give you two examples, and we're going to refer this -- I'm going to refer to this as poly pharmacy, meaning many different pharmaceuticals coming together. The people out on the streets, addicts, the individuals who are looking for different ways to get high, have experimented and have found that there are certain combinations that work extremely well to provide a euphoria and, therefore, unfortunately, contribute to long-term addiction.

One of those combinations is what's called the Holy Trinity. The Holy Trinity, you know, notwithstanding what we've been taught what the Holy Trinity really is, is a combination of an opioid, you pick the opioid, any one

will do, plus a Benzodiazepine, you pick whatever Benzodiazepine you want, typically it ends up being Xanax, and you add Soma to it. So if you have an opioid plus Xanax or another Benzo, plus Soma, you have what's called the Holy Trinity.

Why is the Holy Trinity so attractive? Why is it so street popular, and why is it named that? Because the Holy Trinity, that combination of Benzo, opioid and Soma will cause a heroin-like euphoria, a heroin-like euphoria. So if an individual is concerned about the medications they might be getting off the street, because you've read a lot lately about, you know, you buy heroin off the street and sometimes it's cut with Fentanyl and instant death results, right. So there's a lot of concern about buying certain drugs off the street, but if you can get the medicine from your doctor in the combination of an opioid, a Benzo and Soma, you get the same heroin-type response with known medications that still would be very deadly and still very addictive. But that's the push for the Holy Trinity combination.

There's not a medical foundation for the use of the Holy Trinity in pain management, but you will see that, and you'll hear me talk about that some more.

The second poly pharmacy combination is called a prescription speedball. These are the only two I'm going

to burden you with here today. Well, that's not true, there are going to be others, but for right now this is the only one. But the prescription speedball -- so take a step back, what's a speedball? A speedball, you've all read about John Belushi died of a speedball. That's cocaine plus heroin. Cocaine is a stimulant, heroin is a narcotic, I don't know if you're aware of that, heroin is a narcotic. It's a very dangerous narcotic, but when you combine a stimulant and a narcotic like cocaine and heroin, you have a speedball. If the doctor prescribes a stimulant and a narcotic, let's say Adderall and pure Amphetamine as the stimulant, plus any of the narcotics, you have what's called a prescription speedball. And it's dangerous, and it's addictive, and there might be sometimes where the two -- the two medications might be medically appropriate, but it would have to be done in conjunction with, say, a psychiatrist or an addictionologist, or somebody who was aware of the concerns when you combine the stimulant with a narcotic, especially multiple narcotics, because it is addictive, and it does lead to death.

So these are the two poly pharmacy combinations that I want to make you aware of.

Q. Where would heroin fall in this chart?

A. Heroin is not on this chart. As I indicated, heroin is a Schedule I. There's no medical utility for

heroin. So it's a Schedule I, meaning it's extremely dangerous, and there's no medical utility.

Q. And you talked about Fentanyl, like, I think in conjunction with the opioid epidemic. Where is Fentanyl in the chart, and is there any medical use for Fentanyl?

A. Yes, Fentanyl is a narcotic or an opioid, so it's in the class of opioid. It doesn't happen to be -- yes, it does, it's right here Fentanyl. There are many preparations for Fentanyl. You can have it as a liquid, as an injectable, and we use that in anesthesia quite a bit. It's not available as a pill, but it is available as a patch. So if we were to prescribe it in the clinic, it would be in the form of a patch. And the brand name for that patch is Duragesic, you probably maybe heard of that before.

And the patches come in different concentrations, different strengths, but they -- but they basically are put on the skin, and the medication is absorbed through the skin over the course of days. We typically think a Duragesic patch has efficacy for about three days, and then has to be changed. But that is a medication we do use from time to time.

There are some problems, both therapeutically and safety associated with it, it's not used as much as some of the other narcotics, but that's the status of the Duragesic

or the Fentanyl.

Q. You can take your seat.

And so opioids, you've talked about them in terms of -- in terms of the class of the Controlled Substances. What are they used to treat?

A. Well, opioids are pain medications. And over the years we've learned that they're very effective for short term pain management. As I indicated, we use the opioids as part of our anesthetic regimen on a regular basis. We have longer opioids and shorter opioids, but we use them as part of a general anesthetic in the operating room.

We also have found the opioids to be very effective for what we call acute pain management. The -- and, you know, if somebody breaks a leg or somebody needs -- is recovering from an operation and may need three or four days of opioids to get over the hump, as it were, until the body starts functioning a little bit better, so let's say after a car accident or a trauma or a fall. But the opioids are very effective not only in anesthesia but also for short term acute pain management.

The third area where they've been shown to be very effective is in cancer pain management, or what we refer to generically as end of life management, and that would include palliative care. Palliative care would be end-of-life management for cancer, plus other medical

conditions as well. But, again, the key factor there is it's for end-of-life treatment. So, again, we're using opioids for short term treatment, whether it's in the operating room or for a couple days after an injury or for end-of-life treatment. And that's -- that's the area that -- where we find opioids to be useful.

Q. How do they work?

A. Opioids work, you really don't want a pharmacology lesson here, so I'll make it pretty simple. There are receptors in the body, opioid receptors or pain receptors you've heard them referred to. And called MU, MU, couple different types, but it's a MU receptor, and they're throughout the body. And when we administer an opioid, whether it's by patch, by pill or by injection, the opioids go to these MU receptors and inhibit the transmission of pain. That's why they work so well short term.

They do other things too, they also inhibit your breathing, and they stop your bowels, and have other kinds of issues associated with it. But we use it for the MU opioid receiver end of things to stop the pain. That's how they work in a nutshell.

Q. And do they affect your brain?

A. They do affect your brain, yes. We -- we don't understand exactly why this is so, but there are opioid

receptors in the brain as well, and in the brain stem. And specifically I mentioned the brain stem because that's where your center of respiratory activity is. You don't think about your breathing, it just occurs automatically because of the activity in your brain stem. But the opioids will -- MU receptors in the brain stem and shut them down, just as it shuts down pain, and you'll stop breathing. Which is why that's one of the key red things we look at when we evaluate a patient to see if they're candidates for opioid therapy. We look to see if they have any respiratory problems that might predispose those even further for stopping breathing, sleep apnea or asthma or chronic obstructive lung disease or any kind of lung disease.

So we have them in the brain up there, and we also have them in the higher centers of the brain that deal with what we call cognition and sedation. Because two of the big side effects besides, or in addition to stopping breathing, is opioids will make you sedate, they'll put you to sleep. Not terribly well, but they will make you sedate so you're not functioning properly, and they will inhibit decision making or what we call the cognitive process. You won't be able to make cogent decisions, your common sense will not be there.

So we worry about sedation, cognitive deficits

and breathing inhibition as a result of some of the opioid receptors that are located in what we call the central nervous system in the brain and spinal cord.

Q. Would they also affect personality?

A. They do affect personality. And again, when we're talking about the use of opioids long-term for chronic pain management and -- and let's say the individual is becoming dependent on the opioids, the opioids long-term and based on dose as well, will begin to affect the prefrontal area of the brain where our -- where our central processing unit is, to use an analogy with the computer. And it will, over time, rewire that, and it will change not only the person's ability to make rationale decisions and to control emotions, but it will definitely change personality.

So, yes, opioids are related, particularly in the long-term, to changes in the person's ability to think properly, to think in a cognitive way, and personality will change.

Q. Are there risks associated with opioid use?

A. I'm sorry?

Q. Are there risks associated with opioid use?

A. Yes. Again, I'll clarify if this what is what you mean, you're talking about long-term?

Q. Yes.

A. There are many risks associated with long-term opioid use, and these risks are not necessarily the risks we see in short-term use for anesthesia, acute pain, and end of life. We have different issues with chronic pain. And we put the long-term concerns of opioids and chronic pain into three categories to help you remember this perhaps.

At the far end of the scale, the worse end of the scale, we worry about respiratory depression, death, and overdose. Those are the big three. And those are the big three drivers that we see as part of the opioid crisis. All these individuals who are presenting to the emergency room in an overdose status, about 10 or 15 percent whom don't survive and actually die of their overdose. But that's one end, and it's real, and we do have to worry about. And we have statistics that we can talk about later about that.

In terms of the middle risk factors, those are equally important too because that -- that involves opioid-induced depression, opioid-induced anxiety, opioid-induced panic attacks, opioid-induced sleep disruption or insomnia. And opioid induced, and this one's going to surprise you if you haven't heard it before, opioid-induced hyperalgesia. That's our fancy word for meaning the opioids make the pain worse. You might say how

can that be. I'm not sure how it can be, we don't totally understand the process, but it's not something a patient makes up. As we escalate the dose of the opioid, over time when we get up to sort of a modest dose and start to elevate from there, we find pain gets worse, it actually gets worse. The patients start to rate their pain at a higher level, starts to interfere with their function on a daily base. It's a real thing. So in the middle class of risk or side effects, we're worried about worsening depression, worsening anxiety, worsening of panic attacks, loss of sleep. We all know what loss of sleep does. If you can't sleep, you can't cope. And if these chronic patients are in a bad way anyway, and they can't sleep, can't cope, makes things a lot worse. And then we have this strange thing called opioid-induced hyperalgesia, where if we continue with the medication and the pain and function don't improve, we have to figure that's due to the medication, and we have to try a different treatment strategy.

The lower class of concerns we have in terms of side effects, such as constipation, nausea, vomiting, that sort of thing, don't threaten the person's well-being from the life -- from the life threatening standpoint. But interestingly enough it tends to be the constipation that is the side effect the patients complain to us about as to

why they can't take the medication any longer. So it tends to be -- constipation tends to be the limiting factor, we can deal with that. But it's the opioid induced mental health issue, sleep disruption, hyperalgesia, as well as the one thing -- in that third category where we are talking about overdose and death, we also have to include addiction in there. Because, arguably, as bad as an overdose death is, addiction is equally as bad. The patient may not die, but the patient's life is going to be totally disrupted, as well as the friends and family close to the patient, as well as the community, and as well as the nation. So addiction has a huge burden associated with it from the patient all the way up to our nation. So I would include that as one of the severe side effects and concerns that we have along with overdose and death.

Q. Earlier I think when you were talking about the chart here, you mentioned the opioid epidemic. When did it begin in the United States?

MR. GIBBONS: Objection.

THE COURT: Grounds?

MR. GIBBONS: Well, relevance. We're talking about 14 patients.

THE COURT: Response?

MS. DUSTIN: It is relevant in terms of how the guidelines have developed over the years with respect to

the prescribing of opioids and how it has evolved.

THE COURT: I'll allow limited inquiry. Overruled.

BY MS. DUSTIN:

Q. So let's talk about into the -- we won't go back any further, maybe starting with the '80s into the '90s, talk about the opioid epidemic and then in conjunction with how opioids were -- the literature on prescribing.

A. Okay. That's a fair question. And I can limit my response in a way that makes sense. We've always known for thousands of years that opioids were addictive and -- and heroin and how -- and we've always known there's problems associated with addiction.

In this country where, from a medical standpoint, it began to be a real -- well, we began to understand the scientific a little better in the '80s. In the mid '80s, based on what was being observed by palliative care and cancer doctors, that they could use their opioids to help with end of care pain treatment for their patients, the question began to be asked, well, if it's a success in cancer, can we apply the same opioid use to chronic non-cancer pain.

Prior to that, opioids were never used for long-term, non-cancer pain because the evidence was it always led to addiction and death. So -- but the question

was raised again in the mid 60s, based on the success with palliative care and cancer doctors, so there began a momentum based on several individuals who sort of led the charge and the drug companies who were also participating in the charge, such that during the 1990s, the -- what I call, this is my term, the big experiment occurred where opioids were then trialed on patients who had chronic pain with devastating circumstances.

During that time, in the 1990s, the studies were maintained, people were followed, and side effects and success was monitored. And during that time frame we were overwhelmed in this country with overdose deaths, emergency room visits, longer hospital stays, more expensive hospital stays because of the excessive use of narcotics across the board. There was no indication that this experiment was heading in a good direction, such that when we hit the 2000s, beginning in the early 2000s, 2002, 2005, enough studies had been done to show that there was no evidence, no support for the use of opioids in the treatment of long-term cancer pain.

The pushback began in the early 2000s, as put forth by publications and peer-reviewed journals, the American Society of Anesthesiology, the Journal of the American Medical Association, all the big agencies, as we started to get these results, momentum slowed down such

that -- such that during the first decade of the 2000s, 2000, 2010, the pendulum began to swing back again. And guidelines, position papers, white papers, began to come out by various institutions and professional agencies saying, look, too many people are dieing and getting addicted, here's the regimen you need to follow if you're going to use it for treatment of chronic pain.

And by the time we hit 2010 to the current date, 2020, let's say, the studies continued to mature to show no objective foundation for the use of opioids in the use of treatment of chronic non-cancer pain.

Q. Are you familiar with the WHO?

A. I am, World Health Organization, yes.

Q. And did they establish what's been commonly referred to as the pain ladder?

A. They did.

Q. And would you tell us what the pain ladder is and its evolution?

A. The pain ladder was initiated by the WHO, the World Health Organization, in 1986, which was when the opioid crisis arguably began to pick up steam, or at least when people started to ask the question could opioids be used for chronic pain. But specifically, and this is important to remember, that document that the WHO put out in 1986 describing the pain ladder -- I should tell you

what the pain ladder is. What the pain ladder said, basically when you use opioids, start out with the lowest effective dose and move up to the next most potent, and then the next most potent. So there were three or four steps, so they referred to it as a ladder, with the idea that if the pain were real severe you would use the more potent opioids, and if it were less severe, you would use less potent. There's some common sense to that, but here's the thing. They put that out explicitly for cancer pain, and it wasn't inappropriate for cancer pain. There was a concern that the world in general, particularly the third world countries whose patients didn't have access to the kind of care we do in the United States, were not even being allowed to have morphine for end of life cancer scenarios.

So the World Health Organization, in an effort to address that -- that need, put the pain ladder forth for only the pharmacologic treatment of cancer pain. And very specifically in that first document they said this does not apply to chronic pain because chronic pain is a different mechanism, a different physiology, and requires different treatment, they were very explicit about that, and they were correct. They were correct.

What happened was that document sort of picked up momentum and was adopted by some individuals who thought

that chronic opioids should be able to be used for chronic pain, notwithstanding the studies that were coming forth in the United States are peer reviewed literature that was not supporting that, our government, Whitehouse, D.C., the Drug Enforcement Administration was saying, no, no, no, we're having problems, don't do it.

And the publications that were being put forth in the United States as the years went on, as we got into the '90s and the 2000s, never even referenced the WHO pain ladder because it was only for cancer, later for palliative care, and only pharmacologic treatment. It didn't include any other treatments like interventions or shots or surgeries or psychological resources for addiction let's say. It only was pharmalogic treatment of end-of-life care. So it never really was applicable to the opioid epidemic. Actually contributed to the opioid epidemic because it implied that we should be able to use opioids for everything and -- and that's not true, and that hasn't turned out to be a wise -- wise walk. So I could talk some more about it, but that's the foundational --

Q. Let's talk about, are you aware of the 2005 universal precautions?

A. Yes. The universal precautions that were published, I don't remember the journal, but I think it was the Journal of Pain, one of our major publications, 2005.

Now, again, keep in mind all the dates I've told you, 2005 the pendulum was now starting to swing back and say the experiment hasn't worked, we need to quit this free flow of opioids for everybody.

So in 2005, this publication entitled Universal Precautions, I don't know the title exactly, but it was a rational approach to the use of opioids in the treatment of non-cancer pain. Actually, I think that's exactly what the title is, a rationale approach to the use of opioids. And what it did, is it said look, we are -- all of the research to date has not shown that opioids are effective for chronic pain, but if you're going to use it, there are certain guidelines that have to be followed so that you can prevent addiction, or at least minimize addiction and overdose death. And in the first couple paragraphs of that article they say, whereas it's impossible to know who's going to be a problematic user of narcotics, we have to, as physicians, use a universal approach, precautions to minimize the risk of overdose and addiction. It makes sense. It was very sensible.

And they went on to list ten items, which if you were to list them you would probably come up with some of the same items. They said do a complete evaluation, look to see if there's any history of addiction or abuse, are there any mental health issues that need to be identified

because mental health is often associated with substance abuse. We all know that. And -- and it went on to say do a trial and use moderate doses, use what they call rationale pharmacology. Don't just start people out on an escalating dose of high morphine equivalent narcotics. Start out low and look for improvement. Look for improvement in pain, look for improvement in function, because in the end we all have to understand, even I as a specialist for many, many decades, I can't cure chronic pain, nobody can cure chronic pain. I can make it better, maybe, and whatever's left over I'll help the patient deal with it. I'll help him and teach him ways to cope with it, and I'll keep an eye on it as time goes on and do the best we can. But we can't expect to take care of chronic pain simply by ratcheting up our shots or ratcheting up our use of opioids. That's never going to win so the universal precautions says walk softly, walk carefully, consider these ten things as you start your patient on these medications and if you can't demonstrate that there's improvement, then stop the medication. If you -- one more thing then I'll stop. That makes imminent common sense, because over time you've all had kids or relatives who have gone to the doctor's office with a sore throat, and if the penicillin you got didn't work, does it make sense to bring your child back in another three weeks and get more

penicillin and keep going on ad infinitum? That's what happens in pain management. We see time and time again that opioids are prescribed, they don't work, but the opioids are represcribed or elevated or escalated or other ones are added. If it doesn't work, it doesn't work, and that's what universal precautions said, take care, evaluate the improvement, and if there's no improvement, consider different treatment options.

Q. You mentioned two words in there I want to explain. What's a trial?

A. Opioid trial, well, the opioid trial, generally thought to be between let's say two to six weeks. That's adequate to find out, you may argue and say I want to do it for two months, I don't really care, but in general the literature says an opioid trial is two to six years, somewhere in that time frame. It's not two years, it's not five years, it's not ten years of ineffective opioid therapy. It's a couple weeks, maybe a month our two.

And during that trial there are two things that have to be demonstrated by standard of care. Standard of care says if opioids are going to continue to be prescribed, they have to show an improvement in pain level, maybe not zero, but it has to be improved, and there has to be an improvement in function, because, as I said a few moments ago, the whole issue about pain treatment is I'm

really trying to improve the function of patients, trying to have them get back to their normal daily activities as best we can, as they have been impeded by pain, so we monitor pain level and we monitor function. Both those things have to be shown to improve during that trial. And if -- if a low dose tends to work and you say, well, the patient's pain score went from seven out of ten to five out of ten, maybe I should bump up the opioids a little bit, okay, fair enough. But that's still part of the trial. It's incumbent on the doctor to show improvement.

Q. You also mentioned morphine equivalent. And can you explain that concept?

A. We have to compare apples to apples. That chart that I just talked to you about a few minutes ago had a lot of different opioids. We had Fentanyl, we had Norco, we had Oxycodone, we had Methadone, we had Duragesic, all of those. How do we compare all those because some are more potent on a milligram-by-milligram basis than others.

Quite a while ago we came up, through the cancer pain management world, by the way, we came up with the ability to, in the case of cancer pain, to take a patient let's say off of morphine and put them on methadone by comparing the strength of the dose, or the efficacy of the dose. And we always use morphine as our gold standard. So when we talk about, well, how strong is Oxycodone, we

compare it to morphine. And we find on a milligram-for-milligram basis, Oxycodone or Oxycontin is 1.5 times as potent as morphine. So the morphine equivalency for Oxycodone is 1 1/2 times whatever the dose is. So we -- everything is -- is described in terms of a morphine equivalent. So we could compare apples to apples. And -- well, I can talk to you why that's important, but is that --

Q. I think that's a sufficient explanation for now.

Let's go back to the universal precautions and the article. Did it also mention the four As?

A. Yes.

Q. What are the four As?

A. The four As, again, as part, as you correctly say the universal precautions, four questions or areas of inquiry that -- that are done when a patient comes back for follow up. Remember I told you about the practice of medicine, the fourth one is we follow up with the patient to see if they're improving, but we also have to ask other questions; any side effects, you know, is the patient's mental health okay, are we trending toward addiction, various things. Those are summarized in the four As.

The four As that must be explicitly and objectively answered during a follow up for pain medicine are these: I'll tell you what the four As are, then I'll

describe them to you.

One is analgesia, is the pain level improving.

Number two is activity, is the function or the activity of the patient objectively improving.

The other is adverse side effects. Remember I told you most people stop opioids because they get constipated, but there are other things in terms of worsening mental health and addiction, opioid-induced hyperalgesia. The -- is adverse side effects, so we look for those and document those.

And then the fourth -- the fourth actually is two things. It's addiction -- well, it's three things, it's addiction/abhorrent behavior/affect. It's a little bit of catch all. What that asks is are there any abhorrent behaviors, is the patient selling their medication, are they asking for early refills all the time, are we getting anonymous phone calls saying my patient is selling their medication, that sort of thing. So we look for that as abhorrent, as an example of abhorrent behaviors.

But the other A is affect. Affect is depression. We know opioids will make depression and anxiety worse. I talked to you about that. We check on that specifically as part of the mental health evaluation when we do the four As or 5-As. When they come back, that's our checklist to effectively document we're not missing anything critical on

follow up.

Q. How often should a pain management or a physician practicing pain management like Dr. Bauer monitor the four As?

A. Every time, every visit, every visit. Yeah, it's recommended that it be followed every visit. I can expand to that just a wee bit if you'd like.

Q. Please.

A. A corollary question, how often should we follow up with our patients in the office if they're on chronic opioid therapy, or even if they're not, even if they're just a pain patient that's not receiving opioids, how often should we see our patients. The general recommendation by the CDC and other agencies is a minimum of every three months. And that's for stable patients, for patients who have been on a regimen, let's say of opioids, or injections, or whatever for awhile over a course of years and have shown themselves to be stable with regard to their pain and function. So the minimum amount we need to see our patients is every three months.

And during that time, we'll look at their -- on each visit we'll look at their analgesia, their activity, any adverse side effects, abhorrent behavior, addiction, we'll do that each time. If a patient is not stable and is still having their medications changed or is still

complaining of increased pain, or is saying, hey, the medication isn't working, I'm in more pain, then we might see them more often, but perhaps every month, or perhaps even in the initial stages, if we've got a urine drug screen that shows they're maybe not taking their medications as prescribed, we might see them every two weeks. But somewhere in that time frame from weeks to three months for a stable patient we should see them. And the four As should be done at each visit.

Q. Should opioids be the first option for pain treatment?

A. No. Our professional agencies, organizations, as well as the CDC, are very explicit in this regard. And they say opioids should never be the first treatment option for patients in chronic pain.

Q. What -- what options should be tried before opioids?

A. We refer to treatment of a chronic pain patient in terms of multi-modal or multi-disciplinary treatment because the opioids aren't going to solve the problem. They're hopefully going to maybe help with function a little bit, but they're not going to solve the problem.

So the three or four areas that we look at in terms of treatment options for our patients, well -- so medication is one of them, opioids might be a medication,

but there are a lot of non-opioid medications that don't have addictive qualities associated with them, anti-inflammatory medications to Tylenol medications to anti-depressant medications, to various types of muscle relaxants. So there are various non-opioid medication that are options.

Secondly, moving from the medication realm to what we call the physical medicine realm, we have physical therapy, TENS unit, massage, stretch and spray for trigger point treatments, exercise, aerobic exercise, water aerobics. There's a whole host of physical medicine things where we actually try to get the patient more active.

And in the end that's probably the most important part of our treatment regimen in the sense that if our goal is to get the patient as active as we can, let's look at some of these physical medical options beyond physical therapy. Let's see what we can do to get them active.

The fourth or the third large area of treatment option would be what we would call interventional. I do a lot of that. I do epidural injections under x-ray guidance, sacroiliac joint injections, various types of injections in different parts of the body. That's a tool, it's not an end all, but it's a tool, both diagnostic and therapeutic. Sometimes surgery is necessarily, rarely but occasionally. So that's the interventional group of

options.

The fourth group of options, actually there's five. The fourth one is very important in pain medicine, that's the psychological end of things. As I told you, I don't care if it's Dr. Bauer or myself, we're not going to cure these pain problems. We have to teach the patient to live with them. And that's where the psychological options come up. So I've had patients, you think I'm crazy, you think the pain's in my head. No, I don't actually. I think the pain is really true, and I think you're telling me about it, but I'm not sure that your pain's going to be adequately addressed by narcotics or shots. Let me see if I can team you up with a psychologist to present various ways to cope with your pain a little bit better. I don't think you're crazy at all.

And we have three main ways, I'm not going to describe them to you, but just let you know in case you've heard them before. There's cognitive behavioral therapy, which teaches the patient essentially how to cope with the pain. And it turns out to be, on studies that we've done, more effective than opioids by a long shot.

Second is ACT therapy, ACT, or its -- it's commitment therapy, the CT is commit action, action commitment therapy. And it basically shows you that you may have to change your expectations, but it works. We're

trying to get patients functional, and if they're always thinking I want to get back to running a couple miles and they can't, we're going have to have a little bit of a discussion with them and have them manage their expectations.

And other is what's called mindfulness. And all these fancy psychological names, but they're helpful for you to understand that we're teaching the people to deal with things. Mindfulness is sort of making the right choice at the moment of decision. I'm going to shoot up my heroin again, no, I'm going to just take a moment here, five seconds and think about it, is that a good choice. We have these various psychological ways, plus psychological, psychiatric -- psychiatry is also helpful in dealing with patients who have psychosocial issues. You know, maybe they were abused, maybe they had a history of pre-adolescent sexual abuse. Regrettably we see a lot of that that drives a lot of they reason why, typically young women, and occasionally young men come in addicted and looking for pain management, opioids when, in fact, they never really have been able to address some of the traumatic episodes in their early life, whether it's sexual or emotional or other types of physical abuse. So the psychiatric part is a very critical part of what we must do as multi-disciplinary pain management doctors to

effectively do the right thing for our patients.

Q. How would a doctor like Dr. Bauer be able to determine if a patient might have psychosomatic pain?

A. Okay. So let's address what psychosomatic pain is. And I'm going to take a step back, and I'm going to address what pain is for a moment, if I may, because I think the jury, you may be asking yourself the question, well, what is pain exactly. If I hurt, can't I have an opioid? No. Maybe, but probably not, and here's why.

If we ask the definition of what is pain, pain is -- pain is a response -- it's an unpleasant response. We all would agree with that. Pain is an unpleasant response that is both real and emotional. And it's described in terms of -- of something broken where something may not be broken, but we'll describe it in those terms. Feels like I'm being pierced, feels like I'm being cut, feels like it's a boring pain. Some of those descriptions may actually be accurate because maybe you were pierced with a needle or arrow or something. But we describe pain in terms of something broken in terms of tissue disruption, but we may not have tissue disruption. But to go back for a moment to the fact that it's both real and emotional. What does that mean? That means there's always an emotional or psychiatric or psychologic component to pain. And if we, as physicians, ignore that, we do that

at the peril of our patients. Why? Because there is -- to go back to your term, counselor, the psychosomatic pain.

Psychosomatic pain means that it feels like there's a body part that's broken and in pain, but nothing's wrong with that body part. It's in the head. Does that mean the patient's making it up? No. It's an expression of emotional suffering. If I ask the patient, does your back really hurt; yeah, it really hurts. But that back pain or abdominal pain or Myofascial pain or muscle pain or pelvic pain may actually be an expression of emotional suffering. The brain doesn't know how to -- how to express its suffering in terms of that makes sense so it expresses it to the patient as your back hurts or your neck hurts or your muscle hurts. And if we, as a physician, don't make that differentiation, if we don't say this is a psychosomatic pain, or this emotional component causing this pain, and we elect to use opioids or shots, there'll be no effect. All the patient will do is suffer the potential side effects of additional steroids, the risk of additional injections, and the risk of long-term opioids that I've already told you will make depression worse, panic attacks worse and disrupt sleep. So if a patient has psychosomatic pain, meaning pain that we can call emotional suffering -- and it's real. Again, it could come from preadolescent sexual abuse, it could come from the stresses

of being homeless and jobless and living on the street. It could come from living in a family where your kids or your significant other is a drug abuser and you kind of fall into that. Those are psychosocial contributions, but those are all somatic pains.

About 50 percent of patients who present with depression, anxiety, post traumatic stress disorder or Schizophrenia, to pick four common ones that we see, about somewhere, give and take a little bit, 50 percent of those patients will present with a psychosomatic pain. Not a trivial number, but if we treat them with opioids, we've done them a huge disservice because, as a physician, we have not made the right diagnosis. So we have to, as part of our thorough history and complete examination, sort out the mental health and what we call the psychosocial contributions to the chronic pain.

Q. Is it appropriate to treat psychosomatic pain with narcotics like Oxycodone and Hydrocodone?

A. It's contraindicated to use Oxycodone, Hydrocodone, or any opioids, to treat psychosomatic pain for the reasons we're taught might make mental health worse.

Q. Do neurologist have experience in handling psychological issues?

A. In the beginning, back in the olden days, which

is where I and Dr. Bauer come from, there -- the specialty of neurology was generally coupled with psychiatry. So the -- the -- the formal organization is the American Society of Neurology and Psychiatry or Psychiatry and Neurology, so involves both. So actually, by assumption, he may have had, or neurologists may have had perhaps a little bit more exposure to mental health and psychiatry than I, as an anesthesiologist, would have. But certainly, as a pain management physician, knowing that's a major risk factor, all of us who specialize and are board certified have brought ourselves up to speed and understand the concerns, red flags associated with mental illness.

Q. So if opioids are going to be used, what dose should a doctor prescribe?

A. If opioids are chosen carefully after thought full consideration and evaluation of the patient, the lowest dose effective should be used. And this is a concept that, as I've said many times in the past, this was taught to me as a medical student in pharmacology class. You always start out, doesn't make any difference if it's an opioid -- well, let's say opioids, you start out with the lowest effective dose, and then go forth with your trial, as we talked about, to see if there's any improvement. If there is, you may opt to bump it up a little bit, assuming that improvement continued, but you

always start with -- well, so the phrase is go slow and start low, or, well, start low and go slow. That's the phrase, and that's been adopted by the CDC as well, but that particular phrase and philosophy's been around for decades.

Q. If pain stays the same or increases, do you increase the dose?

A. You describe a failed opioid trial, and if the opioid trial fails, if pain doesn't improve and function doesn't improve, then you most certainly do not increase the dose. You wean the patient down and stop it. And you should, by the way, have this conversation with the patient beforehand.

As a matter of fact -- and I'm sorry to stray, but I want to add on one thing here, or one concept. If I decide to start a patient on opioids, the first thing we have is a conversation about the treatment goals, and this is standard of care. It's not just me, it's required. You have a conversation, I'm going to start you on opioids, what are your treatment goals, are we going to get you back to you can run an hour, are we going to get back to work, back to work in the garden. We're going to put down measurable, meaningful definition of treatment goals, and then we're going to start our opioid trial. And if you don't meet those goals, we will have had the conversation

that went something like this. If we don't meet the goals, we're going to wean you off the opioids and look at other choices of treatment to treat you for your pain. We have a bunch of them, but if the opioids don't work, you don't continue them. If you don't reach the predefined treatment goals that standard of care requires, the opioids be weaned and stopped.

Q. As part of that initial discussion, should it include the risks of addiction?

A. Absolutely. Yeah. I mean, that's -- yes, I could expound about that for a long time. It is possible -- addiction is generally -- the concern about addiction is related to the potency of the narcotic, among other things, the potency of the narcotic and the duration of the narcotic. Some -- I'm just going to mention one statistic. But if I put a patient on opioids for three months, and this a CDC -- a CDC statistic. If a patient is maintained on opioids for three months, which is not all that long a time when you think about it, we expose that patient to a 12X chance of addiction beyond what that patient would have been an exposed to otherwise. So simply starting the patient and maintaining them for three months on an opioid exposes them to 12 times the chance of addiction.

The other statistic in this regard and of some

concern is that the dose -- I mentioned there were two things that might cause addiction. One would be the duration, and it could as short as a couple months. The other is dose. We talked about morphines equivalence, and it turns out the higher the dose, the morphine equivalency, the higher the chance the patient's going to get addicted and/or have an overdose event. So if you ask me why we had all that discussion about what morphine equivalency is, it's because of this, the risk of overdose and death and addiction increases as at morphine equivalency goes up. So we have to think very carefully, as providers, before starting somebody on opioids. We have to make sure they're effective because, yes, the risks of addiction is very real, and it is not trivial.

Q. In addition to the conversation about addiction with the patient, should you also discuss side effects?

A. Absolutely. Yeah, so, you know, I told you the three categories of side effects. This is what we call informed consent, and by standard of care it's required. You have to bring it down to a discussion such that the patient understands. Not everybody is going to understand it, so, as a physician, you have to present it in a way that makes sense. But, yeah, you have to talk to the patient about addiction, about overdose, about death, about respiratory depression, about what it's going to do to

their mental health, what it's going to do to their cognition, to their thinking, to their sleep, what it's going to do to their bowels, what it's going to do in terms of pain levels, if we get up high enough it may cause their pain to get worse. Have to have a quite serious discussion about these things, and it's required to do so as part of the informed consent. Just as you would expect if a surgeon were going to operate on you and do an open heart procedure, you would sit down with the surgeon and have a discussion an informed consent about what are the potential side effects, what are the chance of problems. The standard of care requires we have the same conversation prior to starting somebody on opioid therapy.

Q. Once a doctor starts prescribing opioids, should that doctor continue to prescribe them forever?

A. No. It's not a sentence that you're constrained to follow over the course of a lifetime. Why? Because the pain condition changes, and you change, sometimes for the better, sometimes for the worse. Sometimes you adapt to the pain. Sometimes, as a result of that, you don't need as many pain medications. Sometimes your function improves and you're able to back off on some of the opioids. But it's not a life sentence, unlike, well, okay, addiction is a life sentence. But the need for opioids for the treatment of chronic pain is not a life sentence.

And it's part of the reason why we follow up with the patients at a minimum of every three months, because conditions change, needs change, and we don't always have to look at the concerns about ratcheting up the medicine. Sometimes we can bring it down, and that's a good thing.

Q. How does a doctor, like a pain management doctor, know if it's really -- if the opioids are really working.

A. Very easy. I may disagree with you as a physician, let's say prescribing opioids on somebody, but if you show me that the pain level has improved, what we call the VAS pain score, the one to ten pain score, if you show me on the patient you started on opioids that their pain score's improving, if you show me that their functional goals have been met, and they continue to be met in a measurable, meaningful and sustained manner, those are the three criteria we use, over time, then I would say good job, you made the right decision.

So the proof -- I like to say, when I lecture it to some of our younger medical people, I say the proof's in the pudding. Show me that the patient gets better show me objectively the patient gets better. We may disagrees on the medicines or the dose, but if you show me the patient's getting better, then I will say it's a good choice, you showed me that it was the correct choice.

Q. You've testified that opioids are highly

addictive. What about Benzodiazepines?

A. Yeah, so we've talked a lot about opioids, so let's talk about the Benzos, that's what we call them sometimes. So the Benzos are the sedatives, the Xanax, the Valium, two of the most common. And it turns out they're in a lower schedule. They're Schedule IV, as I talked to you about over there. So they're not quite as addictive, but they're addictive. They're really addictive. And the concern about them is that if you're on opioids, and I decide to wean you off, and I would do carefully and thoughtfully, you might have some side effects. You might have a few withdrawal symptoms, but we can manage those. And they're not life threatening in the case of opioids. They are life threatening in the case of Benzos, so whereas they might not be quite as addictive, if you are addicted to them and you need to take the patient off, it's a life threatening issue, convulsions, cardio pulmonary collapse, seizures. It generally has to be done as an inpatient, in hospital-type scenario. It's made horribly worse if the patient is also on opioids or stimulants or illegal drugs.

But to your point, the Benzodiazepines, although not quite as addictive, have severe problems associated with weaning, so we hate to see when a patient is addicted to the Benzodiazepines. It's a dangerous course. It's dangerous when we wean them off. It's dangerous to

continue with them because they interact with opioids to provide disproportionate respiratory depression and death.

THE COURT: Counsel, apologies for interrupting. I have some matters to take care of over the lunch hour. I'd like you to, if you can, find a good stopping point now or in the next five minutes or so.

MS. DUSTIN: Sure. Let me just ask a couple questions about this and then --

THE COURT: That's fine, whenever.

MS. DUSTIN: And then we'll pick up with addiction when we return.

BY MS. DUSTIN:

Q. So just to conclude about Benzos, should doctors take the same precautions when prescribing them?

A. Yes, they should, plus additional ones. The FDA came out with what we call a black box warning a number of years ago. I'm inclined to think it was 2016, not quite sure, but we knew about it before then. But they came out with a black box warning saying do not prescribe Benzodiazepines concurrently with opioids because -- and I think the way they phrased it was high incidence of life threatening respiratory depression. Patients stop breathing, they stop breathing with the opioids, they stop breathing with the Benzos, but when you combine them you've got the synergistic effect that people really die.

So if you're prescribing it, stop. Or if somebody else is prescribing it, and you're prescribing the opioids, then at least have a conversation with the other doctor and say, look, this combination is deadly. One of us, or maybe the two of us, can work out lowering the dose, or do we need both medications. So, yes, it's of great concern.

Q. Dr. King, how would you know what another doctor is prescribing?

A. There is the concept of the PDMP, the prescription drug monitoring program, that is effective in each state, all states but one. But the prescription drug monitoring program or the PDMP, in Ohio it's called the OARRS program, O-A-R-R-S. I never remember what that stands for, but it keeps a list of the pharmacies when you come in to fill a prescription for Controlled Substance, opioid, Benzos stimulant, Soma, whatever. The pharmacies keep track of those and put that into a central register in the state so that any doctor who has signed up for the OARRS program, and we're all encouraged as physicians to do so if we practice in Ohio, to -- and we can do this on our computer when we're talking care of the patients. We can pull up the pharmacy profile for that patient and see what medication that patient's getting, not only from me but from other doctors as well. But if that patient's getting

Benzodiazepines from another doctor, I'll have it right here in front of me and I will know, and that will queue me to say we've got a potential problem here. We call the other doctor or let me modify what I'm prescribing you, but it's black and white as a result of the PDMP, or in Ohio the OARRS program.

MS. DUSTIN: Thank you.

THE COURT: Let's take our lunch break at this point. It's ten of 12. Let's try to be back and start promptly at 1:00.

Please remember all the rules. We're in recess. Thank you.

(A brief recess was taken for lunch.)

THE COURT: Welcome back. You may be seated everyone. Hope you had a chance to stretch your legs. Counsel you may continue with your exam.

MS. DUSTIN: Thank you.

BY MS. DUSTIN:

Q. So, Dr. King, let's pick up with maybe talking specifically about some patients in this case.

Did we ask you to review 14 patient charts from Dr. Bauer's practice?

A. Yes, you did.

Q. And with respect to any of the patients, did you perform an exam on any of the patients?

A. No, I had no personal contact with any of the patients.
Q. Did you physically see any of the patients?
A. No, I've not physically seen them either.
Q. Did you rely predominately on the information contained in the patient files?
A. I did, yes.
Q. And did you look at any reports in terms of PDMP outside the patient files, OARRS reports?
A. OARRS reports were presented to me as separate files for those 14 patients.
Q. Is it appropriate to expect that you can rely on a doctor's patient file to examine a patient's treatment over the course of time?
A. It is appropriate, yes.
Q. So lets first talk about the patient with the first name of Amy.
Did you review Dr. Bauer's patient chart for Amy?
A. I did, yes.
Q. And just, in general, before we start talking about Amy. For Amy and all of the patients, explain how this review process occurred.
A. Earlier -- excuse me. Earlier when I discussed that I had a registered nurse and some additional help in putting together the files, here's how -- here's how the

organization works.

As I indicated, typically each patient may have a file that's between 1,000 and 1,500 pages. That's a lot of pages. It typically is an electronic file, so there's not a lot of handwriting involved. But it has to be organized in terms of chronologically so I can review the information when the patient first presented, and then the progress, or lack of progress, that may have been made as the patient went along in order to put together an assessment regarding whether opioids or injections were used appropriately, I have to have a chronology, a timeline, if you will, of how everything occurred.

So the nurses organize the charts into an Excel spreadsheet. And in that Excel spreadsheet, every office visit that's in the patient's chart, either with Dr. Bauer or one of his colleagues, or with a different doctor, or an emergency room or hospitalization, every imaging study, every MRI, every x-ray, every electro diagnostic tests, EMGs and so on, every phone call, every note is put into that chronology. So that chronology tells the whole story.

But it's in an Excel format, and it's color coded so that the office visits, just by convention, we use light blue to represent an office visit with Dr. Bauer. I use a pink or an orange to represent an office visit from a different doctor or institution. Urine drug tests are

color coded green. It's white if it's an office note or a telephone conversation, let's say from a pharmacist. So I have this compendium, this Excel spreadsheet, that is taken from the medical chart, and it's a chronological timeline, it's color coded as to event. And that's put into one folder. And then that's used to tell the story. That basically tells the story.

And then from that we have a common reference to events and so on because it's all Bates stamped back to the original chart. So if there's a question about, well, I made this observation, whereas in the original chart it's Bates stamped with a page number so we can go there and source it out at the original document, so it's very precise. It's very meticulous. It has everything in it. It's just put into a readable format, an Excel spreadsheet.

And then at the top of that spreadsheet there's what I call demographic analysis where we -- where I put down the age of the patient, the gender of the patient, how many visits the patient has, what were the dates of care, the medications they were prescribed, the pain diagnosis. By the way, I'm referring to my computer here because I've got one of these up. So the pain diagnosis, the red flag history like smoking history, alcohol history, illegal drug history, medications, mental health co-morbidities, all the things that are appropriate for me to make an appropriate

determination of an opioid use and injections.

So that's all part of a large document that for each patient I call the forensic chronology. And maybe I can show them.

Q. Absolutely. I was going to ask you, please, if you have one, maybe if you can pick up one from Amy and show us what the forensic chronology looks like.

A. So all right. So one, two, three -- this is one of three volumes that I put together. All total it ended up being, I've got three volumes. This ends up, all total, being about 12 -- about 12,000 -- 12,000, yeah, about 12,000 pages is what I put together.

Q. Does your staff essentially do the clerical work of putting the information into a readable format for you?

A. That's correct. They do the clerical work. They pull it all together. They -- I do the interpretation work, and obviously form the opinion based on things. They do the -- the initial translation of taking information from the medical chart, putting it into the spreadsheet, and then I reviewed the spreadsheet and chart side by side to make sure all the critical items were obtained. This is what it looks like. It's the smallest font I can get because there's so much information. So this is for the patient Amy, and there are -- for her there are --

Q. In fact, while you're speaking, let's bring up

Exhibit 901.

A. And there are about 70 pages for Amy. And I'm sure we'll be talking about and reviewing those, but this is what the work product looks like, the forensic chronology is what I refer to it as.

THE COURT: The record should reflect that Exhibit 901 is on the monitors in the courtroom.

MS. DUSTIN: Can we go to the first page of 901?

BY MS. DUSTIN:

Q. So looking at trial Exhibit 90I, and it's marked one of 80, and it has your name in the upper right corner, correct?

A. That's correct, yes.

Q. All right. And is this the summary page you just described?

A. Yes, it is. By the way, just a correction. I said 12,000, but it's 1,200 pages is what my work product ended up being, 1,200 pages, so yes.

Q. All right. And you have then after your summary page, does the timeline begin?

A. Yes. So after -- after the first couple lines where I have this summary information, then begins the actual record demonstrating all the information that was in the actual patient chart, color coded and chronologically put together.

Q. So what color would the treatment, beginning with ANA or Advanced Neurological Associates, and then Dr. Bauer, what color would that begin with?
A. Light blue.
Q. So if we can move to the next page, we're looking at Page 4 of 80, and it looks like -- entry on top is ANA and it looks like Brendan Bauer?
A. That's correct.
Q. Now, we're going to get to this a little bit later, but since you mention red flags, what are red flags?
A. It's well understood, as we talked earlier this morning, that there are certain predispositions, medical conditions, mental health disorders, that a patient may have that will make them more liable to addiction or abuse of Controlled Substances. We refer to these predispositions as red flags. And they're -- you want me to describe the three different categories of red flags?
Q. Yes, please.
A. We think of it in terms of three different categories where, as a physician, as a provider exercising universal precautions, that would need to be documented and examined before opioids might be started.
The first would be mental health. We talked about that briefly. We know that there is an, unfortunately, a significant association with drug abuse

and mental health. And part of that is because of the emotional suffering that causes the patient to have pain, and then seek out opioids, perhaps. Although opioids aren't appropriate for emotional pain. But nevertheless, mental health is one of the factors that we look at. So incorporated in that we're looking at depression -- as examples, depression and anxiety are the two big ones, post traumatic stress disorder, PTSD, Schizophrenia, mostly depression, anxiety, depression, panic attacks and that sort of thing are, unfortunately, are associated disproportionately with the inappropriate use of opioids in addiction. So that's one category.

Second category would be what I referred to as the psychosocial factors. And that would be, again, picking up on what we discussed earlier today, that would be some individuals are suffering in life because of their living conditions. Maybe they're living, again, with a spouse or children who are actively taking medications, illegal medications, and they're reinforcing that behavior in the family, or maybe that are victims of preadolescent sexual abuse, or physical abuse, of other types or emotional abuse. We know there's a high association with that problem, that social problem, if you will, and drug abuse.

And we -- and we look for other indications like

homelessness, or financial stressor, relationship stresses. Relationship stresses is pretty broad, but if you look at suicide and drug overdose and addiction, and we look at the causes --

Q. Suicide is a red flag?

A. Suicide is a major red flag. Previous history of abuse, drug abuse is a red flag. Previous history of overdose is a red flag. These are obvious things that, if you think about it, you would say these things need to be looked at before a commitment to use opioids with a patient would be made.

And then the third category, so we have psychosocial, mental health, and the third one is co-morbid illnesses. For example, I talked earlier about if a patient has respiratory problems, preexisting, and then we add opioids or Benzodiazepines on top of that, we predispose them further to death to stopping breathing. So as part of an evaluation of their general health or co-morbid conditions, as we call it, we look for asthma, sleep apnea is a big one. Sleep apnea, people quit breathing already, so if they have a history of sleep apnea and we add opioids on top of that, we're putting them in danger of stopping breathing all together.

So we look for lung or breathing problems. We look for cardiac or heart problems, and we look for kidney

or liver problems. Why those? Well, the heart, I think it's obvious, if a patient has heart disease we don't want them to slow down their breathing because it might precipitate a heart attack, and they might die.

With regard to the kidney or liver, those are the two that metabolize the drugs, that clear them from our system. It's important to find out if the patient has a history of liver problems, hepatitis or alcohol abuse or enlarged liver as a result of alcohol.

Q. So alcohol abuse itself is a red flag?

A. Alcohol abuse, sure, and that would be part of an addiction history, let's say. So an addiction history doesn't always have to be just the opioids, it could be alcohol, it could be illegal drugs, so yes.

Q. Speaking of illegal drugs, what about abhorrent behaviors?

A. Abhorrent behaviors, yes. Sort of a category, and maybe they should stand on their own. But certainly what -- what the counselor is referring to is that if an individual is -- is acting in an abhorrent fashion, by that we mean if they're drug seeking, maybe they've got full-blown addiction, or maybe they're not quite to the fully addictive state, maybe they've got what we call substance use disorder and on the road to addiction, but what we used to call dependency. If they've got abhorrent

behavior that indicate they're opioid seeking, or they're high risk takers, or they're showing us indications that they're not following medication directions appropriately, they're early out on their medications, they're asking for early refills, there are incidents of lost and stolen medications, those sorts of things are abhorrent behaviors that must be reviewed by the physician prior to committing to opioid therapy so as not to fall into the trap of providing opioids for continued addiction. And that's where the universal precautions concepts come in because it's hard to predict, so we have to do our homework. Standard of care requires we do our homework in this regard and to outline the red flags or high risk areas.

Q. If a doctor encounters a patient with one or more red flags, what does the doctor need to do?

A. The red flags need to be addressed. Red flags are like symptoms. You come to the doctor with a belly ache or headache, that's a symptom. So in the same manner, you come to the doctor and the doctor discerns you've got some red flags or abhorrent behavior, the doctor has to have a high index of suspicion when we're dealing with opioids. Trust the patient, but also understanding that we can't always predict whether the patient's going to use those drugs in a -- in an abusive or diverting manner. The doctor must seek to explain those. If we get an anonymous

phone call that says our patient's selling their meds or overusing them, we have to have that discussion with the patient and try to discern, is the patient telling the truth, or is the anonymous caller telling the truth. If there are multiple incidences where the -- where they're early out medications, early refill medications and stolen medications, we call those three abhorrent behaviors. We call that the abusive triad. And if those show up in a patient, we have a high index of suspicion, as a physician, that those drugs are being used for purposes of abuse, addiction or diversion. So we must have a conversation with the patient, and if appropriate, standard of care requires us to wean the patient of those and to choose other treatment options for their pain syndrome.

Q. Let's get back to the Amy chart.

Based on your review of Amy's chart, did Dr. Bauer follow the standard of care for prescribing Controlled Substances?

A. He did not.

Q. And based on your review of the Amy chart, did Dr. Bauer write prescriptions for Controlled Substances with a legitimate medical purpose and within the course of professional medical practice?

A. He did not.

Q. Would you please describe, for the jury, Amy?

A. Amy is a young woman.
Q. And let me say -- before you start, what are you using to refer to?
A. I'm looking at my forensic chronology at the top section where I have the summary or demographics, you saw it briefly, but that's what I'm referring to now.
Q. So in front of you is Trial Exhibit 901, and you have it electronically in front of you, and also have the paper copy, correct?
A. Correct.
Q. So please describe for us the Amy patient.
A. Amy is a young woman.
Q. And we had this patient testify so we can use her last name. Her name is Amy Clift.
A. And that's -- and that's always, I think respectful, because these are real people who have real problems, and we have to be cautious as physicians, and we have to be respectful. And we have to look at them as troubled individuals, in many cases with legitimate medical problems.

Amy is a young woman who was 36 years old at time of her last visit. She was under care with Dr. Bauer for 14 years, which puts her age at initial visit at 22. She's a very young woman, she's 22 years old. She's disabled, based on the chart. Her chief complaint on the initial

couple visits had to do with tailbone that she claimed was broken in a motor vehicle accident. A review of the chart indicated no indication of a broken tailbone, and certainly no objective indication that she needed opioids for that.

Q. That's not sufficient enough to support a diagnosis of pain?

A. No. Standard of care requires that the -- that the pain diagnosis be both objective -- well, three things, objective -- and well two things: Objective and legitimate, in the sense that it's an appropriate diagnosis for the use of opioids. We all have pain. We all have pain, but we don't all require opioids. And some types of pain can't be effectively treated with opioids and shouldn't be. So it has to be a diagnosis that's generally accepted for opioid treatment. Tailbone pain is not one of those. Maybe pain, but not one for the use of chronic opioid therapy.

She also had diagnosis of various pains in her shoulder and in her hip. Fibromyalgia, back pain, leg pain, Sacroiliac pain, thoracic outlet syndrome. There's a whole host of diagnosis here, none of which were either objective in the sense that they were demonstrated by MRI or on physical exam, and none of which were legitimate in the sense they weren't generally accepted for treatment with opioids.

She had a heavy smoking history. She denied use of alcohol and illegal drugs. She was main -- she had a multitude of red -- well, before I get to that. She had mental health co-morbidities. She has bipolar disorder, she had a history of depression, anxiety, narcolepsy and anxiety attacks. These are significant. We often see bipolar associated with -- associated with opioid abuse. So she had a constellation of mental health co-morbidities that were red flags, caution flags in and of themselves.

In terms of treatment noncompliance.

Q. Let me just ask you, based on your review of Amy's chart, would you give us an overview of Amy as a patient being treated with opioids and Controlled Substances for the management of pain?

A. In terms of how she did over the course of time?

Q. Yes.

A. Yes. So as part of my review of the chart, I go back and I examine the complaints of the patient at each visit, what they rated their pain at, if the pain score was asked for, and what dose of medication, what morphine equivalency they were on.

So initially, when Amy presented in 2003 of low back pain and tailbone pain, she was not on any narcotics. She saw Dr. Bauer for the first time in January of 2004, again, complaining of low back pain. And her pain scores

in those early days was about five out of ten. Again, scale of one to ten, she was a five out of ten, where a ten is horrible and five is in the middle.

Q. Tell us about the pain scores. How do we arrive at a pain score?

A. Okay. So VAS stands for visual analog score. And, again, simple as scale of one to ten how do you feel. But that's the key, how do you feel, how do you rate your pain. It's directly up to the patient to tell me, as their provider, what the pain is, whatever it is I'll accept it as that. It's an expression of their suffering, which we call pain, but may not be pain, might be emotional suffering. We talked about that. But whatever it is, their total score is whatever they tell me in terms of their VAS score. So we generally find that, to put it into a more familiar scale, we all have pains, right, we stub our toe we do this, we're achy, I dug something up in the back yard, we're sore, we're tired. We generally describe most of our daily pains on the order of one, two or three out of ten. That would be what we all encounter from day-to-day, or we could take Tylenol, Ibuprofen, or rest, or heat, or massage. Those are the things we put -- if it's a scale of VAS three, three or four out of ten, we don't need opioids. We can put up with that, and we can take care of it with over-the-counter medications and

treatments.

Once we get over four, those scores, typically about five or six or higher, is what bring the patients in to see us as pain providers. And -- and those -- those pain scores are quite significant. Generally patients who tried over-the-counter, it doesn't work, so we have to examine it from there to find out how much of this is an emotional pain, or pain associated with mental illness or psychosocial problems, and how much is due to something broken that we can take care of with a shot or with opioids let's say.

But we monitor that. It's -- it's required that we monitor that, by standard of care, to see what the VAS pain score does over time. Standard of care requires -- you remember me telling you this, that the score must improve over time with the use of opioids to justify the use of opioids.

And I guess the last thing I would state in that regard, that there's a general sense in terms of standard of care put out by the CDC and other professional organizations that what justifies a -- an objective improvement in VAS score to support the opioids is generally conceded to be a level of three. So if you come up with pain -- and pain, let's say it's eight out of ten, if I treat you with opioids or -- and your pain comes down

three points to a sustained value of five out of ten or less, we can we consider that -- we consider that as objective evidence that our opioids are justified. It has to be accompanied by an improvement in function. But in terms of the VAS score, that's what we look for.

Q. And we're going to get to your summary chart in a moment, and we'll start explaining -- having you explain diagnosis and support of diagnosis.

Can you just give us an overview of Amy's treatment? And I think you left off with the VAS score when I interrupted you.

A. Amy's original VAS score that we have documented is five out of ten. Over time it varied from five out of ten to six out of ten to four out of ten, but it was always in that area. After being treated for 14 years, her last VAS pain score was six out of ten, again, compared to the five out of 10 that she started out with 14 years prior, so her pain scores never improved. They didn't vary much, and they were always basically at the same level that she presented with. With regard to other comments --

Q. Can you tell us about the Controlled Substances that Dr. Bauer prescribed to her?

A. The Controlled Substances were -- included Percocet, Klonopin; Klonopin is the Benzodiazepine, and from time to time she had anti-depressants and various

stimulants provided. Ultram was an additional narcotic that was prescribed to her in conjunction with the Percocet. So she was on quite a number of medications of opioids, sedatives and stimulants. Her -- her morphine equivalency originally started out as zero, she wasn't on any narcotics, she was ratcheted up to somewhere on the order of 20 to 30 morphine equivalents, then 50 to 60, and then her high, as best I could tell from the chart, the PDMP data, her morphine equivalency got up to somewhere around 90 morphine equivalence, which, at that time, was a combination of Percocet -- and, again, as we talked, Percocet is Oxycodone with Tylenol, so it's a combination of Percocet plus Ultram.

So at the end of her care in 2015, 2016, 2017, she was taking Percocet, Ultram, Clonazepam, Modafinil, which is a stimulant, Methylphenidate, which is a stimulant, and she was receiving Prednisone, both orally as well as by injection.

THE COURT: I'm sorry to interrupt, but I'm going to exercise that right. I want you to, very briefly, please explain the significance, if any, because we have part of an exhibit on the screen, the significance of the difference in writing. Some things are in black, some are in red, and some are highlighted with yellow, and maybe counsel was going to get there, but before we go further I

think it would be helpful for you to explain. Again, very briefly, if there's any significance to the difference in writing, typing, color.

A. The -- the typing should be all the same font. If not, that's just me. On the other hand, the colors represent my notes, my personal notes. On the upper left hand -- so if it's red, those -- like we see under mental health co-morbidities, those turn out to be significant red flags that I want to remember when I finally write my narrative report.

On the right there at the top where it says critical observations, typically I will put the medications in red so I can remember, as we go through the chronology there, and the dates, what the medications are and what their corresponding morphine equivalents are, which are in black, but the medications are in red, again, just as a visual reminder to me.

There are some orange marks there, which, from time to time, are points that I noted in the history of the chart that I wanted to remember. In this case there was one period in 2008 where Amy was not present for four to seven months. There was an absence, so I just put that in orange just so I could note that at the time when I finally wrote the narrative summary.

The black is -- is, again, it's -- it's generally

a bolded, but that's because I use the black bolded to -- as a quote when the patient or the doctor is defining the actual complaint or statement that's coming from the patient or from the chart.

THE COURT: In case the jury was trying to correlate the testimony with the exhibit, he is reading from a different page than the page that is on the screen. So the highlighted version, as he calls it the orange, it is now on your screen, and when you can see in the lower right-hand side of the screen the four to seven month absences highlighted, he calls it orange. And that's sufficient for an answer to my question. Thank you.

MS. DUSTIN: Thank you.

BY MS. DUSTIN:

Q. So what do absences from -- in terms of visits at a practice -- let's say for a pain management type patient, why is that significant?

A. Pain management care requires a continuum. We're providing patients with a significant pharmacy, in some cases a poly pharmacy, that has to be followed carefully. If there's a significant absence, let's say more than three months, assuming the patient's stable, that can create problems of withdrawal if the patient doesn't get the medications or raises the question of what happened. Did the patient die or get sick or get hospitalized, because

we're dealing with quite significant potentially dangerous and addictive substances.

So we, as providers, have to keep track of our patients. We end up knowing our patients pretty well because they -- they have to be accounted for at all times. So any sort of time frame where they're absent, we need to know what's going on.

Q. Did you ultimately prepare a chart to summarize your findings regarding Amy?

A. I did.

Q. If we can bring up Trial Exhibit 945.

And would you explain the headings starting with diagnosis and support of diagnosis? Let's take those together.

A. Originally I had talked to you about the bullet points that define the practice of medicine. So the orange across the top where it says standards of care, that applies to the bullet points. So the diagnosis we talked about, the support of diagnosis, is part of the patient evaluation that we talked about. And did you want me to go on across the top there?

Q. Yes. Just explain what makes up the diagnosis or diagnosis which you look for.

A. I'm still not following.

Q. What you're looking for in order to determine if

those aspects are supported by the patient chart.

A. Okay. So the diagnosis, as I indicated also earlier, must be individualized and must be -- sorry.

The diagnosis must be one that -- that is objective and generally accepted as a condition for the use of chronic opioids. So the diagnosis ultimately must be expressed as such.

The diagnosis, moving on to the next column, must be supported. The diagnosis can't be just sort of ambivalent or guessed at or generalized. It has to be supported by the diagnosis, meaning a complete history has to have been performed, including past medical records and -- and examination of any previous trials of opioid patients may have been on a targeted physical exam must be performed and documented, and a clinical workup must be performed, which would include such things as MRI imaging, electro diagnostics labs, or consulting expert opinions and -- you know, if it's a back problem let's say from an orthopaedic surgeon or spine surgeon. All those things will go together for the clinic to compose the clinical workup, which, in combination with the physician's clinical exam and clinical history, would then define a diagnosis.

Q. And then moving over to the top, risk assessment. What are you considering in assessing risk?

A. Risk assessment is part of the thorough history.

It holds a particular place in pain medicine because the use of opioids, or the use of steroids, or the use of injections, can have devastating consequences. So risk assessment, as we talked about, would include a very careful examination of the patient's mental health background, of the psychosocial factors. Sometimes we put psychosocial into mental health. They're actually two separate, but that would include those two.

And then we look at the medical co-morbidities like we talked about that might predispose the patient to not respond to the medication in a safe fashion, such as stopping breathing, or not being able to metabolize the medications.

Q. And then moving on to the treatment plan.

What are you focusing on when you're looking at the parameters for opioid prescribing for a treatment plan?

A. The treatment plan must be individualized and multi modal. You're going to hear that until you're tired of hearing that. But each patient is individualized because each pain presentation is individual, because it includes emotion and that patient's social and mental health life so it has to be individualized.

But as part of the treatment plan, we recognize that there are a couple of red flags that we know can cause significant problems, and I'll start over on the right

where it says MEQ greater than 100. You heard me say that the morphine equivalent dose is proportional to the risk of overdose or death or abuse or diversion. The morphine equivalency, once we get to 100 and above is -- has been shown statistically to be associated with a ten times increase in risk of overdose or death. So we sometimes refer to morphine equivalence when we get up to the 90 to 100 range as to the region of extreme concern because of all the problems and side effects and adverse events that are associated with doses at that level and above. So I look to find out if the morphine equivalency is at that level or above and consider that a major risk factor.

Working backwards where it says high risk drugs and combos. We talked about that a little bit earlier when I was boring you with the pharmacology of it. I talked to you about the Holy Trinity, I talked to you about the prescription speedball, and the other one that I will add, because I promised you I was going to have another one, is a combination of -- poly pharmacy combination that's extremely dangerous and addictive when you combine an opioid with a Benzodiazepine. That would be like Percocet plus Klonopin, which is what we see here in the case of Amy. And that's where the FDA says don't do that, and all our professional organizations say don't do that. It's proportionally associated with stopping respirations and

the patient dieing. We don't have a name for that combination like we do the others, but it's a combination of opioid plus Benzo. So if we see any high risk drug or poly pharmacy medications, that goes in that column.

And then the one there defined treatment plan, this goes back to the fact that each patient has to be individually assessed and individually treated, and the treatment plan has to be written and it has to be multi modal. Can't just say I'm going to give everybody a shot, I'm going to give everybody steroids month after month after month, I'm going to give everybody opioids. No, some people may need opioids, some people may need steroids, some people may need shots that include steroids, some people may need smoking cessation, weight loss, nonimpact weight training, cardiovascular rehabilitation, psychologic services. We have to take all those into consideration. We can't use the same treatment plan.

Q. Let me ask you, as you're considering the different aspects of the standard of care, how are you tracking -- how are you, let's say, determining -- once -- whether it's fulfilled or not in the chart, how do you show whether or not it's fulfilled?

A. Ultimately if that particular standard of the -- well, the 14 here we look at, but ultimately if I find that that standard of care is met, based on generally understood

scientific and medical principals, not my thought but what's in the literature that supports it, if the physician has met that standard, I will give them a green checkmark. If that standard is not met, I will give them a red X. So that's what you're going to see here in a few moments, but that's the way I designate it.

Q. And do you also have a mark that supports no documentation?

A. Yes, sometimes I'll use a zero or an O if there's really no documentation, or no answer that can be inferred, sometimes I can infer some of this. And occasionally the other mark that you'll see here is a XX. A XX is, how shall I describe it, a XX is representation that the standard was not only not met, it was not met so critically that had it been observed, that the end effect would not have occurred, that in all likelihood the patient would not have died, or would not have developed addiction, or would not have gone on to have the severe suffering that was evident in the chart in the medical record. So XX is one of those that makes me kind of say, whoa, that -- that not only was a standard that was not observed, that impacted and did harm to the patient.

Q. And then moving over in your continuum at procedures, you're considering what type of procedures with respect to opioid parameters?

A. Yeah, we're looking at procedures or interventions, as I prefer to call them, but pain injections is what they are. And pain injections are inherent -- inherently dangerous. We're sticking needles into various parts of the body, sometimes deeply into the body, into the spine, into the thoracic area and lumbar area. These are not trivial procedures, they have to be taken seriously. There has to be medical indications that suggest, yes, it's appropriate to do that. And number two, it's appropriate to put the medication in. And we can put excessive medication in, we can put medication in the wrong location, we can put bad combinations of medicine in. So all that goes into my determination of whether the pain procedures were medically indicated and appropriate.

Q. And then lastly, you have compliance, enforcement, and outcome, as considerations in the standard of care.

A. This is the follow-up part of the four bullet points that I told you comprises the practice of medicine. You have to follow up with your patient, you have to make sure that you're doing good and not doing harm. You have to make sure that the treatment plan you put together is actually working. So we divide this into -- I divide this into five different areas here, five different columns.

The UDS stands for urine drug scene. Standard of

care requires us to do urine drug testing on patients initially before we start the opioids, and then, from time to time, over the course of treatment, depending on what risk category they're at. If they're a high-risk patient, we might do three or four or five of them a year. If they're a low risk patient, and I'm happy that things are -- there are no abhorrent behaviors, and things are going well, and things are controlled, I might do a urine drug screen once a year, in that range. And then I look to find out, as I examine the chart, not only were urine drug screens done, but what did they show. Did they show illegal substances, did they show that the patient was or was not taking their medication, in which case we have to, as providers, act accordingly.

Q. So if the urine screen shows a medication that is not being taken, does -- is that a fail?

A. That's a fail. Well, that's an abhorrent behavior, that then has to be interpreted in the context of the total care of the patient. Is the patient getting better and has maybe one failure that may not be too critical, say doesn't involve an illegal substance, or maybe it does, let's say it's cocaine, which is a show stopper, if there's cocaine or heroin or something like that.

Another show stopper would be if I had the

patient on high doses of morphine equivalence, whatever opioid, say Oxycodone or Oxycontin, and all of a sudden I did a urine drug screen and the medicine wasn't there, that tells me that the medicine's not being taken. And that tells me the patient's at risk for not only abuse, but maybe they're selling the medication. So if, objectively, I find out that the medication I am prescribing at a high dose is all of a sudden not showing up, that's a show stopper, and we have to, as physicians, figure out whether it's safe or appropriate to prescribing opioids.

Q. Moving over, can you briefly explain the PDMP?

A. The PDMP, we talked about that's the OARRS report in The State of Ohio. And, again, that shows whether -- well, it shows how many pharmacies the patient's going to, how many medical providers the patient is going to, and what medications the patient is receiving, as we worry about poly pharmacy combinations like we talked about.

Also will demonstrate early refills of medications, and it will demonstrate if, what we call doctor shopping, is occurring. Maybe my patient's going to you as another provider and getting duplicate prescriptions or different medications. The PDMP is easy to use, just takes me a few moments, pull it up on my computer, but it gives me a wealth of information that helps me define how compliant the patient is, and, therefore, is required by

standard of care to be followed.

Q. And also pill counts are another tool that a doctor can use in monitoring compliance?

A. Yes. Pill counts I don't have listed on here, but it certainly is a methodology easy enough to use, and very appropriate to hold the patient accountable to show what pills they've got left, and is it the right number.

Q. And then moving to the -- I think you already discussed chemical improvement. And we do also have drug risk behaviors and observations, and I think I just want to touch on those briefly. I think you talked about early refills and lost or stolen medications.

A. Correct, there's nothing new there. You can read it there, early refills, lost or stolen meds, missing scripts, and we look at drug risk behavior or observations to include is the patient's pain controlled or not controlled, are they going to the emergency room to seek pain medications for treatment of their pain. Are there hospitalizations involved, perhaps not only for pain but perhaps for mental health issues. Are there any arrests, is there any legal history that would serve as a red flag that maybe the patient's not using the medications appropriately. Is there any history of overdose or suicide. Those would be things we look for in that category.

Q. Ultimately how does death or discharge, how is that significant in this continuum?

A. Well, those are bad outcomes. If the patient dies, that's a bad outcome. If the patient's discharged, that means the patient was discharged because of misbehavior, abhorrent activity. So I look to see if the patient has any history of, well, death or discharge. Would you like me to comment on what information that gives me as a physician or gives us as a provider?

Death is important because it's prudent. If I'm providing a dangerous and addictive substance over time to a patient and that patient dies, it's prudent to ask the question did I have any part in that death, did my opioids either result directly or indirectly, because of adverse side effects, contribute to the death of that patient. That's what we call a sentinel event, and that's kind of saying that's obvious, but death is a sentinel event. If one death occurs, if one death occurs in my practice -- people die all the time, old age, complications of diabetes and maybe heart failure, one thing or another, but it doesn't occur very often. We get to know these patients personally, so if the patient unexpectedly dies --

MR. GIBBONS: Your Honor, can I object? This poster board has been placed in front of us.

MS. DUSTIN: We're just going to bring this up

here. I wasn't sure if it was going to block your view or not. I'm sorry, keep going.

A. So death is a sentinel event. And if it occurs, the standard of care requires that the protocol or an audit of that patient's chart be performed to ask and answer the question did I, as a provider, have anything to do that may have contributed to this death. A review of the chart, an audit of the chart, is required if the patient death is -- is noted.

With regard to discharge, there are many reasons why perhaps a patient might be discharged. Maybe there were too many abhorrent behaviors, maybe the urine drug screens were repeatedly -- or maybe even just once, showed some dangerous things that maybe we thought it was prudent to stop prescribing at that point. Or maybe the patient was just misbehaving, that happens a lot too. But if for some reason the patient is discharged, that has to be a very thoughtful event. We don't -- we don't abandon patients. I might say, look, your behaviors have been unacceptable. You've violated your contract of care -- and it is standard of care to have a contract -- you would agree to take my medications as prescribed, I agree to examine you and provide treatment for you. But if you're discharged, and that has to be a thoughtful event with foresight that's defined as part of the treatment

agreement. If it occurs, then it occurs, you don't just takes the patient back again after a couple weeks or a couple months.

Those are significant abhorrent events that might reasonably, based on standard of care considerations, say I'll continue to take care of you as a patient, but we're going to take opioids off the table. I'll continue to take cake of you, but you have to agree to quit acting up in my office and we're taking opioids off the table. So the treatment agreement's a discharge as it relates to opioids is important, and that's why that column's there, to look to see have there been any discharged from care by their provider; and if so, why, and what happened afterwards.

Q. So let's get back to patient Amy.

Based on your review of Amy's chart, and in conjunction with Trial Exhibit 945, did Dr. Bauer adequately diagnosis Amy's medical issues?

A. No. There was no objective diagnosis in terms of Amy's pain condition.

Q. And did Dr. Bauer adequately support his diagnosis?

A. No. The -- again, we would have to have a -- an evaluation. That's a term I'll use, a full evaluation, which includes history and physical and testing and imaging. An evaluation was not performed such that a

diagnosis could be defined, and -- and a diagnosis would be generally accepted for a treatment with chronic opioids.

Q. Well, Amy had a broken tailbone from a motor vehicle accident, isn't that enough to support a diagnosis of pain?

A. Amy complained of pain, and she complained of a tailbone that she said was injured in a motor vehicle accident. But x-rays, images, MRIs did not demonstrate a broken tailbone.

She later complained of diffuse back pain, but, again, there were no MRIs that showed any -- any indication of actual injury. Remember, Amy was 20 some years old, she was a young woman, so as was otherwise would be expected to be pretty healthy. There was no objective support of a -- of anything other than a subjective complaint of pain.

And, again, part of her background showed that she had significant mental health co-morbidities, which could have very easily and appropriately counted for her pain addiction, possible addiction, I would add to that.

Q. And did Dr. Bauer perform a targeted physical exam?

A. He performed a neurologic exam, a targeted exam, but it -- it tended to be repetitive, did not show any focal -- what we call focal deficits that would support any neurologic deficits to help us form a -- a diagnosis

supportive of the use of opioids.

Q. Did he perform his own clinical workup?

A. The clinical workup was vague, superficial, subjective and did not define a pain condition.

Q. Based on your review of Amy's chart, did Dr. Bauer adequately assess the risks of prescribing Controlled Substances to Amy?

A. No. He ignored the mental health co-morbidities that we've discussed. There were quite -- there was a single -- there might have been a second urine drug screen done, but maximum there were only one or two urine drug screens done over a 14 year time frame, so that was inadequate.

And then with regard to treatment compliance, there was -- there were a host of -- of red flags that were noted.

Q. Did Amy have an opioid trial?

A. She had a greater than 14 year opioid trial. She was trialed on medications, including Oxycodone, by her prior provider before she presented to Dr. Bauer. And she had had a lumbar MRI, by the way, which was normal during that timeframe. So even back then she went through a trial, had an evaluation that didn't show anything. So, essentially, she had a failed opioid trial even before she got to Dr. Bauer.

But Dr. Bauer continued to prescribe and escalated the opioids, as we've described, with -- with, again, no improvement in her pain syndrome, or her pain score, no improvement in function.

Q. In reviewing the Amy chart and the types of combinations of Controlled Substances, did you have any concerns?

A. I had several concerns with regard to what you're really asking, which is the poly pharmacy end of things.

First of all, Percocet is -- the Oxycodone portion of Percocet is well known to be a particularly addictive dependent type substance. Percocets -- short answer is Percocets are real popular on the street, so we worry about prescribing Percocets, or prescribing them to a patient that might get addicted, or we might make addicted. So she was on a combination of Percocet and Oxycontin at one time. And she, as part of that, she was on a stimulant, Methylphenidate. So she was on duel potent street popular narcotics, that's one concern.

Second concern is she was on a combination of those narcotics with a stimulant, which is, as we've talked, the prescription speedball, highly addictive combination. And there were times when she was -- when she was prescribed Klonopin, which is a Benzodiazepine, like Xanax, in combination with her multiple opioids. And

again, that Benzo/opioid combination is highly addictive and associated with respiratory depression or overdose death. There were several of those three poly pharmacy combinations I was concerned with.

Q. Now, earlier you talked a little bit about the morphine equivalence that you saw reflected in Amy's chart. And you have been referring to certain limits.

Could you tell us about whether or not there are any guidelines issued by the Ohio Medical Board with respect to MEQs?

A. Yeah. To put that into context, the -- well --

Q. Let's --

A. -- short answer is 80 milligrams, 80 milligrams was the -- is the -- is the dose that the Ohio Medical Board puts forth that says sort of stop, look and listen, and consider this a -- a -- anything above this a potentially dangerous and addictive dose. So Ohio states it at 80 milligrams.

Q. Let me have you look at Trial Exhibit 301.

Do you recognize that article?

A. Yes. This is it's Ohio Guidelines for prescribing opioids for the treatment of chronic non-cancer pain. And again, it emphasizes what I just said, that the 80-milligram morphine equivalent daily dose is what the medical board refers to as -- well, what the government's

cabinet refers to as a trigger point, or expressed differently, Indiana says it's a stop, look and listen point. But it's -- it's sort of the point where you don't go any further until you carefully reconsider where you're going with the care of the patient.

Q. And when -- when were these guidelines issued?

A. If you can scroll down to the bottom of that page, it says October of 2013.

Q. And when it refers to trigger point, we're not talking about an injection, right, they're talking about using it as a stopping point?

A. That's correct, yes.

Q. Okay. And have the Ohio Guidelines been reduced since 2013?

A. They have been reduced below that 80 milligrams since that time, yes. The general tendency, as we learn more about how ineffective and dangerous opioids are, the guidelines across the board have been coming down. And Indiana's, for instance, is 50, and Ohio's has been brought down as well.

Q. And let me --

A. Can I add one thing to that? There's a reason for that, and that is because studies have shown that somewhere in the 40 to 50 morphine equivalent range we've observed between a doubling to a tripling of overdose

deaths. Remember I told you originally when we get up to 90 to 100 it was 10 X, so 40 to 50 it's two to three X, which is not insignificant. And as we've recognized that, this is 2013 so we've known it for awhile, the states have changed their recommendation of where the trigger point is.

Q. So we talked about Ohio. So let's now look at Trial Exhibit 306.

Has the American Academy of Neurology put together a position paper defining the proper use of opioids for chronic non-cancer pain?

A. Yes. This is an extremely well-written article and was put forth, as you say, by the American Academy of Neurology. And it's a position paper, and they have taken note of the increased number of overdoses and the addiction issue associated with the use of opioids. And they put forth this paper on how to appropriately use opioids for chronic pain. And they have -- and they've done a good job in their bibliographic reference, that they took their information from, to put together this position paper. It was also quite robust and was -- and was quoting the studies of many peer reviewed journals, professional organizations, the government, the CDC, in a manner I thought that was -- that was well articulated.

Q. What guidelines did the American Academy of Neurology establish?

A. If we can scroll down a little bit to, down the way there, they may have it listed in a manner that I can real quickly tick off, but maybe not. Maybe I'll have to do it by memory.

Q. Do you remember what year this was published?

A. This was published in 2014. So -- so I'll just, from memory, kind of tell you what some of the things are here, but it keeps growing down sort of further in the article there if you would. Thank you. Just want to double check one thing. I was hoping they had a bullet point list, they don't.

But basically what they recognized, which is also what was recognized by American Society of Anesthesiologists and the CDC and the American Pain Society, American Academy of Pain Medicine, everybody's agreeing on these, including the American Academy of Neurology. What they said is that there is no evidence that supports the effective and safe use of chronic opioids in the treatment of chronic pain. They say that up in the beginning. There's no evidence that supports the use of chronic opioids for chronic pain. But if -- and they go on to say that, nevertheless, if they're used, there has to be concern about the safety of the patient, so the dose has to be at the lowest possible dose. There has to be a trial period. These are all going to sound familiar to you.

There has to be a trial period, and if the trial period does not allow the patient to meet predefined treatment goals, then it's obligatory to bring that opioid dose down and stop it and look at other treatment options that makes sense, it's logical, and it's in agreement across the board with the other agencies.

It also goes on to indicate that there are significant concerns related to the duration of opioid treatment and to the dose, the morphine equivalency as we've talked about. And I've given you several examples there, what the bad statistics are. But it confirms pretty much what's being said by -- by the other agencies. And it says, start low, go slow, if you have to go at all, and if you can't prove that the patient's improving, then stop.

Q. Let's now look at the CDC. Did they develop a checklist for prescribing opioids?

A. The CDC -- so we're changing courses here a little bit. Yes, the CDC has put together a checklist series of things that providers are expected to do if they're going to use opioids. So again, there's -- this checklist, okay, you're showing me was a response to the 2016 CDC guideline list that came out, which is very long. I can't remember, it was like 100 -- 100 and some pages. Some of us read it, but it was -- it was a lot to read.

So they put together a checklist here of the

basic bullet points and parameters for physicians to follow. And again, this is going to sound very familiar to you, and it's very consistent with what the American Academy of Neurology said, and what all our anesthesia journals put forth in terms of recommendations. They indicated that the -- that non-opioid -- I'll just go down the list here. There has to be -- there need to be goals for pain and function based on an appropriate diagnosis. So can't be just I feel better, it has to be, no, I can walk around the block now, and my pain level was an eight out of ten, now it's five out of ten, something of that sort.

It goes on to indicate that the patient needs to have an informed consent. We need to let the patient know there's real risk of addiction and overdose. Addiction is a topic we'll talk about, I suspect a little bit later, but it is possible, you know, within the first couple doses that a patient might become addicted. We have to worry about that as providers. And I gave you the statistics, after three months there's a 12 times increase in addiction. It's not insignificant.

And then there has to be a criteria put forth for stopping or continuing opioids, which means if there's no improvement in pain and function, the opioids are stopped. That's what that means. And there has to be -- I skipped

there, the evaluation of risks of harm and misuse, and we talked about that.

The PDMP needs to be checked on a regular basis. There's a wealth of data in the PDMP. It should be checked, it's standard of care to require it to be checked.

Urine drug screens. Urine drug tests, again, that's a very easy thing to do, and it needs to be addressed for the safe and continuous use of opioids.

Q. And then --

A. Go ahead.

Q. -- I think we've talked about all these things, so let's look at Trial Exhibit 303.

This is another publication from the CDC.

A. Okay. So again, this was in response to the 2016 publication of guidelines by the CDC. And I don't mean to be silly about it, but doctors sometimes don't take the time to read 150 page, or whatever it was, document.

So here the CDC put out what's called the vital signs publication. They have a series of these, and this was meant to address everything from family practice on up. And it says, okay, doctor remember these ten things. So it listed a, you know, list of ten things. You have highlighted one here, which is number five, which says -- and we talked about this, the 50 morphine equivalence, or the 50 MEQ as I refer to them, is the first sign when you

stop, look and listen as a provider and say do I really have to go this high, or any higher than this because there's significant risk of overdose and death associated with this.

And they continue to reinforce that at 90 morphine equivalents. Again, some of the guidelines were 100, but 90 to 100 is where that 10 X increase in severe life threatening problems occurs. So the CDC is reaffirming, look, the 90 morphine equivalence is absolutely the area of extreme concern, my words, but at halfway there, at the 40 to 50 area, there's significant doubling, or maybe a little more than doubling, so be careful at that point too.

THE COURT: What is the approximate date of these last two publications, Exhibits 302, 303, anyone who may have an approximate date, please?

A. I can answer that, sir.

THE COURT: Thank you.

A. 2016.

THE COURT: Thank you.

BY MS. DUSTIN:

Q. And then we can remove that one.

Dr. King, should a board certified neurologist be aware of the CDC guidelines, the Ohio guidelines, and the American Academy of Neurology's 2014 article regarding the

opioids --
A. Yes.
Q. -- use?
A. Yes, a practicing neurologist would be expected to be aware of those things.
Q. Should a physician be practicing pain management be aware of those articles?
A. Yes.
Q. Is Dr. Bauer board certified in pain management?
A. To my knowledge, he is not. He's board certified in neurology, but not in the sub-specialty of pain management.
Q. Was there a board certification for pain management available when Dr. Bauer went to medical school?
A. When Dr. Bauer and I, back in the olden days, were in medical school, there was not board certification in pain management. Pain management became a specialty primarily through anesthesia. As I've talked about, we deal with these drugs and these injections on a regular basis. So the whole sub-specialty of pain management came through anesthesiology in the late 1980s. And then it took awhile to put together training programs and board certification. Board certification for pain management for any specialty became available in about 1992, 1993.
Q. Would Dr. Bauer be considered grandfathered in?

A. No. Dr. Bauer and I, when we took our original board certification examinations, oral and written, way back when, me in anesthesiology and him in neurology, at that time, once we passed board certification, we had lifetime certification. Since then, that's no longer the case. New neurologists coming out, new anesthesiologists coming out, take a board certification, both written and oral, but you have to recertify every ten years -- every ten years. So Dr. Bauer would not have been grandfather -- well, he never took -- well, I don't know if he ever took the board certification exam for pain medicine, but -- but if he had, he would have been required, like I am, to recertify my board certification in pain medicine every ten years.

Q. I want you to look at one more article, and then we'll go back and talk about Amy.

Exhibit 304, and which -- what publication is this, and can you tell us the significance?

A. If you can scroll down just a little bit, please. I just wanted to be sure.

These are the guidelines that I've been referring to, and we've been discussing, put forth by the CDC in 2016 for the use of opioids and the treatment of chronic pain.

Q. And that was 2016?

A. That's correct.

Q. Thank you. Based on your review of the Amy chart and on risk assessment, was Amy a good candidate for long-term opioid treatment?

A. She was not a good candidate because she had too many abhorrent behaviors, mental health, co-morbidities and no indication of improvement in either her pain score or function over the course of 14 years.

Q. Based on your review of the Amy chart, did you see any red flags in the use of opioids and Controlled Substances by Amy?

A. I saw multiple red flags.

Q. And speaking of red flags, let me show you what's been marked as Trial Exhibit 305.

And do you recognize that publication?

A. Yes, that's an actual list of red flags as put forth by the Ohio State Medical Board.

Q. And when was that?

A. 2015.

Q. And did you also prepare a summary of red flags with respect to the patient Amy?

A. Yes, I put together a separate list of red flags. Because there was so many, I put together a separate list.

Q. And let's look at Exhibit 902.

Can you identify that, please?

A. Yes. That's the list of -- at least the way I

have it here, about 85, 86 red flags that I noted in review of her chart.

Q. That's a two-page document?

A. Yes, two-page document.

Q. Or one and a half?

A. Yes.

Q. Is that part of your forensic timeline?

A. Yes, it is. It's what I call my red flag timeline.

Q. Can you explain what's -- what you noted on the chart, just in general?

A. Some of these are more critical than others, but they all mount up. And basically the three columns, it's fairly self explanatory. On the left we have the date of -- that particular red flag was noted.

And in the center it's -- it's a brief description of what the red flag actually is.

And then on the right-hand side, the Bates number, is the source documentation actually in the chart so one can go back and see what the original entry was that led me to list it as a red flag condition.

Q. Could you describe for us the red print versus the black print?

A. The red print again, as The Judge asked me a little bit earlier, those are my notes. Those are

indications of abhorrent behaviors that I particularly wanted to note when I wrote my narrative summary and formulated my final opinion. So those are ones you might say that are particularly -- they're egregious and point to the fact that opioids are being prescribed not for a legitimate medical purpose.

Q. And can you just point out a few of the red flags? Actually let's move down and look at the next part of Exhibit 902. Can you explain for us what this chart is?

A. Give me just two moments here?

Q. Actually, this is a graph.

A. A graph, yeah, I'm sorry, I'm just pulling up here on my computer. Excuse me a moment.

There were two observations that I generally made about the majority of the patients that I reviewed.

Q. Can you explain the graph in general? This is a two-page graph, correct?

A. Yes.

Q. Just explain, in general, what's above the date line, what's below it and the colors?

A. So what this graph represents is, are three continuums of information. So it's all along a date line. So the gray line there goes from 2003 to 2010. During this time frame, I needed a way to convey various things that were happening, so the top part where you see those red

flags or pennants up there, those are actually red flag events. And you can -- and I had to keep it brief, couldn't do a lot of explanation. But for instance, there's, like, a no show, or a discharge from practice, or an early medication request, or non-compliance. We can go back into the chart and find out exactly what they means. But these are red flag events that occurred with -- with great frequency, so I needed to put it onto a timeline so we could have a better feeling of how often abhorrent behaviors were occurring.

On the bottom part of that gray date line are little blue pennants. And those blue pennants represent injections or interventions performed by Dr. Bauer. Well, I'm sorry, they represent injections plus the administration of steroids. Now, generally the steroids were administered by way of injection as part of the injection. Sometimes the steroids were administered orally, but those bottom blue-colored pennants are a list of steroid and whether administered orally or injections that generally included steroid as part of the medication injected. So the bottom part are basically steroid intervention record.

The very bottom line there, which is greenish, says MEQs 0 to 100. I didn't have, with this particular computer program, the ability to actually put the MEQ, so I

had to ballpark it, and it will change as we look at different patients. But if the MEQ range was between 0 and 100. It's this color. And others you'll see if it was raised higher or lower, it will be shown accordingly, but the bottom line there is the general morphine equivalency dose range that the patient had during that time frame.

Q. And does this graph go into a second page?

A. Yes.

Q. Is similar information plotted on to that graph?

A. Yes, I just couldn't get the whole timeline on one page, some took two pages, but it's the same rhythm.

Q. Based on your review of the Amy chart, did you find any evidence that Dr. Bauer tried to ensure that Amy was taking her medications as directed?

A. No, I did not.

Q. Did you see any evidence in the Amy chart that urine drug screens were conducted?

A. As I indicated the one or two urine drug screens, but over the course of 14 years, that was a woefully inadequate number.

Q. Did you see any evidence in the Amy chart that Dr. Bauer ever enforced a pill count or requested a pill count?

A. I don't recall there were any pill counts on this patient.

Q. There were none, or you don't recall any --
A. I mean, looking at my 85-point list here to be sure --
Q. Sorry.
A. -- but certainly pill counts were not a large part of overview of compliance. I recall there was one patient that had a pill count, I don't know if she was the one. But I don't -- I'm just reviewing the list here very quickly. I don't see any indication that there were any pill counts done.
Q. Did you see any evidence of early refill requests by Amy?
A. Yes, there were multiple indications of early refill requests documented in the chart.
Q. Did you see any evidence of pharmacy shopping by Amy?
A. There were multiple indications of pharmacy shopping by Amy.
Q. Based on your review of the Amy chart, were there indications that she was inconsistent with taking her meds, or the meds were not working?
A. There were multiple indications where she indicated the meds were not working, and multiple pieces of documentation that indicated she was noncompliant with the medications.

Q. Did Amy ever request, based on your review of the chart, being prescribed certain medications?
A. She, to a large extent, talked a lot about which medications she wanted. There were frequent requests to take this stimulant or that stimulant or this opioid or that opioid.
Q. Who should be controlling those decisions?
A. Those decisions rightfully belong to the physician. The physician's the captain of the ship. He knows the concerns with the poly pharmacy dangers and addiction dangers associated with those medications. We always want to make a decision in concert with the patient, but there can only be one person at the helm, and it has to be the doctor.
Q. Did you see any indication in the Amy chart that mental health medications were not working?
A. Yes. There were significant issues, or significant indications, of mental health, had significant problems. I can give you an example if you'd like.
Q. Yes, please.
A. In 2015 she was admitted to Fireland's Hospital for three weeks. That's a significant period of time for psychiatric-related issues due to depression, suicidal thoughts. And that was right in the middle of her treatment time frame with Dr. Bauer.

Q. Based on the patient chart, did you determine that Amy had Narcolepsy?
A. There was a diagnosis of Narcolepsy given to Amy. There was never any confirming past medical records that defined how that diagnosis came about, but it was historically put forth as a diagnosis.
Q. Is there concern about giving -- prescribing opioid and Controlled Substance medications on top of a diagnosis of Narcolepsy?
A. Yes, there is. There's a significant problem. If you don't totally understand what Narcolepsy is, it's -- I'm going to -- I'm not going to be real precise here, but for purposes of understanding, Narcolepsy is severe daytime drowsiness, can't stay awake. We all do that from time to time, but this is so severe that the patient will, like, fall asleep, you know, on a moment's notice and can't function. Obviously that becomes an issue if the individual's driving or carrying out some sort of care to a child or to, you know, a parent or something, but Narcolepsy is quite significant. It's a very severe episodic daytime drowsiness. Why are we concerned with respect to pain management? Because all of our medications will cause drowsiness, or cause over sedation, or cause respiratory depression, so we're adding to the potential clinical problem when we put a patient on opioids or

sedative hypnotics.

Q. If -- let's just say I want you to, as a hypothetical, suppose that a patient said after a period of time of being on opioids and then having not taken them for a period of time, if they said that they thought the opioids caused more pain, would that be consistent with any diagnosis?

A. If -- yes, it would. If the patient were to notice that -- to rephrase, as you just said if the patient were to notice that the opioids were not only unhelpful but were actually associated with increased pain, that's consistent with what we talked about earlier, Opioid-Induced Hyperalgesia. In other words, the opioids are causing the pain now, and the way to stop that is to stop the opioids to wean them down. If a patient were enlightened enough to notice that, then that would be very consistent in terms of reality. But it also would -- it would also raise the question as to whether the pain condition to begin with was really something to do with the back, or whether it was more of a psychosomatic pain as a result of emotional suffering of which, in the case of Amy, we know there was a great deal. She had bipolar disorder, had been admitted to psychiatric institutions, so there's plenty of reason to anticipate that her diagnosis was more psychosomatic, and that observation of Opioid-Induced

Hyperalgesia would tend to confirm that.

Q. Let's take a look at some specific documentations from Amy's chart.

So bringing up Exhibit 401, and let's look at Page 000637. So directing you to Amy's visit on May 23rd, 2011, did you find anything significant in terms of her care?

A. She was complaining on that date of chronic neck pain and low back pain with radiculopathy. Radiculopathy is our fancy word for sciatica. It goes on to say patient here for discussion of getting off the pain meds due to meds for Narcolepsy battling against each other. So my concern is two fold on this. One is I didn't see an objective diagnosis for sciatica or radiculopathy as part of her evaluation. She did have an MRI, which was normal earlier, and no indication of nerve root impingement or herniated disc. So diagnosis of radiculopathy was not supported.

And the other part is she's sensing that she's on pain medications that are not helpful, and that they are interfering or interacting with her Narcolepsy medications. We ask what are Narcolepsy medications, those are the stimulants, and that goes back to that poly pharmacy combination I talked to you about, when you've got opioids plus stimulants, and we've got the prescription speedball

so she's recognizing, in her words, that something isn't right.

Q. And then was there any indication, based on her visit with Dr. Bauer, that her function had improved?

A. No, there was no indication showing function had improved.

Q. Any indication that Amy's pain improved?

A. No. As we previously discussed, the VAS score didn't change significantly over the course of 14 years.

Q. And based on your opinion, should Dr. Bauer have continued Amy on scheduled controlled narcotic prescriptions?

A. No, he should not have. The standard of care would require that she be weaned off her medications, her opioid pain medications.

Q. All right. Let's look at Page 189. And in looking at Amy's visit with Dr. Bauer, I believe this was on 4-1 of 2015, did you have any concerns about Amy's treatment in that -- at that time period?

A. Well, she was complaining of fatigue, which one would have to wonder if that was a response to the opioids that she was on. The -- under the HPI, which is history of present illness general neurology, there's a section there that says under problem, lumbar pain, it shows a number of things. She -- it indicates that she's still complaining

of, quote, constant low back pain, increased muscle spasms many, increased paresthesia into her lower extremities, and the observation that those symptoms have increased over the past few months. And then it goes on to conclude that she's taking Tramadol and Percocet, which are two types of opioids which, again, we don't like to give opioids in poly pharmacy combination. One or the other should be sufficient in the majority of cases. But the point is here, despite duel opioids and worsening pain over the last several months, she was -- I can't read that one part, oh, she hasn't been able to get out of bed for days, although she states she's doing better now. All kinds of red flags there about whether the treatment with Controlled Substances is appropriate.

Q. Based on your review of the Amy chart, should Dr. Bauer have continued her on scheduled Controlled Substances prescriptions?

A. No. These mental health red flags, including admission for suicidal ideas, and the fact that she was not getting better, and the fact that she was taking a dangerous policy pharmacy, were all indications of prescriptions outside the usual course of medical practice.

Q. Now, during Amy's treatment, did she also receive injections by Dr. Bauer?

A. Yes, she did.

Q. And let me show you Trial Exhibit 903. And would you describe for us this -- this chart and how you put it together and what it shows?

A. To the best of our ability I tried to list all the injections where medications such as steroids were injected because I wanted to find -- steroids or, excuse me, the injections were so frequent that I had a concern that there were probably excessive steroids being administered. So as part of this list I also put down oral Prednisone or oral steroids, because I was trying to get to not only how many and what type of injections were being done, but how much steroid was being presented. And to a certain extent is color coded, there's a light blue there, that is the oral Prednisone, the gray that are epidural injections. That's where it says TFESI, which stands for transforaminal epidural steroids injections, and other injections, like trigger points or other injections, I think there's a host of them there. But this is a list of injections plus steroids.

And over on the right-hand side there you see a column entitled cumulative Medrol equivalent, and that's one of the columns I want you to pay particular attention to because that's, to the best of our ability -- sometimes the documentation wasn't the best in the chart -- but to the best of our ability to estimate how much steroid was

given. It was compiled in a cumulative fashion, such as on that last date of 7-21-17 she had received a total of 2,070 milligrams of Medrol, which is a steroid equivalent.

Q. And if you page down on this exhibit, can you describe this graph please?

A. This is a summation, in a graphical form, about how much steroid she received and when she received it.

Also at the bottom there I've boxed, again, the approximate number of injections she had that contributed to this graph. As an example, where it says LESI that's lumbar epidural steroid injection, she had 11 epidural steroid injections. She had 12 trigger point injections, and so on across there. And then again, to the best of my ability, the amount of steroid accumulatively is listed above in the graph.

Q. Dr. Bauer, we really -- Dr. King, we haven't talked much about injections. Would you explain for us the different injections that are common in pain management practices?

A. As an anesthesiologist, I was trained in all kinds of injections, and indeed I've continued to be fascicle on them and teach them as the years have gone on. So a complex topic, but let me -- let me give you a few bullet points.

First of all, the injections, for the most part,

are what we call therapeutic. That is to say we're putting medicine into a specific spot to try to reduce the inflammation, to reduce the pain. So if we use steroids, which is our main medication that we inject, it's with the thought that something is inflamed, maybe a nerve root is impinged like a herniated disk. So the idea is reduce that inflammation, reduce the pressure on the nerve, reduce the pain that's associated with that. So most of the injections, with some exceptions, are treating inflammatory contributions to the pain. There's no inflammatory contribution to the pain, there's really no reason to use steroid injections at all, which unfortunately was the case a lot of time here. There were no indications of any inflammatory conditions, but the steroids were still used excessively and to the patient's detriment.

The types of injections, the one you've heard of most commonly is an epidural-type injection, you've heard me refer to it as TFESI, which is a transforaminal epidural injection. We can give epidural injections by several routes. We can put the needle in different locations to try to get it into the epidural space. All the injections performed of an epidural manner by Dr. Bauer were listed as transforaminal epidurals. That's an injection that requires a great deal of skill because the needle doesn't go straight into the back of the spine into the epidural

space like you would do, say, if you were giving an anesthetic for child birth. Instead this goes in along the side. Transforaminal epidural you have about a 6-inch needle that has a bend in it, and the reason it has a bend at the tip so you can steer it. You come in on the side of the back under x-ray guidance because it's imperative to know where the needle's going. And you basically steer that needle into the spine, around the corner, and tuck it into the side of the spine where the individual nerves are coming out kind of like Christmas tree branches. So it's a very delicate procedure that has to be done under x-ray guidance. It's a lengthy needle, and the needle has to be placed right adjacent to the nerve or sciatic nerve immediately as it leaves the spinal cord.

So these were the types of epidural injections, transforaminal injections that were done. We have other injections, trigger point injections, media nerve injections, Sacroiliac injection, trochanteric bursa injections, brachial plexus injections, we'd be here all day on those, but epidurals -- but the take on this is they're all in various areas of the body, and they're meant to treat inflammatory conditions.

Q. What are trigger point injections?

A. Trigger point injections were the second most commonly performed injection by Dr. Bauer. Trigger points,

you've all heard of those, but medically I need to tell you what a trigger point is. A trigger point is like a marble in the muscle, and it's very easily palpable, and it's usually secondary to a trauma, maybe got hit there, or maybe went out back and dug a bunch of holes for some new trees you were planting in your back yard, and you overused the muscle. So it's overuse stress or trauma injury to a particular muscle, the supraspinatus, one of the paracervical muscles, the trapezius muscle, the deltoid muscle, it is a specific muscle where this abnormality occurs that can be palpated that is associated with a region of pain described by the patient. The pain can be reproduced by pushing on that nodule, and that nodule can be tweaked. It's sometimes called a taut -- taut -- a taut string, and you can kind of pluck it like you would a guitar, and it will send shooting pains down into the area where the patient has pain. But the key is it's in a particular muscle, it has a defined radiating pattern, it's easily palpable, and it reproduces the patient's pain. And we've had trigger points forever. And the problem occurs is that everybody says, oh, trigger point, well, that's a sore spot; no, it's not a sore spot, it's a very specific sore spot, has to do with muscle injury and transmission of pain. Well, it's just because I've got sore muscles, no, it's not just because you've got sore muscles, it isn't

fibromyalgia, it isn't sore muscles, it isn't tender points, it's a trigger point. You can trigger the pain in a specific and predictable manner by tweaking that thing and you can identify, and standard of care requires you do identify, which muscle it's in.

Q. And you can divide it between trigger and epidural by answering this question, but tells us, in terms of pain management how often these injections should be given if you're following standard of care that's established for those injections.

A. Okay. Again, that's a long discussion so I'm going to be very summary about it.

Q. Yes.

A. So trigger points are generally identified, again, because of muscle trauma, so if I opt, or a pain management doctor opts to inject the trigger point, saline or salt water in there, maybe a little local anesthetic or maybe some steroid, which is what happened here a lot, you don't need steroid. It's not been proven to be a necessary component of what you inject. But if you needled the trigger point, it has to be done in conjunction with, like, physical therapy and stretching and massage.

So trigger points injections will help break the cycle, but in and of themselves they're not a complete treatment. So the insurance companies, the standard of

care for various guidelines that are published is that maybe three, four, five trigger Point Injections would be more than adequate to break the cycle, and then introduce the patient into a physical therapy environment where they would continue to work and stretch and address those trigger points. So maybe four, to pick a number of the trigger points, after an inciting event let's say, because it's not thought to be a -- a long term chronic problem. It's an acute injury to muscle.

With regard to the epidural steroids injections, we -- we worry about the -- we worry about two things that determine the frequency. You've all heard about, like, a series of three epidural injections. Unfortunately that's nonsense, and that's not standard of care, but for various reasons that's sort of come into popularity over the decades. The thing about epidural, you do one and then you show that there's improvement. By the way, you have to do that with trigger points, you have to do one and show there's a sustained improvement. And if the epidural injection shows sustained improvement, maybe the patient gets a reasonable improvement for two weeks, then that's a foundation to do a second one. You don't do just three in a row, or four in a row, or five in a row. You do one, show some improvement, do a second one, hope to get some more improvement, and you can do that up to about three

times over the course of, lets say, six months. And then you kind of have to sit tight because at that point there begins to be an accumulation of steroid that has its own detrimental effects. You can repeat another series of maybe one, two or three, so a total of maybe four, five or six epidurals a year if you're showing that there's improvement. But the concern is accumulation of steroid, as well as mechanical risk because you're putting a long needle into vital location.

Q. Tell us some of the risks associated with epidural injections.

A. I'll talk about steroids separately, but with regard to the actual mechanical epidural, the reason it's done under x-ray is because there's a lot of things in the spine that you need to be aware of and don't want to put a needle into. So the needle can go into a nerve, and that can be devastating and induce a neuropathic pain syndrome that's horrible and difficult to control. So you can pierce a nerve. You can pierce the spinal cord, which is very dangerous and can cause infarction or death of the spinal cord if something is injected that then kills the area of the spinal cord you're injecting. You can put the needle subarachnoid or the spinal space or spinal fluid. Neurologists do that frequently for diagnostic purposes, but you don't want to do it inadvertently because you have

to deal with spinal headaches and putting local anesthetics in there or steroids in there that might cause their own problems. So that's an issue.

One of the things that we are concerned about to a great deal is perhaps putting a needle into an artery or into a vein, and then injecting the medication. And the technique we were talking about here, the transforaminal epidural injections, there's a little artery that comes out that accompanies that nerve as it exits the spine. And if we were to put a needle into the artery which feeds back to the spinal cord, that -- that steroid, or that local anesthetic, might infarct the spinal cord and cause permanent paralysis.

So there are a number of -- that's why we do it under x-ray, by the way, that's why we use x-ray dye, x-ray dye is required based on standard of care. You put a little dye in, and under live x-ray, can control, see if you're in a vein, see if you're in an artery, see if you're in the spinal space. You'll know if you're in a nerve, patient would be jumping off the table. But the point is we always do it under x-ray guidance with x-ray contrast so we can be sure we're in the safe spot and putting the medication into a safe spot not infarcting the cord or causing permanent damage. There are more but those are the big ones.

Q. And any concern with the steroid itself?
A. The steroid itself we have to be aware of. You may not be quite so aware of the potential problems associated with steroids, you're aware of the problems associated with opioids and Controlled Substances for sure, but lesser known is the problem associated with steroids. A few steroids every now and then are not likely to cause a problem. But -- but with excessive steroid use you start getting at one end of the spectrum, weight gain, sugar imbalance, sodium and water imbalance. If a person has diabetes and I give them the steroid injection as part of an epidural, I will disrupt their insulin and their sugar control for a couple days, and we have to talk to him about that. If you're taking it on a chronic basis, you're going to disrupt their diabetic sugar control over the long-term, and you have to be aware of that and talk with their internal medical doctor to account with what you're going to do with the steroid.

Steroids cause insomnia. If they're used on a chronic basis, they will cause sleep disruption, that's quite significant. And here's a key point, if you use steroids on a high dose chronic basis, it will cause all kinds of mental health issues, not dissimilar to a lot of the ones we talked about. It will cause psychosis. You heard maybe of steroid psychosis or roid rage. It can

cause rage issues and change the personality. And these are real, on a chronic basis these things will happen. It can cause, in and of itself, worsening depression and anxiety and, as I said, personality changes. These are things that the steroids cause, we have to be aware of that.

The steroids reduce the immune response to the patient's more likely to be susceptible to injection and healing, which is a devastating issue if the patient has problems with their sugar control and diabetes. But perhaps the worst thing, and the thing I was concerned about the most in reviewing Dr. Bauer's cases here, is what we call adrenal suppression. You understand that when we give opioids, people can become tolerant to them, and if we keep pushing the opioids, we can cause them to stop breathing and die and become addicted.

In a similar vein, if we give steroids, they're not going to -- well, if we give too many steroids we will suppress the body's normal production of steroid from the adrenal gland, and then the patient will become dependent on the provider to fill in the blank. In other words, the adrenal gland will be suppressed so the body's depending on steroids that are injected or taken orally because we have to have steroids. We have to have steroids. Steroids are our stress response -- if we don't have the ability to

moderate our steroid dose internally with our adrenal glands, if they've been suppressed because of too many injections, then we can get into cardiovascular stability problems. We can die if there's a sudden stress and we're unable to bring forth the steroids necessary to address the stress in life, whether it's emotional, whether it's physical. So it's the steroid suppression that we get concerned about, and this is not theoretical. This is -- this is very real. The dependency on the steroid is such that if you'll be given a lot of steroids for a pain condition and you haven't had them for awhile and you're steroid depressed, your pain's going to get worse. You'll think my pain's coming back, I've got to get back to the doctor. Or maybe it's because you've been steroid suppressed and you need more steroids because that will cause pain too to come forth. And maybe it's the low steroids that bring you back to the doctor, which I think was the case here in a lot of these instances. So there was a dependency that developed on the steroids just like there's a dependency that develops with opioids.

Q. Was Amy, based on her chart, also prescribed oral steroids?

A. Yes, she was.

Q. And based on your chart review, were the injections that Dr. Bauer administered to Amy administered

with a legitimate medical purpose and within the course of professional medical practice?

A. I don't think the steroids or the injections were performed with medical necessity. And, again, I'm not sure how you want me to phrase this, but I don't think the -- there was a legitimate medical purpose for the use of the steroids. I don't think there was a legitimate medical purpose for the use of the injections. I think that the steroids and the injections were used outside the usual course of medical practice.

Q. Getting back to --

A. I'm sorry, can I add one sentence to that?

Q. Yes.

A. I should put a period on that by saying part of the reason I believe that, the majority of the reason I believe that is because there was no indication of improvement.

Q. Yes, I was going to ask you that question. Thank you for reminding me.

If a patient indicated that an injection did not improve their pain, would a doctor continue -- who continued to -- to administer the injection be administrating it with medical necessity?

A. They would not, and you're correct in the way you say that. Much like the opioids where we do a trial and

see if they improve in pain and function, we do the same thing with injections and with steroids. And if they don't improve, and, again, most people feel better if I give them a little opioids right off the bat. That's not what we're looking for. Most people feel better if I give them cortisone right off the bat. That's not what we're looking for, we're looking for sustained improvement. Not just two weeks, I'm looking over the course of six months, are they improving, did my injection -- or did my opioid really allow them to improve their function and make them feel better for months at a time. So there has to be a sustained improvement to help them -- well, to there -- to define medical necessity. There's no improvement, then medical necessity is not proved, and a continued use of steroids or injections or opioids, for that matter, are outside the usual course of medical practice.

Q. And what type of things would you look at in terms of improved function, the ability to hold a job?

A. Right. Well, again these things would be discussed with the patient prior to starting the injections, prior to starting the medications, and it would be negotiations, maybe it's -- maybe it's go back to work, that would be great. Maybe it's I can't walk right now more than about 10 feet. Maybe you can walk around the block, maybe that's a reasonable goal, or maybe you can go

out to the garden. A lot of our -- who have raised chronic pain, arthritic issues, rheumatoid, so we put together a meaningful set of treatment goals based on the individual and what they can do. It has to be meaningful. It has to be measurable, and has to be sustained.

Q. Okay. Let's look at Exhibit 501.

Is this a prescription?

A. Yes.

Q. And it's written -- and I'll just have you, after we identify the first one, if you can just quickly identify each one, just tell us it's a prescription for what, issued to who, on what day by whom?

A. This is a prescription for Adderall, which is Amphetamine prescribed to Amy on July 21st, 2017.

Q. By?

A. By Dr. Bauer.

Q. And Exhibit 502?

A. This is a prescription for Adderall, which is Amphetamine, prescribed to Amy by Dr. Bauer on July 21st, 2017.

Q. And then let's look at Exhibit 503, a chart note, Page 6.

Is there an Adderall -- another Adderall prescription that is reflected that it was written on 7-21-17 to Amy by Dr. Bauer?

A. I reviewed this in the past, and yes, there is -- I'm at an awkward angle here, and I'm having trouble reading it. So this is 7-21-17.

Q. It's a little blurry, I'm sorry.

A. That's helpful. Thank you. So there's Adderall -- let me get the date on this.

Right, so there's Adderall near the top there. That's prescribed on 7-21-17. And then there's Adderall prescribed on 7-21-17, and then there's Adderall prescribed on 7-22-17.

Q. Now, explain to us when a prescription is written, are they ever, and why would they be, like, post dated?

A. Controlled Substances cannot be renewed in general for obvious reasons, for safety reasons. So if I have a patient, or if we have a patient who we want to provide a three-month subscription -- prescription to, I will give them, perhaps, three prescriptions. One will be for the current day that I'm examining the patient.

The second one would be post dated, not to be filled until a month from now.

And then the other one will be post dated with the -- with the date that says not to be filled until two months from now. And that's legitimate, and that's fair, and that's okay. And that keeps our patients from having

to run back and forth all the time. As long as, as a physician, we are sure that the patient is stable and is taking the medications in a compliant fashion. So that would be the way that we would predate and don't fill until on the various prescriptions.

Q. If you had a concern about a patient displaying red flags, would you prescribe in that manner?

A. No, no. If -- if the patient were not stable, first of all, I wouldn't wait until three months to see them. I might do it on a monthly basis, or two-weeks basis. Some of these prescriptions we just looked at looked like certainly the do not fill was very similar dates, it was not even a week out, so they look to be duplicate -- not duplicative prescriptions, for excessive medication.

Q. Let's look at trial Exhibit 504.

What is this?

A. This is a prescription for Percocet 10-milligram prescribed to Amy on July 21, 2017 by Dr. Bauer.

Q. And Exhibit 505?

A. This is a prescription issued on July 21st, 2017, again, for Percocet to Amy by Dr. Bauer.

Q. And finally, Exhibit 506?

A. And this is a third prescription for the same date July 21, 2017 for Tramadol to Amy by Dr. Bauer.

Q. Dr. King, based on your review, were the three Adderall prescriptions Dr. Bauer wrote for Amy July 21st 2017 dispensed for legitimate medical purpose and within the course of legitimate medical practice?

A. They were not .

Q. Speaking of dispense, we were just looking at a chart note. At what point is a prescription dispensed?

A. A -- well, a prescription is issued in the manner that we just spoke of, and it is dispensed when the prescription's taken to the pharmacy, and the patient actually receives the physical pills.

Q. Dr. King, were the two Percocet prescriptions Dr. Bauer wrote for Amy on July 21, 2017, dispensed with a legitimate medical purpose and within the course of professional medical practice?

A. They were not.

Q. Dr. King, was the Ultram that Dr. Bauer prescribed to Amy on July 21st, 2017 dispensed with a legitimate medical purpose and within the course of professional medical practice?

A. It was not.

Q. And would you tell us why these prescriptions for Controlled Substances were not medically necessary and outside the course of professional medical practice?

A. The medications had been prescribed for many

years, and it demonstrated no improvement in the patient with regard to pain control, or with regard to improvement in function. Therefore, they serve no legitimate medical purpose.

Secondarily, there were multiple abhorrent behaviors demonstrated by the patient that suggested medication was being abused and diverted. In other words, indications that the patient was addicted. These were very evident, they were very obvious and occurred over a long period of time, along with the fact that a very dangerous and addictive combination of poly pharmacy, namely either duel opioids or opioid plus Benzodiazepine, or prescription speedball, those combinations were prescribed to someone who a prudent practitioner would have looked at and made the diagnosis of probable addiction.

So in combination with no improvement over many years, there was never established a legitimate medical purpose for the use of the medicines. If there's not a legitimate medical purpose for the use of medications, but yet they were still prescribed, then by definition those medications were prescribed outside the usual course of medical practice.

THE COURT: Is this a good place to break?

MS. DUSTIN: Yes, Your Honor, it is.

THE COURT: Ladies and gentlemen, afternoon break

time. Let's shoot for 15 to 20 after.

Remember all the rules. We're in recess.

(Jury excused.)

THE COURT: The jury has left, and we're here in the courtroom with counsel. I appreciate that the government needs to have this key witness give adequate reasons and explanation for conclusions; however, I note that there is a great deal of repetition. And as I observe the jury, I think it's to the benefit of all concerned, and I'll treat all such experts this way, that the repetition be minimized. And counsel, it is up to you to please exercise control and indicate to your witnesses when enough is enough. And that's all I'm going to say. Thank you.

(A brief recess was taken.)

THE COURT: Counsel, you may continue with your exam.

MS. DUSTIN: Thank you.

BY MS. DUSTIN:

Q. Let's move on to another patient, Dr. King.

Directing your attention to Melody. Did you review Dr. Bauer's patient chart for Melody?

A. I did, yes.

Q. Based on your review of the Melody chart, did Dr. Bauer follow the standard of care for prescribing Controlled Substances?

A. No, he did not.
Q. Based on your review of the Melody chart, did Dr. Bauer write prescriptions for Controlled Substances with a legitimate medical purpose and within the course of professional medical practice?
A. They were not.
Q. Can you please describe for us Melody?
A. Melody was a woman -- a young woman, 48 years old at time of her death. She been under care with Dr. Bauer for about seven years, which meant she was about 41 years old on the initial visit. She was unemployed. She complained of headaches and hip pain, rather vague pains.

She was -- she had a history of a closed head injury, she was -- she was treated for -- she also had significant mental health co-morbidities, including bipolar disorder, extreme depression with suicidal ideations, anxiety. She had a history of three previous suicide attempts. She had a preadolescent -- well, preadolescent child abuse. She had PTSD, and was diagnosed with mixed personality traits.

She also had significant physical co-morbidities. She was obese. She was morbidly obese. She weighed 330 pounds with a body mass index of 53, which is quite high.

She also had obstructive sleep apnea, diabetes

and complaints of multiple falls and had ER visits. Sometimes it related to those falls and head injury. She had no urine drug screens documented over the course of her seven years of care. She was maintained on Norco, Methadone, Ambien, Xanax, Valium or Diazepam or Flexeril.

That's sort of foundational. I can go -- well, I'll stop there.

Q. Did you prepare a forensic timeline to summarize Melody's chart?

A. I did.

Q. Exhibit 928, please.

Is that the forensic timeline --

A. Yes.

Q. -- for Melody?

A. I'm sorry, yes.

Q. And based on your review of Melody's chart, can you give us an overview as her -- as a patient being treated with opioids and Controlled Substances for the long-term management of pain?

A. She was inappropriately treated with opioids over the seven years. She demonstrated no improvement in her VAS pain score. She demonstrated no improvement in function. Functional treatment goals were neither established, nor talked about in the course of her seven years of care. Over the course of time, she continued to

complain of pain, despite being treated with the medications that I referenced earlier. And despite having multiple injections of various types, primarily epidural-type injections as well as some others. She frequently complained of -- of pain that -- well, there were times when she overtook her medications, when she was early out of Norco and expressed concerns about, quote, cannot tolerate pain.

Q. And did you prepare a forensic summary of your findings regarding Melody?

A. I did.

Q. And Exhibit 945?

With respect to the row attributed with Melody, based on your row of Melody's chart, did Dr. Bauer's adequately diagnose Melody's medical issues?

A. He did not. Of the 14 standard of care columns that we've previously described, he did not fulfill the standard of care in any of them.

Q. Did he conduct a targeted physical exam of Melody?

A. He did not.

Q. Did he perform a clinical workup?

A. He did not.

Q. Based on your review of the Melody chart, did he adequately -- I'm sorry, I meant to ask you, Melody had a

head injury. Isn't that enough to support a diagnosis of pain?

A. Well, she had a head injury, and she complained of headaches, so the two could be certainly combined. But headaches are not, as we've talked about earlier, a generally acceptable diagnosis for the use of chronic opioids.

Q. And she also complained of lower back pain and hip pain. With having sustained a fall, would that not be enough to support a diagnosis?

A. No. There was no indication that she had anything that was broken or any nerve root compression or displacement or instability. The American Academy of Neurology also has said that migraine headaches and diffuse back pain and fibromyalgia are not acceptable diagnosis for the use of chronic opioids.

Q. Did you see any evidence of diagnostic tests being ordered over the years?

A. No.

Q. Based on your review of Melody's chart, did Dr. Bauer adequately assess the risks of prescribing Controlled Substances to Melody?

A. He did not.

Q. Why not?

A. He, first of all, didn't take into consideration

the mental health co-morbidities which, as I indicated, included child abuse, PTSD, and multiple suicide attempts. Those three abhorrent behaviors or historical events would be, in and of themselves, enough to not pursue chronic opioid therapy.

Q. Did Melody also have medical co-morbidities?

A. She had medical co-morbidities to include morbid obesity, obstructive sleep apnea, diabetes and a history of multiple falls.

Q. Was there any written treatment plan in Melody's chart?

A. It was not defined. There was not a defined treatment plan. It was the same sort of repetitive default that I saw in review of all the charts, which involved opioids, poly pharmacy, excessive injections, and excessive steroid use.

Q. Were high risk drugs prescribed to Melody?

A. Yes.

Q. What type of high risk drugs?

A. She was placed on a combination, at one point, of Methadone plus Norco, plus Nuvigil, which is a stimulant, plus additional medications called Trileptal and Flexeril. So she was on, at least at that point, on five poly pharmacy drugs, which would be expected to interact in an adverse manner.

At another point she was on a combination of Methadone and Oxycodone and was receiving two Benzodiazepines, Xanax and Valium, albeit from a different provider, but again, that -- that very dangerous and addictive combination of multiple opioids plus multiple Benzodiazepines.

Q. What range of morphine equivalence were prescribed to Melody during her treatment with Dr. Bauer?

A. Initially in 2008, on the initial visit with Dr. Bauer, she was on some -- on a very low dose, somewhere around 20 morphine equivalents. Over the course of the seven years she was treated, she was sequentially escalated, the morphine equivalents escalated, the additional narcotics added, and her final MEQ -- well, she got to a high 307, 307. And the last calculation I did was 280.

Q. And did you note of any concern with respect to her co-morbidities combined with any of the medications that she was being prescribed?

A. I have a particular concern with the fact that she was on Methadone. Methadone is a unique medication that, unfortunately, is highly associated with overdose. And the reason it is, is because Methadone works differently in different people. It has different half lives. So it doesn't ware off or create tolerance in the

same manner that her other ones do, so it's unpredictable. So we have to go extremely slow with Methadone, and the general recommendation is that providers avoid Methadone unless they've had significant experience with it in the past. It's a dangerous and unpredictable drug. In and of itself it's bad enough, but particularly when combined with Benzodiazepines or additional sedatives, which it was in her, creates a very potentially dangerous situation.

Q. Did you also note from Amy's chart -- I'm sorry, Melody's chart, any respiratory issues she had?

A. She was a smoker. Beyond that, I don't have any -- there were no observations to talk about any past medical issues with regard to pulmonary or -- or lung problems. She did have a, as I say, extreme obesity. That's a significant risk factor that's worth at least mentioning once again. Methadone absorbs into the fatty tissues into the body, which is part of why that's unpredictable. We don't know how that's released, that's a depot of the end medication. But the fact that she was morbidly obese and then had Methadone on top of that was a -- was a concern.

Q. Did you glean from the chart, Melody's chart, that she used a Cpap at night?

A. Yes, she had by BiPAP, Cpap. Yes.

Q. And was that of concern with the prescription of

opioids?

A. Well, it is, because as we talked if -- if the -- if the patient is not consistent in their use of the Cpap, and let's say they don't take it one night, and they are prone to respiratory distress anyway, then the opioids on top of that might be enough to put them over the top to die, to stop breathing all together. If patients are adequately and appropriately treated with Cpap, and if opioids are thought to be appropriate, there's a very careful discussion with the patient that don't you not use you're Cpap because the medication, especially in the dosage range we're talking about here, would be enough to cause respiratory depression and death.

Q. And you indicated there was another doctor prescribing simultaneously?

A. Correct.

Q. Which -- which prescriptions were being prescribed by the other doctor?

A. The other doctor was prescribing the combination of Xanax and Valium.

Q. And for the treatment of what?

A. Well, I don't know. We didn't have the past medical records or the current medical records, and actually there's a third medicine that was being prescribed, another provider, which was Ambien, so the

patient was on three sedative hypnotics.
Q. Was any of those combinations of concern?
A. Well, they are, yes. Again, this would be evident on OARRS, and Dr. Bauer should have, and if he had looked at the OARRS, seen that these medications were co-prescribed, and that would have required immediate addressing because of the dangerous poly pharmacy combination they're in.
Q. Did you see any evidence from the patient chart that Dr. Bauer checked OARRS on the Melody -- for Melody?
A. I did not.
Q. Did Dr. Bauer administer any procedures to Melody?
A. Yes.
Q. Let's look at Exhibit 930.
And what is that?
A. That's a list of the procedures and oral Medrol that was presented to Melody during the time frame of treatment, and that's the X, Y graph showing the cumulative dose that she was administered over the course of time.
Q. And how many injections were administered to Melody by Dr. Bauer during his treatment of her?
A. Well, that's at the bottom. I don't have a total, but 26 epidural injections, quite a number. Nine trigger points, eight trochanteric bursa injections, and

three doses of oral Prednisone.

Q. And what was the cumulative equivalence of the steroids?

A. Yeah, the cumulative Medrol equivalent was just over 2,000-milligrams. We might put that in context in terms of what might be expected as a normal equivalent.

Q. What is expected as a normal, and does it matter if it's a male or female?

A. It does matter for a little bit, but for purposes of our discussion, we typically start to see prolonged adrenal suppression at a dose of somewhere around 2- to 300 morphine equivalents per year. And, again, this is over 2,000. So we would expect this adrenal suppression and all the other adrenal -- or sorry, steroid potential side effects that I talked about earlier might be present and would be of concern in this patient.

Q. And based on your review of the Melody chart, were the injections that Dr. Bauer gave to Melody administered with a legitimate medical purpose?

A. No. There was no indication that the injections or the steroids demonstrated any improvement in the VAS pain score or any improvement in function. Therefore, they were without medical necessity, and did not -- and were outside the usual course of medical practice.

Q. Tell us about the VA -- VAS pain score that

Melody -- that reflected Melody's treatment with Dr. Bauer.
A. On the initial visit where -- it wasn't the initial visit, but because there was no VAS pain score documented for the first year visit, the first document is -- we have is ten out of ten, whereas she was expressing depression and was crying and expressed suicide ideations, feels like she wants to hurt herself. On that visit she was rating her pain ten out of ten.

As the years went on, her pain was mostly six, seven or eight out of ten over the course of most of the seven years. And on the final visit before her death, her VAS score was continuing to be somewhere around seven, eight, or in one case nine out of ten. In other words, it had not changed substantially.

Q. Does that support the long-term prescription of Controlled Substances?

A. It does not.

Q. And did you -- let's show you Exhibit 902.

And is that the red flag summary and timeline?

A. It is, yes.

Q. 929, sorry.

THE COURT: We are looking at Exhibit 929?

MS. DUSTIN: 929, yes.

BY MS. DUSTIN:

Q. And would you explain to the jury if you had seen

any -- any red flags during the course of Melody's treatment by Dr. Bauer?

A. Well, these are multiple red flags. One of them, most significant which was she had multiple falls, and some of those falls took her to the emergency room. We know that high MEQs, and she was on high MEQs, are associated with multiple falls and fractures. So a reasonably prudent practitioner would recognize that potential association, but, additionally, she's got a history of suicidal thoughts, and fact that many of the medications make her too sleepy were not helpful. She was requesting higher doses. She was overtaking some -- or at least out of medications for her bipolar meds and was overtaking the Norco. So we have here a situation where not only the medication's not working, but there's a significant number of abhorrent activities, abhorrent events that were occurring that any couple of which should have been enough to cause a physician to reconsider the ongoing use of high MEQ poly pharmacy.

Q. Did you find any evidence from Melody's chart that Dr. Bauer tried to ensure that Melody was taking her medication as directed?

A. No.

Q. Did you see any evidence in the Melody chart that urine drug screens were conducted?

A. There were no urine drug screens documented over the course of the seven years.
Q. Did you see any evidence that Dr. Bauer ever did a pill count with respect to Melody?
A. There was no evidence that any pill counts were performed.
Q. Did you see in the Melody chart early refills?
A. There were incidents of early refills, yes.
Q. Did you see any drug risk behaviors in the Melody chart?
A. There drug risk behavior in the sense there were early refills, there were incidents of suicidal ideations and -- and these things tend towards defining of her pain as more psychosomatic or related to mental health, so yes, they were of concern.
Q. Did see any evidence in the Melody chart that Melody's function improved during her treatment with --
A. No.
Q. -- opioids and Controlled Substances by Dr. Bauer?
A. I'm sorry, there were no indication of improvement and function.
Q. And did you note on your red flag list that at one point she was fired from a job for falling asleep?
A. Yes. There was indeed late in her treatment

regimen, but in 2013, yes, she was falling asleep at her job, and apparently was falling asleep while driving is what the note said as well. So yes, that's quite significant.

Q. Let's look at some specific events in the Melody chart.

Looking at Exhibit 410, Page 299. And this is dated 12-3-2012.

A. This is, again, a medical note for Melody as put forth by Dr. Bauer, and it indicates it's actually a phone call.

Q. Phone call?

A. Phone call. And it indicates that she has, quote, re-injured her back; feet, ankles and calfs are adenomyosis and bluish in color with excruciating pain, and she was requesting a sooner appointment than 12-7-12. She indicates she had been taking six to seven pain pills per day, which was approaching twice as many as what she was prescribed. And she thus indicated she would be running out early, but could not tolerate the pain and needed to be seen.

Q. Is that in -- is that in opposite to the standard of care?

A. Well, it's an indication that she's not able to control her pain with the medications being prescribed.

Indeed there's no indication throughout seven years that she controlled her pain with opioids, despite escalating high doses, so this would be consistent with the fact that there was probably an emotional or mental health type crisis that was driving the pain and -- and causing her to overtake her medications.

Q. Was she continued to be prescribed medication despite not having improvement in pain?

A. She was, yes. She continued to be prescribed.

Q. And looking at now Exhibit 410, chart Page 469, date of service 2-13-2005, was there any significant -- anything significant with Melody on that date?

A. Just for the record, that's 2015, I believe.

Q. I'm sorry, 2015.

A. She indicated that her pain score was still a level eight out of ten, and she was --

Q. In reading --

A. She --

Q. This area, please?

A. Yeah. So again, her pain was, again, a level eight out ten on that, with one being barely noticeable and ten being a terrible pain. But the important part there is on exam where she had a very short-lived response to the epidural but continues to deteriorate with significant back pain, which is actually worse after physical therapy. So

again, despite being treated for many years with the medications as discussed, her pain was deteriorating. It was significant and worse.

Q. And would this support the continued use of steroid injections?

A. No. As we talked about the four As, the first A is analgesia, her pain's not improving, it's getting worse. So it's a rather obvious situation here that medications aren't working and they should be stopped.

Q. Did Dr. Bauer do harm in continuing to prescribe to Melody?

A. Yes, he did harm.

Q. Why?

A. He continued to expose her to the risks that, associated with long-term high dose opioids, which is as we talked about overdose, death, addiction, and all those other things in terms of worsening mental health, and she clearly had significant mental health issues. And again, additionally the steroids added to that as well because they trend in the same direction in terms of worsening mental health issues, so yes, Dr. Bauer did harm by exposing her to this dangerous and addictive poly pharmacy over the course of seven years.

Q. Was there any improvement in function demonstrated?

A. No.
Q. Did Melody's treatment by Dr. Bauer end?
A. Yes.
Q. How?
A. She died. She died of what toxicologist, or the pathologist, called combined drug toxicity.
Q. Now, when you reviewed Melody's patient chart, was there any reports from the pathologist or the coroner with respect to Melody's death from Dr. Bauer's patient chart?
A. Yes. There was a note in Dr. Bauer's patient chart dated 9-14-15 where Dr. Bauer was, quote, made aware of the patient's death.
Q. Okay. How was he made aware?
A. Let me check my record here to see what I have. That made aware is in quotes. It was an office note, and the office note says mother calls and states patient passed away 9-13-15. Mother thinks it was her heart, but they will do an autopsy, W.R. B., meaning Dr. Bauer, made aware.
Q. Okay. Was that the only note in the Melody chart with respect to either the cause or manner of death?
A. Well, there was -- there was -- there was an entry on 9-13-15 where the coroners indicated that death was due to combined drug toxicity.
Q. Do you recall if that page was in the original

chart that you received from -- with respect to Dr. Bauer's chart?

A. I see what you're saying. No, that was not part of the original Dr. Bauer chart. That was an addendum of information the government made available to me.

Q. So going back to my original question, was there any notation in Dr. Bauer's chart of reports from the pathologist or coroner referencing Melody's death?

A. No.

Q. Now, in the course of a -- of any practice, but let's concentrate on a pain management practice, is that type of information about a patient's death, is that relevant?

A. Yes, very relevant.

Q. Okay. And why so, if you would explain in the course of the pain management practice?

A. As I indicated earlier, it's a sentinel event, a single death is a sentinel event, and that triggers a requirement, from the standard of care standpoint, to review or audit the chart to see if you, as a physician, or your practice, may have materially contributed to, advertently or inadvertently -- well, hopefully inadvertently to the cause of death. In other words, maybe the opioids protocols were not appropriate. A patient's death with combined drug toxicity would allow the

opportunity to audit the chart and maybe change the protocols in that practice. It's actually required by, as I said, standard of care because it's a sentinel event, and the physician in this case was made aware that there was a death, so it should have been followed up on.

Q. Now, is there anything that governs what prescriber should take the lead in coordination of medication?

A. So from a pain management standpoint, assuming there's no doctor shopping going on, the provider, the prescriber will have the authority with regard to the pain medications. But where we get into a problem is where there's poly pharmacy, like in this case, where her non-pain medications, the Benzos, were being prescribed by another doctor. So your question really is who should pick up the phone first. Well, it should be a race. Both prescribers, both the one prescribing the Benzos, as well as Dr. Bauer, should have picked up the phone and said, hey, we've got a poly pharmacy dangerous problem here. So the first one to see it, but they both should have been checking on each patient, follow ups, so it's a shared responsibility, and each person is mutually responsible.

Q. And without even picking up the phone, there was -- there was a quicker way to check, isn't there?

A. To check?

Q. If there is a poly pharmacy situation?
A. Well, there -- certainly the ability, in most cases, to communicate actually on the OARRS. You can send an email or something to the other doctor.
Q. You can also look at the OARRS?
A. Right, assuming that's how the discovery was made. And then the question is asked how quickly do you respond. Sometimes, I don't know if the others has the ability to immediately message the other doctor. It's that way in Indiana, I don't know if it is on OARRS, but certainly picking up the phone and call that doctor because all of the identification is right there, it doesn't take much to do.
Q. All right. Let's look at Exhibit 556.
A. This is an Oxycodone prescription written to Melody by Dr. Bauer on January -- I can't read the date, 6 maybe, I can't read that date.
Q. Okay. So Oxycodone January 6th of 2015?
A. Okay.
Q. And it was for what?
A. For Oxycodone.
Q. 15-milligram?
A. 15-milligrams. There were 90 of them, assuming that's for a month, that would be three of them a day.
Q. And next going to Exhibit 557.

A. This would be Oxycodone written to Melody on January 6th, 2015 for Methadone at a dose of 90 of them, so assuming that's for 30 days, and they're 10 milligrams each, would be 10 milligrams three times a day or 30 milligrams a day.

Q. And Exhibit 558. I know that's difficult to read.

A. I can't read the date, but it's certainly for Melody and it's Norco, 10 milligrams, 120 of them, which, again, would be averaging four per day by Dr. Bauer.

Q. And for the record, that is February 13th of 2015.

Next, Exhibit 559. What is that?

A. This is a Norco prescription to Melody on May 18th, 2015 for 120 pills, averaging four per day by Dr. Bauer.

Q. And finally, Exhibit 560, what is that?

A. This is a prescription written to Melody by Dr. Bauer, May 18th, 2015, for Methadone, 10 milligrams three times a day for a total of 30 milligrams a day.

Q. Dr. King, was the Oxycodone prescription Dr. Bauer wrote for Melody on January 6th, 2015 dispensed with a legitimate medical purpose and within the course of professional medical practice?

A. It was not.

Q. What about the Methadone prescribed to Melody on January 6th, 2015, was it dispensed with a legitimate medical purpose and within the course of professional medical practice?
A. It was not.
Q. Was the Norco Dr. Bauer prescribed to Melody on February 13th, 2015 and May 18th, 2015 dispensed with a legitimate medical purpose and within the course of professional medical practice?
A. It was not.
Q. And what about the Methadone prescribed to Melody by Dr. Bauer on May 15th -- May 18th, 2015, was it dispensed with a legitimate medical purpose and within the course of professional medical practice?
A. It was not.
Q. And tell us why -- why were these medications not dispensed with legitimate medical purposes within the course of professional medical practice?
A. Okay, three major points. The first was she had been on opioids for many years and had been unresponsive. Neither the pain score improved, nor the function improved.

Secondly, she had significant mental health issues that, more than likely, accounted for her complaints of pain. In other words, she had a psychosomatic pain that would be expected to get worse with the use of opioids.

And then the third is there was significant dangerous and addictive poly pharmacy combinations, Methadone, in combination with other opioids like Norco and Oxycodone. And then in combination with additional Benzodiazepine pharmacy as prescribed by another physician. So it was a dangerous, addictive and foreseeable combination that -- that had no medical merit and was prescribed outside the usual course.

Q. Let's turn to patient Rick.

Did you review Dr. Bauer's patient chart for Rick?

A. I did.

Q. Based on your review of the Rick chart, did Dr. Bauer follow the standard of care for prescribing Controlled Substances?

A. He did not.

Q. And based on your review of the Rick chart, did Dr. Bauer write prescriptions for Controlled Substances with a legitimate medical purpose and within the course of medical practice?

A. He failed to do so.

Q. Did you prepare a forensic timeline of Rick's chart?

A. I did.

Q. And can you look at Trial Exhibit 919.

Would you please describe Rick?

A. I'm scrolling to the front of the chart, bear with me for a second.

Rick was a 56 year old gentleman who was under the care of Dr. Bauer for approximately seven years, which means he was about 49 years old at time of initial visit.

His main complaints were chronic neck pain and arm pain, and he complained over the course of the years, he was treated of SI joint pain, low back pain, sciatic pain, thoracic pain, migraine headaches and muscle pain or fibromyalgia. He had a lot of complaints. That in and of itself is a concern.

The mental health aspect of his care indicated that he had significant problems with -- mental health problems -- mental illness including drug dependency, depression, he had -- he left counseling that he had undergone at one point for depression. He had significant issues with anxiety, and he had been through drug rehab in the past. So those are all quite significant.

In addition, he had several significant co-morbid health issues. He was a smoker and a chronic obstructive lung disease. He suffered from fibromyalgia, he had hepatitis.

And with regard to abhorrent behaviors, he demonstrated multiple urine drug screen inconsistencies for

illegal substances including marijuana, cocaine, MDMA, which is a stimulant medication, Methadone, non-prescribed Methadone, and he had multiple abhorrent behaviors.

Q. And we're going to get to those in a second. So I'm going to have you just kind of give us an overview of what type of opioids Rick was prescribed by Dr. Bauer for the management of pain.

A. He was prescribed initially Percocet, Flexeril at the beginning of his care in 2010. And as the years went on, those medications were changed and escalated to include -- at one point, which is Buprenorphine and Morphine, Morphine and Oxycodone. And in the latter part of his care there were high MEQ combinations of Oxycodone plus Morphine or Oxycodone plus Oxycontin.

Q. Based on your review of the Rick chart, did Dr. Bauer adequately diagnose Rick's medical issues?

A. Rick was addicted and abused medications that -- that was not recognized and addressed. So the answer is no, he did not do a complete workup and use medications for legitimate medical purpose.

Q. Did Dr. Bauer conduct a targeted physical exam of Rick?

A. He did a targeted medical exam, and it did not show any focal medical deficits. There was no support of a reason to prescribe opioids.

Q. Did Dr. Bauer perform a clinical workup?
A. He did an inadequate clinical workup. There were no tests or images to support the continued use of opioids.
Q. Based on your review of the chart, did Dr. Bauer adequately assess the risks of prescribing Controlled Substances to Rick?
A. He absolutely did not.
Q. Why not?
A. As I indicated, there were significant mental health issues, including a history of drug rehab, which should have been a show stopper at that point.

But additionally, over the course of time there were many abhorrent behaviors that included early out medications and requests for new medication refills. There were motor vehicle accidents, there was a drunkenness and -- and arrest related to the drunkenness. So he had exhibited an alcohol abuse problem. He was aggressive and uncooperative and hostile while in the emergency room at one point where upon they had to let him go because they couldn't do an examination on him. He apparently had an anger management issue, and in Dr. Bauer's office had issues with anger and name calling.

He tried to fill his prescriptions early. He had medication stolen, lost medications, and indications of pharmacy shopping. Over the course of time, he visited up

to 12 different pharmacies, which is a major red flag suggesting he was trying to not put any pharmacy on notice that he was -- he was consuming some of these dangerous medications.

THE COURT: It's hard for me to read some of these. I don't know if while he's testifying you can blow it up a little bigger to make it easier on those of us who are challenged with our eyesight.

MS. DUSTIN: Absolutely, we can do that.

BY MS. DUSTIN:

Q. Was there a treatment plan in Rick's chart?

A. There was no written treatment plan, no.

Q. And you did indicate earlier that there were high morphine equivalents, what were they, what ranges?

A. I don't know if I'm out of place, but I might offer The Judge my printed copies. I'm reading --

THE COURT: I think he wants the jury to see it too, more than me.

A. I'm sorry, I'm reading off my computer so I don't need my copies.

Q. Would it be helpful to put up the Exhibit 920?

And what is that?

A. That is Rick's red flag timeline, and that's -- go ahead.

Q. Is that what you were looking at a little

earlier?
A. No, I was reading that off the forensic chronology, but this is taken from the forensic chronology so it's the same source.
Q. And it indicates a number of red flags?
A. Correct.
Q. You earlier indicated that we were -- the morphine equivalent -- if we move down, let's go to the next page. And explain to us, based on your graph there, what the MEQs, how they changed over the course of Rick's treatment by Dr. Bauer?
A. The MEQs, on the initial stages of treatment, were fairly low. They were less than 100, on the order of about 30 to 45 or so. Then over time they escalated up to over 100. And then over further time, they escalated up to, well, up to about 200, 200 plus. And then over time they escalated up to 300 plus. On -- by 2017 there was a -- the highest MEQs were a 315, and they were maintained at that level for some time, a year, year-and-a-half, two years. They ultimately started to come down again towards the end of his treatment regimen, and were brought down to around the 200 or high 100 range.
Q. Are those ranges concerning?
A. They're very concerning, yes, for multiple reasons.

Q. And then in terms of the red flags on the top, you indicated I think you previously testified to most of them?

A. Yes.

Q. How many -- you mentioned a positive urine screen. Did you see any evidence of how many drug screens were conducted?

A. I saw a record of four urine drug screens over the course of seven years.

Q. And did Rick -- he failed some of those?

A. Of the four that were documented here, he failed all of them.

Q. And tell us how he failed them.

A. There was -- okay, so I'll go through each one. So the first one indicates a positive -- positive for cannabis. And that's of concern, and we can talk about that later.

The second one was positive for Oxycodone, which was not being prescribed at that time, but still positive for cannabis.

The third first done in 2017 was, again, positive for cannabis, but also it was positive for cocaine, for opioids that he was not being prescribed, for Ecstasy, MD MA, that obviously is an illegal drug, and by Methadone that he was not being prescribed, and by Tricyclic

antidepressants, which are sometimes used on the black market to augment a euphoria or high. So that urine drug screen taken on 3-22-2017 had all kinds of illegal substances and non-prescribed medications.

And then critically in 2018 on 6-5-18, he had a drug screen where there were no drugs detected, including the ones that he was prescribed. So this is clearly a pattern of abuse and diversion.

Q. And the previous drug screen where he was positive for MDMA, was he prescribed Controlled Substances by Dr. Bauer after that positive drug screen?

A. Yes, despite that drug screen, he was continued in his prescribing of Controlled Substances.

Q. And what's the date of the last positive drug screen?

A. 6-5-18.

Q. And was Rick, based on the patient chart, prescribed Controlled Substances after that positive drug screen?

A. Well, that was -- to be sure that was a negative drug screen. He had shown up in the office with slurred speech, but had -- but then a couple days following the urine drug screen showed no drugs detected, including no prescribed drugs. But Dr. Bauer reissued Oxycodone and Tramadol, despite that inconsistent urine drug screen.

Q. Okay. And then let's look at the bottom of the graph. What is that reflective of in terms of Rick's -- are those his injections?

A. Those are his injections. There's a large number there. And they -- and none of them meet the criteria for medical necessity based on the patient's presentation, imaging studies, electro diagnostic studies or physical exam. There's just no indication there really for any of those. Most of them are epidural injections of one sort or another which uses steroids. And there was never any indication that the -- either the opioids or the injections, or the steroids, offered Rick any improvement in pain score or function. So there was significant poly pharmacy going on, but no improvement in function or pain.

Q. Let's look at Exhibit 921.

And what is 921?

A. Again, this is the opioid -- I'm sorry, the steroid and injection timeline.

Q. And how many injections were administered, or can you describe, in summary fashion, the injections administered to Rick?

A. Sure. If you can scroll down to -- there you go. So to the graph, if you would, please. Down a little bit further. There you go, that box at the bottom shows that he had 18 cervical epidurals, 25 lumbar epidurals, 34

trigger point injections, eight brachial plexus injections 23 trochanteric bursa injections, and then of course oral Prednisone times two and sacroiliac joint injection. This is an extraordinary number of injections, particularly with the epidurals and trigger points .

Q. And what would his cumulative steroid equivalents be?

A. It was somewhere between 4,000 and 4,500 milligrams during the course of that seven year time frame.

Q. Did these injections put Rick at risk of more harm?

A. It did. As we previously discussed, there was potential injection harm, or procedural harm, with the multitude of injections, 18 of which were in the neck. And that's a very high risk area. And in addition, he had significant steroids, which would be expected because of adrenal suppression, and can cause a host of other problems and interact badly with mental health issues and the co-prescribed opioids, so yes, he was exposed to significant harm.

Q. Were the trigger point injections given to Rick on August 17th, 2015, May 13th, 2016, July 8th, 2016, and September 23rd, 2016, administered with a legitimate medical purpose and within the course of professional

medical practice?

A. They were not.

Q. And with respect to the injections administered, the epidural injections given to Rick on October 20th, 2015 and May 10th, 2018, let's look at the image, which is Exhibit 94, for the October 20th, 2015 epidural injection. What are we looking at?

A. Well, the jury should understand that when we do these injections, we need to have photographs or x-ray pictures that verify the needle is placed in the right position and dye should be used, by standard of care, to show that the medication's going to the right spot. For needle placement and medication placement, we need what we call fluoroscopy images. Fluoroscopy is a movable medical x-ray, we can look at different perspectives on the patient's body to project the track of the needle. These are required by standard of care to be in the chart such that a reviewer, like myself, can go back and answer the question is the needle in the right spot.

As I look at this, and this is an example of a documented fluoroscopy image, it's unreadable. You can look at that yourself, and you can say what am I looking at. I'm looking at it, and with my high degree of training, say it looks like a lumbar spine, looks like a sideway view of the lumbar spine. I can vaguely see a

couple disc spaces, but there's no evidence of needle placement, and it's only a single photograph. It doesn't have multiple photographs which are needed to triangulate safely the position of the needle. So it's a totally inadequate documentation of a -- of a pain injection.

Q. So this is an image from Rick's chart on Page 971?

A. Yes.

Q. And based on your review of Rick's chart and this injection, which is Exhibit 594, was this epidural injection given to Rick administered with a legitimate medical purpose and within the course of professional medical practice?

A. No, it was not.

Q. And who administered this injection?

A. Dr. Bauer.

Q. All right. Now, let's look at May 10, 2018. I believe there is no image of this, but was there an injection, epidural injection administered to Rick by Dr. Bauer on May 10th of 2018?

A. Yes.

Q. And was that epidural injection administered by Dr. Bauer with a legitimate medical purpose and within the course of professional medical practice?

A. It was not.

Q. Earlier you talked about Rick being called in to the office and having some -- some concerning behavior.

Let's look at Exhibit 407, chart Page 180. And is that notation in the chart significant?

A. Yes. Again, this is a chart note, it was a call for Dr. Bauer, the patient, Rick, quote, states he is -- has serious -- he's in serious trouble. Last night called an ambulance for severe leg swelling, was arrested and placed in handcuffs, rambles about money and closing the office. Drank a couple beers with his girlfriend, his leg locked up and was swollen immediately. Patient called ambulance and was evaluated and determined as agitated, intoxicated, ER, emergency room would not call Dr. Bauer. Patient -- okay, few more comments there, and patient is agitated, asked why he's getting charged for these and -- well, okay, that's not germane here. And he's waiting to go back to Dr. Bauer for a continued evaluation.

Q. Based on Rick's conduct on that date, it was August 3rd, 2012, did -- was it indicated, contraindicated to continue to prescription opioid medications to Rick?

A. It was, yes.

Q. Which one?

A. Well, all of the Controlled Substances, because the -- whatever he was on at that time, I can go back and check that. Is that what you need me to do on that?

Q. Was it -- to support the standard of care, was it contraindicated, or was it outside the --

A. Oh, it was outside the standard of care and without a legitimate medical purpose, because at this point Rick was reasonably diagnosed with alcohol abuse and perhaps alcoholism long-term, and to co-prescribe Controlled Substances with that condition is contraindicated, is outside the standard of care.

Q. In looking at Exhibit 407, let's look at Page 1042. And what is this?

A. This is the sheet giving the results of the urine drug screen, toxicology for Rick on -- the date's there somewhere. What was that, 3-22-17.

Q. And these show that the results were what?

A. This is the urine drug screen that showed that the urine for Rick was positive for marijuana, positive for cocaine, positive for opioids, positive for Ecstasy, MDMA, positive for Methadone, which he was not being prescribed, positive for tricyclic antidepressants, which we have no record of being prescribed, and positive for Oxycodone, which he was being prescribed.

Q. Is there a chart page with respect to that? Let's go to chart page 1096 to 1097. Can we go to the next page, please, 1097.

Is there a concern with the way that Rick

appeared that date?

A. Yes.

Q. At the office -- and if you can indicate the date of his appearance at the office?

A. Yeah, his -- the date is 7 -- well, let's see, a part of the date's obscured there.

Q. We can go back to the date. What was the concern?

A. The concern was Rick had come in for a procedure, an injection on that day, and that last sentence indicates the patient is seen today for low back pain, but also has slurred speech, and then there's some question about whether it's because he's edentulous, but -- but the reality is he's got slurred speech. And for an individual who's got a history of abhorrent behaviors and probable addiction, this would reasonably be assumed to be a response to drugs that the patient was taking, so it should have been a major red flag that, again, should have been discussed with the patient and led to the cessation of Controlled Substances.

Q. And let's look at the page so we have a date.

A. May 31, 2018.

Q. And then finally, let's look at a chart Page 1098.

And what is this?

A. This is another drug test that was performed on Rick, and the date is -- the date is 6-5-2018. And it indicates, quote, no drugs detected.

Q. That was June of '18. In July of 2018 did you see any evidence from the patient chart that law enforcement reached out to Dr. Bauer?

A. Yes. There's a note in the chart that in July of 2018, the drug task force with the Seneca County Sheriff's Office made an appearance in Dr. -- I don't think made an appearance, made a phone call, I don't remember which, but, in any event, notified the office that Rick is using fake pills to pass his pill counts, and that Rick is selling heroin and Oxycodone, and goes on to observe that fake prescription drugs are hard to tell apart from the real thing. And the sheriff's office offered the ability to test any pills that Dr. Bauer's office might think would be fake, and they could test them for him. And it was left with the recommendation that Dr. Bauer could call the Bellevue Police Department if needed. But there was notice put on that Rick is an addict, is selling his medications, and using heroin and -- and making fake pills.

Q. Dr. King, was that information that you just read from the chart?

A. Yes.

Q. And was Rick prescribed Controlled Substances by

Dr. Bauer in July after that phone call, or after the notation in the chart I should say?

A. Yes, correct.

Q. And what was he -- what day was he prescribed, and what was he prescribed?

A. 7-6-18. Let me go down and be precise on this. Okay, so the visit with law enforcement occurred on 5-31-18. Rick was prescribed --

Q. I thought you said July -- 5-31, correct?

A. I'm sorry, that's incorrect on my part. It was July 17 -- excuse me, July 16th, 2018 the interaction with law enforcement occurred with Dr. Bauer's office. After that on 7 -- 7-26-18 -- excuse me, well, on 7-24-18, after that interaction with law enforcement, a prescription was issued for Oxycodone, 30 milligrams, 60 of them.

Q. Okay. Let's look at Exhibit 542.

And what is that?

A. That's an office note for Rick dated 3-22-17.

Q. And what's the date on it?

A. 3-22-17. Yeah, 3-22-17.

Q. Okay. And then does it indicate someplace on the office note, going to that Methadone, that Rick had a prescription written on March 23rd of 2017?

A. Yes. Methadone was written on 3-23-17. Actually, two prescriptions for Methadone were written.

And Tramadol was written on that same day, and a third prescription for Methadone was written.

Q. Okay. So March 23rd of 17, Methadone, what milligram?

A. 10-milligram, three times a day.

Q. And was there --

A. I'm sorry, 5-milligrams, three times a day.

Q. And that was written by whom?

A. That was written by Dr. Bauer.

Q. To?

A. To Rick.

Q. And there's also another prescription written to Rick on the same day?

A. Well, Ultram was prescribed as well.

Q. And what about Tramadol?

A. Tramadol and Ultram are the same drug.

Q. Okay, I'm sorry. What milligram for the Tramadol?

A. That's 50 milligrams, 50.

Q. How many?

A. He was prescribed 120 of them to be taken four a day.

Q. And that was written by Dr. Bauer?

A. Correct.

Q. All right. Let's look at Exhibit 544.

And what is this?

A. This is a prescription issued to Rick by Dr. Bauer for Oxycodone, and the date is April 13, 2017.

Q. And what was that for?

A. For Oxycodone, 15 milligrams.

Q. And Dr. Bauer wrote that?

A. Yes.

Q. And let's look at Exhibit 545.

And what is this?

A. This is an office visit for Rick on the date 4-13-17.

Q. And was there a prescription for Tramadol written?

A. Yes, Tramadol or Ultram was written on 4-13-17.

Q. For what milligram?

A. 50 milligrams to be taken four times a day.

Q. And who wrote that prescription?

A. Dr. Bauer.

Q. And finally, let's look at Exhibit 546.

And what is that?

A. That is a prescription for Oxycodone, 30-milligrams, prescribed to Rick to take four times a day.

Q. And what's the date of this prescription?

A. 6-8-18.

Q. And who wrote this prescription?

A. I don't see enough on this particular pull out here, if you could give me a larger picture.
Q. Take the box down.
A. By Dr. Bauer.
Q. All right. Dr. King, was the Methadone prescription Dr. Bauer wrote for Rick on March 23rd, 2017, dispensed with a legitimate medical purpose and within the course of professional medical practice?
A. It was not.
Q. Dr. King, was the Tramadol Dr. Bauer prescribed to Rick on March 23rd, 2017 and April 13th, 2017, dispensed with a legitimate medical purpose and within the course of professional medical practice?
A. It was not.
Q. Was the Oxycodone Dr. Bauer prescribed to Rick on April 13th, 2017, and June 8th, 2018 dispensed with a legitimate medical purpose and within the course of professional medical practice?
A. It was not.
Q. And would you tell us your conclusions with respect to those prescriptions, why did you conclude that way?
A. The medications were issued in support of ongoing addiction. The patient was admittedly -- and he did admit to this in the chart notes, was admittedly addicted and was

told he needed to receive drug counseling. That did not occur. He was a known addict, multiple Controlled Substances were prescribed, he had a lengthy history of no evidence there was any improvement in the VAS pain score or improvement in function. His medications were -- were issued in support of addiction.

Q. All right. Now, we've talked about three patient charts and saw the type of review that you have done with the help of your staff. How many hours did you and your staff spend on this -- on this review?

A. By my calculation, the number of hours we spent was -- was -- I'm going to estimate, but it's in the ballpark of 700 hours on this project.

Q. And have you been compensated for your work and time in this case?

A. I have, yes.

Q. And how were you compensated in terms of your rates?

A. My rate is $350 per hour, my nurse's rate is $200 per hour. Approximately 2/3 of those hours were due to nursing work, not 2/3, approximately 60 percent of those 700 hours were due to nursing work, and then the remainder, little less than half were time that I put in.

Q. And to date, how much have you been compensated for your work and your staff work?

A. Total amount is approximately $125,000.
Q. Okay. Let's move on to patient James L.
Now, are there two different patients with the same first name?
A. Yes, there are.
Q. And then why -- how are we distinguishing, what are we using to distinguish between the two?
A. Instead of using their last name initial we're using their middle initial.
Q. So we have James L, correct, is one of the patients?
A. Yes, and I need to be sure I pull up the correct one here.
Q. I'll give you a minute to do that.
A. I don't have a key that tells me which one that is. Is there some way you can give me the last name, and I can reference it in my computer.
Q. I can show you.
A. Thank up.
Q. Did you review Dr. Bauer's patient chart for a patient named James L?
A. I did, yes.
Q. Based on your review of the James L chart, did Dr. Bauer follow the standard of care for prescribing Controlled Substances?

A. He did not.
Q. And based on your review of the James L chart, did Dr. Bauer write prescriptions for Controlled Substances with a legitimate medical purpose and within the course of professional medical practice?
A. He did not.
Q. Did you prepare a forensic timeline to summarize James L's chart?
A. I did, yes.
Q. Let's look at Exhibit 910. All right. Now, let's just blow up the left side of 910 for the ease of following along as you review your time line.
Would you please describe James L?
A. James L was 69 years old at time of his death. He had been under care with Dr. Bauer for a little over six years, which meant he was approximately 63 years old on his initial visit. He was a male, he was unemployed. He was in the nursing home and under the care of Adult Protective Services at some point.
His main complaint was chronic low back pain with radiculopathy, abdominal pain, right leg pain and testicle pain, which is an unusual assortment of complaints, but nevertheless that's what it was. He also complained of various types of back pain and joint pain.
Over the course of time, the chart documented no

urine drug screens.

James had significant mental health co-morbidities, including fibromyalgia, depression, anxiety, panic attacks, post traumatic stress disorder, a history of having been abused by his step-dad and abused by caregivers.

In addition to that, mental health co-morbidities listed, he had significant physical co-morbidities, he had Crohns disease, diabetes, emphysema, and a history of multiple accidents, but also a history of multiple falls, which, as we discussed, can sometimes be indicative of overmedication.

But he was -- but that's sort of foundational. I'll hold off on the abhorrent behaviors, I figure you'll ask me about that later.

Q. Can you give us an overview of the prescriptions that James L received while being treated by Dr. Bauer?

A. Initially, yeah, James was treated with a combination of Oxycodone, Soma and Klonopin, as well as Paxil, which is an antidepressant. The jury will recognize that combination of Oxycodone, Soma and Klonopin as the Holy Trinity.

The Holy Trinity was prescribed at a fairly large morphine equivalency, 135 morphine equivalents initially, and over time the dose of morphine equivalency was

escalated up to the low 200s, to a high of 235, and towards the end, and prior to his death he was brought down to about 150 morphine equivalents. The combination of an opioid plus Soma plus Klonopin, the Holy Trinity was maintained for many years.

There were additional medications added to the Oxycontin and Oxycodone, which included Tramadol. So there was a significant and concerning poly pharmacy over time with that combination of medications.

Q. Let's look at Exhibit 945.

Is this the standard of care summary you prepared --

A. Yes.

Q. -- to summarize your findings?

A. Yes.

Q. And is there a -- is there a row on here for James L?

A. James L is represented by the first row there, yes.

Q. And based on your review of James L's chart, did Dr. Bauer adequately diagnosis James L's medical issues?

A. He did not.

Q. Did he -- did Dr. Bauer's conduct a targeted physical exam of James L?

A. He performed a tar -- he performed a physical

exam, but there were no focal deficits to support a pain diagnosis.

Q. Did Dr. Bauer conduct a clinical workup of James L?

A. He did not.

Q. And based on your review of James L's chart, did Dr. Bauer adequately assess the risks of prescribing Controlled Substances to James L?

A. He did not.

Q. Was James L a good candidate for long-term opioid treatment?

A. James L was a noncandidate for the use of opioids.

Q. Did Dr. Bauer formulate a defined treatment plan for James L?

A. He did not. The patient received multiple injections and opioids, but that treatment plan was, as we've talked about, fairly cloned and was not specific to James .

Q. Let's look at Exhibit 911.

And in conjunction with compliance enforcement and outcome, 911 shows a number of red flags?

A. Yes.

Q. Would you review some of those, please?

A. The red flags are extensive. James was abused by

his mother's husband when he was young. As a young man he stated he was an alcoholic, that's up on 1308, that's foundational. This is a psychosomatic pain syndrome related to his abuse and his history of alcohol abuse. But multiple times throughout the red flags there are indications that the medications are not working, the pill count was incorrect, that he wanted to change medications, he was early out of medications multiple times and requested early refills. He -- there are indications of meds stolen. And there were indications of what I called the -- the -- the abuse triad where he was early out, requested early medications and had stolen and lost medications. So the abuse triad was evident here multiple times.

But the bottom line is even as late of 2016, well on to his care, he indicated that the pain meds weren't working and indicated additionally he wasn't taking them as prescribed, but they continued to be prescribed.

Q. I can't recall, did you indicate whether or not there was any urine drug screens?

A. The -- the medical chart indicated no urine drug screens during that time, what was that, six year time frame of care.

Q. Did you see any evidence, based on your review of the James L chart, of clinical improvement?

A. No. Specifically the VAS scores, which on initial visit were nine out of ten, stayed pretty much at that level throughout. There were times when it was ten out of ten towards the end prior -- prior to his death. The last pain scores were nine out of ten, nine out of ten, eight out of ten. So there was no significant change in the VAS change scores, despite six years of treatment.

With regard to the function, he was unemployed, and ultimately there was some nursing home issues involved here, but clearly his standard of -- his -- his function did not improve. He was progressively unable to take care of himself.

Q. So Dr. Bauer -- why would Dr. Bauer continue James L on opioid therapy if, for years, his quality of life wasn't improving?

A. There's no medical rationale. Dr. Bauer prescribed the medications without a legitimate medical purpose. There was no indication James was getting better, and he prescribed it outside the usual course of medical practice because, despite all the abhorrent behaviors, there was failure to perform urine drug screens, and failure to understand that the mental illness issues, particularly the history of abuse, is reasonable to cause the etiology of the ongoing pain. It was a psychosomatic pain. Dr. Bauer should have recognized that and should

never have initiated the opioids, but certainly should have ceased them at some point.

Q. You said ultimately was -- was James L ever discharged for noncompliance?

A. You can direct me to a point.

Q. Was he ever discharged because he was not complying?

A. I see what you're saying. No, he was not. There were abhorrent activities that showed he was noncompliant, but he was never discharged.

Q. Ultimately how did his treatment end?

A. He died.

Q. We do not know the cause?

A. I do not know the cause.

Q. There was nothing in the chart to reflect cause of death or any reason.

A. That's correct.

Q. Okay. We just don't have that information?

A. Correct.

Q. Did Dr. Bauer administer any injections to James L?

A. Yes, there were multiple injections administered here, as evidenced here on the time line.

Q. And let's look at Exhibit 912.

And if you can give a summary of how many and

what type of injections were administered to James L by Dr. Bauer?

A. Cumulative steroids get up to between 3,000 and 3,500, which, again, is a very significant high dose. There were multiple types of injections. Again, as we talked about, most of them were epidural-type injections and trigger point injection. You have 31 lumbar epidural injections, trigger point injections 15, trochanteric bursa injections 12, and SI joint was injected four times.

Q. Based on your review of the James L chart, did the injections result in any improvement in pain or function?

A. There was no evidence that there was any improvement in pain or function.

Q. And you indicated that James L had 31 epidural injections?

A. Yes.

Q. Is that number, in and of itself, significant?

A. It's a large number. Again, to help the jury understand this, most people may have a couple epidural injections, if they've got back problems or herniated discs, maybe a couple times in their life, maybe two or three times. If you've got a back pain that's responsive, you might have an epidural injection or two on a yearly basis. But 31 is a number that I -- I -- is extremely high

and most unusual, particularly on an individual like James here who never even had an MRI done of his lumbar spine. He had no MRI, had no electro diagnostic testing to show the presence of sciatica, and he had no specific physical findings that would suggest there were neurologic deficits to support a diagnosis of sciatica.

So in the end, the 31 epidural injections is a really large number that exposed him to the side effects of the steroids of which we've talked a lot in combination of the side effects of Controlled Substances, with no evidence of any -- actually with a deterioration of physical function over time.

MS. DUSTIN: May we have one moment, Your Honor?

THE COURT: Sure.

(Government counsel conferring off the record.)

MS. DUSTIN: Let's bring up Exhibit 580.

THE COURT: Are we still with James?

MS. DUSTIN: Yes.

THE COURT: Thank you.

BY MS. DUSTIN:

Q. And do you recognize this chart page -- it's Exhibit 580 from the James L chart?

A. I do.

Q. And what is that?

A. This is a fluoroscopic x-ray picture similar to what we talked about a little while ago showing the image of the back and needle placement for an epidural or a transforaminal epidural injection.

Q. And is it significant?

A. It's very significant. Would you like me to explain why?

First of all, it's a bad photograph in the sense that the technique makes it difficult to read. Again, this is what I do on a regular basis, so I recognize that as a sideways or lateral picture of the lumbar spine, but it's not a good one. It's difficult to identify some of the key areas. So it's only one photograph, it's a sideways or lateral image.

The other is, on this one we can actually see the needle, and I -- if I draw on this, can the jury see?

Q. Yes.

A. So there's a hint of a needle right along there (indicating), I'm trying that underneath, and where -- right where I've stopped, that is where the needle stops. So there's a picture of a needle coming in, but this is described as a transforaminal epidural, which means the needle goes into the foramen of the spine, and I'm going to draw a circle around where the foramen of the spine is, right here (indicating), so the needle is nowhere near to

its target. And we don't have another picture to show the complete three dimensional position of the needle. But at least based on this one, the needle is nowhere near where it was supposed to be, based on the -- the description of the procedure. So assuming the medication -- well, and there's no x-ray contrast dye used here, which, again, is standard of care required to make sure the medication's in the right spot. We have a needle that's inches away from where it's supposed to be, no contrast to show that it's going to go to the right spot but it's not because the needle's in the wrong spot, and we only have a single very bad image here to describe the procedure.

Q. But based on your review of Exhibit 580, was the epidural injection that Dr. Bauer gave to James L on February 10th, 2015 administered with a legitimate medical purpose and within the course of professional medical practice?

A. No, it was not, but I also hasten -- it was not an epidural injection based on this documentation, but clearly, as such, it was outside the usual course, and not for a legitimate medical purpose.

Q. You would not consider that an epidural injection?

A. This -- it was not an epidural injection. The needle is in the incorrect position.

Q. Okay. And then was there a trigger point injection administered to James L on May 25th, 2018?
A. Yes, there was.
Q. And can we look at 581?
And that just reflects what?
A. I don't know how to erase my marks on here.
Q. And was a procedure administered to James L on May 25th, 2018?
A. Yes.
Q. And what was the procedure?
A. The procedure was a trigger point injection.
Q. And there's no view of that, is there, there wouldn't be -- no view?
A. Correct, this is not done under x-ray guidance.
Q. Right, but based on your review of the James L patient chart, was a trigger point injection that Dr. Bauer gave to James L on May 25, 2018 administered with a legitimate medical purpose and within the course of professional medical practice?
A. It was not.
Q. Why not?
A. The -- the requirements to qualify for medical necessity require that the trigger point be identified -- in its particular muscle be identified in terms of its texture and location, and be identified based on palpations

of the trigger point resulting in pain distributing to the correct area that the patient describes.

Also, there were previous trigger points injected, or allegedly injected, that offered no improvement; therefore, there was no medical foundation to repeat yet another one. So the diagnosis was not established, the medical need was not established, and therefore, it was not legitimately necessary, it was outside the usual course of medical practice.

Q. And then let's look at Exhibit 516.

And what is that?

A. This is a prescription for James written on March 20, 2017 for Clonazepam written by Dr. Bauer.

Q. And then let's look at Exhibit 517.

A. This is a prescription written for Oxycodone on the same day, March 20, 2017, for James issued by Dr. Bauer for Oxycodone 30 milligrams three per day.

Q. And Exhibit 518?

A. This is a prescription issued to James, I can't read the date up there, March 20, it's covered up.

Q. 2017?

A. I -- okay. I'll tell you what, based on the signature there, it's 2017. So it makes sense to think that this is March 20, 2017 for Oxycodone to James issued by Dr. Bauer.

Q. And Exhibit 519?
A. And this is a prescription, if I could just see the whole prescription there. Yeah, this was a prescription issued to James for Oxycodone issued by Dr. Bauer. And if we could just not do the call out, just leave the page as it is, I can probably read the date. Well, the signature -- the signature date there says 3-20-17. I'm trying to find a date somewhere else. There's no other date. Oh, there it is, 3-20-17. Thank you.
Q. And it was for what?
A. Oxycodone, 30 milligrams for three times a day.
Q. And Exhibit 520?
A. Again, another prescription to James L all on the same day, March 20, 2017 for the narcotic Opana, 15 milligrams twice a day issued by Dr. Bauer.
Q. Is that Opana, it says ER?
A. Opana is extended release. We talked about that earlier, Opana is Oxymorphone, a very potent narcotic related to Oxycodone, but ER is extended release.
Q. And then Exhibit 521?
A. Prescription issued on the same day to James by Dr. Bauer March 20, 2017. The prescription is for Opana, 15 milligrams twice a day.
Q. And then 522?

A. This is a prescription, again, issued on the same day, 3-20 to James by Dr. Bauer for Opana ER 15 milligrams twice a day. Actually --

Q. And that was written --

A. -- twice a day, yes.

Q. 3-20-2017?

A. A correction there. I'm not sure if this was prescribed for twice a day or once a day, but all the rest of the description is correct.

Q. It was issued on 3-20 of 17?

A. Correct.

Q. And then let's look at Exhibit 523. And what is this?

A. This is a prescription for Soma issued to James on -- on, yeah, 5-3-17. The Soma is the addictive muscle relaxer we talked about, to be taken three times a day issued by Dr. Bauer to James.

Q. And 524?

A. This is a prescription to James issued May 24, 2017 by Dr. Bauer for Clonazepam to be taken twice a day.

Q. 525, we're going to skip to 526. So as they're searching for the last two exhibits, Dr. King, were the Clonazepam, Oxycodone and Opana prescriptions Dr. Bauer wrote for James L on March 20th, 2017 dispensed with a legitimate medical purpose and within the course of

professional medical practice?

A. They were not.

Q. And was the Soma prescription Dr. Bauer prescribed to James L on May 3rd, 2017, dispensed with a legitimate medical purpose and within the course of professional medical practice?

A. It was not.

THE COURT: Have you completed the discussion of James L?

MS. DUSTIN: We have two more exhibits, and we will have a couple follow-up questions, and we will have concluded James L.

BY MS. DUSTIN:

Q. So Dr. Bauer, looking at Exhibit 525.

And what is this?

A. This is a prescription issued to James by Dr. Bauer on May 24, 2017, for Oxycodone, 30 milligrams, three times a day.

Q. And finally, Exhibit 526?

A. A prescription issued to James L on May 24, 2017, by Dr. Bauer for Opana to be taken once a day.

Q. And that was also the ER?

A. Opana ER, correct.

Q. Dr. King, were the last prescriptions we looked at for the Klonopin, Oxycontin and Opana ER, did Dr. Bauer

write these prescriptions to James L on May 24th, 2017; and were they dispensed with a legitimate medical purpose and within the course of professional medical practice?

A. They were not.

Q. All right. With respect to your opinion on all these prescriptions we just reviewed, these last exhibit numbers, why did you make that conclusion?

A. Similar to what I've said in the past. Number one is there was no indication over course of time that the opioids were improving the VAS pain score or improving the function of the patient. That's critical to support the ongoing use of opioids.

The second was there was significant danger and addictiveness associated with these combinations, the Oxycontin plus the Soma, or the Opana plus the Soma, plus Clonazepam is, as you know now, the Holy Trinity, which would, in part, a heroin-like euphoria. So there's danger with regard to overdose, death and ongoing addiction. There was no medical reason to prescribe those medications, in combination or individually, since there was no evidence of clinical improvement over the course of greater than six years.

Q. From the chart, did it appear that James L's quality of life improved while he was being prescribed Controlled Substances by Dr. Bauer?

A. It did not. Ultimately he was taken into a nursing facility and -- and was overseen because his function diminished.

Q. Thank you.

MS. DUSTIN: No further questions for today.

THE COURT: I suspected that was your response.

We're at a good place to break for the day, ladies and gentlemen. Appreciate your attentiveness during today, even the government computer konked out after awhile, but I noted that you all were doing your very best, and we appreciate that.

I'm going to invite you, Doctor, back tomorrow to complete your testimony.

And with that, remind you to remember all the rules. We're in recess until 9:00 a.m. tomorrow morning. Thank you.

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C E R T I F I C A T E

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

s:/Angela D. Nixon May 6, 2022

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Angela D. Nixon, RMR, CRR Date

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