UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
WESTERN DIVISION

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

Plaintiff, July 13, 2021

v Toledo, Ohio

WILLIAM R. BAUER,

Defendant.

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TRANSCRIPT OF JURY TRIAL, VOLUME 5
BEFORE THE HONORABLE JACK ZOUHARY
UNITED STATES DISTRICT JUDGE

APPEARANCES:

On Behalf of the Plaintiff:

Ava Rotell Dustin
Robert N. Melching
Office of the U.S. Attorney
Four SeaGate, Suite 308
Toledo, Ohio 43604
(419) 259-6376

Michael A. Sullivan
Office of the U.S. Attorney
801 Superior Avenue, W
Suite 400
Cleveland, Ohio 44113
(216) 622-3977

On Behalf of the Defendant:

John B. Gibbons
55 Public Square
Suite 2100
Cleveland, Ohio 44113
(216) 363-6086

Orville E. Stifel, II
5310 Franklin Blvd.
Cleveland, Ohio 44102
(216) 225-9855

Court Reporter:

Angela Nixon, RMR, CRR
United States District Court
1716 Spielbusch, Suite 118
Toledo, Ohio 43604
(419) 213-5518

THE COURT: Welcome back. Everyone may be seated. We have a new nickname for this courtroom. It's Little Siberia. Give the jury a moment to organize their notes.

Counsel, you may continue with your examination of the witness.

THE COURT: Thank you.

DIRECT EXAMINATION CONTINUED

BY MS. DUSTIN:

Q. Good morning, Dr. King.

A. Good morning.

Q. Yesterday we spoke about James L, do you recall?

A. I do, yes.

Q. We discussed his prescriptions and the injections. Let me ask you one more question about James L. Should he have -- should Dr. Bauer had ever started James L on Controlled Substance medications?

A. No, he should have never been initiated on Controlled Substances. He was never a candidate for chronic opioid therapy.

Q. Why not?

A. Opening his file here, just a moment.

The reason is because James had a history of significant mental health co-morbidities and abhorrent behaviors even prior to seeing Dr. Bauer. He had

established himself as being an addict for alcohol, had a history of physical abuse, which predisposed him to ongoing addiction. And what he really required at initial treatment was referral for continued mental health care and addiction treatment. He did not need further and escalation of opioids.

Q. Let's now talk about James P.

Did you review Dr. Bauer's patient chart for a patient named James P?

A. I did, and, again, I don't have my key, if you could perhaps show me which one that is so I can pull it up appropriately.

Q. Yes. Dr. King, based on your review of the James P 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 P 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. Let's look at Exhibit 913.

And as we're -- before we talk substantively about James P, I also want you to -- is this your forensic timeline?

A. Yes.
Q. And that is the same -- the same format as you prepared for the other patients?
A. That's correct, yes.
Q. Now, I also want you to look at Exhibit 946. And this is a first time we've looked at this exhibit.
What is 946?
A. 946 is a document or an Excel spreadsheet that I prepared that was an intermediary document between the forensic chronologies where I took information out of the chart itself, and then ultimately converted it to what we've seen from time to time where I have the checkmarks and the Xs where I give my ultimate decision about whether specific standard of cares were within or without the standard of care. This is an intermediate document that briefly, in a bullet point fashion, itemizes some, but not all of the observations that help me to decide ultimately whether a specific standard of care is within or without the standards, so this is an intermediate sort of bullet point that assists in making the final decision.
Q. And does this summary include bullet points and your conclusions with -- for each category with respect to all 14 patients?
A. It does, yes.
Q. So it's what supports your standard of care

summary?

A. That's correct.

Q. Okay. And let's go back to Exhibit 913.

Would you please describe James P?

A. James, at time of his last visit, was a 41 year old gentleman. He had been under care with Dr. Bauer for about nine-and-a-half years, which puts his initial age when he first began medical care with Dr. Bauer at about 30 or 31. 31, 32, somewhere in that area. He was disabled. He complained primarily of, on his initial visit, of a -- of a hip to toe pain, or leg pain, or back pain as a result of a motor vehicle accident. Over time, he complained of many additional issues, including muscle pain, thoracic back pain, cervical pain, sciatic pain, generalized backache and sacrum pain, a rotator cuff pain. He complained of quite a number of different things after the initial visit.

When we look at some of the red flag conditions that we've talked about extensively, to begin with the mental health co-morbidities, James had a history of depression, migraine headaches, paranoia, bipolar disorder, Schizophrenia, general anxiety disorder, and importantly he had a history of eight suicide attempts. So there are quite a number of issues there that are worthy of note.

In addition to that, he had physical

co-morbidities, he had a history of epilepsy or seizures, high blood pressure, dizziness, and he was -- he was -- he was on the border of being classified morbidly obese, and that has some medical concerns as well as we've talked about.

In terms of the psychosocial background, beyond the fact that we know he had multiple suicide attempts, I don't have any history of -- of what he had done in the past in terms of work or family relationships or past history of any suicide or substance abuse, we don't have that documented in the chart. But essentially he came to seek attention for diffuse, vague and ill defined spine pain with a history of significant mental health and suicide issues.

Q. And let's look at Exhibit 945.

Dr. King, based on your review of James P's chart, did Dr. Bauer adequately diagnose James P's medical issues?

A. He did not. He did not fulfill any of the standards of care in any of those 11 categories.

Q. Specifically with respect to diagnosis, did -- did Dr. Bauer conduct a targeted physical exam of James P?

A. A physical exam was performed, but it was not indicative of any focus neurologic or musculoskeletal deficits to support a diagnosis.

Q. Did Dr. Bauer order, or conduct a clinical -- a complete clinical workup?
A. He did not. There were no indications of imaging tests or EMG studies to support diagnosis of structural back pain or sciatica.
Q. Based on your review of James P's chart, did Dr. Bauer adequately assess the risks of prescribing Controlled Substances to James P?
A. No, he most certainly did not incorporate that or adequately look at them. As I indicated, there were multiple suicide attempts that stood out and were major red flags.
Q. Was James P a good candidate for long-term opioid treatment?
A. James was never a candidate for long-term opioid therapy.
Q. Because of the co-morbidities, the mental co-morbidities?
A. Because of his history of mental illness and suicide attempts and failure to establish a -- an objective pain diagnosis.
Q. Did Dr. Bauer define a treatment plan for James P?
A. A specific treatment plan was never defined. It was default injections and opioids in the same manner that

we've seen cloned in the previous review of patients.

Q. Can you give us an overview of the opioids and other Controlled Substances that James P was prescribed?

A. I'm pulling up the document. Just a moment. I'm having difficulty pulling up the document that has the total numbers. I found it. I'm sorry, here it is.

James had a history of receiving 84 lumbar epidural injections, ten sets of trigger point --

Q. I'm sorry, I'm not talking about the injections right now, I'm talking about the opioids and Controlled Substances.

A. I'm sorry, I thought you said steroids. Would you rephrase the question, please?

Q. Can you give us an overview of the opioids or Controlled Substances that James P received from Dr. Bauer during his care?

A. Initially when he met with Dr. Bauer, he -- it was on approximately 45 to 50 morphine equivalents. That was a combination mostly of Percocet, Neurontin or Gabapentin, a non-opioid was part of that poly pharmacy regimen but mostly it was Oxycodone or Percocet. That was escalated over time.

Again, he was under care for nine-and-a-half years, but as time went on, that -- that dose -- that morphine equivalency was escalated up to 100 and then over

300. At one point, by calculation, when Duragesic or Fentanyl patch was added, it was as high as 725 morphine equivalents. The morphine equivalency varied over time, over the next couple years between 220 to somewhere around 500.

On the -- on the last visit, on the final visit with Dr. Bauer in 2019, the morphine equivalency was about 240 to 250 morphine equivalents, and that consisted primarily of medication, Oxycontin and Oxycodone, in combination with some additional medications, inclusive of Lyrica and Valium, a Benzodiazepine.

Q. And are the amounts of any significance to you?

A. They're very significant. As we've talked, that morphine equivalency is certainly well above the 80-milligram, I think was referred to as a trigger point amount in the Ohio recommendations for use of opioids. And it certainly is way beyond the 90 milligrams recommended as a level of concern by the CDC. It's well into what I describe as the region of extreme concern.

Q. And you started to talk about procedures. Did Dr. Bauer administer any procedures to James P?

A. He did. Many procedures were administered. If you'd like, I can go back to the list I started to.

Q. Yeah, let's look at Exhibit 915.

And do you recognize 915? What is that there?

A. Yes, that's the timeline of steroids and injections that James received.
Q. And that -- is that -- how many pages is that one?
A. Well, it's a couple pages anyway. Oh, I didn't count.
Q. Can you give a summary?
A. I'm sorry, I didn't count them as you went through.
Q. Can you give us a summary of how many total numbers of injections James P received with respect to each type of injection?
A. He received approximately 84 lumbar epidural injections, ten trigger point injections, six trochanteric bursa injections, four doses of oral Prednisone and four sacroiliac joint injections.
Q. And do you find the type or number of injections significant?
A. They're excessive. They're clearly excessive, and they're associated with excessive administration of steroids as well.
Q. And tell us about his cumulative dose of steroids.
A. The cumulative dose -- the cumulative dose was approximately -- well, just shy of 5,400 milligrams,

5,392 milligrams to be specific, of Depo Medrol steroid equivalent over the course of time. That's a very high, very significant number.

Q. We talked about yearly doses of steroids I think early on in your testimony. Is there any limit, or any thought to limiting a person's lifetime dose of steroids?

A. There's been a great deal of discussion about what is the upper dose, what's the safest dose of steroids that can be administered to a patient, both on a yearly basis, as well as a lifetime basis. Those studies are not as objective as we would like, so they don't give us an exact number that says don't go beyond this number like we see with opioids that have been brought forth. Nevertheless, there are guidelines, and I would refer to them as guidelines. The guidelines for -- for the general upper administration of steroid on a yearly basis is somewhere around 220 to 240-milligrams. I mentioned that yesterday. The guideline for a lifetime dose of steroids, assuming the patient doesn't have a disease that requires it in order for him to be alive, and there are situations like that, but a general guideline for a lifetime dose would be somewhere around 400, 3- to 400, maybe 500, somewhere in that range. And there are reasons for that, but, again, they're guidelines. We don't have exact numbers.

Q. Tell us, is there any -- any literature or discussion about lifetime risks for that high of steroids amounts?

A. Yes. And again, the lifetime risk is the correct way to think about that. Back in the olden days when I was going through pharmacology, steroids -- steroids have been around for a long time, just like opioids. And we understood way back then, even when I was in training, that there were lifetime risks associated with steroids. And I think I went through some of those yesterday, if I'm not mistaken, but just to key in on a couple bullet point red flags on the steroids.

We worry about worsening of mental health because we know the steroids can cause, or worsen, depression, anxiety, panic attacks. Steroids can cause psychosis, those are the important mental health. Steroids also cause gain, changes in sugar metabolism, which is particularly important if the patient is diabetic. It contributes to significant weight gain over time. The -- there are concerns with regard to the immune status of the patient, the patient loses immunity with steroid administration. And then the biggest, most critical thing of all, is the fact that adrenal suppression occurs. In other words, the body stops producing steroids because the person's getting so many steroids from an external source, so in the time of

crisis, the body's not able to mobilize steroids to meet the crisis. You don't hear about this, but it's critical in medication because that can create a situation where there's cardiovascular collapse, and the patient can die if they can't -- if they can't bring forth the steroids necessary to meet the physiologic stress of whatever it is, a heart attack or an accident or a fall or something of that sort. So adrenal suppression is something we are very, very concerned about because it robs the body of its ability to moderate and respond to stress that might occur over the course of a life. So those are the long-term concerns we have.

Q. And just, let's go back to the top of this exhibit, please. And we obviously it has a date, and then the injection type. So for the January 6th, 2009 when it says left L5-S1 what does that mean?

A. That's my abbreviation for an epidural injection. The point -- point of exact fact, it refers to Dr. Bauer's description of doing a transforaminal epidural steroid injection. Those are the types of epidurals that he performed, and my shorthand here is -- is a description of what level it was administered, or allegedly administered, on the spine.

Q. So those are epidural injections when you describe them in that fashion?

A. That's correct.
Q. Okay. And then the next category is what?
A. Next category in the gray there, trigger point injections.
Q. And going across the top on the continuum, the first -- the third column, what is the heading of the third column?
A. The third column is steroid, is that what you're referring to.
Q. Yes. What does that describe?
A. That describes the type of steroids. We actually have multiple types of steroids, and we can inject different types, and we choose which one we're going to inject based on various parameters. But as I talked yesterday, all the steroids can be compared in apples to apples comparison by converting them to a Medrol dose, so that's why we see Medrol equivalent in one column.
Q. In the last column, what's the cumulative Medrol equivalent?
A. That's the summation of all the Medrol equivalents, the various injections or oral administration of steroids as they occur over time.
Q. Looking at this page just in general, you talk about trigger point lumbar muscles.
A. Yes. Again, as -- as we went through these

charts, as I examined them, there were -- the documentation was -- was, in many cases, cloned, and it was not specific, and it didn't describe in any case the -- I don't know about in any case, but the vast majority of cases it did not describe the specific muscle that was injected. So as a reminder to me as to what area of the body was injected, I would sometimes put lumbar, in other words, low back, which is what I did in this case.

Q. So if it just says trigger point lumbar muscles, we just don't know exactly where?

A. We don't know which muscle was injected, it was not documented, correct.

Q. And in the regular course of practice, would you expect a chart to reflect where a trigger point Injection was given?

A. Yes. Standard of care requires that the specific muscle be identified. And I gave you several examples yesterday of specific muscles, but the whole point of a trigger point is it's isolated to a single muscle, and the pain that it causes is referred within a specific distribution unique to that muscle. And we have charts on our wall that I show to patients that show if you have a trigger point here, here's where your pain should be. So yes, it's important standard of care to define which muscles is being addressed when a trigger point is being

injected.

Q. Is there any risk when a steroid is injected repeatedly into the same muscle area?

A. We get into the risk of repeated steroid injection and the repeated dose of steroid, but additionally, the actual physical act of injecting the steroids can be a problem. For instance, we know that steroids repeatedly injected in one location break down the tendon, tendon rupture can occur. That has occurred over time very frequently, and that's not a good thing. There can be scar formation, there can be degeneration of the muscle, there can be change in pigmentation of the skin with excessive injection at the same point with steroids over time, so there are a number of local issues which, perhaps worse of which, is weakening of the tendon and tendon rupture.

Q. Looking at the first page, how you describe the epidural injections at L4 and L5, are all the predominant epidural injections on the first page. Is there any concern with repeated injections in the same area for epidurals?

A. Different considerations when compared to the trigger points, but the main take-home message here is there are multiple injections of the same area over time. And when we look at the chart, there's no improvement so

there's no rationale, as we put it -- as I put it, officially there's no medical necessity to repeat these injections. They didn't work initially, there's no reason to repeat them. And, again, then we run into the issue of concerns regarding cumulative steroid injection and running the risk each time an injection is done that the needle might be put in the wrong location. We went through that yesterday via nerve, blood vessels, spinal cord or spinal space, all kinds of places where you don't want to put a needle or inject any medication so those risks become accumulated as well.

Q. And then going to the next page, what are indicated SI joint at the very bottom, November 1st, 2011?

A. Yes, SI joint is our medical shorthand for sacroiliac, and you've heard that, but the sacroiliac joint is a specific joint. We have one on left side and one on the right side, and it's the juncture of where the sacrum and ilium come together. In one sense it's where the upper part of our body connects to the lower part of our body, very sizable joint, especially in women. It tends to be a source of pain that is treated mostly with physical therapy and maybe some manipulations, occasionally maybe diagnostically with one or two injections over time if there's an inflammatory component. But the sacroiliac joint is -- is typically a source, particularly in women,

that we look at as possible etiology of ongoing pain.

Q. And on this page, which is Page 2 of this graph, you have several milligram amounts highlighted in red. Can you explain that, why?

A. The -- the documentation of how much medication, how much steroid was injected was -- was not always clear. When I added that -- and that's why I made the notation in my notes that these are best estimates.

In this particular case, the trigger point injections received 80 milligrams of Solumedrol. That's a fairly high dose, and it -- to the best of my estimation, that's what was really administered, but that would serve a notation to me that that was -- that was a pretty high dose for trigger point injections.

Q. And did James P also receive oral steroids?

A. That's correct.

Q. And those are also highlighted in red?

A. Yes. So those are highlighted in red because, as you can see, those are pretty high numbers. To the best that literature and our -- and our pharmacy colleagues can tell us, the equivalency of injecting a steroid versus taking it orally is still the same. It's one thing if 40 milligrams of Depo Medrol is injected in the form of an epidural, another thing if 80 milligrams is injected in the form of a trigger point injection, and yet another thing if

210 milligrams is taken orally. It still counts, it's still part of the summary calculation of a cumulative dose that can cause problems, including adrenal suppression over time.

Q. Okay. Now let's move to Page -- I think it's Page 7 of this chart graph. And keep moving down, down.

Did James P receive some rescue injections?

A. Yes. We haven't talked about that, but he received an inordinate number of what we call rescue injections.

Q. And what are rescue injections?

A. Rescue injections aren't an official -- well, it's a term that came from cancer pain treatment. If an individual was being treated for end of life cancer and the tumor was expanding, and we see this, we know this happens, let's say the individual's being treated with opioids, they're sort of marginally keeping things under control, and all of a sudden the tumor starts to impinge on a nerve or on an organ of the body, or invade the bone, and all of a sudden the pain becomes a whole lot different, or worse, and then requires rescue medication because of the change of what's happening in cancer. That term has been borrowed, and occasionally applied inappropriately to chronic pain management. We're not dealing with expanding tumors, but sometimes, as in this case, it references the

fact that even with high dose opioids, as James was receiving, he was still complaining of significant pain.

So in Dr. Bauer's terms, the patient would require rescue shots, and when James came into the office, he would receive these injections. And the rescue shot in this case was composed of Demerol plus Phenergan. And fairly high Demerol, it was like 100 milligrams each time, and Phenergan was not insignificant at 25 milligrams. Phenergan's non-opioid, it's a different type of medicine, it's an anti-nausea, anti-allergy type medicine, but it's also used in combination with opioids because it enhances the effect of the opioid.

So James received, over the course of time, by my count, 44 rescue injections. That sends a particular message too, the fact that he needed 44 rescue injections on top of his already high morphine equivalency that he was receiving.

Q. And what's significant about that being administered in conjunction with the opioids?

A. Well, I don't take the computations into account in this case. In other words, when I gave you those morphine equivalents, those really high morphine equivalents didn't include this, this just adds to that, and of course in the manner that's just not right. And we have to be concerned about the fact how much more damage

was being done by the addition of this -- this so-called rescue medication by elevating morphine equivalency, again, putting the patient at risk of Opioid-Induced Hyperalgesia, making pain worse, worsening depression, anxiety, insomnia and so on.

Q. Let's look at a couple specific injections. Exhibit 577, please.

And do you recognize what's depicted in this exhibit, Dr. King?

A. Yes, this is a very poor quality fluoroscopy film taken at time of injection. It represents the lumbar spine. It's a sideways' view, and I can make out the different disc spaces. The dark areas that you see there are -- is actually what we refer to as instrumentation. There are screws and plates and rods that have been placed. James has had a previous history of back operations, and what you see here are the -- are the mechanisms that are part of the fusion that he had at that time.

Q. And is this taken from James P chart?

A. Yes, it is.

Q. And does it indicate the date of the injection? You can see it, I know it's a little blurry, sorry.

A. 1-6-2015.

Q. Okay. Does it also indicate his name?

A. His name is up at the top as well, yes.

Q. And what type of injection was this?
A. This was indicated to have been transforaminal epidural and steroid injection.
Q. And Dr. Bauer administered this injection?
A. That's correct.
Q. And can you tell us whether or not you can decipher whether the injection was administered appropriately?
A. There's nothing on this photograph to indicate that the needle is placed correctly. In fact, there's no indication of a needle on here at all. There's no indication that any contrast dye was injected to verify the tip of the needle location and the location where the medication would have been delivered, that's not on here at all. And there's only one film here. It's what we call a lateral photograph. There's no AP, or anterior posterior, photograph or oblique photograph that would show us a needle position in three-dimensional space. So this ends up being inadequate for documentation of appropriate needle or medication placement.
If this -- I take that back. As I look at this in a slightly different perspective, it's awkward for me to see it, but as I look at it from a slightly different perspective, I do see a needle on here.
Q. Where do you see a needle?

A. Do I have the ability to write on here?
Q. Yes, you can use your finger to draw.
A. I'm drawing that line just slightly below the needle. To the extent I can tell, the tip of the needle is about the -- below that line, maybe a little bit further, but that's approximately where the needle ends, and the needle is ending well short of the transforaminal area in a manner similar to what I talked about yesterday. The foramen, or the ultimate target as described and dictated in Dr. Bauer's note, is actually right about here (indicating), and the one above is located about right here (indicating). But the needle is not even on the trajectory to address either of those target areas. This indicates that the needle is in the wrong location, and that the transforaminal epidural injection, in fact, was not what was performed. This was not an epidural injection at all.
Q. It was documented as an epidural?
A. Correct.
Q. But your opinion is that it was actually not -- did not result in an epidural injection?
A. That's correct. Well, didn't result, that the needle is not placed in the epidural space by any route. So I don't -- in this case I don't even need multiple photographs to determine that because the needle is well short of the foraminal or epidural space. This -- this is

basically an injection into the muscles of the back. It is not an epidural injection of any sort.

Q. So you would -- let me ask you, with respect to contrast, was there any documentation in the chart that contrast dye was used?

A. No, there was no documentation in the procedure note that contrast was used.

Q. And was contrast dye used, could you tell that from looking at the photograph?

A. You can tell if contrast was used, it shows up. That's why we used it of course.

Q. Was any contrast dye used?

A. No, there's no contrast dye visualized in this photograph.

Q. Based on your review of the James P chart, did the injections, the epidural injections or the trigger point -- and the trigger point injections, result in any improvement in function or pain?

A. No, there's no indication that function or pain improved with the injections of any sort.

Q. Was what is described in the chart as an epidural injection that Dr. Bauer administered to James P on January 5th -- January 6th, 2015, was it administered with a legitimate medical purpose?

A. It was not.

Q. Why not?
A. Again, to go back to the question that you're asking me to explain why the injections were not appropriate?
Q. That particular injection on that day.
A. That particular injection did not verify that the needle was actually in the epidural space. An epidural injection was not performed.
Q. And it was not medically necessary?
A. There was no diagnosis to support the use of an epidural injection. There were no findings, either on MRI or electro diagnostics, or physical exam, that supported the medical necessity of performing an epidural injection.
Q. Let's look at 578. And what's depicted in this photograph?
A. Is there a way that I can get rid of my notation on there?
Q. Yes. Sorry.
THE COURT: Upper left.
COURTROOM DEPUTY: Right.
A. Thank you. This, again, is a single picture of the lumbar spine of James as -- in a procedure dated 6-25-18 performed by Dr. Bauer. It's a very poor photograph. It doesn't document any needle placement. I can't see the presence of any needle. We can see on this

the vague outlines of the hardware that we talked about previously that was part of the fusion of the lumbar spine. I can see -- I can make out vaguely the disc spaces of a couple of the lower lumbar discs. I cannot make out the foraminal areas, but I know, from my anatomy, where they should be. So this is -- and I will show you where they should be.

Q. And is this Exhibit 578 taken from James P's chart?

A. Yes, it is, it's taken from the chart. And it accompanies the dictation, the procedure note by Dr. Bauer indicating that he was performing a transforaminal epidural injection. There's no verification here that an injection was done at all because I can't see any needle. There's no indication that medication was delivered to the epidural space because there's no needle, and there's no x-ray contrast dye. And the photograph is -- is only a single photograph. Again, we require multiple photographs to fix a needle, if the needle were there, to fix the needle and location and space.

Q. And was contrast used?

A. No contrast was used.

Q. Was this injection supported by the standard of care?

A. It was not. The injection was defined as a

transforaminal epidural injection. The documentation of fluoroscopy is meant to verify that that injection was performed as described. There's nothing on the photograph here that suggests the injection was performed as described. This is not representative of an epidural injection.

Q. And was the epidural injection that Dr. Bauer administered to James P on June 26th, 2018 medically necessary?

A. It was not medically necessary.

Q. Why not?

A. There's no diagnostic indication that an epidural was necessary, and there was no -- as I indicated previously, there's no supportive evaluation, such as MRI or electro diagnostic or physical findings, to support the use of an -- excuse me, support the use of an epidural injection.

Q. Thank you. So if we can remove the exhibit, please.

Let's go on to talking about Dr. Bauer's prescriptions and treatment of James P. Did you see any evidence in James P's chart that urine drug screens were conducted?

A. There was no -- well, there was documentation of one urine drug screen that was done in 2012. It was

inconsistent. It was abnormal. It indicated the presence of a medication not prescribed.

Q. And what medication was that?

A. Hydromorphone was the medication that was found. We know that under the brand name of Dilaudid.

Q. And do you know from the chart whether or not there was any type of consultation with James P or discharge or any -- what happened after that inconsistent urine drug screen?

A. There was no indication that there was any discussion regarding that abnormal finding. I will add that that -- just a moment. Let me look at one thing here for a moment.

No, there's no indication that that abnormal finding was discussed by -- by Dr. Bauer with the patient.

Q. Okay. Let's look at Exhibit 946. Let's look at the row for James P.

And with respect to urine drug screens, what is your summary of results, or in terms of how many were given?

A. He indicates here he was given -- he had three urine drug screens over nine years, and the one we just discussed was inconsistent for the presence of Hydromorphone or Dilaudid.

Q. And I think you earlier said one, is that

correct?
A. I did say one, yes.
Q. Okay. So can you explain, is it one or three?
A. What I -- I didn't say as clear as I should have, there was one inconsistent urine drug screen.
Q. I misunderstood you.
A. I may not have stated that clearly, that's what I meant.
Q. There were three total urine drug screens?
A. Correct.
Q. One was inconsistent, meaning what was the result of the other two?
A. The other two were presumed normal.
Q. Okay. Thank you.
Did you see any evidence in the chart that Dr. Bauer requested pill counts from James P?
A. I did not.
Q. And did you see any evidence of clinical improvement from looking at James P's chart?
A. No. There was absolutely no indication of clinical improvement, and I can delineate that if you'd like.
Q. Yes, please.
A. Again, as we've talked over the last day, we look at the VAS pain score, and we look at any improvement in

function. With regard to the VAS pain score, when James first presented to Dr. Bauer, his -- James described his VAS pain score as seven out of ten. Every visit thereafter over the course of nine-and-a-half years the pain was either same or higher. It got up to nine out of ten and then ten out of ten. And on the last visit, the -- the last visit with Dr. Bauer, it was described -- well, near the last visit with Dr. Bauer, it was described as ten plus out of ten. And thereafter when his care was taken over by Dr. Bauer's partner, Dr. Hassett, James described his pain as 20 out of ten. So there was no indication that the opioids were helpful from a VAS pain score or pain level standpoint.

With regard to function, James remained disabled, unemployed, and demonstrated no improvement in terms of function at any time.

Q. Why was James P continued on opioid therapy for years his quality of life wasn't improving?

A. He should not have been. He should not have been initiated on opioids because there was no diagnostic, no diagnosis that supported the use of opioids from the beginning. And as time went on, with the significant mental health issues, multiple, as I say, up to eight suicide attempts, he should not have been maintained on opioids at all, let alone on the high morphine equivalents.

He should neither have been started or maintained on opioid therapy.

Q. Let's look at any risk behavior he may have exhibited. Let's bring up 914, please.

What is 914?

A. 914 is my list. It's the abhorrent behavior timeline.

Q. The red flags?

A. The red flags, yes.

Q. Were there drug risk behaviors or abhorrent behaviors?

A. Yes, multiple ones over time.

Q. Let's look at the first page of 914.

And would you please just tell us about some significant risk behaviors you noted from the chart?

A. Well, I'll just hit a couple of the bullet points here, but he was always requesting sooner appointments -- not always, he frequently requested sooner appointments to request additional medications. He was requesting Vicodin early. He was overtaking his Neurontin. I should mention Neurontin is Gabapentin, although that's not a scheduled Controlled Substance, we regard it as, what we call in the pain management practice, an enhancer. It enhances the euphoria associated with opioids. And we see this a lot out on the -- out on the street. Users like Neurontin

because it enhances the euphoria of whatever narcotic they're prescribed. So he was -- James was overtaking his -- his Neurontin, and that's a red flag, as well as overtaking his Vicodin. He is requesting care in the emergency room from time to time for additional, quote, severe pain management.

Again, multiple indications of overtaking the Vicodin, going to the ER, multiple indications of overtaking the medications, overtaking the medications, asking for early refills, wants more injections. And is -- and James appears to be calling the shots. He appears to be telling Dr. Bauer what he wants. Oxycontin, Dilaudid, Oxycontin again. So he is -- it's always a red flag when the patient starts dictating what medications he wants, particularly if there's not a solid or objective reason why the medication should be switched, which there was not in this case.

Q. Let's look at the next page of the red flag chart.

Any significant -- was there anything different than essentially what you've described?

A. Some of the different things we observe here is that he's, again, talking about the medication being not effective. So he's, again, directing and requesting switching back to Methadone or Dilaudid, going back and

forth. There's an incident here where he had a seizure. Seizures are always important because an increased risk of seizures are associated with our high MEQs or addicted patients. They self prescribe, and sometimes when they withdraw themselves too quickly, they can precipitate seizures. So seizures are always a red flag that have to be interpreted in the context of abuse and diversion.

So again, it's the same thing about demanding this, demanding that. He was in the ER at one time demanding IV Dilaudid, and he signed out against medical advice, so he was not -- clearly he was not compliant with medical care across the board, Dr. Bauer, as well as the emergency rooms.

Q. And he was also requesting early refills?

A. Early refills throughout, yes.

Q. And next page, anything significant? Does this refer to OARRS?

A. Yes. He was -- he went to the -- James went to the pharmacy to request a refill of Soma, which you'll recall is part of the Holy Trinity and a very addictive muscle relaxer. It indicated that the OARRS showed that he had received 140 of them, and the hospital gave him some additional ones, and Dr. Bauer gave him some additional ones. And the wife, on that phone call, indicates that James must have been taking too many or misplaced them. So

an examination of the OARRS at that time frame indicated that James was pharmacy shopping. He saw ten pharmacies, and he was doctor shopping in the sense that he was going to nine providers to obtain Controlled Substances. That's a major red flag.

Q. So I know earlier you said that you had some OARRS reports provided to you. Were these OARRS reports within the records or reports that you were looking at separately?

A. Both. There were sometimes when the OARRS reports were in the chart as I recall. The majority of the ones that I reviewed were the ones provided by the government that were not in the chart.

Q. And let's look at the third page. Any other significant? I mean, obviously they're all significant, but are there any different -- anything different that appears on this page?

A. I guess what I would emphasize to the jury here is we're seeing a repetition here where we have to kind of stand up and say, wow, this is over the top.

There's one comment that was made in 2012 where James says pain is gone when I'm unconscious. I don't know what stronger red flag you need to indicate that the opioids are not working and likely contributing to some of the problems that are described here that really define

abuse and addiction. But again, we see the same pattern here of early refills, the pain medications aren't working, I want more. The patient seems agitated today, which is probably withdrawal and consistent with the other comment I made about seizures being a possible indicator of medication withdrawal. This is just a litany of almost all the red flags you can imagine that would be suggestive of ongoing addiction and abuse.

Q. And direct your attention to March 26th of 2015. Did -- there's evidence in the chart that James P was agitated?

A. Yes.

Q. And what happened that date?

A. Again, I pointed that as well too. He was -- he was indicating -- well, the note here indicates that he was very sweaty and labored breathing and in a lot of pain. That's, unless otherwise specified, that's an indication of withdrawal.

Q. And he was demanding something that day?

A. He was -- well, he was demanding to be seen, which, according to the rhythm of what he's requested in the past, he's going to follow that up with I want more pain medications.

Q. And just two months later did James -- James lose -- James P lose his medications?

A. Yes.
Q. And what did he say on May 20th, 2015?
A. It indicates that the patient comes to the office stating wife dropped some of his meds down the sink and he needs a refill date changed to today instead of tomorrow. It's basically the requesting early refill claiming his wife dropped his medications down the sink.
Q. Let's move on to the graphs.
And what's -- what's depicted in the next two pages?
A. The next two pages, as the jury I think is familiar with now, that's an indication of my timeline indicating red flag events on the top, injections or oral steroids on the bottom, and then I don't think in this particular set of graphics I showed the morphine equivalency, but it's red flag conditions on the top and injections and steroid doses on the bottom.
Q. Actually I'm sorry, that's three pages, correct?
A. Correct.
Q. And this just plots all of the different red flags and injections, correct?
A. Well, yes. I should point out, because the jury may ask this, why do I have black flags amongst the red flags. The black flags, if you look at it, represent the suicide attempts.

Q. Between 2012 and 2014, as displayed on this chart, were there any suicide attempts by James P?

A. Yes, during this time frame there were four suicide attempts. And the important thing there not to lose the context is that those suicide attempts occurred in the middle of other multiple abhorrent behaviors where medications were requested early, and there were other evidences, as you see there, where it says self harm, and there were mental status concerns. So it was in an environment there where any prudent physician would have said opioids need to stop.

Q. And do you yourself have a -- your own summary of James P's suicide attempts?

A. Yes, I have a separate summary of the suicide attempts.

Q. Would you tell us the date of the suicide attempt and what your -- and the -- what type of attempt of suicide it was? And let me ask you, before you do that, where did you get that information?

A. All that information came out of the chart.

Q. So if you could just summarize the date and the attempt?

A. So beginning in August of 2010, the first documented suicide attempt was by slashing of the wrist.

Two months later in October of 2010, a second

suicide attempt was made by taking an overdose of methadone.

The next documented suicide attempt was in June of 2013, which was attempted by taking an overdose of Soma, or Carisoprodol.

The next suicide attempt one month after that in July of 2013 was, again, an overdose attempt and of the medication which is not defined.

The next overdose attempt's July 2014, the next year, was attempted again with cutting himself.

The next suicide attempt on -- in October of 2014 was attempted by taking an overdose of his medication Lyrica.

The seventh overdose attempt was in April of 2015, which was attempted with an overdose of Depakote.

And the last overdose that we have documented was in December of 2015, which was an attempt of overdose -- was a suicide attempt by taking an overdose of Tegretol.

Q. And based on your review of James P's chart, and your -- is this -- is it consistent with the standard of care to continue opioid prescriptions after a patient has one or more suicide attempts?

A. It's inconsistent -- it's inconsistent to, based on the standard of care, to continue opioids at all after a single suicide attempt, let alone multiple medication

overdoses. It's completely outside the standard of care. It's outside the practice of medicine to do so, I would state it that way as well.

Q. And did ultimately James P's treatment end with Dr. Bauer in August of 2019?

A. Yes.

Q. All right. I want to show you some exhibits, prescription exhibits, for you to identify.

Exhibit 527, what is that?

A. This is a prescription issued by Dr. Bauer on 12-1-18 for Oxycodone, 15 milligrams to be taken four times a day issued to James P.

Q. Okay. And you said -- it says due, and what's the date that it was actually issued?

A. It was -- it was issued 12-1-18.

Q. Is there another date on there, to the right of the --

A. I'm sorry, I was looking in the wrong location, yes. The date was actually issued -- let me rephrase this, the prescription was actually issued on 10-23-18 --

Q. Thank you.

A. -- and it was filled on 12-1-18.

Q. Doesn't it say due 12-1-18 due to increased pain, due 12-1. What does that mean?

A. Well, I think that references the fact that

whereas the prescription was given to the patient on 10-23-18, the prescription was not meant to be filled until 12-1-18, which it appears that was the date it actually was filled.

Q. My question is, does it sound like he was given this medication because his pain increased?

A. Oh, yes, the indication there is that there -- there's a concern about increased pain as it clearly states there why he.

Q. Is that consistent with the standard of care?

A. No. James has -- to go back to what we talked about in terms of opioid trials, James has a lengthy history of failed opioid trials, so the fact that his pain is still high as we reference with the VAS scores, the fact that there's no increase in function and the fact that the pain is still increasing, based on what we see here, there's no medical foundation for the use of continued opioids. That would be outside the usual course of medical practice. It would not be the practice of medicine.

Q. All right. Let's look at Exhibit 528.

What is that?

A. This is a prescription issued to James P by Dr. Bauer. It was issued on 10-23-18, same date we just referenced.

Q. For what?

A. For Oxycodone 15 milligrams to be taken four times a day.
Q. And then Exhibit 529.
What is this?
A. This is a prescription issued to James P by Dr. Bauer, Oxycodone 15 milligrams to be taken four times a day, same date, 10-23-18 is the date the prescription was issued.
Q. And 530.
A. This is a prescription issued to James P by Dr. Bauer on 10-23-18, the same date we were referring to for Oxycontin, 40 milligrams to be taken three times a day.
Q. 531, , please?
A. This is a prescription issued to James P by Dr. Bauer on 10-23-18 for Oxycontin 40 milligrams to be taken three times a day.
Q. And that's extended release?
A. That's extended release, correct.
Q. And Exhibit 532?
A. This is a prescription issued to James P by Dr. Bauer on 10-23-18 for Oxycontin, extended release Oxycodone 40 milligrams to be taken three times a day.
Q. Exhibit 533, please?
A. This is a prescription issued to James P by Dr. Bauer on 11-14-18 for methadone, 5 milligrams to be taken

three times a day.

Q. Exhibit 534, please?

A. This is a prescription issued to James P by Dr. Bauer on 12-11-18 for Diazepam, which we know brand name of Valium, 5 milligrams to be taken three times a day.

Q. And 535?

A. This is a prescription issued to James P by Dr. Bauer on 12-11-18 for Lyrica, 100 milligrams to be taken three times per day.

Q. Dr. King, were the Oxycodone, Oxycodone ER, Methadone, Valium and Lyrica prescriptions written on the dates we just reviewed, October 23rd, 2018, November 14th, 2018, December 11th, 2018, were they prescribed to James P and dispensed with a legitimate medical purpose and within the course of professional medical practice?

A. They were not.

Q. Why not?

A. A legitimate pain diagnosis for James P was never established. As we monitor James' care over the course of time and look at his VAS pain scores and his level of function, the pain scores intended to increase. There was no indication that function improved. There was no indication that quality of life improved. There was no legitimate medical foundation for the use of these opioids because James had failed multiple opioid trials with

multiple medications and was not a candidate to begin with for opioid therapy because of his mental health and suicide history.

These medications were issued in support of dependency and addiction, and not for a legitimate medical purpose. The medications were issued not in the usual course of medical practice.

Q. Before we talk about the next patient, are you familiar with an article Pain The Fifth Vital Sign?

A. I am. Well, I'm familiar with the concept, yes.

Q. Tell us about the concept and when the concept was brought in to medical -- the medical field.

A. You may have heard reference to pain is a fifth vital sign over the years. This was a concept that was introduced in, I'll say the late 1990s, and it was introduced as part of a discussion whereby physicians were asked to consider the patient's pain. There was some perception that maybe as providers we weren't really asking the patient and taking seriously their complaints of pain. So in the late 1990s a comment was made at one of the pain conferences that maybe we should look at a pain score or ask the patient their -- their rating of pain in the same manner that we take vital signs. Vital signs are, like, blood pressure, pulse, temperature, that sort of thing, things that we can actually measure in the office and get a

handle on. As a result of that discussion that we should maybe be taking patients' complaints of pain a little more seriously. And I won't go into the whole history, the concept of pain as a fifth vital sign was brought up. It was erroneous and caused all kinds of problems from the very beginning.

And in an attempt to try to get a number to represent a person's pain, we reverted -- or people reverted to the VAS pain score, which we've talked a lot about. But the VAS pain score is your index of suffering, so it includes your psychosocial problems, includes your mental health problems, includes the fact that you didn't sleep well last night and you got up and felt crummy. So when we ask people what their VAS pain score is, we understand that's their total number that tells us how bad they feel. It's not an indicator of how much Morphine they need. It was meant originally as a way to be aware, as a provider, that you're still not feeling good. But it's not meant to be an index whereby I prescribe you more and more opioids, which is what happened, which is what happened.

So within a year or two after that concept was introduced in, like, 2000, 2001 by the Joint Commission of Healthcare accreditation people, and I know you don't know that agency, but it's a big agency, and they said -- they said we need to take pain seriously, you need to take a

pain score. And within a year of two after introducing that pain is a fifth vital sign, they shut it down because what happened? Patients were getting way more opioids than were appropriate. More people started being admitted to the emergency room for overdose, there were longer stays in the hospital as a result. People in the recovery room after anesthesia were given more medication, more opioids to try to address their -- their pain as they were waking from anesthesia, and they were staying in the recovery room long, they were staying in the hospital longer. The whole thing backfired.

So the joint commission shut that down about a year after it started and formally shut down any reference to it over the course of the next couple years. And the American Medical Association completely shut it down by 2016. It was a bad attempt -- well, it was a well-meaning attempt for us as providers to be aware that maybe we weren't paying as close attention to people's personal pain as we could, but it was erroneously assumed to be a reason why more and more opioids should be prescribed, and it was never meant as that, but that's what happened, and all these bad things happened, so eventually it got totally shut down about 2016.

Q. Let's look at another patient.

Did you review a patient chart for a patient by

the name of McKinley?
A. I did, yes.
Q. And based on your review of the McKinley chart, did Dr. Bauer follow the standard of care for prescribing Controlled Substances?
A. I'm sorry, if you give me a moment, I just need to pull that up.
Q. Sure.
A. Again, we're referencing the patient by the name of McKinley.
Q. Yes.
A. I'm sorry, would you repeat your question, or restate your question?
BY MS. DUSTIN:
Q. Based on your review of the McKinley chart, did Dr. Bauer follow the standard of care for prescribing Controlled Substances?
A. He did not.
Q. Based on your review of the McKinley chart, did Dr. Bauer write prescriptions for Controlled Substances with a legitimate medical purpose and within the course of professional medical substance?
A. He did not.
Q. And let's look at Exhibit 931.
Dr. King, did you prepare a forensic timeline to

summarize McKinley's chart?

A. I did, yes.

Q. And would you describe McKinley, please?

A. Mr. McKinley was 66 years old at time of his last visit with Dr. Bauer. He had been under care with Dr. Bauer for about four-and-a-half years, which indicated he was about 61 or 62 years of age for the initial visit. He was disabled. His initial diagnosis in terms of pain was history of a stroke with left paralysis and chronic pain. He was described with additional diagnosis of pain during the multiple years of care to include fibromyalgia, central pain syndrome, muscle spasms, migraine headaches, brachial plexus and thoracic pain and neck pain, so there were a multiple dispirit complaints, none of which -- well, we'll come back to that.

He was treated -- excuse me. His past medical history, his past history of mental health included depression, anxiety and dementia.

His physical co-morbidities for his health conditions that needed to be considered prior to committing to opioid therapy included Hepatitis C, history of stroke, as I mentioned with -- with paralysis, high blood pressure, hypertension, he also had significantly end stage renal failure, kidney failure and was on dialysis. He also had a history of seizures, a history of diabetes and a history of

anemia.

He also had a history of IV drug abuse in the past, and he had a history of alcohol abuse and was a former smoker, which, I guess pales in comparison to the alcohol and IV drug abuse, but, nevertheless, all those things were of concern as part of his past history.

Q. Did you prepare a forensic summary of your findings regarding McKinley?

A. I did, yes.

Q. And Exhibit 945, please.

Is this the summary exhibit you prepared?

A. It is, yes.

Q. And is McKinley the last row of that summary?

A. It is, yes.

Q. Based on your review of the McKinley chart, did Dr. Bauer adequately diagnosis McKinley's medical issues?

A. He did not.

Q. Now, in looking at the chart on the bottom, I see that it refers to a green check under clinical workup. What does that mean?

A. That means --

THE COURT: I'm going to pause you for a moment. Can you try and blow up when the witness is referring to a specific part of a chart and make it easier to read? Appreciate that.

BY MS. DUSTIN:

Q. Thank you. Perfect.

A. So the green check under clinical workup asks the question were appropriate imaging studies or evaluations done in the workup of the patient. And in this case there appeared to be an adequate neurologic evaluation.

Q. And what type of evaluation did you say there was?

A. Neurologic evaluation.

Q. Okay. And with respect to the other two parts of diagnosis, did -- were -- was there a targeted physical exam?

A. There was a targeted physical exam, which demonstrated the patient was -- was paralyzed. But there was no support for a diagnosis that would be considered objectively treated with chronic opioids.

Q. And was there a pertinent clinical history?

A. The clinical history was not properly assessed. As I indicated, there were multiple issues there associated with past medical history of the patient that were not taken into consideration.

Q. And that would be the second column?

A. That's correct.

Q. So ultimately, although there was a neurological workup, and you did check clinical workup, did Dr. Bauer

support the diagnosis for McKinley?
A. A precise diagnosis was not established. And as I indicated when I talked about the various pain complaints of the patient, which included everything from fibromyalgia and muscle spasms to rotator cuff, brachial plexus pain, thoracic pain, neck pain, those were not supported as diagnosis.
Q. This patient had a stroke, right?
A. Correct.
Q. Wouldn't that be enough to support the diagnosis?
A. Well, one would have to ask the question which diagnosis are we talking about. It's fair to say that a patient might have multiple diagnosis, both medically and with regard to pain. But the reason we're here today is to ask was there a diagnosis established with regard to pain such that opioids were an appropriate choice, and the answer is no. He did have multiple diagnosis, none of which were adequate or generally accepted for treatment by chronic opioid therapy.
Q. Would there be -- in this case, was there evidence in the record that McKinley had a thalamic stroke?
A. There's indication that he had a thalamic stroke, and I'm sure the jury's not familiar with that.
Q. What is a thalamic stroke?
A. A thalamic stroke is an area of the brain which,

when the stroke occurs, can cause what we call a central pain syndrome, or neuropathic-type pain a nerve-type pain. And in a case like that, we find -- first of all, it does happen, and it's difficult to treat. We find that it's not appropriately or adequately treated with opioids. Some of the other non-opioid medications are generally our first line and primary choices when we're trying to treat it, things like Neurontin or Lyrica, or perhaps some of the Tricyclic or other types of anti-depressants. Opioids are not a major player and not generally accepted as a major tool for treatment of thalamic pain.

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

A. He did not.

Q. Did McKinley have a history of mental illness?

A. He did, yes.

Q. Did have medical co-morbidities?

A. Several significant ones, yes.

Q. Was McKinley a good candidate for long-term opioid treatment?

A. He was not.

Q. Based on your review of McKinley's chart, was there a defined treatment plan?

A. The treatment plan was primarily one of steroid

and opioids, again, the same sort of combination we've seen in the past. But there was no indication that there was a multi disciplinary or individualized treatment plan documented in the medical record.

Q. And then how did you rate the treatment plan with respect to your standard of care chart, if you look at the continuum?

A. Oh, the -- the -- defined treatment plan I gave him a check because it was not inappropriate to trial a low dose of opioids to begin with. But in the end it was recognized that they were unhelpful and should not have been continued.

Q. Based on your review of McKinley's chart, did you identify concerns with the types or combination of drugs prescribed to McKinley?

A. There were multiple combinations, yes.

Q. And would you explain to us the morphine equivalence?

A. The morphine equivalence initially when -- when McKinley presented for care were 30 morphine equivalents, rather modest amount. As time went on over the course of four-and-a-half years of care, that -- that was escalated up to a high of 157 morphine equivalents, and then ultimately brought down towards the end Dr. Bauer's participation with the patient to about 67 morphine

equivalents.

Q. Did Dr. Bauer meet the standard of care for morphine equivalents based on your assessment and -- of your standard of care continuum here?

A. Okay. I'm not sure -- oh, I gave him a green check mark there, although that 67 morphine equivalents was moderately high, as we've talked about, somewhere around 40 to 50 elevates the risk of overdose and long-term concerns about two to three times. Nevertheless, this individual was -- was suffering, and it was not inappropriate to at least put him on a trial of opioids to begin with.

Q. Did you have any concerns about any of the combinations of opioids or Controlled Substances prescribed to McKinley?

A. Yes. There was concern in the -- particularly in the beginning. There was a combination of Oxycodone and very high dose of Neurontin and Trileptal. That poly pharmacy combination is one that may or may not be indicated, depending on the patient's health status, but it is a combination that is associated with drug abuse, euphoria and addiction and overdose.

Later I had concerns about the combination of Oxycontin, along with Opana. That was a combination that raised red flags from the safety standpoint and a respiratory depression standpoint.

Later there was a combination of Oxycontin and Morphine, which would raise the same concerns as the MEQ approached 100.

The other issue is that the patient had a -- had kidney failure and was on dialysis, so the metabolism of these medications was likely to be unknown at best. So the adage that I mentioned yesterday about start low go slow certainly was something that would want to be addressed here. These morphine equivalents are not particularly high relative to some of the ones we've seen, but in a patient who's had a history of Hepatitis, liver isn't working presumably very well, and we know the kidneys aren't working at all and can't excrete the medications that are given, I think the morphine equivalency has to be seen as perhaps excessive in this type of patient.

Q. Did Dr. Bauer administer any procedures to McKinley?

A. Yes. There were a moderate number of procedures, approximately 15 different procedures.

Q. All right. Let's look at Exhibit 933.

And what types of procedures?

A. These procedures largely considered were trigger point injections and what Dr. Bauer considered brachial plexus injections.

Q. And this is a summary that you prepared of the

injections Dr. Bauer administered to McKinley?
A. Correct.
Q. And going back to the first page, and these were between June of 14 and April of 16?
A. That's correct.
Q. And what was the cumulative amount of steroid that -- lifetime steroids that McKinley received during that time period?
A. Over the course of two years, McKinley received approximately 600 steroid equivalents.
Q. Okay. I said lifetime, I meant to say those two years.
And let's look at the bottom of that exhibit, the next page. How many total injections did McKinley receive --
A. Fifteen.
Q. -- from Dr. Bauer?
A. He received 15 injections.
Q. And what were they?
A. Trigger point injections, which eight were performed, brachial plexus injections of which six were performed, and a shoulder injection.
Q. Based on your review of the McKinley chart, did they result in any improvement in function or pain?
A. No, there was no indication that either pain, in

terms of VAS pain score, or function improved.

Q. And do you have an opinion of whether or not the injections were medically necessary?

A. There's no indication to support the medical necessity of these -- of these medications, rather, these injections. And -- and, again, there was no indication to continue them since there was no significant improvement with any of them.

Q. All right. Now, let's go on to your compliance enforcement and outcome parts of your standard of care summary.

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

A. If I can ask when we blow those up -- well, I just -- I guess we can't have it all. I need to know which row we're looking at.

Q. We're looking at the first row.

A. I'm sorry, it's awkward for me to read. That's why I was asking.

Q. Right to the left, the urine drug screens. Referring back to your other --

A. So yes, as far as I know from the documentation in the chart, there were no urine drug screens performed. I'm sorry, let me rephrase that. There was a single urine drug screen performed during the four-and-a-half years of

care, and it was negative for all medications at that time, which would have made it inconsistent.

Q. And what's the concern about it being negative?

A. Being negative meaning the medications were not present, and one would expect the medications that were prescribed to be present. But having failed the urine drug screen to show they're present, one has to ask the question, well, what's going on with the medications, is the patient taking them, is somebody else taking them and not giving them to the patient, but there's an issue here that needs to be resolved since the medications were not shown to be present on that urine drug screen.

Q. Did you see any evidence in the chart that Dr. Bauer requested pill counts from McKinley?

A. No.

Q. Did you see any evidence of clinical improvement from the chart?

A. No.

Q. With regard to function, did McKinley have any meaningful improvement in pain or function based on your review of the record, the chart?

A. He did not. Despite being treated with the various injections and the medications that we reviewed, his initial VAS score, which was between six and ten out of ten, remained the same throughout. The last documented VAS

score we have was seven out of ten. They did not improve, and, again, there was no indication of functional goals or functional improvement or quality of life improvement during the time of his care and treatment with injections and opioids.

Q. Now, going back to the PDMP row of your standard of care summary, what was your conclusion about whether McKinley -- the standard of care was met with McKinley for that factor?

A. There was a PDMP that was reviewed.

Q. And that means -- what does PDMP --

A. Again, that's the OARRS. The Ohio OARRS basically it's a prescription drug monitoring program to review who is prescribing for the patient in terms of Controlled Substances and what was being prescribed.

Q. And based on your conclusion and looking at the last row, did you decide whether or not Dr. Bauer met the standard of care for that factor?

A. He did, yes.

Q. And you gave him a green checkmark?

A. Yes.

Q. And that would indicate that there were not multiple pharmacies or multiple providers or poly pharmacy?

A. That's correct.

Q. Well, if McKinley didn't have any meaningful

improvement in pain or function, why was he continued on opioid therapy if his life wasn't -- quality of life wasn't improving?

A. He should not have been. As I indicated earlier, I think trial on low dose opioid was not inappropriate, but that would have been part of an opioid trial, and it failed. He didn't have any improvement even when it was escalated by three times from 30 morphine equivalents to 97, so there was no foundation for the use of opioids thereafter.

Q. Were there any drug risk behaviors or abhorrent behaviors displayed by McKinley based on your review of the chart?

A. The abhorrent behaviors were --

Q. Were there?

A. Not current, there were past abhorrent behaviors, yes.

Q. Okay. Well, let's look at Exhibit 932.

And what is that?

A. That's the red flag timeline that I constructed.

Q. Okay. And does that reflect risk behaviors or abhorrent behaviors?

A. It definitely does, yes.

Q. Okay. And what were they?

A. To begin with, again, he had a -- McKinley had a

history of significant mental illness, including depression and anxiety, which made him a suboptimal candidate for sure for use of chronic opioids, and it was noted that he had been poorly responsive to opioid type medications, but he still received high doses, well, relatively high doses given his kidney failure.

He also received Neurontin and Gralise, which I indicated are enhancers with regard to the euphoria or addiction capability of opioids. His wife kept requesting a higher dose of Vicodin, even though the Vicodin was noted to be ineffective. The fact that the patient was on kidney dialysis and could not excrete the medications in a normal fashion from his body is of great concern. And then we get into some situational issues with the family here where it appears that the patient -- well, you can read it here, the patient was kidnapped by the son and taken to Mississippi for a month. And a note that says the patient was noncompliant at home with dialysis and home meds, despite end stage renal failure. So there was a noncompliance with a very critical treatment option here, which was dialysis.

There was no indication that -- and we talked about this, the opioids or any of the medications or injections certainly were not working because of this note, unable to increase activities or to decrease usage of pain medications, canceled appointments, and then the

observation that the family was diverting his Oxycodone scripts, and McKinley was not apparently receiving the Oxycodone. It was coincidently noted that the wife and the daughter were patients of Dr. Bauer as well, and that creates a red flag for --

Q. How is it a red flag when there's multiple family members as patients?

A. It has been long recognized that when families are co-dependent on opioids, and often describe the same sorts of back pain or pain problems, that there is issues of abuse and possible diversion going on. This is a red flag that has been noted, certainly by the DEA back in 2006 in their handbook given to physicians as things to be careful of. We've always known that if we have spouses or daughter -- or siblings or children in a family who are -- who are pain patients of the same physician receiving similar medications, that, again, diversion and abuse have to be raised as considerations and looked at carefully. It's statistically unlikely that a family or couple of family members will have the same diagnosis and receive the same Controlled Substance medications from the same doctor.

Q. And if we can look quickly at Exhibit 420, Page 205.

What is this?

A. This is a report from St. Catherine's Manor of

Fostoria. If you can blow that up, please.

That is a list of medications, specifically Oxycodone, delivered or administered to McKinley for the timeframe listed there, and the date range extends out to 4-30-2018.

Q. All right. Now, let's look at some prescriptions in this case.

A. Are we going to come back to this?

MS. DUSTIN: May I have one moment?

(Government counsel conferring off the record.)

THE COURT: How about we take our mid-morning break?

MS. DUSTIN: Perfect timing. I'm trying to find a page. Lots of pages.

THE COURT: Ladies and gentlemen, we'll take our mid-morning break now. It is 10:30. We'll try and be back and start up again in 15, 20 minutes.

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

(A brief recess was taken.)

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

MS. DUSTIN: Thank you.

BY MS. DUSTIN:

Q. Let's look at Exhibit 411, Page 205.

And do you recognize this as a page of the

McKinley chart, Dr. King?
A. I do, yes.
Q. And was -- what is the date of this patient chart page?
A. The date is May 30th, 2018.
Q. And was there a comment entered on McKinley's patient chart about a conversation with the patient and the family?
A. Yes, there is a conversation documented.
Q. And what is -- can you describe this to us?
A. It indicates that the patient came in today with the wife and daughter-in-law who, quote, told their side of the story to Dr. Bauer. Dr. Bauer, I'm paraphrasing here, elected to discontinue morphine, but is going to continue Oxycodone.

The family then goes on to state that the -- McKinley is to be discharged from the nursing home tomorrow. The author of this note indicated that she called the nursing home to verify, and indicated the nursing home indicated they have no record of the patient being discharged or discharged in the near future. The -- again, there was -- I don't know how much of this detail you want me to show, but --
Q. Yes, if you want to continue.
A. So the author indicated that I let them know that

Dr. Bauer is prescribing Oxycodone 15 milligrams three times a day and printing scripts to give to the family. They repeated again that the patient -- they meaning the nursing home -- does not -- the patient does not complain of pain. Per Dr. Bauer, we are to get records from of the nursing home. The patient is being discharged and set up with home health nurse, per the family. And the patient and patient's wife signed the release of records form.

Q. And does this chart page indicate that the author notified Dr. Bauer of that information?

A. Yes, correct.

Q. And what does the chart page indicate of Dr. Bauer's knowledge of that information?

A. It indicates that Dr. Bauer was unaware that the patient was in a nursing home.

Q. And then what happened?

A. Per Dr. Bauer, the family that brings the patient to his appointments or to have the narcotics discontinued and urine drug screen. Dr. Bauer is then going to call the nursing home and talk to the doctor about the situation and have that doctor prescribe the pain medication.

Q. And does it indicate that that was done? Let's go on.

Was OARRS reviewed?

A. The -- the -- yes, yes, and next section

indicates that the author of this indicated, quote, after reviewing the OARRS, the patient's medications have been getting filled at Kroger in Fostoria. So yes, the OARRS was reviewed and checked.

Q. Now, getting back, was there another call from St. Katherines to Dr. Bauer's office?

A. Yes. Brenda from St. Katherines called let us know that the patient has been there for six months and has not been getting pain medication, states the daughter did not tell them that he, meaning McKinley, has a doctor's appointment. That is why we do not get orders from the nursing home. Also that the patient does not complain of pain, only occasional headaches, which Tylenol takes care of.

Q. Was there another call later that day from St. Katherines?

A. Yes, St. Katherines called a second time indicating that the patient's family has been filling the patient's medications for Oxycodone and Morphine and the patient has not been taking any of the medications.

Q. And just going back to the previous paragraph, let's say from the bottom third paragraph, from the bottom last line, does it indicate who had been filling McKinley's scripts at the Krogers?

A. It indicates the scripts were filled in March by

a Dominic Morton, and the script filled in May was filled by either a Jennifer or Cheryl Gross.

Q. Thank you. Do you see that -- did you find that information significant in terms of patient risk behaviors, compliance?

A. Well, it's obvious diversion. That's what's going on. The family is -- is taking the prescriptions as issued by Dr. Bauer and filling them, and the patient is not receiving them.

Dr. Bauer's not aware that the patient's even in the nursing home. And we have documentation, I don't know who those individuals were, but some other individuals were actually filling the prescriptions for Oxycontin and Morphine as issued by Dr. Bauer. So there's a well-defined situation here of drug diversion going on.

Q. And let's look now back at Exhibit 420, Page 205. And what is -- what is this? Is this a record from where?

A. This is a record from St. Katherines Manor of Fostoria, we referenced it a little bit earlier. It's a documentation of how much Oxycodone is being administered to McKinley based on the dates that are documented there.

Q. And what dates range does this cover?

A. This covers -- part of it's covered, but I think it's a date range of the beginning of April, 4-1 through the end of April 4-30 in 2018.

Q. And what was the medication referenced?
A. Medication is in reference to Oxycodone 15 milligrams, which were -- which was issued for four times a day.
Q. And if you would tell us, is there also an indication of pain level on that record? Does it have a column or row for pain level?
A. It does, yes. There's a level for what the VAS pain score was.
Q. And is there a row also called PRN?
A. Yes. PRN is listed there as well.
Q. And what's PRN?
A. PRN is our Latin abbreviation translated for as needed. PRN medication is when it's given as needed rather than on a regular basis.
Q. Is that also described underneath the schedule for April 15 for Oxycodone, how often it's supposed to be given with respect to the Oxycodone?
A. Yes.
Q. What does it say?
A. It says give one tablet by mouth every six hours as needed for pain, right upper extremity, for seven days for up to -- for up to seven days.
Q. And when was the start date?
A. The start date, 3-20-18.

Q. Does the record indicate McKinley's pain level between April 1st and April 30, 2018?
A. It does, in two instances.
Q. What date does it reflect a level?
A. April 2 and April 4 pain seven out of ten.
Q. And what are the pain levels for the other days?
A. Pain levels for the other days are not represented, there's an X in the box indicating pain level.
Q. And what did you understand that to mean?
A. My best interpretation of this, from a medical standpoint, would be there's no significant pain.
Q. And then looking at the PRN as needed, does it indicate whether or not pain medication, the Oxycodone, was needed between April 1st, 2030 and April -- April 1st 2030 -- I'm sorry, April 1st, 2018 and April 30th, 2018?
A. There are two instances where the PRN indication that medication was given on April 2 and April 4. All the rest of the days there's no indication that medication was given.
Q. Thank you.
Now, let's look at Exhibit 561.
And what is that?
A. This is a prescription issued to McKinley by Dr. Bauer -- excuse me, on 7-12-17 for Oxycodone, 15 milligrams to be taken three times a day.

Q. And let's look at Exhibit 562.
And what is that?
A. This is a prescription issued to McKinley by Dr. Bauer on 7-12-17 for Morphine, 15 milligrams, to be taken twice a day.
Q. And let's look at Exhibit 63.
What is that?
A. This is an -- a prescription issued to McKinley by Dr. Bauer on 5-30-18 for Oxycodone, 15 milligrams to be taken three times a day.
Q. And was this issued the same day as the call was previously described from St. Katherines nursing home?
A. As I recall it's the same date.
Q. And let's look at 564. And what's that?
A. This is a prescription issued to McKinley by Dr. Bauer on 10-1-18 for Oxycodone, 15-milligrams to be taken three times a day.
Q. Okay. Is that 10-1-18, is that the date of service?
A. That's -- that's the date of service. The date of --
Q. What was the written date?
A. There, yes, the written date was 9-20-18.
Q. And let's look at Exhibit 564.
A. This is a prescription issued to McKinley by Dr.

Bauer on 12-7-18 for Oxycodone 15-milligrams to be taken three times a day.

Q. Okay. I'm sorry, I called that 564. This is 565, Exhibit 565. It was written 12-7 of '8, correct?

A. That's correct.

Q. To McKinley?

A. Yes.

Q. And that was for Oxycodone?

A. Correct.

Q. All right. Let's look at 566. We're just going to switch computers here.

Okay. Let's look at 567. And what is the date on this prescription?

A. This prescription was issued on 6-28-19.

Q. And what is this for?

A. This is written to McKinley by Dr. Bauer for Oxycodone 15-milligrams three times a day.

Q. And that was 567. Okay. And looking at Exhibit 566, what are we looking at?

A. We are looking at a prescription issued to McKinley by Dr. Bauer on 3-26-19 for Oxycodone 15-milligrams issued for three times a day.

Q. Dr. King, were the prescriptions for Oxycodone and morphine that were written to McKinley by Dr. Bauer on July 12, 2017, May 30th, 2018, September 20th, 2018,

December 7th, 2018, March 26th, 2019, June 28th, 2019 and July 12th, 2017, were they dispensed with a legitimate medical purpose and within the course of professional medical practice?

A. They were not.

Q. Why not?

A. As indicated earlier, there's no indication that -- for the indication of ongoing opioid treatment for McKinley. There was -- he was not responding to the opioids. The VAS pain scores did not vary. They stayed high. The indication of any improvement in function was not noted.

The medications were combined with -- with other enhancers, such as Neurontin or Gralise, which created additional poly pharmacy concerns. Some of the medications -- and the medications were being issued with -- with -- with the knowledge that there was -- that there was renal insufficiency. And the doses, as well as the combinations in the face of renal insufficiency, added additional concerns such that there was no medical foundation for the use of these medications. They were prescribed without a legitimate medical purpose, and as we just reviewed, you want me to go for purposes of diversion rather for legitimate medical purpose, they were prescribed outside the usual course of medical practice.

Q. Thank you. Dr. King, did you review a patient chart of Dr. Bauer's for the patient named Shannon?
A. I did.
Q. And based on your review of the Shannon 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 Shannon 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 Shannon's chart?
A. I did.
Q. And let's look at Exhibit 934.
Would you describe patient Shannon?
A. Shannon was a young woman, 45 years of age at date of last visit. She was under care with Dr. Bauer for approximately four years, which would have put her at an age, about 41 for her initial visit. She was disabled, she was unemployed, she complained of low back pain, quote, more on the right than on the left.
Over the course of time while treated by Dr. Bauer, she also complained of -- of neck pain, hip pain,

rotator cuff pain, low back pain, migraines, fibromyalgia and sciatica.

She had significant mental health disorders which included bipolar disorder, depression, anxiety, panic disorder. She also had significant physical co-morbid health conditions, including epilepsy or seizures, chronic obstructive lung disease, diabetes, severe asthma. At one point she was hospitalized because of her asthma. She also complained of fibromyalgia. She had a history of -- well, there are additional things, but perhaps that's a reasonable place to begin our discussion.

Q. And did you include Shannon in your forensic timeline to summarize her standard of care?

A. I did, yes.

Q. And let's look at Exhibit 934 in the Shannon row.

And as that's coming up, based on -- if you could just bring up the row.

Based on your review of Shannon's chart, could you give us an overview of how Shannon was treated with opioids and Controlled Substances for the management of pain, just what were her prescriptions?

A. Just looking for one thing. Just a moment.

Okay. She was -- she was treated with medications inclusive of Morphine, Norco, Fentanyl, Oxycodone, Lyrica, over the course of time. She had a pain

score, VAS pain score, between six to ten out of ten on her earliest-documented visit. Over time her pain scores remained about the same, ranging from eight or nine. And on her final documentation of VAS pain score on 9-3-19, she rated her VAS pain score at eight out of ten. So there was no significant change, certainly no sustained improvement demonstrated in pain perception. There was no indication of improvement in function. She remained disabled. She remained unemployed.

And there are quite of number of abhorrent behaviors that were noted during that time frame, which I'm sure we'll discuss. But in terms of any improvement in pain or function, there was none documented.

Q. Based on your review of Shannon's chart, did Dr. Bauer adequately diagnosis Shannon's medical issues?

A. He did not.

Q. Did Dr. Bauer conduct a targeted physical exam?

A. He did, and he demonstrated no deficits.

Q. And did he perform a clinical workup?

A. He did not. He failed to obtain any imaging or MRI or x-rays or EMG or electro diagnostics to support a diagnosis of back pain and sciatica.

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

A. He did not. He did not take into consideration her history of treatment noncompliance including inconsistent urine drug screens. He did not consider the physical co-morbid conditions that existed with the patient, or the significant red flag mental health co-morbidities.

Q. Did Dr. Bauer define a treatment plan for Shannon?

A. There was no specific treatment plan that was individualized or multi modal. The same choices of steroid injections and opioids that we've discussed in the past were primarily used to treat her without emphasis on other multi disciplinary -- more appropriate and conservative treatment options.

Q. Was Shannon a good candidate for long-term opioid treatment for management of pain?

A. She was not. Back in 2014 she had been on opioids provided by four different providers over the course of six weeks, which in and of itself would have been adequate for an opioid trial, but it did not improve her pain or function. And when as she started care with Dr. Bauer, the opioids were continued and escalated, beginning at 120 morphine equivalents up to 270 and maintained at around 150 for the second part of her care. There was no indication that the opioids were -- should have been

initiated, and no indication -- no support for their continued use.

Q. Based on your review of the Shannon chart, did you identify concerns with the types or combination of drugs prescribed to Shannon by Dr. Bauer?

A. I did.

Q. And what are those concerns?

A. She had been trialed on multiple opioids. I went through some of the examples, Norco, Fentanyl, Morphine, Oxycontin, MS Contin, and in most cases, or most instances here, those medications were combined. For instance, we have multiple times here where she was prescribed both Morphine and Oxycodone, which is of concern with regard to cumulative side effects or adverse effects. So there was a concern about concurrent potent opioids being prescribed.

Secondly, there is a concern with regard to Neurontin being prescribed concurrent with them. Sometimes that's indicated, particularly if there's an indication that the pain and function are improving, which neither did in this case. But Neurontin is known to be, as I mentioned a little bit earlier, an enhancer, and it will facilitate the euphoric or addictive effects of any -- excuse me, any -- any opioid. And in this case, two opioids were being given, so the combination of Neurontin is an enhancer with two opioids was inappropriate and of concern.

There were additional medications prescribed, such as Lyrica, which is related to Neurontin, and has similar concerns because it acts as an enhancer and has its own addictive qualities associated with it. Baclofen, a potent muscle relaxer, was also prescribed along with other various other medications, but the primary poly pharmacy concerns had to do with duel opioids in combination with Lyrica or Neurontin.

Q. Did Dr. Bauer administer any procedures to Shannon?

A. He did.

Q. And what were they? Let's look at Exhibit 936.

And if you could summarize maybe from the next page what procedures --

A. This is a list -- this is a timeline list of procedures and steroids which we've seen before. And she received, over the course of -- of treatment frame, which was approximately four years, she received four epidural injections, 12 trigger point injections, four brachial plexus injections, two courses of oral Prednisone or steroid, one course of IV steroids, a perineal nerve block, and nine trochanteric bursa injections.

Q. And what was her cumulative Medrol dose?

A. Her cumulative Medrol dose, if we can move up on that chart just one page, please, was 600 morphine --

excuse me, 600 steroid equivalents.

Q. Based on your review of the Shannon chart, did these injections result in any sustained improvement function or pain?

A. There was no medical use of any of these injections. There was no indication in the chart that her VAS pain score or her level of function improved as a result of the injections.

Q. Did you see any -- and we're going to -- our next exhibit's going to be 935. Did you see any evidence in the chart that urine drug screens were conducted?

A. Yes.

Q. And how many?

A. I don't have a -- a number for how many were performed. I have here an indication that there were two urine drug screens that were inconsistent.

Q. That were?

A. Inconsistent, abnormal.

Q. Okay. You note two inconsistent urine screens?

A. Correct.

Q. Did you see any evidence in the chart that Dr. Bauer requested pill counts from Shannon?

A. I did not.

Q. Did you see any evidence from Shannon's chart of clinical improvement?

A. There was no indication of clinical improvement.
Q. Why was Shannon continued on opioid therapy for years if her quality of life wasn't improving?
A. She should not have been started, and she definitely should not have been continued on opioids for all the reasons that we mentioned. What we haven't talked about that we'll probably get to are all the abhorrent behaviors.
Q. I want to ask you, were there risk behaviors, or abhorrent behaviors, that you noted red flags?
A. There were significant abhorrent behaviors suggestive of ongoing abuse and diversion and illegal drug use. Would you like me to walk through those?
Q. Yes, please.
A. So the notations, again, that were in the medical chart, the first one that I'd like to reference was on 6-8-15 where there was an indication that, quote, patient is selling her medications and is pregnant, and is using heroin, and there was a notation of stolen medications at that time as well.
Q. Says Anon, what is that referring to?
A. Anonymous.
Q. Okay. Thank you.
A. Shortly thereafter, approximately 11 days thereafter on 6-19-15, there was a third-party report from

a, quote, former roommate of -- of Shannon selling heroin, and notification that there's a warrant out for her arrest. And then approximately two months later there's a note in the chart that indicates, and I believe -- and this is, I'm going to put it in quotation marks, this is how it's put by the office personnel by Dr. Bauer, we are aware of her arrest for trafficking in drugs and incarceration, end of quote. Can still see her for injections and nonnarcotic meds.

And it goes on to say no further opioids from Bauer were prescribed until 4-14-17, which was, what, about a year-and-a-half later when Dr. Bauer began to prescribe Oxycodone and Morphine once again.

There was also an indication on that 8-21-15 visit that Shannon was doctor shopping. There were five different providers who were prescribing Controlled Substances for her, including Morphine, Oxycodone, Tramadol, Norco, and multiple Benzodiazepines.

Shortly thereafter, approximately three to four months, she was hospitalized for seizures, which is a major red flag. As I indicated to you, generally seizures, in the case of a patient who, in this case, is an admitted illegal drug user, probably multiple drugs, both prescription and illegal -- well, for sure prescription and illegal drugs, whenever there's a history of seizures, we

relate that statistically to the inappropriate use of medications. And indeed, on that date where there's an indication of hospitalization for seizures, there's a note that says that she is, quote, out of medications. Her seizures could have been a result of running out of medications and self medication.

Her urine tox screen at that time was positive for Benzodiazepines and opioids. Neither of which were being prescribed.

Q. Let me ask you a couple -- about a couple chart notes. Let's look at Exhibit 412, Page 83. And is this a page from the Shannon patient chart?

A. It is.

Q. And what is the date?

A. The date is 6-8-2015. And it's an indication of the phone call that I referenced whereby there was a report of the patient, Shannon, selling her medication and using heroin and being pregnant, by the way, at the same time, which opens a whole host of other concerns.

Q. All right. And was she -- was action taken as a result of this phone call?

A. The action taken is -- was that she needed to come to her appointment now and, quote, we will still be able to see her. So the other indication here in that second -- one of those middle paragraphs indicated, tried

to call her to advise that if we do not get a pill count on her today, we will not be able to write her pain medication going forward per WRB, Dr. Bauer. Patient did not answer her phone. Voice mail was full. I will call her again this afternoon. Basically those were the actions taken.

Q. And then later that afternoon, did someone from Dr. Bauer's office speak with Shannon?

A. I believe that's correct, yes.

Q. And what does it indicate?

A. It indicates that the patient said she was in Norwalk, and -- in Norwalk, and it was advised that she can come in to her appointment now and we will still be able to see her, meaning Dr. Bauer's office.

Q. Okay. Let's look at now Page 85 of Exhibit 412.

Is this a page from the Shannon chart?

A. It is yes.

Q. And what happened that day?

A. That date, dated 6-8-15, indicates the patient was called to come into the office, as we just discussed, due to a report that she was selling her medication, and was advised to come in for a pill count. She states that her medication was stolen today while she was not at home. So apparently she did not bring in any medication for a pill count.

Q. So there was actually no pill count?

A. There's no pill count, that's correct.
Q. Okay. And then let's look at Page 88. Despite the lack of the pill count and Shannon not bringing in the medications as requested, did Dr. Bauer prescribe medications to her the same day?
A. Yes. Oxycodone 30-milligram tablets were prescribed as well as MS Contin, which is controlled release Morphine, was prescribed in 30-milligram tabs.
Q. Any other medications prescribed that day?
A. Additional medications, we talked about the Oxycodone, additional medications would be Trileptal, which was prescribed, I'm looking for a date there to confirm, yes, 6-8-15. Lyrica was prescribed on 6-8-15. We talked about the Morphine extended release, or MS Contin. And then Ultram was also prescribed as part of the poly pharmacy on 6-8-15.
Q. And what was the date these medications were prescribed?
A. 6-8-15.
Q. All right. Let's look at Exhibit 412, Page 92.
Is this a page from the Shannon chart?
A. It is, yes.
Q. Was there another call referencing Shannon on that date?
A. Yes.

Q. What's the date of this chart?
A. This is 6-15-19, and it's a phone note indicating female caller message states this patient is selling her medication and has a warrant out for her arrest.
Q. Was there a request made of Shannon on that date?
A. Per Dr. Bauer, bring the patient in on Monday for pill count and tox screen.
Q. And was there -- do you know if there was ever a pill count done or tox screen?
A. There was no indication that a tox screen was done during that time frame. There's no indication that a pill count was performed.
Q. And did -- was Shannon discharged after any of these events?
A. No, she was not discharged.
Q. Let me show you Exhibit 568.
And what is that?
A. This is a prescription issued to Shannon by Dr. Bauer on -- I have to search for the date.
Well, the prescription is for Morphine 30 milligrams, MS Contin, Morphine 30 milligrams, to be taken three a day. And if I can find the date -- well, it was filled on 7-29-15.
Q. And looking back at the chart we had just referenced, does this appear to be the prescription written

to Shannon by Dr. Bauer on June 8th, 2015?
A. That would make -- that would be consistent, yes.
Q. And this is for Morphabond ER?
A. Correct.
Q. And let's look at Exhibit 569.
What is this?
A. This is a prescription to Shannon by Dr. Bauer issued on June 8th, 2015 for Oxycodone, 30-milligrams to be taken four per day.
Q. And Exhibit 570?
A. This is a prescription issued to Shannon by Dr. Bauer on June 8th, 2015 for Tramadol, 15-milligrams, to be taken three times a day.
Q. Specifically with respect to those three prescriptions, based on the chart review you just looked at, the chart pages you just looked at, were the Morphabond, Oxycodone and Ultram written on June 8, 2015 written by Dr. Bauer to Shannon, dispensed with a legitimate medical purpose and within the course of professional medical practice?
A. No, they were definitely not.
Q. Why not?
A. Well, they were -- she's an admitted addict, an admitted illegal drug user, she's a heroin user. And we have additional reports that she is selling the

medications, trafficking in them, and was at least represented as being arrested for them. She's an addict. The medications were being prescribed in support of addiction and abuse and diversion. They were not prescribed by Dr. Bauer for a legitimate medical purpose.

Q. All right.

A. A prudent practitioner would have ceased all Controlled Substances at that time.

Q. Now, let's look at Exhibit 571.

Can you identify that, please?

A. This is a prescription issued to Shannon by Dr. Bauer on 3-15-19 for Oxycodone 10 milligrams to be taken three times a day.

Q. And Exhibit 572?

A. This is a prescription issued to Shannon by Dr. Bauer on 6-13-19 for Oxycodone 10 milligrams to be taken four times a day.

Q. Dr. King, were the prescriptions for Oxycodone written on March 15th, 2019 and June 30th, 2019 prescribed by Dr. Bauer and written to Shannon dispensed with a legitimate medical purpose and within the course of professional medical practice?

A. They were not.

Q. Why not?

A. Shannon, unfortunately, is an addict. And we

have a history, an objective history, that she is an addict of -- of illegal medications and prescription medications. And until there's an indication for a legitimate use of opioids, which there was clearly not in this case, she should not have had them prescribed. She was -- they were prescribed in support of ongoing diversion and abuse and addiction, but not for a legitimate pain purpose.

Q. Okay. Well, let's turn to another patient.

Dr. King, did you review Dr. Bauer's patient chart for a patient named Jamie?

A. Again, if I could ask you, if you can show me that last name as well.

Q. Absolutely.

A. Actually we only have one Jamie here, I have it.

Yes, I did review the chart for the patient named Jamie.

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

A. He did not.

Q. Did you prepare a forensic timeline to summarize Jamie's chart?
A. I did.
Q. And look at Exhibit 940. Is that your forensic timeline for Jamie?
A. It is, yes.
Q. And is -- let me ask you, is Jamie a woman or a man?
A. Jamie is a female.
Q. Okay.
A. Despite the fact I have a very good friend who's a male whose name is Jamie.
Q. Did you originally indicate otherwise --
A. I did, yes.
Q. -- in your report?
A. I did.
Q. And describe Jamie.
A. Jamie was 42 years old when she last saw Dr. Bauer. She was under care with Dr. Bauer for about three-and-a-half years, which means she was in her late 30s, 38, 39 when she first saw Dr. Bauer. Over the course of 23 visits with Dr. Bauer, she complained primarily of chronic low back pain with radiation into her leg. There were multiple other complaints that came forth during the time frame of her care with Dr. Bauer, including hip pain,

rheumatoid arthritis, sacroiliac joint dysfunction, neck pain, chronic muscle pains of various sorts, herniated discs, has pain in her limb. So there were multiple complaints that she had.

The -- the concern with regard to red flags include the fact that she had a history of alcohol addiction from another provider. She also had a history of alcohol abuse treatment as an inpatient from 2006 -- or in 2006.

She also had, although she denied use of illegal drugs, the other provider indicated in his history that she had consumed cocaine while she was in her 20s. And she also was treated as an inpatient for cocaine addiction in 2006, in addition to being treated for alcohol abuse.

She had multiple other risk factors from the psycho social standpoint. Her father was a heroin addict. Her mother had a, quote, psychiatric history. I don't know any further details other than documentation she had a psychiatric history. But importantly, and critically, there is documentation here that Jamie had preadolescent sexual abuse and molestation at the age of seven. She had had multiple separations and unsuccessful marriages. She was a -- she presented with mental health disorders of anxiety of depression, as well as physical co-morbidities of high blood pressure and Hepatitis C.

Q. Can you just give us an overview of what types, if any, of medications Jamie was prescribed for the treatment of pain?

A. I'm reviewing my list here for a moment. Just prior to visiting Dr. Bauer, she had seen 16 providers and had been prescribed what one might reasonably assume is an opioid trial. She was put on Norco during that time. She had also had Dilaudid and Percocet prescribed to her. This was all prior to Dr. Bauer. So she had failed a previous opioid trial, which, frankly, would have been predictable given her history of abuse and previous addiction to multiple substances.

Her initial visit to Dr. Bauer was then met with a initiation of Morphine, plus Oxycodone, plus Neurontin, for Morphine equivalency of about 75, 75 morphine equivalents.

She then was switched to Dilaudid plus Oxycodone that raised the Morphine equivalency to 135. Over course of time, she received Dilaudid and Oxycodone with Morphine equivalency that ultimately was escalated to 180 morphine equivalence. Again, that was combination of Dilaudid plus Oxycodone.

And on her final visit with Dr. Bauer, she was rating her pain still at ten out of ten, and was on 180 morphine equivalents and was being prescribed Oxycodone,

Dilaudid, Gabapentin, or Neurontin, plus Trileptal.

Q. Did you prepare a forensic summary of your findings with respect to Jamie?

A. I did, yes.

Q. And let's look at Exhibit 945.

In the row attributed to Jamie, is that your summary?

A. Yes, it is.

Q. Based on your review of the Jamie chart, did Dr. Bauer adequately diagnosis Jamie's medical issues?

A. He did not.

Q. Did he conduct a targeted exam, physical exam?

A. He -- he performed an exam but demonstrated no focal, motor or sensory or musculoskeletal deficits that would support an objective and legitimate diagnosis.

Q. Did Dr. Bauer conduct or perform a clinical workup of Jamie?

A. There was an EMG performed, which is one of our standard tests to look for indication of nerve compression, or nerve damage, or sciatica. It was normal.

There was an MRI performed to look at any indication of herniated disc, instability or nerve compression. And it showed none of those things. It essentially was normal for her age.

So he performed a physical exam, electro

diagnostic testing and imaging, but none of them demonstrated there were any deficits, or any indication that she had anything wrong, so they were basically ignored and opioids were prescribed anyway.

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

A. He did not.

Q. She had a history mental illness?

A. Mental illness, drug addiction, and preadolescent sexual abuse, which, for a young woman, is a critical thing to note.

Q. Did she have medical co-morbidities?

A. She had some medical co-morbidities, yes. Blood pressure and Hepatitis.

Q. Was Jamie a good candidate for opioid treatment?

A. She was never a candidate for opioid treatment. She had been through 16 providers prior to seeing Dr. Bauer and had failed treatment with multiple opioids prior to seeing Dr. Bauer. Nevertheless, Dr. Bauer initiated very potent opioids, started her on Dilaudid and Oxycodone, and she continued, not surprisingly, to not improve. There was no indication, not only to start her on them, there was no indication to continue them as parter her care. She required treatment for mental health and addiction and

psychiatric assistance with her -- with her psycho social history, which included pre-adolescent sexual abuse.

Q. Did Dr. Bauer define a treatment plan for Jamie?

A. No, his treatment plan was a reflection of what we have seen many times. Opioids were used, and injections and steroids were used, but there was no -- no other individual -- there was no individualization or -- or multi-disciplinary approach to her care.

Q. You told us about the Morphine equivalence. Did you identify any concerns with the combinations or types of Controlled Substances prescribed to Jamie?

A. Yes. The jury will recognize a similar situation here, similar to previous patients where opioids were being prescribed. We have got Morphine being prescribed concurrent with Oxycodone. We've got Dilaudid -- hang on just a moment. We've got Dilaudid being prescribed concurrent with Oxycodone. So we have the concern about duel potent opioids and the effects that they have and the adverse effects that can be seen, and we have concerns with regard to the duel opioids being prescribed along with other psychoactive medications and enhancer medications, such as Neurontin or Gabapentin that we talked about previously.

Q. Did Dr. Bauer administer any procedures to Jamie?

A. Yes, he did.

Q. Let's look at Exhibit 942.
What is that?
A. This is my timeline of injection and steroid use for Jamie.
Q. Summarize for us the injections that were administered by Dr. Bauer to Jamie.
A. Injections include -- scroll up just a little bit there so I can see the list itself. There was epidural injections, and I think I mentioned oral steroids injections. So trigger points, epidural injections, trochanteric bursa injections were the primary ones that were performed.
Q. And what was the cumulative Medrol dosage of steroids administered to Jamie by Dr. Bauer during her treatment with Dr. Bauer?
A. The total Medrol equivalent was approximately 904 steroid equivalents.
Q. Was that of any concern?
A. That's a concern. That, again, as we've talked about, if one would use as a guideline no more than 200 or 220 milligrams for a year, and no more than 400 or 500 milligrams for a lifetime. She received 900 milligrams over the course of her treatment timeframe, which was about three-and-a-half years.
Q. Correct me if I'm wrong, I don't think I ever

asked you if there was a difference for steroids being administered to a woman versus a man, if there's -- if there's any more concern for amounts or placement or types of injections?

A. That's a good question, and the answer is there are subtle differences. A male will have testosterone suppression and unable to function sexually. And that's fairly dramatic in a male who's receiving steroids or opioids, actually, for that matter.

A female will respond in a slightly different manner, but by and large the side effects to chronic steroid or high dose steroid administration between male to female are going to be the same.

We're going to worry about mental health issues, psychosis, depression, anxiety, adrenal suppression, immune suppression, insomnia. And, again, those would be some of the big ones. They're pretty similar, though, between male and female.

Q. Okay. And based on your review of the Jamie chart, did the injections that Dr. Bauer administered to Jamie result in any improvement in function or pain?

A. There's no indication that the pain or function improved. VAS score just prior to coming to Dr. Bauer was 12 out of ten. When she visited Dr. Bauer, she described it as eight out of ten. The last documented visual analog

score, pain score, would have for her, under the care of Dr. Bauer, was ten out of ten, so there was no indication that the pain improved at all.

In terms of function, there's clearly no indication that function improved.

Again, we were dealing with an unfortunate young woman here who had a horrible psycho social history of abuse and intoxication, addiction, and did not have a pain condition that warranted the use of opioids.

Q. Based on your review of the chart, were the injections administered by Dr. Bauer to Jamie medically necessary?

A. No, there was no indication, based on MRI testing or EMG testing or physical exam, that she needed any of these injections. There was no medical foundation for them.

Q. All right. Let's talk about whether or not Jamie presented with any drug risk behaviors, or abhorrent behaviors. And look at Exhibit 941.

What is 941?

A. This is a list I put together, my red flag timeframe, time sheet.

Q. And looking at the chart there, would you highlight for us any red flags that you saw during March 22nd of '16 and February of 2019 while Dr. Bauer was

treating Jamie?

A. Just picking out some of the more pertinent, which I think the jury can probably pick out at this point, but there were requests for early refills of Norco, multiple requests for increase of Norco, quote, at every visit.

In addition to the early refills, there were times when the patient did not show up for visiting.

The OARRS report showed that she was receiving Controlled Substances from six providers and three different pharmacies. So she had a documented history of doctor shopping and pharmacy shopping.

And then she went on to indicate that her pain medications were, quote, not adequate. And unfortunately, we would expect that given some of the psycho social, psychosomatic concerns that we've discussed.

Additionally, there were anonymous calls coming in that the patient was selling her medication, and she was, indeed, as we know, because OARRS showed it, doctor shopping. There was even one OARRS that showed that she was seeing seven providers during a certain time frame.

The -- there was several indications that her medications were lost or stolen. Her husband, quote, threw her meds in the toilet. The patient was unable to be contacted but still called for early refills, and was --

again, another report that she was selling drugs dated as late as February of 2019. That's a pretty significant list of abhorrent behaviors.

Q. And did you reflect your red flags onto a graph?

A. I did, yes.

Q. And let's look at that page of the exhibit.

And what does this show?

A. This is, as we've seen many times, is my representation, over the course of treatment, where the red flags on the top there show the abhorrent behaviors that we just briefly went through, of which there are, unfortunately, many. And they are significant, and they should have been enough to cause a change in the treatment of the patient.

Below that, the blue pennants representing the various injections the patient had, the epidural injections and the other types of non-epidural medications that involve steroid injection.

And down at the bottom was an overlay of the approximate number of Morphine equivalents that were being prescribed during a time frame.

Q. Dr. King, after all of the indications that you just reviewed in terms of the red flags, should Jamie have continued to see -- receive prescriptions for opioid medications?

A. No, she should never have been initiated on the opioids. Having failed the previous trial, she should never have been maintained on the opioids over time for Dr. Bauer for many reasons.

Q. With regard to function and your review of the chart, did Jamie have any meaningful improvement in pain or function?

A. No. She demonstrated no improvement in VAS pain score or function. She remained unemployed and was applying for disability.

Q. And why was Jamie continued on opioid therapy for years if her quality of life did not improve?

A. She should not have been. The Controlled Substances were prescribed outside the usual course of medical practice. A prudent practitioner would not have maintained Controlled Substances under these circumstances. A prudent practitioner would not have initiated opioids to a patient with a history of addiction and abuse.

Q. And ultimately did Jamie's treatment with Dr. Bauer end in August of 2019?

A. Yes, it ended at that time.

Q. Let me show you Exhibit 575.

And what is that?

A. This is a prescription issued to Jamie on 5-17-19 for oxymorphone, which is Opana, 15 milligrams twice a day,

and the date is -- I gave you the date, yes.
Q. And what is the date?
A. I mean -- sorry, I thought I had stated it, maybe I didn't.
Q. You may have.
A. The date was 5-17-19.
Q. Thank you. And Exhibit 576, what is that?
A. This is a prescription issued to Jamie by Dr. Bauer for Oxycodone 15 milligrams three times a day. It was issued on 5-17-19.
Q. Dr. Bauer, were the Opana and Oxycone (sic) prescriptions written to Jamie by Dr. Bauer on May 17th, 2019 dispensed with a legitimate medical purpose and within the course of professional medical practice?
A. They were not.
Q. Why not?
A. They were prescribed for maintenance of addiction. They were not prescribed for establishment or treatment of a legitimate pain diagnosis. There was no indication that there was any improvement in VAS pain score or function. There were multiple indications that the patient was suffering from psycho social, psychosomatic pain issues, and indications that the patient had a history of alcohol and cocaine addiction.
Q. And I'm going to bring up one more exhibit with

respect to Jamie. Let's look at Exhibit 414, Page 271.

And is this Jamie's chart?

A. It is, yes.

Q. And what is the date of the chart?

A. The date on this is -- thank you.

The date is 2 -- February 12, 2019, as authored by Dr. Bauer.

Q. Okay. And what does this note reflect?

A. It indicated that the patient was, quote, seen today for acute and chronic low back pain into the left leg with pain levels ranging from six to nine out of ten. Worse with activities of daily living as well as bending, lifting and stooping.

Further indicates that the patient is under significant stress because her ex-husband is threatening her and the property and made a phone call possibly accusing her of selling her medications.

Would you like me to continue with that?

Q. Yes.

A. We reviewed the pills and her urine, which was positive for her medications, and also possibly for cocaine, but she had a negative test or swab yesterday for a job interview, and she also, about three days ago, was intoxicated and may have been given R, I don't -- Tuck is the word there, I don't know what that means, R Tuck, the

medication, but she denies any usage. We have not had problems with her medications.

Q. Is that visit with Jamie significant in terms of whether or not she should have been continued on opioid therapy?

A. Absolutely. This is a major red flag. We've got a person who's not anonymous, although he may have a bias against her, but at least he identified himself calling in indicating that she was selling her medications. That deserves a very careful explanation and discussion with the patient.

The urine drug screen that apparently was performed by Dr. Bauer on this visit indicated, quote, possibly for cocaine. Well, that demands on explanation. Cocaine is one of the substances we test for on urine drug screens that has very few false positives. If we have a positive for cocaine, we pay attention to that because it's unlikely to be a false positive, likely to be the real thing, and it has to be assumed to be the real thing until demonstrated otherwise.

It goes on to say here that she had a job interview yesterday, and had a swab test -- swab taken at that time that apparently was negative. Well, we don't have a confirmation of that. That's what the patient's saying, and, regrettably, if the patient is an addict, they

will say and do whatever they have to do in order to obtain, or continue the flow of her medications. So we can't trust that she was giving a correct answer regarding a negative swab the other day for a job application.

She also indicates that she was intoxicated, so yet another page major part of this red flag. What was she intoxicated with? She has a history of alcohol intoxication and addiction. Is it alcohol that she was intoxicated with, or was it cocaine, or was it with some other illegal or prescription drug? This statement here is -- here is what I teach to our younger doctors as a show stopper; you have major indications here that there's addiction, abuse, and possible diversion going on, and it demands an evaluation and a weaning and a stopping of all pain medications unless something -- or reasonable explanation be given, and I can't imagine a reasonable explanation for all this.

Q. Was there any evidence in the chart that Jamie was weaned or stopped prescribing opioid medications?

A. No.

Q. In fact, the date of this note was when?

A. The date of this note was 2-12-19.

Q. And was Jamie prescribed, as we heard from the previous exhibits, Opana and Oxycodone, by Dr. Bauer in May of 2019?

A. Yes.
Q. Dr. King, can opioid addicts be trusted to give truthful information to the doctor who's writing the prescription?
A. I say this gently and respectfully because we have respect for all our patients, even our individuals who are suffering from mental health and addiction issues, but the truth is no, they cannot be trusted, and that's a statement made based on the definition and the understanding of what addiction entails. No, they cannot be trusted.
Q. Why not?
A. To understand that we have to understand what addiction is. And so if I may just give a quick bullet point just so you understand essentially when we talk about addiction what we're saying.

Addiction is, and sometimes we describe it in terms of the four Cs, the four Cs of addiction. So the four Cs of addiction indicate that a patient has a craving, a compulsion, a lack of control, and a failure to understand the consequences of their actions. What does that mean? They crave the medication, they think about it all the time. They are compulsively seeking the next way to obtain their fix or their chosen medication, which means they're always looking for a way to get the medication, or

at least not to interrupt their current supply of medication, let's say from Dr. Bauer. They can't control themselves. I don't think anybody wants to be an addict. We show them respect. Nobody wants to be an addict, but they cannot control their compulsion and their craving, and we understand why that's a separate discussion, but, nevertheless, that's the case, they can't control it. And they continue it, and this is the hard part to understand, they continue it regardless of what the consequences are. You lose your job, you lose your health, you get hepatitis, you get HIV, you live on the street, you lose your kids, you lose your spouse, you lose your job, and that's a problem not only within the family, but also the larger part of society and our nation as we talked about. But we cannot, in answer to counsel's question here, we cannot, as physicians, take at face value what the addicts say we have to exercise. What you've heard me say in the past are universal precautions, trust but verify. I want to believe you, but I can't believe you because I know you've got a disease called addiction that disrupts your common sense and your ability to speak the truth because you're always craving and compulsively seeking and can't control it. So that would be a -- perhaps a wordy summary of why we can't trust at face value what they say.

Q. Thank you.

MS. DUSTIN: Judge, this would be a good breaking point.

THE COURT: Then let's do it. Lunch time. High noon.

Ladies and gentlemen, please remember all the rules. We'll start back again at 1:00 p.m. We're in recess.

(A brief recess was taken for lunch.)

THE COURT: Welcome back. You may be seated.

BY MS. DUSTIN:

Q. Dr. King, let's resume.

Before we go into the next patient, I wanted to ask you, are there any concerns if a woman happens to be pregnant and is on Controlled Substances or opioid medications for a danger to an unborn fetus?

A. Yes. That's a well-asked question. There are significant concerns. Sorry, I just ran upstairs, lost my breath.

THE COURT: Take a moment. Catch your breath. It's all right.

A. The concern very simply boils down to this, if a mother is on opioids of any sort, whether they're prescription or Controlled Substances, actually, whether they're prescription or whether they're illegal, the child, unborn child has a -- is going to be born addicted. That's

the problem. And it's a serious problem, and it's a growing problem, and it's a devastating problem. And we refer to that syndrome when the child is born addicted as Neonatal Abstinence Syndrome, NAS, basically when the child is born addicted. And as a result of the horrible situation that arises, I hope none of you will have to know that the child is kept in the neonatal ICU for days or weeks while they're administered Phenobarbital to keep them from seizing or to help wean them down. But it's an environment where the child has to be kept in a quiet, darkened environment with nothing excitable because they tend to be hyperreactive and can go into seizures, and they're crying all the time, and they don't eat and they're underweight and at risk for developmental issues in terms of non emotion and intellect and cognitive abilities going forward. It's a horrible circumstance.

As a result of that, standard of care requires that the mother, if she's of child-bearing age, or of course if she's pregnant, particularly, but if she's of child-bearing age, that an informed consent be given to the mother, say this is a concern. If I give you opioids, we're likely to make your baby dependent on them as well, so let's consider are you pregnant or likely to be pregnant. And that should inform the doctor's decision about whether opioids should be prescribed for a chronic

pain problem. Hopefully not prescribed because we don't want to deal with Neonatal Abstinence Syndrome, so, yes, that's what that's all about.

Q. I just want to go back to Shannon's patient's chart, which is Exhibit 412. And if you can, we can pull back up Page 83.

Was there any indication, we referred to this earlier when we discussed the call that Dr. Bauer's office received about Shannon selling her medication, was also information provided by the caller that Shannon was pregnant?

A. That is correct, yes, that's what it says. It indicates that she is selling her medications and is pregnant and using heroin.

Q. And in looking at that page and the following pages, up to maybe Page 88 or 89, is there any indication of whether or not Shannon was questioned about being pregnant or whether there was any tests performed to indicate whether or not she was pregnant?

A. No, there were none. I thought about that. I was aware and concerned about that when I first reviewed her record because that stood out to be yet another major red flag. I saw no indication that Dr. Bauer inquired as to the possible state of current pregnancy or past pregnancy, or the possibility that she was likely to get

pregnant in the future. There was -- it was -- the concern was totally ignored. There were no comments on it.

Q. And was Shannon prescribed opioid and Controlled Substances medications on June 15th, 2018?

A. Yes, she was.

Q. Now, let's talk about patient Connie.

Did you review Dr. Bauer's patient chart for patient Connie?

A. I did, yes.

Q. And based on your review of the Connie chart, did Dr. Bauer follow the standard of care for prescribed Controlled Substances?

A. He did not.

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

A. He did not.

Q. And again, did you prepare a forensic timeline to summarize Connie's chart?

A. I did, yes.

Q. And let's look at Exhibit 904.

And would you describe for us patient Connie?

A. Connie was 56 years old at time of her last visit with Dr. Bauer. She was disabled. She had been under care

with Dr. Bauer for eight years, which puts her age at about 48 when she had her initial visit with Dr. Bauer. She complained of chronic low back pain with -- with radiation into the leg. She also complained of fibromyalgia, brachial plexus type pain, carpal tunnel, headaches, neck pain, shoulder pain, SI joint pain, TMJ pain, temporal mandibular joint pain, and sacral pain, bursa pain, tendon pain, thoracic pain, trochanteric bursa pain. She pretty much had pain throughout her entire body.

And as she presented to Dr. Bauer, she also offered a significant mental health history with multiple red flags, including diagnosis of depression, anxiety, and a history of previous psychiatric hospitalizations. It was not delineated as to what kind of psychiatric issues were present, but she had, at least at some point, been hospitalized for them.

She also had a long term -- I'm sorry, she also had a history of using marijuana. She denied any alcohol history, but -- but that essentially was how she presented.

Q. And based on your review of Connie's chart, would you give us kind of an overview of the medications that Dr. Bauer prescribed for her for the management of pain?

A. Again, she was under care for approximately eight years. At the beginning of that time frame, Dr. Bauer initiated low dose opioid medications. He started her on

Percocet, 5 milligrams just once a day. So that morphine equivalency turns out to be seven, just seven.

And then as time went on, that was escalated. She was shortly thereafter escalated up to a dose of 30 Morphine equivalents, 45, 60, 70, 127. And then again in 2012, mid 2012, she was escalated to 130, 160, and then 200 plus. And then as we approached the 2014, she was escalated up to morphine equivalencies of about 300.

Thereafter, the morphine equivalency varied somewhere in the 200 to 300 range. The last morphine equivalency calculated was 225. This was a combination of multiple medications. She was receiving Oxycodone as well as Percocet, which, as you know, also contains Oxycodone in combination with a third opioid analgesic, which was Duragesic, which you know as Fentanyl.

There were additional medications prescribed beyond that, but she was maintained on those three, Oxycodone, Percocet, and Duragesic combinations for some time. As time went on, the doses of those medications, particularly the Duragesic, were escalated. She was -- she was taking ultimately a 50-microgram Duragesic and five Percocets a day when we approached 2017 towards the latter part of her care with Dr. Bauer. I'm sorry, I missed one column here.

That's correct. I don't have anything to add.

That's still consistent with what I -- with what I just told you.

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

A. I did.

Q. And let's look at Exhibit 945 in the attributed to Connie.

And is that the graph, the timeline, that shows your standard of care summary?

A. It's not a timeline, but it does portray the forensic summary.

Q. Your standard of care summary?

A. I'm sorry, standard of care summary, correct.

Q. Thank you. Based on your review of Connie's chart, did Dr. Bauer adequately diagnose Connie's medical issues?

A. He did not.

Q. Did Dr. Bauer conduct a targeted physical exam?

A. He performed a physical exam, but it demonstrated no focal neurologic deficits or musculoskeletal deficits that would support a legitimate or effective diagnosis.

Q. Did Dr. Bauer perform a clinical workup of Connie?

A. The clinical workup was notably absent in the sense that her main complaints, or at least initial

complaints, had to do with back pain and leg pain which he labeled as sciatica or radiculopathy, along with the fact that he did nothing to support that, neither MRI examination of the lumbar spine, no electro diagnostic or EMG testing, to look for nerve damage. And the physical exams demonstrated no objective support for sciatica, so the evaluation was -- was not according to standard of care.

Q. Did Dr. Bauer order an EMG?

A. I did not see evidence of an EMG.

Q. And I want you to look at your -- let's look at Exhibit 94 -- 946.

And under the row -- is this your forensic summary?

A. Yes, it is.

Q. Under the row associated with Connie, when you discussed the clinical workup, can you explain your findings with respect -- with respect to imaging for Connie?

A. Under -- under the clinical workup, it indicates EMGs demonstrated no cervical or lumbar radiculopathy, and that the brain MRI reflected very minimal demyelination. That last part refers to the fact -- I think I'd have to go back and double check, but I think that refers to the fact that there was maybe an inferred diagnosis of MS, but I'd

have to double check that.

Q. So did Dr. Bauer order EMGs or an MRI, or were those from a prior physician, if you recall?

A. Looking at my forensic chronology at the moment, at least the top part, I don't see any indication that any EMGs were performed or documented. I -- so there remains a -- I would have to go through it in detail to see if there's documentation of any normal MRIs or EMGs, I don't see that there are any documented at the moment.

Q. Okay. Let's talk about the next step of your forensic summary.

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

A. He did not.

Q. Did Connie have a history of mental illness?

A. She had a history of significant mental illness, as I discussed, yes, on the initial review.

Q. And did she have medical co-morbidities?

A. She had significant medical co-morbidities -- excuse me. She had some medical co-morbidities which were of concern. She had been given a -- by Dr. Bauer a diagnosis of Multiple Sclerosis. She had a history of COPD. She was a smoker. She claimed a half pack per day and, again, a history of having used marijuana.

She also had, I would add to that, significant issues with regard to memory loss and multiple falls, which are red flags, begging the question as to why she's falling and why she has memory loss, and whether that's due to disease or narcotics or -- or other drugs being used.

Q. Was Connie a good candidate for long-term opioid treatment?

A. No, she was not.

Q. Why not?

A. Multiple reasons. The first is she did not have an objective diagnosis confirmed. There was nothing that would suggest she had an acceptable diagnosis for the use of chronic opioid therapy.

Secondly, there were no significant past medical records reviewed to find out if she had been treated with opioids previously, and if so, how had she -- how has she responded. A prudent physicians depends a great deal on prior medical records so we don't have to reinvent the wheel or expose the patient to additional risks a second or third time if they'd already had certain therapies or treatments in the past. In this case there were no medical records, which standard of care would have required should have been reviewed first prior to opioids. So lacking a diagnosis, lacking past medical history, we find that she had significant mental health co-morbidities, including

psychiatric hospitalization.

Again, based on what you heard me say before, mental health, particularly depression and anxiety, is -- is commonly related to chronic pain, not to diminish it, but it is commonly related. And in the past, the cases of presenting depression and -- and anxiety, the patient can manifest a chronic pain syndrome secondary to the mental illness, a psychosomatic pain, but not due to anything that opioids can help. So it was not established that she was a candidate initially for opioids, and she was not a candidate, over course of treatment time for -- maybe I'm getting ahead of myself.

Q. Okay. Let me ask you, did Dr. Bauer define a treatment plan for Connie?

A. No -- well, no. The treatment plan was default to opioids and injections, which we have seen repeatedly. There was no individualization or treatment or multi-disciplinary approach to treatment.

Q. So Dr. Bauer administered procedures, injections to Connie?

A. Yes.

Q. Let's look at Exhibit 906.

And is that your summary of injections administered to Connie beginning in April 2011?

A. Yes, this is the timeline for steroids and

injections.

Q. And can you summarize how many and what types of injections Connie received from Dr. Bauer?

A. Yes. Let's see, is there a box there that shows the totals, or is that the lowest page?

Q. We don't see a totals there?

A. All right. Let me just see if I have totals in mine. Yes, I do.

She received a total of 38 lumbar epidural injections, 37 trigger point injections, 24 trochanteric bursa injections, four wrist injections, 16 doses of oral prednisone, two injections of the sacroiliac joint, four injections of the occipital nerve at the base of the held, one shoulder injection and one facet injection. I don't know what that totals up to, but that's a large number of injections.

Q. And what was -- what did you determine the cumulative Medrol dose to be during Dr. Bauer treatment?

A. Her cumulative Medrol does that's indicated on this form that we're looking at here indicate 8,760, so approximately 87- 8,800 milligrams of steroids over the course of treatment.

Q. Do you find that number significant?

A. I find that extraordinarily excessive. As we talked about before, it's well beyond what we look at as a

guideline for a lifetime use of steroids. We have to recognize that this is a relatively young woman. She's in her early 50s, so we -- it's hard to understand why that dose of steroid is necessary. I see no medical foundation, or medical necessity, for the injections or that amount of steroids. So, yes, I find that quite concerning.

Q. Based on your review of the Connie chart, did the injections result in any improvement in function or pain?

A. No, there was no indication of improvement and function. She was disabled when -- during the course of care, and there was no indication that she had any improvement in either function or quality of life.

I'm sorry, you asked me about pain as well?

Q. Yes.

A. If we look at her VAS pain scores, her initial VAS pain score that's documented by Dr. Bauer was seven out of ten. Over the course of time it varied in that region, around seven or eight out of ten.

Towards the end of her care with Dr. Bauer, her VAS pain scores, the last -- well, the last documented one while under care with Dr. Bauer was listed as five to nine out of ten, and that's fairly consistent with what went on previously. So there was no indication of sustained improvement as a result of treatment with the injections or the medications.

Q. In fact, let's look at Exhibit 402 of the patient chart at Page 1290.

And what's the date of this visit with Connie?

A. This is dated November 21, 2017.

Q. And she had a visit with Dr. Bauer?

A. It was a visit Connie with Dr. Bauer, correct.

Q. And in terms of the history she presented on that date, can you -- can you summarize for us her -- how she described her pain?

A. There's a lengthy description here of her pain, but essentially she is describing it as acute and chronic pain into the left arm, plexus distribution, back and hip pan and left hand pain, and ranks her pains of five to nine out of ten, worse with activities of daily living, and exhibiting -- and recent stress causing significant -- with significant -- significant other's stroke -- with significant other's stroke, I presume her husband or male friend. The patient presents with low back pain, left leg pain, bilateral leg pain, neck pain, left arm pain and left hip pain. She describes the pain as sharp, stabbing, burning, aching, pinching and dull with radiation to the neck, the left shoulder, left arm, lower back, left hip, bilateral hips and bilateral legs.

Q. And then she does describe, if you go down to the next line all the way down to let's say -- up here. Stop,

please.

Can you please explain how she described her pain in terms of whether it was improved or worse?

A. Yes. With regard to that visit, the description that I just read, she's describing her pain as worse than it was on the previous visit.

Q. Did she also talk about epidural?

A. She indicates that, yes, but that's overlying it. There we go.

Since the last epidural 12 weeks ago the pain was increased by 50 percent or more and lasted ten weeks.

Q. If a patient presents after being treated with opioids with pain that has worsened, would you continue them on the opioids?

A. No.

Q. What would -- what would you expect a pain management physician to do?

A. A prudent -- a prudent physician would reduce or stop the narcotics all together. There's not been an indication of the three parameters here that we look for, and that is a measurable, meaningful, and sustained improvement in function, and a significant -- clinically significant improvement in pain. Those things were not achieved, and, therefore, that requires, by standard of care, that the opioids be weaned and stopped and an

emphasis placed on other choices for pain management.

Q. Let's look at some other injections. First, let's look at Exhibit 582.

And is this from the Connie chart?

A. Yes.

Q. And what was the date of the procedure?

A. 2-29-2016.

Q. 2-29 or 2-09?

A. I believe that is 2-09.

Q. And what type of injection was this?

A. Again, for the jury, this is a picture of the patient's back, lumbar spine, at time of injection. It's the sideways or lateral photograph, and it presumably -- well, not presumably, put forth as documentation of having performed a transforaminal lumbar epidural injection.

Q. And can you see the needle on Exhibit 582?

A. I can see the needle. And you see me kind of looking at it from various ways because it's a terrible photograph. It's inadequate documentation, but I can make out a needle, and I can make out some of the basic concepts of anatomy, although this would not be satisfactory if I were looking at it in realtime trying to place the needle in the patient's back. But the needle, to the best I can discern here on this photograph --

Q. Can you draw a line any place --

A. Right there (indicating), with the tip of the needle ending right where the end of the line is.

Would you like me to further comment --

Q. Yes, please.

A. -- on why that's inappropriately placed?

Okay. So you should be getting pretty good in anatomy at this point. So the foramen, which is where Dr. Bauer indicated he was going to put the medication. Foramen, by the way, is opening. In our words when we say foramen, it's where the spinal nerve root comes out, and that's transforaminal injection, putting the medication where the nerve exits the spine. Here's one foramen right here, and here's the other one up here (indicating). Those are the foramen that where, in a properly executed transforaminal injection, the needle would go. The needle is not in either of those locations, the tip of the needle is well outside the spine. And even if the needle were projected forward from where we see it documented here, it would go right there into the bone and would miss the foramen entirely. So I interpret this not only as an incorrect needle placement, but one that even if it were pushed forward would not have gone to the right location.

There's also a lack of a second view here to show where the needle really is located. And you've heard me say that before, and there's also lack of x-ray contrast

dye put in to verify that the medication would be going to the right location. So it's -- this photograph, this x-ray, indicates that a transforaminal epidural injection was not done, even though it was billed and described as such.

Q. Would you classify this as more akin to a trigger point injection?

A. Well -- well, I -- we have some concerns about trigger point injections, so let me modify that just a little bit. This is probably an injection into the muscle.

Now, a trigger point injection is also an injection into the muscle but with other parameters associated with it. So the extent that trigger point injections, or injections into the muscle, this particular injection, as we review it in this picture, is also probably an injection into the muscle. That's -- there is a relationship there.

Q. So with respect to the injection on February 9th of 2016, was it performed in accordance with the standard of care that you would expect a physician to apply?

A. It was not.

Q. And was it, based on your review of the chart, and of this -- the exhibit, medically necessary?

A. It was not medically necessary.

Q. Why not?

A. First of all, it was not medically necessary because the patient did not exhibit any symptoms that would suggest the need to perform a transforaminal epidural injection.

And secondly, it was not medically necessary because the patient had quite a number of these with no sustained improvement. Therefore, there was no foundation to keep repeating them ad infinitum over time and just adding more and more steroid to the poly pharmacy and safety concerns to the patient. So there was no diagnostic indication to use it, there was no therapeutic improvement to suggest it should still be used.

And then thirdly, and importantly, this was not an epidural injection.

Q. And let's look at Exhibit 583. You want to look at Page 1289, chart number -- Exhibit 402, Page 1289.

And what is this, Dr. King?

A. This is a x-ray fluoroscopy film, as we've been looking at from time to time, representing -- or what is purported to represent the correct placement of medication and a needle in the spine for a transforaminal epidural injection.

Q. On what date?

A. The date is 10-24-17 as performed by Dr. Bauer.

Q. And did the chart indicate this would have been what was described as an epidural injection administered by Dr. Bauer to Connie on October 24th of 2017?
A. Yes.
Q. And based on your review of this photograph, were you able to determine whether that procedure was successful?
A. There's no indication on this photograph that indicates an epidural was done. For that matter, except for my extensive experience in reading the x-rays, I think the average physician wouldn't even be able to tell what body part's being looked at here, but I see vague outlines to suggest this is the tailbone and possibly the lower part of the lower disc. It's a horrible photograph that certainly does not verify either that an injection was done or that any needle was placed. I do not see a needle on this photograph, and there is no indication here that the procedure, as described by Dr. Bauer, was actually done.
Q. Let's look next at Exhibit 584.
And what is 584, Dr. Bauer -- or Dr. King, I'm sorry?
A. I'm still looking at the same picture here, or is this a different one?
Q. No, that is 584, you're right. I'm sorry, 585. I misspoke.

And does 585 indicate that there was a trigger point injection administered to Connie on March 11th, 2016?

A. Yes. That document indicates that there is a trigger point injection to Connie by Dr. Bauer on the date of -- where is the date, 12- -- 12-20-17.

Q. 12-20 of '17 there was a trigger point injection administered?

A. Yes.

Q. And then let's look at -- and that was administered by Dr. Bauer?

A. Correct.

Q. And let's look at Exhibit 587. I think they're both the same so I'm not going to ask you about that. That's the exact same Exhibit.

Let's get back to Exhibit 585.

And that's the same trigger point injection that was administered by Dr. Bauer --

A. Yes.

Q. -- on Connie?

A. Yes.

Q. Can we bring up your summary exhibit of trigger and epidural injections? Let's look at Exhibit 906.

Does 906 reflect there was an injection on October 24th of 2017?

A. Yes, it -- no, it indicates there was -- excuse

me. It indicates there were -- there were epidurals injected on that date.

Q. And what type of injection on October 24th of 2017?

A. A bilateral epidural injection at the level L5-S1.

Q. And does your summary chart also indicate there was an injection on January 25th of 2018? There is none there, okay. And one more. Can you move this up a little bit, please? Would you go to the previous page of the exhibit? One more page up.

And does your summary exhibit here indicate there was an injection on March 11th of 2016?

A. Yes, there was an injection done on 3-11 -- actually, several injections done on 3-11-16.

Q. And I believe now we have spoken about -- we've talked about the epidural, and I think we talked about the March 11th, 2016, December 20th of 2017 injections.

Dr. King, were the injections administered to Jamie (sic) administered with medical necessity?

A. No. Medical necessity was lacking for those injections.

Q. Why so?

A. A diagnosis, an objective diagnosis was not established that would merit the use of those injections.

The injections were not documented, as we looked at in the x-rays to have been done as they are advertised or as they were dictated and described. The injections had been done multiple times over the course of care, and none of them had demonstrated any improvement in either pain or function; therefore, again, there was no medical necessity to repeat them again or to offer them. So as a result, they were given without medical necessity, without medical indication and outside the usual course of medical care.

Q. And I will rephrase, and I made a mistake. I indicated Jamie, the prior patient, instead of Connie. Were you referring to Connie?

A. I was referring to Connie, yes.

Q. Thank you. Thank you.

Dr. King, did -- let's talk about compliance enforcement and outcome as it relates to the medications prescribed to Connie.

Did you see any evidence in the chart that there was clinical improvement?

A. There was no indication of clinical improvement as she remained disabled throughout.

Q. Did you see any drug risk behaviors or red flags?

A. There was significant drug risk behaviors and multiple red flags.

Q. Can we look at Exhibit 941, please?

Is this your red flag chart, Exhibit 905, for Connie?

A. It is, yes.

Q. And does it describe any abhorrent behaviors or risk behaviors that you noted after reviewing the Connie chart?

A. Yes. It demonstrates multiple abhorrent behaviors of concern, and I can kind of run down and generalize. So, in general, here we're dealing with an individual who's requesting various medications, stronger dose or pain patch formulation, which tells us that the medications aren't working.

There are various rescue medications, and we've discussed that previously that she is requesting and includes in the office, injection of Demerol and Phenergan. For a moment I have to point out this one question -- this one statement here that the dog ate her Percocet. This is, unfortunately, a repeated excuse that we see in the clinic frequently to the point where it becomes kind of one of the you roll your eyes when the patient says the dog ate my medication. Why didn't your dog then die of opioid overdose if they really ate your medication? Virtually all the time it is an excuse because the medication was either sold or diverted in some manner or taken excessively. So with that thought in mind, she complains or states that the

dog ate her Percocet, which is a terrible excuse. So she's -- the medications aren't working, she's losing her medication and accusing the dog of eating it. She is demonstrating inconsistent urine drug tests. And this particular indication it was inconsistent for the presence of marijuana, THC, and it was interesting that she pleaded with Dr. Bauer to, quote, don't validate the THC results. For some reason she desperately did not want that validated in black and white on her chart. I don't know why, but that's -- that's of concern. More early refill requests with excuses that she, quote, dropped a couple somewhere. She's been in the emergency room because she fell out of bed, that's highly unusual on a woman of young age, which she is. Again, early refills at the pharmacy, inconsistent urine drug screens continuing to show up, and indicating that her pain is not only still a problem, but it getting worse.

Q. At some point here did Connie suffer a mental breakdown?

A. Yes. On 8-15-2015 she was admitted through the emergency room, quote, for acting strangely for the past 24 hours and was consequently transferred to Northern Ohio Psychiatric Hospital. I don't have the hospitalization or the report of exactly why she was acting strangely or what the diagnosis was, but in the context of everything we've

seen here, it is highly likely to be drug related.
Q. And does your chart reflect inconsistent urine drug screens with that -- that showed positive for THC?
A. Yes, three of the UDCs were positive for THC.
Q. Is she also requesting early refills?
A. Yes, multiple times.
Q. All right. I want to show you one more image with respect to an injection. Let's look at Exhibit 402. Chart Pages 1443 to 1450. Well, we're going to move on while they're bringing that up.
Let's talk about whether or not you saw any improvement with either the medications or the injections at the end of Dr. -- at the end of Connie's treatment with Dr. Bauer.
A. There was no indication that either the VAS pain scores or function had improved over the course of treatment or by the end of treatment. As a matter of fact, there was several indications, statements by the patient's part, that the pain was worse than it previously was, and that could be a reflection, by the way, of the fact that as the Morphine equivalency increased, as the jury now knows, Opioid-Induced Hyperalgesia could have been kicking in and starting to cause worsening pain based actually on the drugs that were being administered.
Q. We'll look at the prescriptions in a minute, but

did you see from the patient chart that Connie was prescribed Fentanyl by Dr. Bauer on January 25th, 2018?

A. I'm not looking at anything on the screen. Would you like me to look up on my -- I'm scrolling to it, so if you can give me that date again.

Q. January 25th, 2018.

A. 1-25-18. Yes, on 1-25-18, Dr. Bauer prescribed to Connie a prescription for Percocet, 10 milligrams, five of them per day.

Q. Of Percocet?

A. Yes. Well, Oxycodone, but in the form of Percocet, yes.

Q. And were there three separate prescriptions written on 1-25 of 18?

A. Yes. Yes, there were. And they were each for the Percocet 10-milligrams to be taken five per day.

Q. And did Dr. Bauer also prescribe Fentanyl to Connie on January 25th, 2018?

A. I have the Fentanyl prescription on -- range on -- just a moment. Yes, on January 25, 2018, Dr. Bauer prescribed Fentanyl, 50 microgram patch to Connie.

Q. All right. And were there two other prescriptions that were refills for the same Fentanyl Duragesic patch at 50-milligram -- 50 MCG patches on 1-25 of '18?

A. I don't have that information.
Q. Okay. So let's look at Exhibit 508.
A. This is a prescription issued to Connie by Dr. Bauer on 1-25-18 for 50-microgram Duragesic transdermal patch.
Q. And 501, 509?
A. This is a prescription issued to Connie by Dr. Bauer on 1-20-18, Duragesic 50-microgram transdermal patch.
Q. And 507?
A. This is, again, a prescription issued to Connie by Dr. Bauer on 1-25-18 for Duragesic 50-microgram transdermal patch.
Q. And those three are Fentanyl, correct?
A. Those are all Fentanyl formulations, correct.
Q. And moving on to the Percocet prescriptions you described earlier. Exhibits 510, 11 and 12, 510, 511 and 512, can you describe those as they come up?
A. 510 is a prescription to Connie by Dr. Bauer on 1-25-18, Percocet 10 milligrams, five of them per day.
Q. 5-11?
A. This is a prescription issued to Connie by Dr. Bauer for Percocet 10-milligrams, five per day issued, again, on 1-25-18.
Q. And 512?
A. This is another prescription of the same type

issued to Connie by Dr. Bauer for Percocet 10-milligrams to be taken five per day, dated 1-25-18.

Q. Dr. King, were the prescriptions for Fentanyl and Percocet Dr. Bauer wrote to Connie on January 25th, 2018 dispensed with a legitimate medical purpose and within the course of professional medical practice?

A. They were not.

Q. Why not?

A. First of all, a legitimate and objective pain diagnosis was never established. There were multiple indications here that she was addicted to the medications, and was requiring them for that purpose.

And then, thirdly, the medications had been prescribed for some time, but had offered no improvement in VAS pain scores or function; therefore, were not medically indicated and were, therefore, prescribed without a legitimate medical purpose. A prudent practitioner would not have continued to prescribe medications under these circumstances.

Q. Thank you. All right. Now, let's go back and look at Exhibit 20, Pages 1443 to 1450. All right, are you familiar with this chart?

A. With this chart picture?

Q. Yes.

A. Yes, I am.

Q. And is this a portion of Connie's chart when she received care at ANA post Dr. Bauer?
A. Yes, it is.
Q. Okay. So she was not being treated by Dr. Bauer at this time?
A. That's correct. This is not a picture of a procedure that was performed by Dr. Bauer.
Q. Okay. Was this a procedure performed by a different doctor?
A. Yes. I don't see it listed on here, but my recollection is it was performed by one of Dr. Bauer's colleagues.
Q. Okay. And what was the date?
A. The date on this is 4-14-2020.
Q. And what procedure was performed?
A. If you give me just a moment I'm going to cross reference it on my list here. The procedure being performed here is a transforaminal epidural injection, the same type of procedure that was represented previously when we looked Dr. Bauer's photographs.
Q. And what, if anything, is significant in this exhibit as you look at the image?
A. Well, many things are significant. First is my recollection is that this is one of several picture that were taken during the time of this injection. And I'm sure

you'll show them here in a moment and I can critique them, but the fact is this one of many pictures which, number one, is appropriate. You heard me say you need to have several pictures so we can fix the location of the needle in the three-dimensional space.

The second here you can see the needle there, I'll outline it anyway. The needle tip, at least in this location, is located right here (indicating).

MR. GIBBONS: Your Honor, can I ask what Exhibit Number that comes from?

MS. DUSTIN: This is exhibit --

THE COURT: 420.

MS. DUSTIN: Yes.

MR. GIBBONS: Thank you.

THE COURT: 402.

MR. GIBBONS: Thank you.

A. The needle tip has a slight bend to it, which is intentional. We bend the tip of the needle so we can rotate the needle and steer it as we enter it into the location we need. So this, based on my recollection that there are other injections which will show the final location, nevertheless shows that, excuse me, shows that the needle is properly presented, and is in a proper trajectory to do a transforaminal epidural injection. Also it's clear. I can see the anatomy. This is a well-taken

and well-represented photograph.

Q. And was there contrast used?

A. Not yet.

Q. Okay. And if we can -- you stop us as the image comes up.

A. I'm actually looking for a way to erase my marks here. I'm not sure I know how to do that. I see it here. I can do it.

So this -- that picture we just looked at was front to back. The patient was lying down on their stomach, and the x-ray was taken front to back. Here we have a sideways x-ray taken, and you can clearly see the needle, I'll outline it right here. Whoa, didn't outline. There we go.

You can see the outline of the needle there, and the final position of the needle is correctly located. I don't want to muddy up the picture here, but I'm going to draw a circle around the foramen that you've seen me draw previously, and you will note that the tip of the needle is properly located within the foramen. The foramen is right here (indicating), and the tip of the needle is just barely inside the foramen, which is what we want to see, so this demonstrates the needle on the proper trajectory at the proper location with the needle tip appropriately located and a photograph of film here that defines the anatomy

clearly. And again, this isn't the only one.

We'll go forward here because the question was asked about contrast. You can give me control so I can erase things, or if you want to erase them that's fine.

Q. You want to go previous or later?

A. This is fine. Just erase my --

Q. Okay, erase.

A. Now, this is on the other side. This is on the right side of the patient here, but it was done on both sides, but this is still a good example of an injection where the needle is properly placed. Contrast is used, and the needle tip is shown to be in the right location. So here we see the needle coming in right here, the tip of the needle is where it should be located in the foramen. Again, the foramen -- different here because we're looking at different view front to back, but you see all this dark stuff, this sort of dark cloud here, and I'm going to use a dotted line to show you a couple things. So right here you see sort of a dark line coming down, which is the x-ray contrast material enveloping and defining the nerve as it comes out. The needle is not in the nerve, it's alongside the nerve. And again, this is a perfect picture. This is the way it should be done. So the contrast dye went around the nerve to show the needle is properly located, and if the medication is injected at this location, it's properly

presented.

The other thing you will see here, and I'm going to use the dotted line, is you see all this cloud, that's not a dotted line, all this cloud that kind of comes around here, and then there's a little bit of some dye out here as well. But this cloud here in the center where I'm putting the big X, is proper. That means that the dye has retrograded back into the epidural space because this is an epidural, right, it's a transforaminal approach. Goes in by way of the nerve, and we see that the needle tip is properly laying alongside the nerve, not in the nerve, not in a blood vessel, and the medication, the dye retrogrades back into the epidural space. That's perfect. This is a perfectly done, properly documented procedure as dictated and as advertised. This is not what we saw in Dr. Bauer's photographs.

Q. Thank you. Let's move on to another patient.

Dr. King, did you review Dr. Bauer's patient chart for a patient named Rodney?

A. I did.

Q. And based on your review of the Rodney 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 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. Again, did you prepare a forensic timeline to summarize Rodney's chart?

A. I did, yes.

Q. And let's look at Exhibit 916.

Is 916 your forensic timeline for patient Rodney?

A. Yes, it is.

Q. And describe patient Rodney.

A. Rodney was 44 years old at time of last visit. He was under care with Dr. Bauer for approximately six years, which puts his age at -- in the late 30s, so let's say 38 years of age or so when he first became under the care of Dr. Bauer. So he's young. He's a young man.

His -- his pain diagnosis, his complaints during the initial time with Dr. Bauer included what we sometimes call failed back syndrome, which really means back pain that continues on despite an operation. So he had back pain, chronic low back pain with radiation into his leg. He apparently had trial -- been trialed with treatment of a nerve, a spinal cord stimulator at some point. So it's noted on his initial complaint to the -- to the office that he had, quote, failed Neuromodulation, which means he had

had spinal cord stimulator that didn't work. But he complained of nerve pain, low back pain, arm pain, sacral pain, hip pain, neck pain, herpes zoster pain, arthritis, headaches. Again, there's a litany of pain complaints here put forth by Rodney, mostly centralized around the low back. He had a history of alcohol use, we don't have defined exactly how much alcohol he used. He denied any illegal drug history. He did have a history of depression and anxiety, which, again, has to be taken seriously on any of our patients who were considering opioid treatment.

From a physical co-morbidity standpoint, as far as we can tell, as far as the documentation provided to us, there were -- there were no significant co-morbid illnesses beyond a complaint that he had fibromyalgia or diffuse muscle pain.

Q. Was Rodney related to another patient?

A. Yes, Rodney was related to Amy.

Q. Okay.

A. Amy and --

Q. How so?

A. Husband and wife.

Q. Can you give us an overview of the Controlled Substance and opioids that Rodney was prescribed by Dr. Bauer for the management of pain during his care with Dr. Bauer?

A. Over the course of the six years of treatment with Dr. Bauer, Rodney received initially Oxycontin and Oxycodone, the combination of both of them. The Oxycodone and Oxycontin was continued as various combinations of doses over time.

Opana, and morphine -- controlled release morphine, MS Contin, was also trialed at one point along the care and treatment of the patient. Ultimately after a trial -- unsuccessful trial of Opana and MS Contin, the care was again returned with treatment of Oxycodone, Oxycontin, of various form, utilizations.

In the end, prior to Rodney's death, he was being prescribed a combination of Oxycodone 10-milligrams two a day, Oxycodone 30 milligrams five a day, and Oxycontin, controlled release Oxycodone, 60 milligrams three times a day.

Over the course of his treatment of about six years, he had been escalated from a dose of 22 morphine equivalents, which is what he was at initially when he presented to Dr. Bauer's practice. He was escalated fairly quickly actually over the course of time to the 200s, to the 300s, to the 400s. And during the latter part of his care, Dr. Bauer was prescribing those Oxycodone combinations to a total morphine equivalency of 525 morphine equivalents.

Q. And do you find that number significant?
A. I find that highly significant. Over the course of that time, his VAS scores did not change except perhaps to slightly worsen. His VAS scores when he initially presented to Dr. Bauer's practice was five to six out of ten. Over time it went up to eight out of ten, nine out of ten, ten out of ten, and there were multiple -- pardon me, and there were multiple visits towards the end of his care prior to his death where his VAS scores were ten out of ten. His last documented VAS score was eight out of ten. So we have a rapid and significant escalation of morphine equivalencies with no improvement in the VAS score and no indication that function improved either.
Q. Let's just bring up Exhibit 945. And to the row attributed to Rodney, is that a chart of your standard of care with respect to Rodney?
A. It is. Yes.
Q. And let's talk -- first, based on your review of Rodney's chart, did Dr. Bauer adequately diagnosis Rodney's medical issues?
A. No. There was no objective diagnosis that was established for Rodney's pain syndrome.
Q. We just lost -- sorry. I'll let you keep going while they get that back up for us.
There was no objective diagnosis?

A. Correct.
Q. And was a targeted exam conducted?
A. A physical exam was done, but there was no indication of any focal, motor or neurological deficits that would help establish a foundational and objective diagnosis.
Q. Was -- did Dr. Bauer perform a clinical workup of Rodney.?
A. There was no indication here that a MRI was done or that Electromyography was performed, EMGs to support the diagnosis of radiculopathy or sciatica.
Q. Now, can you -- can you just refer to your forensic summary of Rodney since we don't have the -- right now. We're just going to leave this up right now, we'll leave the standard of care up. If you can yourself refer to your forensic summary -- in fact, and look at clinical workup column.
A. The clinical workup I gave him the -- a green checkmark on that. There was, and I need to pull up one more document here if you'll bear with me for a moment. I'm going to correct what I said initially before we had the power flickering failure there.
He did have EMGs performed, MRIs were performed, and he had had -- that is to say Rodney had had a referral to previous surgeons and orthopaedic physicians so the

appropriate clinical workup was performed and to give credit to Dr. Bauer that standard of care was addressed properly.

Q. Thank you. All right. And next looking at, did -- looking at Rodney's chart, did Dr. Bauer adequately assess the risks of prescribing Controlled Substances to Rodney?

A. I'm going back to my other document, so bear with me for just a moment.

Q. Yeah, we'll let you bring them out while they work out the technical glitches here.

A. I'm sorry, would you repeat the question?

Q. We don't need that. I asked you if Dr. -- based on your review of Rodney's chart if Dr. Bauer performed an adequate risk assessment of Rodney?

A. No, I don't believe an adequate risk assessment was done, and I will explain why if you'd like.

Q. Yes, please.

A. There was significant mental health co-morbidities, as I mentioned, with regard to depression and anxiety. They were not developed, they were not followed up on. Rodney had -- had been complaining of longstanding back pain for a long time. Admittedly, he had had two previous surgeries, but his pain had increased over time, and he had failed multiple opioid trials with pain

medication and had even gotten to the point, as I mentioned, where he had had a spinal cord stimulator implanted. Nothing worked for him from an interventional or pain pharmacology standpoint. So he was not a candidate for additional narcotics because his prior trials had not worked, and so there's no need to repeat them.

Q. He was not a good candidate for long-term opioid treatment?

A. He was not a candidate for -- well, for the continuation or the initiation of the doses, and he was definitely not a candidate for continuation of high dose opioid therapy because of the failed previous trials.

Q. And did Dr. Bauer establish a defined treatment plan for Rodney based on your review of the chart?

A. The treatment was not individualized, and it was -- and it was not multi modal, so a -- a standard of care treatment plan was not defined. It was the same sort of thing we've seen repetitively where it was injections and opioids, and there was not a multi-disciplinary, again, or individualized treatment plan formulated.

Q. Did you, based on the chart, identify concerns with the types or combinations of drugs that Dr. Bauer prescribed to Rodney?

A. I did. I had several concerns.

Q. What are they?

A. The concern mainly was around the fact that Oxycontin in every -- excuse me, Oxycodone and Oxycontin in ever-increasing doses were prescribed years went on despite no improvement in pain or function. Why is that a concern? Because Oxycodone has a particular street popularity and street value. So the combination of 10-milligram Oxycodones, 30-milligram Oxycodones, and 60 milligrams Oxycontins are very street popular. And in addition to being very popular from an abuse standpoint, they also, associated amongst all the opioids that we might consider, they are also greatly associated with addiction and overuse, respiratory depression and death. The particular use of Oxycodone has to be done with care and foresight. The administration of multiple formulations of Oxycodone and Oxycontin have great risk associated with them of death, addiction and diversion. That's where my concerns lie with that particular poly pharmacy combination, aside from the fact that the MEQs were well above 500, which is well into the region of extreme concern where we expect all the side effects that we talked about, including opioid-induced Hyperalgesia, which is to say worsening pain.

Q. With regard to function, did Rodney have any meaningful improvement in pain or function as a result of the medications?

A. He did not.
Q. And why was he continued on opioid therapy for years if his quality of life wasn't improving?
A. He should not have been maintained. The opioids should not have been considered on the initial visit to Dr. Bauer because of a history of failed previous treatment, and he certainly should not have been maintained going forward. A prudent physician would not have continued the opioids and would not have escalated them to the doses that we see or use the combination of Oxycodones and Oxycontins that we've described.
Q. Did you put together a list of red flags or risks that you saw evident based on your review of the Rodney chart?
A. I did, yes.
Q. Okay. So let's go to plan B if we can use the projector. Can we use that?
A. Go for it.
Q. Okay. Let's try.
THE COURT: Let's take a standing break for a couple minutes.
(A brief recess was taken.)
BY MS. DUSTIN:
Q. Dr. King, did you prepare a chart, summary chart, describing the red flags you saw evident in Rodney's chart

between October of 2010 and August of 2013?
A. I did, and that's what's represented here, a timeline, a red flagged timeline.
Q. Can you just summarize and give us a summary of what type of red flags you saw based on your review?
A. There were multiple times -- well, initially here it shows that the meds were not helping, which is consistent with what I indicated earlier. He had been through previous opioid trials with no improvement, and the meds prescribed by Dr. Bauer were not helping, he wanted to, and he made the specific recommendation or notation that neither the Oxycontin or MS Contin, which have the continuous release or extended release formulations of those two medications were helpful. As a result, he started requesting increases of Roxicodone, which is a brand name for Oxycodone, and was a no show at several appointments, no show for a pill count, indicated that an additional medication, Lyrica, was not working, and there's a host of calls there where he indicates that he's out of his medications early, makes early refill requests, and continues to be noncompliant with regard to keeping his appointments. And then the last two there, although it's not specifically defined as such, those are urine drug screens that were inconsistent for various medications. Cyclobenzaprine, which is Flexeril and Tramadol, which is

Ultram.

Q. Why are they in red?

A. They were in red just because they were not prescribed --

Q. They would --

A. -- or at least not noted in the chart as being prescribed.

Q. And did you also determine whether or not there were any urine drug screens, and if we can go back to Exhibit 45 and the row attributed to Rodney.

A. Yes, if you'd like me to comment on the urine drug screen row before we lose our image here. I gave Dr. Bauer the benefit of the doubt and gave him a green checkmark on that particular point of urine drug screen for two reasons. One is neither -- well, Cyclobenzaprine is not a Controlled Substances, so it doesn't show up on the others, and I wasn't, based on the documentation that we have in the chart, I wasn't sure if the Cyclobenzaprine was prescribed by another provider. I did not see it on the list under medications prescribed by Dr. Bauer. In any event, Cyclobenzaprine was not a controlled -- is not a Controlled Substance, and because of the uncertainty about who prescribed it, I -- I didn't count it against Dr. Bauer.

Q. So you indicated he met the standard of care for

that category?
A. Correct. The two year drug series that we do have showed the presence of the prescribed medications, which were the critical aspects, so, again, I gave credit to Dr. Bauer for having fulfilled that standard of care.
Q. And in terms of how often you would expect a doctor to actually perform urine drug screens in the long-term management of an opioid patient, how often would you -- would you like -- would you expect to see that type of urine drug screen performed?
A. Urine drug screen frequency is based on risk. Rodney has significant risk because of -- because of certain behaviors, and because of the morphine equivalencies he was on. He was on an extremely high morphine equivalency. That, by definition, puts him into a high risk category. So the general recommendation for high risk urine drug screening is up to four times a year, perhaps more if the patient shows up intoxicated or has other issues, abhorrent activities, but on the order of about four per year.
Q. And you also indicated that Dr. Bauer met the standard of care under the PDMP column. Can you tell us, based -- why you based your conclusions as -- as having met the standard of care?
A. There were no indications of -- of -- well,

the -- let me pull up my other document that explains that so bear with me a moment.

Q. While Dr. King is doing that, can you bring back up 917?

A. The PDMP for Rodney was consistent in the sense that it did not show any other doctor shopping. I would hasten to point out, however, that there was a history of pharmacy shopping, but because Dr. -- because Rodney had visited, based on the PDMP, five different pharmacies, but at least there was no indication of doctor shopping, and because of that I gave a green checkmark in favor of Dr. Bauer.

Q. And let's look at the next pages of Exhibit 917 since we lost it earlier.

And what does this portion of 915, this graph, represent?

A. The jury will recognize this as a timeline indicating abhorrent events on the upper part demonstrated by red flags, and then blue pennants on the bottom indicating specific injections. And then at the bottom, what we've talked about in terms of a progressive and very high dose morphine equivalency over the course of time.

Q. We haven't talked specifically about injections that Rodney received from Dr. Bauer. Let's look at Exhibit 590.

And do you recognize 590?

A. This is a -- an office note for Rodney. And it is dated 10-22-14, wherein Rodney complains of neck and back pain.

Q. And does Rodney receive an injection on that date?

A. Yes, he -- he receives trigger point -- a trigger point injection on that date.

Q. And --

A. May I point out something on that note for a moment? I just want to reinforce to the jury that part of my comments earlier was for a trigger point to fulfill medical necessity and to be accepted as a legitimate diagnosis for which a trigger point injection is an appropriate part of the description has to be the definition of where that trigger point is. And if it reproduces the pain, if it radiates into the usual location of the patient's complaint, and a description of which muscle is injected, in this particular dictation here, and this is fairly representative of other dictations for trigger point injections by Dr. Bauer, it indicates that the trigger point was, quote, in the upper quarters, and in the infrascapular region, which does not address the medical necessity for saying what muscle was it in and where was the trigger point, and did it reproduce the

patient's pain. I thought this was an example that was worth pointing that out.

Q. Well, based on that, and your review of the patient chart for Rodney, was the trigger point injection that Dr. Bauer gave to Rodney on October 22nd, 2014 administered with legitimate medical purpose?

A. For the reasons I just described, no, it was not.

Q. Now, let's look at the last column, we don't have to put it up for now, of your standard of care summary. It talks about death or discharge. How did Rodney's treatment with Dr. Bauer end?

A. Rodney died.

Q. And do you know the cause of death?

A. He -- based on a note in his wife's chart, Amy, Rodney committed suicide. I don't have any details as how that suicide was committed except the fact was that he did commit suicide.

Q. And was there any notation of -- of that in Rodney's chart, what you could see?

A. Let me double check my notes on that, if I may. I don't have any notes as part of the medical chart that indicates anything further. Again, the notes I have were represented in Amy's chart.

Q. And in the course of treating a patient for the long-term management of pain with opioids, if that

patient's death ends by suicide, would you consider that significant in -- in that treatment -- that patient's treatment?

A. Absolutely, yes. This is an individual who's failed opioid treatment prior to coming to Dr. Bauer, and for six years of care under Dr. Bauer was escalating doses of Oxycodone, and I think this serves as a reminder to all of us as providers that when someone -- when a patient complains of depression and anxiety, we can't simply say, oh, that's just because they've got chronic pain. No, there is an incident, a significant incidence, I don't know if I can provide the percent, but there's a significant incidence of suicide associated with mental illness, and particularly with respect to depression and anxiety.

MR. GIBBONS: Objection.

THE COURT: Grounds?

MR. GIBBONS: Not responsive to the question that was asked.

THE COURT: Overruled. You may cross examine when your turn comes.

A. Given the fact that the mental health co-morbidities were identified by Dr. Bauer, suicide should have been considered as a potential adverse effect, if you will, and the opioids should have been considered and formed with that concern. The opioids should not have

been -- well, the opioids -- there was no indication to begin opioid therapy to begin with, or to maintain it or to escalate it to the levels that suicide should have been a concern for Rodney from the beginning.

Q. In terms of a -- the physician's management of other patients for -- with long-term opioids for the management of pain, would that type of event with another patient affect a physician's treatment going forward with other patients?

A. It should have. And again, this goes back to what we discussed as an audit. This is a sentinel event. A patient has died, a patient has died, in this case by his own hand, by suicide, of the care that was provided. The reasons for providing the patient with the care he had should have been reviewed. The diagnosis, such as they were, should have been reviewed. An audit of the chart should have been looked at to prevent this from happening, to the extent we can, another time.

Q. Let's now look at Exhibit 536.

And describe, what is this?

A. This is a prescription issued to Rodney by Dr. Bauer on April 27, 2016. The medication is Roxicodone which is Oxycodone, 30-milligram tablets, five of them per day.

Q. And you said April 27th, 2016?

A. Correct, yes.
Q. And let's look at Exhibit 537.
A. This is a prescription issued to Rodney by Dr. Bauer on April 27th, 2016 for Oxycontin 10-milligrams, two of them a day.
Q. And Exhibit 538?
A. This is a prescription issued by Rodney -- or to Rodney by Dr. Bauer on April 27th, 2016 for Oxycodone 60 -- excuse me, Oxycontin 60-milligrams, three times a day.
Q. And Exhibit 539?
A. This is a prescription issued to Rodney from Dr. Bauer on April 29th, 2016 for Roxicodone, which is Oxycodone, 30-milligrams, five per day.
Q. 540?
A. This is a prescription issued to Rodney by Dr. Bauer on April 29th, 2016 for Oxycontin, 10-milligrams, two times a day.
Q. And 541?
A. This is a prescription issued to Rodney by Dr. Bauer on April 29, 2016 for Oxycontin, 60 milligrams three times a day.
Q. Dr. King, were the opioid prescriptions Dr. Bauer wrote for Rodney on April 27th and April 29th of 2016 dispensed with a legitimate medical purpose and within the course of professional medical practice?

A. They were not.
Q. Why not?
A. They were prescribed after a history of failed opioid treatment previously. They never should have been eradicated to begin with, and certainly should not have been maintained. What we referred to as an opioid exit strategy should have been exercised. They should have been stopped.

Secondly, there was no indication, either previously or going forward, that there was any indication of improvement in VAS pain scores or in function, which means that there was no medical foundation for the use of ongoing opioids. They were used without a legitimate medical purpose.

And then, additionally, as I indicated, there was a significant risk associated with the mental health co-morbidities of the patient combined with the exceptionally high morphine equivalence, and the very dangerous and addictive combination of Oxycodone and Oxycontin products that would not have been prescribed by a prudent physician; thereby making the prescribing of ongoing opioids outside the usual course of medical practice.

Q. Let's move on to patient Brandon.

Did you review Dr. Bauer's patient chart for a

patient by the name of Brandon?
A. I did, yes.
Q. And based on your review of the Brandon chart, did Dr. Bauer follow the standard of care for prescribing Controlled Substances?
A. No.
Q. Based on your review of the Brandon 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 written for a legitimate medical purpose or in the usual course of medical practice.
Q. And again, did you prepare a forensic timeline to summarize Brandon's chart?
A. I did.
Q. And let's look at Exhibit 937.
And is this your forensic timeline --
A. Yes, it is.
Q. -- pertaining to Brandon? And describe for us Brandon.
A. Brandon was a young man. He was 33 years old at time of his last visit. He was under care with Dr. Bauer for nine-and-a-half years, which essentially meant he was about 22 years old, 21, 22 when he first began care with Dr. Bauer. He was unemployed. He complained of low back

pain, and over the course of time while he was under care with Dr. Bauer, he additionally complained of neuropathy, which is typically thought of as nerve pain, let's say in the feet. That would be the most common location. He complained of cervical pain and nerve pain radiating down his arms. He complained of thoracic spine pain, knee pain, groin pain, again, a host of complaints here, none of which rise to the level of being qualified for the use of chronic opioid therapy. He was a heavy smoker, he smoked about one pack per day.

Of concern from a mental health standpoint, he had depression and anxiety. Again, he's a young man so he's got depression, two significant mental health co-morbidities, depression and anxiety. He's also got a history of alcohol abuse, and at one point had documentation of a DUI.

From a physical and co-morbidity standpoint, he had aortic valve stenosis. Now, that may not mean a lot to the jury, but that's a -- that's the critical valve in the heart, and it's often associated with sudden death. So this is one instance where, as I indicated to you, we have to worry about heart problems with the patient prior to committing to a high dose Controlled Substance or any Controlled Substances. This would be one of those red flags that would say there's potential heart problems, and

we need to keep that in mind as we prescribe a treatment plan. And there we have Brandon.

Q. Did you prepare a forensic timeline to summarize Brandon's chart? I'm sorry, did you prepare a summary of care chart for Brandon?

A. I did, yes.

Q. And let's look at Exhibit 945. And the row associated with Brandon, is that your standard of care summary?

A. Yes, it is.

Q. Based on your review of Brandon's chart, did Dr. Bauer adequately diagnosis Brandon's medical issues?

A. He did not. And an objective and legitimate diagnosis supporting the use of opioids was never established.

Q. Based on your review of the chart, did Dr. Bauer conduct a targeted physical exam?

A. A physical exam was done, but there was no indication that there were any focal neurologic deficits that would support the diagnosis to -- for which opioids should be used.

Q. Did Dr. Bauer perform a clinical workup of Brandon?

A. EMGs were performed, MRIs were performed -- excuse me, I'm looking at the wrong one. Let me back up

here for a moment. I'm scanning through. Here we go.

With regard to clinical workup, there was a normal MRI and a normal EMG, which, again, did not support a clinical diagnosis that would suggest nerve damage, back damage, or support the use of long-term opioids, so the answer is no.

Q. Well, based on your review of Brandon's chart, can you just give us an overview of the opioids and Controlled Substances that Dr. Bauer prescribed to Brandon for the management of pain?

A. The first documentation with Dr. Bauer in 2009 indicated that the medications of Percocet and Lyrica were prescribed. The morphine equivalency was relatively low, 22 morphine equivalents for the 5 milligram Percocets that were prescribed.

Over time there were quite a host of injections that went on. The Percocet dose was elevated over time, escalated over time to more frequent use and then to a higher dosage. Over time the Percocet was eventually prescribed at 10-milligrams, six times a day, which would be a morphine equivalency of 90.

And then as time continued to go on, there was a significant escalation of Brandon's medications to include Methadone and Ultram and Flexeril. Methadone and Ultram being the two analgesic medications, the opioids. The

morphine equivalency at that point was as high as 340 morphine equivalents. The medication was continued over time, and the morphine equivalency reached a high of 520 morphine equivalents.

Q. Did you find that morphine equivalent number significant?

A. That's very significant. And, again, this is very similar to one of the other patients we recently looked at. 500 plus morphine equivalents is extraordinarily high and certainly well above The State of Ohio's 80-milligram trigger point, and well above the 90 morphine equivalents of the CDC, and what I describe as a zone of extreme concern. So yes, this is a young man, and, yes, he may have had a back operation for a diskectomy, but to have this type of pain and to be put on these medication combinations at this dose were of significant concern.

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

A. He did not.

Q. Did Brandon have a history of mental illness?

A. Yes, he had -- as indicated, he had a history of depression and anxiety.

Q. And did he have medical co-morbidities?

A. He had the aortic valve stenosis of concern.

Q. Was Brandon a good candidate for long-term opioid management?

A. He was not. He had been through many, many years of opioids, and, as such, had failed what I referred to as an opioid trial, so he was not a candidate for ongoing opioids.

Q. Did Dr. Bauer define a treatment plan for Brandon?

A. An individualized and multi-modal treatment plan was not defined by Dr. Bauer. It was the default entry into long-term opioids and steroids and injections that was offered to Brandon over time.

Q. Based on your review of Brandon's chart, did you identify any concerns with the types or combinations of drugs prescribed to Brandon?

A. I have great concerns any time Methadone is used. Methadone, in this case, ultimately, as we reach the latter parts of Brandon's care, is prescribed in combination of Flexeril and Ultram. Ultram is opioid anesthetic -- excuse me, opioid analgesic. There is some concern about the combination of Methadone and Ultram, but Methadone is my primary concern here. He was prescribed 50 -- 50 milligrams of Methadone a day. I have concern about the Methadone, especially in a young man like this because Methadone is unpredictable, and is -- and is frequently

associated with overdose death secondarily to respiratory depression. So I had concern with not so much the poly pharmacy as I did the use of high dose Methadone by itself.

Q. And did Dr. Bauer minister any procedures to Brandon?

A. Yes, there were multiple procedures administered over time.

Q. Let's look at Exhibit 939. And is this a summary of the injections administered to Brandon between January of 2009 -- and is there a second page, and can we move up a little bit more -- and March of 2011?

A. Yes. This is -- this is my injection and steroid timeline for Brandon.

Q. And what types of injections did Dr. Bauer administer to Brandon?

A. We see a combination of oral steroids, as well as epidural injections, sacroiliac joint injections, trigger point injections, and one we haven't talked about so far, lumbar facet injections. And trigger point injections, I think I mentioned that already.

Q. What's a lumbar facet injection?

A. Facet -- facets are fancy name anatomically for the small joints in the back. I describe it to patients as the hinges in our back that allow us to bend forward and sideways and so on. But there's a -- there's a joint on

the left and a joint on the right, and they're only about as big as your thumb. They're fairly small, but they're what keep our back in alignment when we bend over so we don't sort of topple like a stack of blocks. But they're the hinges that allow us to move around and maintain what we call range of motion.

Q. And did you track the cumulative Medrol doses administered to Brandon during his treatment with Dr. Bauer?

A. Yes. He had, by this calculation, 955 steroid equivalents over the course of treatment timeframe.

Q. And just, if you would, move down and summarize how many injections he received?

A. He received a total of four epidural injections, four trigger point injections, 11 facet injections, three courses of oral steroid and one sacroiliac joint injection.

Q. Based on your review of the Brandon chart, did the injections result in any improvement in function or pain?

A. No. His VAS scores, which based on initial documentation, were nine out of ten, were still nine out of ten at the end of his treatment timeframe. So there was no significant change and certainly no improvement.

With regard to function, Brandon was unemployed throughout. There were no indications that his improvement

or return to employment was a result of the escalating opioid use.

Q. Were the injections administered to Brandon over the course of his treatment with Dr. Bauer medically necessary?

A. They were not medically necessary.

Q. All right. Let's go back to medications and prescriptions.

Did you track whether or not urine drug screens were conducted with respect to patient Brandon?

A. Review of the chart indicated no documents, no documentation demonstrating urine drug screen.

Q. Did you see any evidence of clinical improvement from the prescription of -- prescription of opioids and Controlled Substances for the management of long-term pain?

A. I saw no improvement.

Q. Did you track any improvement in function by Brandon with respect to the treatment -- the prescriptions of opioids or Controlled Substances?

A. There was no improvement in function documented.

Q. Why was Brandon continued on opioid therapy if his quality of life was not improving?

A. He should not have been maintained on opioids. He came in and began treatment under Dr. Bauer at a very low dose of Percocet. Again, he had failed previous

treatment. He should have -- Dr. Bauer should have exercised an opioid exit strategy at that point and stopped opioids all together. There's no rationale for having them continued over time, and certainly no rationale for escalating them to the high doses that we've discussed.

Q. Let's look at Exhibit 938.

And did you summarize the red flags that you saw from reviewing the Brandon chart?

A. I did, and this is -- and this is my time -- red flag timeline.

Q. And could you please highlight a few of the red flags you noted?

A. He was, not surprisingly requesting, from time to time, increase in his medication, which is reflected here as Percocet. There is a point in 2012 where a, quote, addictive personality is noted by Dr. Bauer, and an indication that the patient is -- is going to rehab, meaning drug rehab I assume. I'm not sure, have to go back and look at my notes to see what that references, but following that there's continued requests for medication, and in this case Methadone. There's -- I need to check one thing here. He undergoes an evaluation in 2012, a -- a -- I'm sorry, I was comparing the two lists there so I'll stay with this list.

In any event, it goes on to increase -- to

indicate the medication is not helping, and he continues to request increase in his pain medication.

Q. Let's specifically talk about a chart page. Looking at Exhibit 413, Page 214. And is this a page from the Brandon chart?

A. It is. This is Brandon's chart dated 10-11-12.

Q. And does it indicate whether or not there was discussion with Brandon regarding his use of narcotics?

A. Yes.

Q. And his pain?

A. Yes. The patient was seen, and a lengthy discussion of his narcotics and pain in his low back condition. I recommended that he is supposed with psychological counseling. I'm not sure exactly what that means except the psychological counseling was obviously brought up in the discussion to avoid narcotics, and if he cannot do so, then he is to look into a Suboxone program. This was reviewed in great detail with the patient and his mother.

Q. And that was a discussion between Brandon and Dr. Bauer?

A. Correct, and Brandon's mother.

Q. And why do you find that significant in his course of his treatment and management of pain?

A. This is a recognition that as early as October of

2012, that the patient has got an addiction problem. And as a reference to that psychological counseling and possible Suboxone treatment was brought up by Dr. Bauer, and again, again, quote, reviewed in great detail. So it's recognition that Dr. Bauer understands that Brandon is -- is dealing with an addiction problem at this point. And again, that's what I referred to as a -- sort of a let's stop and reevaluate the ongoing use of opioids as a result of that recognition.

Q. But were opioids continued?

A. They were. They were prescribed, yes.

Q. Let's look at Exhibit 573.

What is that?

A. That is a prescription issued to Brandon by Dr. Bauer on 7-2-18 for Methadone 10 milligrams five times a day.

Q. And let's look at 537. What is that? I'm sorry, 574. Yes, thank you.

A. This is a prescription issued to Brandon by Dr. Bauer on 7-2-18 for Ultram 50-milligrams approximately four per day.

Q. Dr. King, were the Methadone and Ultram prescriptions that Dr. Bauer wrote for Brandon on July 2nd, 2018 dispensed with a legitimate medical purpose and within the course of professional medical practice?

A. They were not.
Q. Why not?
A. Brandon was an addict. He was a self-admitted addict. Dr. Bauer knew that. His family had been consulted. It -- it -- if we have a situation like that, we, as providers, do not want to continue providing opioids to a known addict, it just makes no sense at all. It's outside the usual course of medical practice. A prudent practitioner would not do that. So opioids were provided for treatment of addiction, not for treatment of pain, and therefore without a legitimate medical purpose.

We've had a history -- Brandon had a history of nine years, nine-and-a-half years of treatment with no improvement as a result of opioids and injections. There was no medical foundation for opioids or for injections.

Q. Thank you.

MS. DUSTIN: Judge, this is a good breaking point if you want to take a break, or you want to keep going?

THE COURT: I was going to go a little longer. How many more do you have?

MS. DUSTIN: We have three patients.

THE COURT: Three pages? Doesn't really tell me about --

MS. DUSTIN: Three patients.

(A brief discussion was had off the record.)

THE COURT: Let's take a break. We're going to take our afternoon recess. We'll resume at 3:15. Please remember all the rules.

(A brief recess was taken.)

THE COURT: Welcome back. You may be seated.

You may continue.

BY MS. DUSTIN:

Q. I just want to ask you a question about a billing code. Let me bring up Exhibit 590, Page 6.

And do you recognize this as a billing -- a bill that would be generated as a result of procedures and office procedures and office visits?

A. It appears to be that, yes. I haven't reviewed this before but, yes, that's what it appears to be.

Q. And I specifically wanted to point you to a billing code 99212. Are you familiar with billing codes in general?

A. In general I am, but I am certainly not an expert on them, and there are only a few that I really understand.

Q. Okay. And are you familiar with that particular billing code 99212?

A. No.

Q. Okay. You don't know what that -- what that bill --

A. I would -- I would offer an educated guess, but I

don't want to guess, so I'm going to say no.
Q. Okay. All right. And then I wanted to ask you about Exhibit 402. This is Connie Lewis' chart at Pages 1305 to 1307. Patient Connie. And from a review of Pages 1305 to 1307, does it indicate whether or not an injection was administered on 10-24-of 17? I'm sorry, was administered on 1-25 of 18?
A. I'm looking for a date that accompanies that explanation.
Q. Okay. If you could take -- yep, right there if you can stop.
THE COURT: It's right below.
A. 1-25-18, yes, trigger point injection and the procedure note that you had just demonstrated, yes.
Q. Okay. And what type of injections was administered to Connie on 1-25 of '18?
A. A trigger point injection.
Q. And then next going to Pages 1302 to 1303, can you look at those pages and tell us if there was an injection administered on December 20th of 2017?
A. Yes, I see the date of an injection on 12-20-17. It's a trigger point injection.
Q. Thank you. All right. Now let's talk about another patient, patient Dale.
Did you review Dr. Bauer's patient chart for

patient Dale?
A. I did, yes.
Q. And based on your review of the Dale chart, did Dr. Bauer follow the standard of care for prescribing Controlled Substances?
A. He did not.
Q. Based on your review of the Dale chart, did Dr. Bauer write prescriptions for Controlled Substances with a legitimate medical purpose and within course of professional medical practice?
A. He did not.
Q. And tell us from your review of Dale and the other patient charts, was Dale related to any other patient?
A. Yes. Dale was the father -- excuse me, let me get all my things in order here. Dale was the father of Nathan, who is the wife of Bethanee, if I have that correct.
Q. Okay. Who was -- Nathan was the what?
A. Nathan was the son of --
Q. Let's back up.
A. Okay.
Q. We're going to talk about three patients now. Dale, Nathan and Bethanee.
A. Yes.

Q. Are Dale, Nathan and Bethanee related?
A. Yes, Nathan is the grandson of Dale, and Bethanee is the wife of Nathan.
Q. Okay, got it.
All right. So Dale is the grandson of Nathan?
A. That's correct.
Q. All right. Got it.
A. No, Nathan is the grandson of Dale.
Q. I transposed, I'm sorry, got it straight?
A. Yes.
Q. Nathan will be coming up in a minute here. So let's look at Dale's chart. Did you prepare a forensic timeline to summarize Dale's chart?
A. I did.
Q. Let's look at Exhibit 907. Tell us about patient Dale.
A. Dale, at the time of last visit with Dr. Bauer, was 86 years old. He was disabled, had been off work since age 55, long-term disability. He was under care with Dr. Bauer for about six-and-a-half years, which would put him at an age of about 79 when he initially came under care with Dr. Bauer.
Dale's primary problems in terms of the initial chief complaints identified for the first visit include spinal stenosis, chronic low back pain with sciatica or

radiculopathy, diabetes and neuropathy. Over the course of the treatment timeframe, six-and-a-half years, he also complained of additional problems, including Myofascial or muscle pain, bursitis, shoulder pain, sacroiliac joint pain, hip pain, carpal tunnel pain, diabetic neuropathy and osteoarthritis. Dale had some significant issues with regard to mental health. Dale suffered from depression, anxiety, insomnia. He had significant physical co-morbidities, including diabetes, hypertension or elevated blood pressure, osteoporosis, dementia. He had various heart problems, including mitral valve insufficiency, severe aortic stenosis, which mentioned that in terms of what that problem was a little bit earlier.

Dale also had issues with regard to chronic obstructive lung disease, and issues with regard to history of previous heart attack or myocardial infarction. So he had significant physical co-morbidities.

Q. Based on the mental health and physical co-morbidities that you just described, did that put Dale at risk for opioid therapy for the treatment -- or for the management of pain?

A. Well, that, plus the fact that he's what we would call extreme age. I hate that term because -- because I'm in the extreme age end of things too by definition, but at least in the case of Dale, he was in his 80s, and there are

significant concerns with regard to Controlled Substance medications administered to individuals in that age group.

Q. Just give us an overview, based on your review of Dale's chart, of Dale as a patient being treated with opioids and Controlled Substances for the management of pain.

A. Dale had a history of previous back operation, laminectomy, back in 2007. Over the course of time, he began care under Dr. Bauer in 2012. At that time, Dr. Bauer began treatment with about 34 morphine equivalents, which was -- which counts for three Percocets per day. As time went on, that dose was escalated to include initially an escalation to 120 morphine equivalents, which was composed of a combination of Percocet 10-milligram pills plus Oxycontin, 20-milligrams, two a day. Later that was changed to include Duragesic, which we know is Fentanyl, as a 25 microgram patch in addition to the Percocets. That was maintained, that combination was maintained for awhile. Additional Duragesic patch 12 microgram patch added to the 25-microgram patch that was prescribed.

Morphine equivalents escalated over time with those Percocet and Duragesic patches to a maximum of about 210 morphine equivalents. No, it's not true it went up from there. The Duragesic was increased over time. It appears that the highest morphine equivalency got up to

345. And after that, the medications were lowered beginning in 2018 down to a level of somewhere between 30 and 100. That was a timeframe when Dale was admitted to Hospice because of end stage aortic stenosis or heart disease and Congestive heart failure.

Q. And based on your review, did you identify concerns with the types, amounts or combinations of the drugs you just described?

A. I -- I have concern with the combination of multiple formulations of Percocet and Oxycontin or Oxycodone with Duragesic. This was a -- a non-standard combination medication, as we talked about before. We've got multiple medications here that are not only street popular, but highly addictive. I have a particular concern about the use of these medications in an elderly man like Dale. And I don't know if now is the time you want me to talk about that or not?

Q. What concerns did you have?

A. I'm going to make the jury aware of a concept called the BEERS schedule, B-E-E-R-S, BEERS schedule. I assume there's a Dr. Beers somewhere, but the BEERS list, as it were, is a list of medications that have been put forth by the American Geriatric Association. These are medications that are high-risk medications for geriatric patients, and have been recommended not to be prescribed.

Common sense prevails in this. You can predict a lot of what -- what the BEERS list of medications would include. But the BEERS list does not recommend the use of high dose, or certainly high-potency narcotics or sedatives or -- or sleep agents to individuals who are up in that age group. And the problem is not just because we're older, but it's because our kidneys don't work as well, or liver can't work as well and we can't -- in the upper age group we can't clear the medications, and we have a higher susceptibility. I guess I have to keep myself in this age group too, higher susceptibility to cognitive problems as a result of taking certain drugs. In other words, older people are understandably more susceptible to problems related to drugs.

So the BEERS schedule of drugs suggests that individuals, and I've forgotten what their cut-off age is where they call, you know, extreme age, but it's somewhere relatively low, like 60 or 65 years of age. And anybody above that, if a provider is going to be using these substances, namely in the case here Controlled Substances, they have to be used with extreme caution. So that's the BEERS list of medications.

Again, Dale is not only in that elder age group in his 80s, but he also has significant problems with regard to heart disease, previous heart attack, critical

valve problems in his heart with his mitral valve and aortic valve which makes him susceptible for sudden death, also congestive heart failure, which is a heart condition for which chronic opioids are contraindicated. These are fragile individuals. That's where I have a concern, not only with the amount of medication, the type of the Oxycodone type medications and the age that Dale is during which time he receives these.

Q. Was Dale a good candidate for long-term opioid management of pain?

A. No, he was not a good candidate initially, and he was not a good candidate long-term.

Q. All right. And speaking of the standard of care, and we won't bring up the chart right now, but did Dr. Bauer, based on your review of Dale's chart, adequately diagnose Dale's medical issues?

A. I'm going to look at one other item here, if you'd bear with me here for just a moment.

No, he did not. Dr. Bauer did not establish an objective diagnosis for the use of long-term opioids.

Q. Did he conduct a targeted physical exam?

A. A physical examination was done, but there were no indications that any physical findings were supportive of a problem that would merit the use of long-term opioids.

Q. And did Dr. Bauer perform a clinical workup of

Dale?

A. An EMG was performed, but it did not support the radiculopathy or sciatica that Dr. Bauer said existed. The lumbar MRI which was performed showed diffuse degenerative changes which we would expect in an individual of 80 some years of age. But there was no indication of spinal instability, herniated disc or nerve root impingement; therefore, the proper tests were done, but they did not support a diagnosis that was -- that would support the use of long-term opioids. So the answer is Dr. Bauer did not do an appropriate or adequate evaluation.

Q. Did Dr. Bauer administer any procedures to Dale?

A. Yes. There were multiple procedures done over time.

Q. And let me show you what's been -- let's bring up Exhibit 588. And as -- as we're doing that, let's -- let's instead bring up Exhibit 5 -- 909.

Okay. And is this a summary of the injections administered or the procedures administered to Dale?

A. It is, yes.

Q. And how many injections were administered?

A. I -- I don't have a total, but I can tell you how they break down.

Q. Yes.

A. Dale received 17 epidural injections in the

lumbar spine. He received 12 trigger point injections, one brachial plexus injection, eight trochanteric bursa injections, one sacroiliac joint injection and two shoulder injections. Actually I do have a total. Dale received 41 injections from Dr. Bauer.

Q. And that was between May 23rd of -- I'm sorry, January 10th of 2012 to January 5th of 2017?

A. That's correct.

Q. And what was his cumulative Medrol dose?

A. His cumulative Medrol dose was -- if we can scroll to the next page there, was 2,320-milligrams approximately over the course of -- of time that he was under care, which was, just to reaffirm, that six-and-a-half years.

Q. And to correct my prior range of time, they went until June of 2018. Do you find that total to be significant?

A. I find that to be a very high level, particularly for an individual of elderly age with the co-morbidities he had, heart disease, I find that to be very disturbing and of concern.

Q. And let's go back and try to look at Exhibit 588. We'll come back to that.

Let me ask you, based on your review of the Dale chart, did the injections that Dale received from Dr. Bauer

result in any improvement in function or pain?
A. No, neither. There was no improvement. Recognizing, ultimately, because of heart problems Dale was admitted in 2018 to Hospice for end-of-life care. Nevertheless, over time his initial VAS pain score when he first began care with Dr. Bauer was listed at four out of ten on the -- in 2012. Over time that VAS pain score went up, somewhat concurrent with the escalation of -- of the opioid or morphine equivalent dose, which raises the question as to whether he was experiencing an opioid induced hyperalgesia. But nevertheless, the VAS scores continued to increase from a VAS of four out of ten to ultimately, the last documented VAS score we have was nine out of ten. So clearly there was no improvement in pain score over the course of time. And unfortunately, clearly that was no improvement in function given the fact that ultimately Dale was in palliative care for end-of-life care, end of life cardiac issues.
Q. And were there drug risk behaviors or other abhorrent behaviors you noted from your review of the Dale chart?
A. Yes, there were a number of abhorrent events that occurred, and I don't know if you want me to talk about those or if you'd like to present them one by one.
Q. Well --

A. I'm sorry, if you're referring to the red flag --
Q. Yes, we are.
A. Okay. So I do have that, and I can address that if you'd like.
Q. Let's start with looking at Exhibit 588 and 589 before we get to the red flags, just completing our discussion of injections.
And what is displayed on this screen?
A. This is a very bad fluoroscopy x-ray of a purported transforaminal epidural injection in the low back.
Q. And what was the date of the injection?
A. The date of the injection is 12-8 -- no, sorry, 4-14-2016.
Q. And did Dr. Bauer administer an injection to Dale on that date?
A. Yes, his name is on the fluoroscopy image.
Q. And what is -- was -- are you able to ascertain any -- anything from that image?
A. No, I -- I can ascertain that it probably is a lumbar spine. I can pick out a couple disc segments there, but this, unfortunately, is typical of the extremely poor quality of films that Dr. Bauer used to document the transforaminal epidural injections. In this particular case, like the others, not only is it a poor-quality film

such that we can't discern any of the anatomy in a manner that would allow us to safely do an injection, there's no indication of any needle placement here. I don't see any needle. There's no indication of any contrast dye, which, as we've talked about, is important from a standard of care -- required from a standard of care standpoint. All we have is a very poor quality lateral image of the spine which does not document, in any meaningful way, that an injection was performed, and certainly does not document the performance of the transforaminal epidural injection.

Q. And let's next look at Exhibit 589.

Can you identify what you see depicted in 589?

A. Yes. This is a -- I smile a little bit because the image is upside down. I don't know why it's upside down, but that seems to be consistent with the poor quality and the bad imaging. This is upside down, it's a lateral picture of the lumbar spine with the tailbone on the upper part and the remainder of the back going down. On this particular image we do see a needle coming in, and I will --

Q. What is the date of this?

A. The date on this is 3-29-2018.

Q. And this would be indicative of a procedure performed on Dale by Dr. Bauer?

A. Yes, and specifically the procedure that was

dictated was a transforaminal lumbar epidural injection.

Q. And were you indicating whether you could see a needle?

A. I can see a needle here, and to the best of my ability to see where the tip of the needle is, which I think is the right there, and the needle track is back there, so the needle tip is right here (indicating). There's no contrast.

Just to give you -- give the jury some perspective, this is a terrible picture, and only because of my knowledge of the anatomy am I going to point out to you where the foramen is. But the foraminal area should be right here at that level and should be about right here at the L4-5 level (indicating), but, as you can see, this needle coming in -- stops well short of either foramen, and is, in fact, outside the spinal area in what we call the paraspinal muscles. I don't have a second view to show me exactly where that tip is, but it's somewhere in the soft tissue of the back. It does not appear, based on this, to be in the spine, and certainly nowhere close to the targeted area that was indicated in Dr. Bauer's dictation as to what he was actually doing.

Q. Was the epidural injection successful?

A. This was not an epidural injection.

Q. Dr. King, is what was noted in the chart as

epidural injections on April 14th, 2016 and March 29th, 2018, administered to Dale by Dr. Bauer, were they administered with a legitimate medical purpose?

A. They were not.

Q. Why not?

A. First of all, there was no indication to perform an epidural.

And secondly, an epidural was not performed.

Q. All right. Let's go back and look at Exhibit 908.

Is this your summary of red flags?

A. It is, yes.

Q. And would you briefly summarize some of the risk behaviors and red flags you noted in the review of the Dale chart?

A. There are a host of them, and some of them, I suspect, we'll discuss in more detail. But some of the more familiar things that we've talked about already that demonstrate abhorrent or abusive or -- or inappropriate use of opioids include early refill requests. I will point out here that in one case the son is calling for an early refill.

Q. The son?

A. Well, it says son there, I would have to go back and see exactly what it says on the chart, but on 2-6-12

says son calls today wanting early refill. I'm guessing that probably should be grandson.

MR. GIBBONS: Objection.

A. Because grandson is the individual that would be Nathan who makes multiple requests for early refills, so I'm guessing this is a typo on somebody's part.

THE COURT: I'll overrule the objection, and that can be inquired further if counsel wish to.

MR. GIBBONS: Okay.

BY MS. DUSTIN:

Q. We can -- we can look for that chart page. Let's start with what happened on January 13th of 2012.

A. January 13th, 2012, the grandson Nathan reports that Dale was having a new pain -- reports that new pain, med offers no relief, and indicated that Dale's pain was nine. He was speaking for Dale and indicating new pain med was not offering any relief.

Q. Can we move that up just a little bit off -- that's good. Thank you.

All right. And what other significant red flags, or summaries of red flags, did you note from the Dale chart?

A. Well, there was an indication that Express Scripts, which is where Dale got his prescriptions filled, notified Dr. Bauer that Doxepin, one of the medications --

I'm reading the wrong thing, I'm sorry.

On 12-2012, the granddaughter and grandson, which would be Bethanee and Nathan, called separately about early refills of Percocet. And then, again, the following entry there in February of 2013 indicated the granddaughter, which would be Bethanee, again calls requesting early Percocet. And then the following month -- I'm sorry, I'll slow down so you can isolate those.

On 3-28-13, again, the grandson calls saying the patient is running short of medications, and the comment was made doesn't think addiction is an issue. Grandson comes to office to request early Percocet refill, states he may share some of his meds with patient, cannot bear to see him suffer. And then --

Q. Did you find that significant?

A. Well, yes, I find that very troubling on a couple points. One is why are the grandson and granddaughter always calling in for medications instead of patient himself? Why is the grandson indicating that addiction is not an issue. That's one of those things that if it were brought up, somebody must have thought somewhere along the line that it was an issue.

The other thing of concern here is that Nathan indicates he may share some of his meds with the patient because allegedly he can't see him suffer. You don't do

that with these types of medications. They must be taken as prescribed, assuming that they were -- they were prescribed in a legitimate and carefully thought-out fashion. Nevertheless, as a result of that following entry here 4-3-13 indicates Dr. Bauer increased the pain meds despite no office visit and no follow-up examination of Dale.

Q. And let's go to the next page.

A. Here --

Q. Go ahead.

A. There are indications here that the patient called and reported that the Fentanyl prescribed was, quote, not working, and Oxycontin was preferred.

And then following that, that would be six days later, the patient apparently called again requesting an early refill of the Duragesic, and Dr. Bauer refilled the prescription.

Q. I want to direct your attention to a chart note now, and look at a chart Exhibit 403 at Page 388. Earlier you were talking about a red flag of diversion. Do you recall a situation in 2017 with possible diversion?

A. Yes, correct.

Q. And can you summarize what happened based on the patient chart utilizing the page in front of you?

A. Let's review what the note says. Note indicates

that the patient Dale called and states that -- I've lost my image here. Just a moment.

Q. And this is date of service of when?

A. This is 1-18-17. So there we go.

On that date the pharmacist, Don, at CVS called, and we talked about this earlier, stated that -- no, we didn't talk about this earlier. The pharmacist called and stated that Nathan had brought in a script written out for Dale for Duragesic. The pharmacist indicated he was not sure why Nathan would bring that to that particular pharmacy since Dale's insurance did not cover refills at CVS. Nathan asked if he could pay cash for the prescription, and the pharmacist told him yes, that he could. He went on to fill the prescription and put it in what they call the hold basket for pick up. Nathan came back and asked for the script back, and they, meaning CVS, gave it back to him, but did not reverse the fill in the -- of the Duragesic in the pick-up box. Nathan took the script to Walgreens and filled it under insurance and then went back to CVS and picked up the script that was mistakenly reversed, or not put back into stock, and paid $110 cash for it. The pharmacist realized what had happened, and that the patient received an extra refill without a prescription. They called him and advised he needed to come in, meaning Nathan, and return the refill

from CVS and they would refund his money. Nathan asked if the refill would show on the OARRS report and pharmacist said yes. Nathan indicated he would bring it back, but has not. They called him ten times, and he would not return their call. CVS Pharmacy is requesting a script for the extra med, presuming requesting a script from Dr. Bauer that was filled if they do not get it returned.

Q. And this was a call from where?

A. From the pharmacy, CVS Pharmacy.

Q. To whom?

A. To Dr. Bauer's office.

Q. And then what happened?

A. Okay. So we have that situation existing. So the person who authored this note indicated that she spoke to Dr. Bauer, and Dr. Bauer stated that the patient needs to explain why he did this, and he needs to return the medication or he will be reported. So that -- that was the next action taken. And then apparently the author, again, of this note from Dr. Bauer's office called the pharmacy back CVS and advised them that, quote, we are trying to reach the patient, meaning Nathan, to have him return the medication. And again, apparently that happened, but there was no return call from Nathan.

Then -- would you like me to go on?

Q. And then ultimately have you reviewed these

patient chart pages previously?
A. I have, yes.
Q. And did Nathan return the prescription?
A. No, he did not.
Q. So essentially what happened?
A. Essentially an extra dose, an extra prescription of Duragesic was filled by the pharmacy and delivered into the hands of Nathan.
Q. Let's move on to Page 388.
And is this also from the Dale chart?
A. It is, yes.
Q. And what happened later that day on January 18th, 2017?
A. Yes, so on that date the patient called and stated that he had received the message, meaning from Dr. Bauer's office, that the medication needed to be returned to the pharmacy. He gives the reason that he was working late, was unable to go to the pharmacy, so he put the medication back in the boxes and in the bag it came from and forgot it the next morning. When he got home from work the next day, he went to get the bag to take it back to the pharmacy, and it was gone. Dale claims that -- he claims -- he claims --
Q. Was this call from Dale, or was it from Nathan? Can you tell from the chart?

A. I will back up. This is not from Nathan. The call is from Dale, that is correct. So Dale is the grandfather of Nathan, so Dale actually made this call. He's the patient, and stated that the -- received a message that the medication needed to be returned, but Dale indicated he was working late and was unable to go to the pharmacy and forgot to deliver it the next morning, but when he got home from work, meaning Dale, the -- the bag was gone.

Q. Dr. King, I want to point you to a line that says Nathan states he will call us later to talk to us directly. So is it clear who made this call?

A. It is not clear who made this call.

Q. And what's the bottom line?

A. The bottom line is we have some missing medication that looks to have been diverted for drug abuse purposes.

Q. And diverted by whom?

A. In all likelihood diverted by Nathan because he seems to be the one who is most involved in picking up the medications, trying to get them filled at multiple pharmacies, paying cash and then not answering the phone calls and not agreeing to return the medication.

Q. Okay. And let's move on. Again, let's bring up 908 and move down to the graph.

And is this your graph of red flags and epidurals along with morphine equivalents?

A. It is. This is the timeline of red flags and morphine and injections and then the MEQs at the bottom.

Q. And just peppered throughout the red flags, who, other than Dale, seems to be noted by most of the red flags?

A. The granddaughter, Bethanee.

Q. And whom else?

A. Well, there are a lot of references to the grandson and the granddaughter, which would be Nathan and Bethanee. Pharmacy -- and multiple pharmacy interactions.

Q. Thank you.

Dr. King, did you see any evidence of clinical improvement with Dale?

A. No, there was no clinical improvement.

Q. From the chart?

A. From the chart, correct.

Q. Let's look at Exhibit 513.

And what is this?

A. This is a prescription issued to Dale by Dr. Bauer on January 5, 2017, for a 25-microgram Fentanyl patch.

Q. And was that the subject -- that prescription that was the subject of what we just discussed?

A. Yes.
Q. And looking next to Exhibit 514.
What is that?
A. This is a prescription issued to Dale by Dr. Bauer for Oxycodone -- well, on the date, 2-14-18 for Oxycodone, 20-milligrams to be taken four times a day.
Q. And Exhibit 515?
A. This is a prescription issued to Dale by Dr. Bauer on 2-14-18 for Ultram, Tramadol, 50-milligrams to be taken, well, four -- approximately five times a day.
Q. Dr. King, were the Fentanyl patch, the Percocet and Tramadol prescriptions that Dr. Bauer wrote for Dale on January 5th, 2017, and February 14th, 2018 dispensed with a legitimate medical purpose and within the course of professional medical practice?
A. They were not.
Q. Why not?
A. Several reasons. The first is Dale had been on multiple Controlled Substances prior for many years and had not responded. Therefore, there was no medical reason, no medical justification to continue prescribing Controlled Substances, or specifically opioids.
Secondly, there -- Dr. Bauer's knowledge -- Dr. Bauer's office was well aware of the fact that there were diversion issues going on here, excuse me, with the

grandson and granddaughter, both of whom were also patients of Dr. Bauer, and both of whom complained of chronic pain and were receiving opioids as well. So there was significant information here suggesting that diversion was going on, and the continued use of opioids were, therefore, in support of diversion and addiction, but not for legitimate medical purpose -- not for a legitimate medical purpose.

Q. Let's talk about the next patient, Bethanee.

Did you review Dr. Bauer's patient chart for the patient Bethanee?

A. Yes, I did.

Q. And based on your review of the Bethanee chart, did Dr. Bauer follow the standard of care for prescribing Controlled Substance?

A. He did not.

Q. Based on your review of the Bethanee chart, did Dr. Bauer write prescriptions for Controlled Substance with a legitimate medical purpose within the course of professional medical practice?

A. They were not prescribed according to those guidelines.

Q. Let's look at Exhibit 925.

Is this a forensic -- your forensic timeline to summarize the Bethanee chart?

A. It is.
Q. And would you describe for us Bethanee?
A. I'm scrolling to the top of my -- my forensic chronology on the computer. Give me just a moment. Here we go. Bethanee was a young woman. She was 32 years old at time of her last visit with Dr. Bauer. She was unemployed, quote, unable to work. She had been under care with Dr. Bauer for approaching nine-and-a-half years, which would have put her in her early 20s when she first came under care with Dr. Bauer. So she was truly a young woman. She complained of, quote, bulging discs and lumbar back pain. So it was a vague and -- and subjective back pain that she was seeking opioids for. Over the course of time with Dr. Bauer, she complained of other pain complaints, including fibromyalgia, bursitis, neck pain, migraine, headaches, sacroiliac joint pain. I think I mentioned neck pain, sacral pain, thoracic back pain. There were very few areas here, certainly no areas in the spine that she was not complaining of pain. She had significant mental health co-morbidities in the sense that she was diagnosed with depression, with anxiety, and with panic attacks. She had significant physical co-morbidities, or at least notable physical co-morbidities in the sense that she was moderately obese. She had a history of hypertension.
And I think that's a good stopping point to lead

into our further discussion now.

Q. And would you just give us an overview of the Controlled Substances and opioids that Dr. Bauer prescribed to Bethanee for the management of pain during the course of his treatment of Bethanee?

A. Dr. Bauer began treating her in 2009, and I do have it computed here. She was 23 years old at that time. On the initial visit, he prescribed her Vicodin, which is Hydrocodone along with Norco, which is Hydrocodone along with Neurontin and Prednisone. The Morphine equivalence was -- was somewhere between 15 and 40. It was difficult, based on the records, to know exactly how much of what she had prescribed, but it was somewhere between 15 and 40 Morphine equivalents. Over the course of time, those doses escalated significantly.

By 2015 Bethanee was being prescribed 120 Morphine equivalents, and as a result of -- of her unable to get her pain under control, so she said, Dr. Bauer escalated the doses further up to 150 and then 270 morphine equivalents. There was a great deal of variability based on what I was able to discern in the chart as to what her Morphine equivalency was at a given time. It varied quite a bit from 210 to 120, somewhere in that range, which is concerning in and of itself. But at the end of her treatment time frame, she was receiving somewhere between

100 to 135 Morphine equivalents.

The medications that she was receiving that led to those Morphine equivalents were mostly Oxycodone products, Percocet and Oxycodone. They were accompanied by Neurontin or Gabapentin, as we've talked about. The doses of Oxycodone were escalated to the 20-milligram formulation of the medication. She also received, as time went on, Oxycontin in the 30-milligram formulation.

And then towards the end of her care, in the last two years of 2017, 2018, she was receiving a combination of Oxycodone 20-milligrams and Methadone concurrently. That was -- that was for a period of time, and then the Methadone was switched back to a 20-milligram Oxycodone poly pharmacy combination. There was not a lot of consistency or rationale that I could discern with regard to why the medications were chosen the way they were, or in the combinations or doses they were. The doses were kind of all over the place. And -- and it did not seem to have any medical foundation.

Q. Did you have any concerns, based on your review of the chart, with the combination of drugs prescribed to Bethanee?

A. Yes. I had concern because there were multiple opioids being prescribed at any given time. No combination of which seemed to offer her consistency in terms of dose

or any improvement in her pain level or her improvement in function. She was being prescribed street popular formulations of Oxycodone and Oxycontin, and she, as we've talked about, had an association with Dale and with Nathan, and there were significant concerns about diversion in their care. And, therefore, that should have been a prime concern in Dr. Bauer's mind about continuing these street popular formulations of Oxycodone and Oxycontin.

Q. And looking at your standard of care summary, without bringing it up for the sake of time, did, based on your review of Bethanee's chart, did Dr. Bauer adequately -- adequately diagnosis Bethanee's medical issues?

A. I'm pulling it up on my chart to be precise here for just a moment.

The answer, however, is no, he did not establish a legitimate or objective pain diagnosis to support the use of long-term opioids.

Q. Did Dr. Bauer conduct a targeted physical exam?

A. He performed a physical examination, however, there were no focal deficits identified, no musculoskeletal or neurological deficits identified on exam that would support a diagnosis that would, again, support the use of opioids, so no.

Q. Did Dr. Bauer perform a clinical workup of

Bethanee?

A. An EMG was performed, which was appropriate, but it was normal. There was no evidence of sciatica or radiculopathy. Bethanee had had MRIs, and they had shown to be normal. And she had had one MRI in the past that demonstrated a herniated disc, but she had undergone a micro diskectomy, a laminectomy, as it were, to address that herniated disc, but despite that surgical treatment, there was no change in her escalation of opioids. So the clinical workup that Dr. Bauer performed essentially was -- was ignored, the results of that workup were ignored.

Q. So Bethanee had had back surgery previously?

A. She had a micro diskectomy, correct.

Q. And if it was not successful in terms of treating her pain, wouldn't that be a good basis for the long-term management of pain with opioids?

A. No. And that's a fair question to ask. So, actually, it would be just the opposite. This is an individual who had been treated for -- for her pain for a long time and had not responded. She falls into the category of the fact that everything was done. She had opioids, she had an operation, she had time to get better, and nothing helped her, which strongly suggests that the pain is either psychosomatic, or at least not a pain that is supported by the use of opioids. Micro discectomies are

minimally invasive operations. I've had one, I dare say a lot of people have had them. They're minimally invasive. You're in and out less than a day. They don't disrupt a lot. You don't have hardware put in, they just take out the herniated disc. It doesn't cause pain, we don't treat people with long-term pain conditions with chronic opioids, it's just -- it's just not medically necessary to do so.

Q. Did Dr. Bauer administer any procedures to Bethanee?

A. He had an excessive number of injections that he performed on Bethanee, along with excessive steroids.

Q. Let's bring up Exhibit 928, please.

So between November 3rd of 2009 until February 1st of 2019, could you summarize for the jury what injections Dr. Bauer administered to Bethanee?

A. Dr. Bauer, over the course of that timeframe, performed 24 lumbar epidurals, 45 trigger point injections, 27 trochanteric bursa injections, one oral dose of corticosteroids, and 17 sacroiliac joint injections. I don't know what the total is there, but it's quite significant.

Q. We can move it up to look at the total. And what was the total amount of cumulative Medrol equivalent administered to Bethanee?

A. The steroid equivalents were on the order of

4,610, which, as we've discussed, is an extremely large number given the yearly recommended guideline of no more than about 200 to 300. And the yearly -- or excuse me, and the lifetime recommendation, or guideline, of being somewhere in the 400-milligram range. She had 4,600-milligrams, but -- well --

Q. Is that number significant in terms of the year -- the lifetime dosage?

A. As I indicated, if a lifetime dosage is somewhere around 500 or 600, again, that's a -- that's a recommended ballpark number. And whatever number we might decide or clinician might decide is appropriate, this, nevertheless, far, far exceeds that by an order of magnitude.

Q. Based on your review of the Bethanee chart, did the injections result in any improvement in function or pain?

A. There was no indication that pain or function improved. As I indicated -- maybe I didn't indicate, the VAS pain score on the initial visit was five out of ten, and then over time it varied considerably from seven or eight to four or five to ten out of ten to eight out of ten. The last documented pain VAS pain score was given as four to nine out of ten a range there. So the VAS pain score demonstrated no significant improvement in a sustained manner.

Additionally, there was no indication of function improvement. If she was -- it was indicated in the chart that she was, quote, unable to work, but we don't have a reason -- well, she was unable to work, so there was no improvement in function as a result of the opioids.

Might I add one other thing here too? Because at one point there was an indication that she might be pregnant. I think it's germane to bring that up at some point in terms of risk factor.

Q. In terms of her potential pregnancy, would there be a risk to an unborn fetus with the opioids issued by Dr. Bauer?

A. Yes, as a previously discussed, that unborn child would be exposed to the opioids that the mother, in this case Bethanee, would be taking, and there would be a strong probability that the child would be born addicted and have a Neonatal Abstinence Syndrome concerned --

Q. You've described that already?

A. We've described that, yes.

Q. Let's talk about also whether you formed an opinion, based on your review of the Bethanee chart, if the injections provided by Dr. Bauer were medically necessary?

A. The injections were not medically necessary.

Q. All right. And did you, in reviewing the Bethanee chart, see any red flags or risk behaviors with

respect to the prescriptions of opioids and Controlled Substances?

A. There were a number of red flags, indicators that I compiled for her.

Q. And let's look at Exhibit 926.

And that is -- this is your red flag summary?

A. It is, several pages worth.

Q. This goes from August 12th, 2009 to February 1st of 2019?

A. Correct.

Q. Can you just pick out some -- some of the, or group them, if you could, in terms of what types of risks -- risk factors you saw in the Bethanee chart?

A. It's hard to know where to start and how to group them because there were so many here that it's difficult to do. But let's -- suffice it to say that she's got -- well, she's got falling episodes, she's got indication here that her mother has the same problem. Remember we talked about families that share the same pain syndrome and take medications, she has a mother who has, quote, the same problems, that's -- that's of concern from a psycho social risk standpoint.

She's receiving Vicodin from one doctor and Norco from Dr. Bauer, so she's -- so she's doctor shopping. She indicates no benefits from the beginning there, no benefits

from the epidural injections, yet Dr. Bauer continued to perform the epidurals.

Q. That was on 6-6 of 2010?

A. 1-12-2010.

Q. Look at 6-6-2010.

A. 6-6-2010 she, again, states no response to epidural or triggers, meaning trigger point injections, so clearly from the beginning she was not responding or improving as a result of the various injections.

Q. And then August 9th of 2010 does she indicate whether or not the medications are helping?

A. No. As a matter of fact, it says meds not helping, and then it follows an entry there that says she's going to leave her job and -- and due to disability.

Q. Did she report her meds as being stolen?

A. Meds were stolen, that was reported. Refills were requested. Early out medications were noted where she took extra medications, and the husband called in wanted to know if he can give her some of his medications. That's entirely inappropriate.

Q. Did she later ask for, in April of 2011, her pain medications to be increased?

A. Yes, she did.

Q. And moving on to the next set?

A. Again, more incident of early-out medication and

sharing of medications between Nathan and his wife, and okay from Dr. Bauer to refill the medications early. And the statement in 2012 May of 2012, indicating that the patient is pregnant, and she was switched at that point to Tylenol with codeine. Child was delivered in January of 2013, and the patient called and wanted an appointment after that requesting injections, wanting to discuss medications, wanting to have pain medications because she can't get to the dentist, early refills, pharmacy shopping noting -- noted on the OARRS. Continue indication of constant pain, meds just help but don't resolve the pain, early refills.

Q. And then do you see in March of 2015 you made a call recording -- or she -- she has a notation regarding whether the epidural helped?

A. March of 2015 she says does not feel the epidural helped her pain at all, end of quote.

Q. And shortly later does she call, or does she ask for an increase in her medication?

A. Yes, Nathan called the following day and said wife in severe pain, and she did not want to ask at her appointment to increase her medication. He, Nathan, would like to know if she could be changed to Oxycontin.

Q. At some point did she lose her script?

A. She lost her scripts and requested replacement.

She continues to complain of severe back pain, fell down the stairs. Didn't take her medications as prescribed.

There's a note in June of 2016 that she's been filling old and new scripts and should only be filling one. She is taking the old dose to another pharmacy and is paying cash and claiming through insurance. She has done this on three occasions per OARRS.

Q. And did Dr. Bauer have her submit to a urine drug test sometime in July of '16?

A. Yes, in July she -- she had a urine drug test that was positive for alcohol.

Q. So that didn't show anything else significant?

A. Correct, it was just positive for the presence of alcohol, which, of course, is contraindicated when opioids are being prescribed, particularly at these doses.

Q. All right. And let's move down to see the graph you put together.

And this shows the graph of what for Bethanee?

A. This, again, the upper portion of this timeline shows the -- the abhorrent activities and event that we talked about, and the bottom shows the injections.

Q. And if we can move down to the next page.

A. We see here that the injections were quite excessive during the time frame of 2016, '17, and into '18, and that at the same time there were significant Morphine

equivalent doses of medication being prescribed.
Q. And this also shows your -- the morphine equivalent graph, correct?
A. Yes, there at the bottom.
Q. Let's bring up Exhibit 553.
What is this?
A. This is a prescription issued to Bethanee by Dr. Bauer on 10-30-2017 for Oxycodone 30-milligrams to be taken every -- three times a day.
Q. And now let's look at Exhibit 554.
A. This is a chart note regarding Bethanee's care as noted by Dr. Bauer.
Q. And was a prescription issued on November 9th, 2017?
MR. GIBBONS: What exhibit is that?
MS. DUSTIN: It's Exhibit 554.
A. This is -- this indicates that Methadone was prescribed 11-9-17 by Dr. Bauer to Bethanee for Methadone three times a day.
Q. And finally, Exhibit 555.
What is this?
A. This is a prescription issued to Bethanee by Dr. Bauer on -- I'm looking for the date -- on 11-9-17 for Oxycontin, 20-milligrams, to be taken twice a day.
Q. Dr. King, was the methadone, the Oxycontin and

the Oxycodone written for Bethanee on November 9th, 2017, October -- and October 30th, 2017, were they dispensed with a legitimate medical purpose and within the course of professional medical practice after having been written by Dr. Bauer?

A. They were not.

Q. Why not?

A. At that point, which was late in her care, she had already been treated with higher doses by Dr. Bauer, and she had not responded. She had not improved either in terms of VAS pain score or function. There was no foundation to continue opioids of any sort, let alone the dangerous poly pharmacy combination of high dose Oxycodone and Methadone. So she was not improving. She had gone through an opioid trial and had failed it over the course of many years.

And then secondly, we have a -- well, we have a concern with regard to pregnancy. She's in child-bearing age and the risk of creating a dependency state on an unborn child is significant.

And then thirdly, there's the concern that the -- a state of diversion and abuse of was going on between Nathan, her husband, and Dale, her -- her grandfather in law, I guess -- I think it was Nathan's grandfather, so it was her inlaw grandfather. But there was a state of

diversion going on that -- that should have made a prudent practitioner understand that opioids should not be prescribed, particularly given the fact that Bethanee never had established a legitimate pain diagnosis. Opioids and opioid exit strategy should have been exercised, and she should have been weaned off all opioids.

Q. Speaking of Nathan, did you review Dr. Bauer's patient chart for the patient named Nathan?

A. I did.

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

A. He did not.

Q. Based on your review of the Nathan 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. Let's look at Exhibit 922.

Is that the forensic timeline you prepared of the Nathan chart?

A. It is, yes.

Q. And would you describe Nathan as a patient?

A. Nathan was a young man. On initial visit he was 40 years old. He was under care with Dr. Bauer for almost

ten years, which means he was about 30 years old on his initial visit with Dr. Bauer.

Prior to seeing Dr. Bauer, Nathan had been under the care of a family doctor for, quote, extreme back pain and tension headaches, and had received Vicodin and Percocets, opioids of various potent types for treatment of his pain. Nathan's pain was allegedly chronic low back pain, excuse me, that he had had for some time. But over the course of care with Dr. Bauer, he also complained of headaches, leg pain, fibromyalgia, hip pain, sacral pain, kidney pain and neuropathic pain. So there's quite a constellation of pain complaints there. There were significant concerns, significant red flags in Nathan's background, including an alcohol history. He drank four to five beers per day. There is a -- there is an indication that while out drinking he had gotten into fights. He had been told to avoid alcohol and jello shots, which apparently were something that he took from time to time. So he had a history of alcohol abuse, and no indication that he was tapering from that.

He also had a drug history, indicating that he had taken drugs from friends, including Opana and, quote, his boss' Vicodin. By definition those are diversionary activities, as he was taking medications, opioids, not prescribed to him. He had a brother or brothers who were

using heroin. And at -- and he was an admitted marijuana user as well.

In addition to the psycho social concerns of his brother's using heroin, there were mental health issues that Nathan suffered from, including depression, anxiety, severe manic bipolar disorder, psychotic features, and concerns about, not surprisingly, insomnia.

Q. Did all of those things put Nathan at risk for being on long-term opioid treatment -- opioid therapy for the treatment of pain?

A. Nathan was not a candidate for opioids either in the beginning or as time went on. He was at significant risk from a mental health, psycho social and addictive background set of concerns.

Q. Based on your review of the Nathan chart, did Dr. Bauer adequately diagnosis Nathan's medical issues?

A. There was no indication that a diagnosis was established that would support the use of long-term opioid therapy.

Q. Did Dr. Bauer conduct a targeted physical exam of Nathan?

A. There is a history of a distant motor vehicle accident, but there was a failure to -- to do a -- review the past medical records to establish an independent medical evaluation and establish a legitimate diagnosis for

the use of opioids.

Q. Did Dr. Bauer perform a clinical workup?

A. There was no EMG or electro diagnostic studies in the chart to support the diagnosis of sciatica or radiculopathy. There were two MRIs which were normal for age, but -- and did not support Nathan's claim of, quote, extreme pain. So the answer is no, Dr. Bauer did not perform -- well, he performed a clinical workup but ignored the results.

Q. Based on your review of the Nathan chart, would you just give us a summary of the types, combinations of drugs that Dr. Bauer prescribed to Nathan during his care of Nathan?

A. On the initial visit in 2009, Nathan was started on Percocet with an MEQ of about 22 by Dr. Bauer. Over a very short period of time, that dose was ratcheted up to include Percocet, plus Oxycontin, 30s, and the MEQs went up to above 100 and 140 and 170. At one point, the MEQs were as high as a little over 200. And then by 2014, the MEQs were 220, 225. And the last -- by the last -- on the second to the last Dr. Bauer visit, the MEQ was 225. And on the final visit, the MEQs had been dramatically lowered to 90, but there was no indication of any withdrawal symptoms at that point, so there was some concerns about whether that really -- whether the patient was really

taking the medications. Nevertheless, the patient was on high MEQ, was prescribed combinations of Oxycontin, Oxycodone and Gabapentin.

And yes, I do have some concerns about --

Q. That's my next question. Do you have concerns about the combination of drugs?

A. Yes, the poly pharmacy combination there, again, and you've heard me say this before, first of all, they're street popular formulations of the Oxycodone product. There's Oxycontin 30 milligrams, which is very popular in the street. And Oxycodone 15 milligrams, which is equally popular on the street. There's no real medical need to prescribe any of these medications, particularly in combination, and then Gabapentin was added to that, Neurontin, Gabapentin, which, as you've heard me say, is an enhancer and is very popular among addicts because it will enhance the euphoria associated with the opioids. So Nathan was supplied with street popular multiple formulations of highly addicted Oxycodone with Gabapentin as an enhancer, despite no improvement of pain or function.

Q. Was there a defined treatment plan by Dr. Bauer?

A. No, a written defined treatment plan was not put forth that was -- that was unique to the patient or multi disciplinary. Again, we see the same rhythm here of multiple injections, multiple opioids, but not a

multi-modal approach to the unique needs of the patient.

Q. And did Dr. Bauer administer any procedures to Nathan?

A. Yes, multiple procedures were performed.

Q. Let's look at Exhibit 924.

Between of June 2009 and January of 2019, what types of procedures were administered?

A. Keep going, one more page, one more page. There we go.

Nathan received 32 lumbar epidural injections, 19 trigger point injections, 13 trochanteric bursa injections, five courses of oral Prednisone and a sacroiliac joint injection. Again, these were excessive numbers of injections for an individual who was not indicating that there was any improvement, despite the injections.

Q. And what was the cumulative Medrol dosage administered?

A. Nathan received, by this calculation, approximately 3,195 steroid equivalents of by way of injection and oral steroid administration.

Q. And based on your review of the Nathan chart, were these injections medically necessary?

A. No, there was no indication that they were medically necessary.

Q. In reviewing the Nathan chart, did you note any

abhorrent or other risk factors in Nathan's use of opioids and Controlled Substance medications?

A. Yes, I have a list of about 94 or 95 abhorrent events and activities in that regard.

Q. Okay. Let's bring up Exhibit 923.

And what is this?

A. This is my timeline of red flags for Nathan.

Q. And let's start with Page 1, which begins in July of 2009.

Can you review for us, or group the red flags and risk factors you noted when reviewing the Nathan chart?

A. Yes, and the jury's probably able to do this quicker than I can say it because there are a lot of familiar concerns here that we've seen in a lot of the other patients, but trying to do the best to pull them together in a coalescent fashion.

Nathan is wanting to change medications so he's calling the shots with regard to which narcotics he wants. He still continues to complain of increased pain, is taking extra medications, and is complaining of early-out medications and is making requests for early refills. We have notation here that he's drinking excessive alcohol as noted by the hospital. He comes in and has trigger point injections. He also relates that there are problems with his brothers and medication, keeping in mind that his

brothers were heroin addicts. He requests, again, medication changes, states the medication is not working and is indicating by the higher dose, by the way more street popular Oxy 40s make a huge difference in his back pain. Even on vacation his pain gets worse, he's early out. He's -- he's missing pills. He was given a prescription for Percocet and now wants another script. He complains of dental pain and requests pain for medication for his dental pain. Dr. Bauer okays early refills for that. He is not compliant and is taking medications, he claims the medications are not helping the pain. Dr. Bauer, again, okays early refill and increase in the Percocet. And then Nathan complains of kidney stones and gets another increase in the Oxycontin at that time. He's noncompliant in his use of the Percocets, again requests early refill. Plus it says he's got pain at the epidural site. He says he's going through withdrawals, has adverse side effects from the Methadone, wants to go back to Morphine. And now his back's hurting because he was sledding with the kids.

Q. And again, he himself, the patient is -- is requesting certain medications?

A. Yes. He's -- he's self requesting, and it's not -- that's always a red flag when the patient's driving the car, as it were, telling the doctor what he needs.

Q. Okay. Let's look at the next page, starting with between February 7th of 2011 and February 10th of 2013.

A. Well, it indicates that he's got an additional injury to his back, and now he's taking more medications, so he's noncompliant. He admits that he was out drinking and got jumped and cracked his nose, and his back is sore. So he admits, essentially, that he was noncompliant combining alcohol consumption with his narcotics. He's noncompliant in the dose, he's taking more Percocets than were prescribed, requests an early refill, which is granted by Dr. Bauer. He asks for an early appointment so he can get trigger injections. He apparently had a seizure at work, which was always a red flag when we see it and, again, ask the question could it be related to medication noncompliance by the patient.

The patient -- Nathan indicated when he got -- 2011 that he needed early refills. All of a sudden now is throwing up his Percocet. The early refill was okayed by Dr. Bauer.

The following month thinks he threw away, and stupid mistake, and asked for early refills. Then he slipped at work and more increased pain, took more opioids than prescribed, hurt his back at home and is now in excruciating pain, he requested more early refills saying that he was using more than he was prescribed, requested

more trigger point injections. Doesn't like the Morphine, he wants to go back on the Oxycontin, and asks for an increased dosage of the Gabapentin or Neurontin. More indications of noncompliance, rejecting to go back on Oxycontin again, lost prescriptions, requesting a replacement, and, again, lost -- he claims he lost several days worth of Percocet because he was vomiting, early out concerns, admitting to overtaking medications.

Q. I'm going to stop you there. Let's look at a chart page at Exhibit 408, Page 415.

Is this a page from Nathan's chart on date of service March 1st, 2012?

A. It is, yes. It's a phone note from Nathan indicating that at last injection Nathan wanted to sit down with Dr. Bauer and have a, quote, hard conversation with the doctor and was not able to do that because the conversation may be understood as betrayal. Patient has been taking more meds than prescribed, then goes through withdrawal because he runs out early. States his pain tolerance has become less responsive to the meds, states he is a responsible father and he needs to get his pain med issue under control, asks for a sooner appointment to discuss this with Dr. Bauer.

Q. And what does this indicate when a patient is saying that they're going through their medications sooner

than prescribed and their tolerance is becoming less responsive, is that significant?

A. Yes. I will tell you, I interpret this note, and I think it's reasonable to do so, as a cry for help. As I indicated earlier, we offer respect to all our patients, even if they're in the throws of addiction or withdrawal. Nobody wants to be addicted, and I think this is a cry for help from Nathan that he's addicted and he wants some help. He's saying, look, I care about my kids, I want to talk with Dr. Bauer, I don't want him to think I'm betraying him, but I need to -- I need to do something, I'm a responsible father, and I need to get my pain med issue under control. I don't see this as a blatant request, at this moment, to get drugs to feed his addiction. I think it's a cry for help, and I think it should be taken quite seriously.

Q. Does it indicate whether or not the pain medications are helping or improving function and pain?

A. No, it -- correctly brought up the medications are not working, he's saying the medications are not working.

Q. Okay. And let's go back to the red flag chart, Exhibit 923. And beginning -- this is the red flags going to March 26th of 2013. Move it up one, please. I'm sorry, you were right.

A. Despite the call for help, medications continued to be prescribed by Dr. Bauer. We continue to see evidence and request of early refill, noncompliance with regard to keeping appointments, additional early refill requests that are okayed by Dr. Bauer. Despite the cry for help, Dr. Bauer continues to provide early refills to the patient. And the patient, again, indicates that he's built up a tolerance to the medication, which is probably true, and he doesn't believe the epidurals are helping with the pain also, which is also probably true. And the OARRS report begins to show that Nathan is doctor shopping, seven providers, and pharmacy shopping, seven pharmacies, and that continues to be noted on several occasions. Despite that, in July of 2013, Dr. Bauer, again, okays a -- a request by Nathan for early refill of his medications.

And the pharmacy, in August, indicates that, look, we just filled a -- a Percocet prescription, so the pharmacy is noting that this doesn't seem to make sense either. And then Nathan indicates his medications were lost, and he, again, requests a replacements.

Of interest, in September of 2013, when being requested to give a urine sample for a tox screen, he says I'm unable to urinate and -- but he does admit -- Nathan does admit that he took Opana last night, which was not a prescribed medication for him, and he also admits that he

took Vicodin from his boss.

Q. And I'm going to stop you there, and let's bring up Exhibit 408 at Page -- the Choice page, laboratory service page at 1052 or 1053.

A. Yes, this is the Choice Laboratory Services the results of the urine drug screen collected by Dr. Bauer of Nathan on 9-4-13.

Q. What are the results?

A. The results indicate -- some of this is difficult to read, but there is a -- there is a comment at the bottom, says took Opana last night. This is not prescribed to him.

Q. So it's positive for Opana. What's Opana?

A. Opana is an Oxymorphone. I'm sorry, yes, Opana is an Oxymorphone.

Q. And was that prescribed to Nathan by Dr. Bauer?

A. No, no one prescribed Opana, so far as we know, to Nathan.

Q. All right.

A. It was a drug that was obtained illegally.

Q. And then referring to the letter in the chart then, and looking at Page 1053.

What is that?

A. That is a letter from Nathan dated 9-4-13. It's addressed to Dr. Bauer. Well, it's a long letter here.

Q. And essentially what is it talking about?
A. Basically it's indicated he's had to move in with his grandfather, which I assume is Dale, because of monetary issues. And it indicates that his meds were lost, and he can't find them, that his pain was very intense. He -- he uses this as a reason to -- excuse why he got some Controlled Substances from a friend, which refers to the Opana, and from his boss, which refers to the Vicodin.

And Nathan goes on to say I felt bad about it because I have kids and my pain gets extreme. I would never have taken them if I had my meds, and then he goes on to apologize to Dr. Bauer about never lying to him, so sorry, and this will never happen again.

Q. Dr. King, based on your review of the patient chart after that day, did Dr. Bauer either wean down or discharge Nathan from the practice?
A. No, he did not. The medications continued to be prescribed, and Dr. Bauer did not discharge him from the practice.
Q. Did Dr. Bauer do anything to address the inconsistent urine screen?
A. Not -- not in any meaningful way. It was noted, but there was no action taken, which is extremely disturbing because this is a statement of addiction. So the continued use of opioids was in support of addiction.

Q. And what would you expect a physician prescribing opioids and Controlled Substances to a patient like Nathan to do at this point in the treatment of a patient when something like a positive screen for -- for unprescribed Controlled Substances happens and they make this call out for help?

A. Nathan called out for help, that's clear as a bell. He recognized he was addicted, he demonstrated he was addicted, he demonstrated loss of control. He demonstrated all four of the Cs that I told you about earlier today. He was craving it, he was -- he was -- he was -- all his time was spent in terms of compulsively trying to figure out how he could get the medication, he couldn't control his use of medication, and he was doing it despite the consequences. So he's addicted. He needs to be referred to an addictionologist or a mental health provider to deal with the addiction. That's clearly what needs to happen. What he does not need is additional opioids prescribed by Dr Bauer purportedly for a pain syndrome that has, for many years, not responded to it, but has, indeed, continued to play and support a state of addiction for Nathan.

Q. Let's look at the entry here on your red flag chart, but looking at the chart page of Exhibit 408, Page 581.

And what is this?

A. This is a phone note regarding Nathan on 3-26-14. It indicates that the patient wants an early refill on the Oxycontin, but wants to fill it today.

Q. And then what is Dr. Bauer's response to Nathan?

A. Per Dr. Bauer, this is the last time. Patient advised under no circumstances will Dr. Bauer fill this again early, so he should take as prescribed. Patient verbalized understanding.

Q. And let's go back to Exhibit 923.

Do you see your entry for March 26th of 2014 that we just reviewed, the patient chart?

A. Yes, and you're correctly outlining it there, yes.

Q. All right. And then what happened after that?

A. If we could expand that, I'll quote it exactly. Because less than a month after that, Nathan, again, requested an early refill of his Oxycontin from Dr. Bauer, and Dr. Bauer indicated no problem.

Q. And, again, what happens on 5-29 of 2014?

A. On 5-29 there was another request for Nathan for an early refill, and per Dr. Bauer, comment was made this is disruptive, and this will be the last time we will be giving him an early refill.

Q. Again, does Nathan call about medications lost?

A. Yes, he calls about medications lost and continues to request early refills.
Q. And turning to the last page, does Nathan lose a prescription?
A. Yes, he loses a prescription.
Q. And that's 7-25 of 14?
A. Correct.
Q. Again, does he ask for an early refill?
A. He asks for an early refill for the Ultram. Dr. Bauer does give him an early refill for a limited dose.
Q. At some point does Nathan become discharged from the practice?
A. Yes.
Q. And then what happens -- and when was he discharged, what was the date?
A. He's discharged on 1-18-18 for, quote, noncompliance. At that time -- well, he was discharged at that time because of noncompliance.
And then -- and then you're asking me what happens after that?
Q. Yes.
A. After that he continues to receive Oxycodone, Oxycontin, and Gabapentin and injections even though he was discharged. He continues to have issues with early-out medications, and ultimately -- and approximately one year

and five months later after the discharge, he has his final visit with Dr. Bauer. But during that interim time frame, he continues to receive narcotics from Dr. Bauer and additional injections.

Q. All right. Well, let's look at some exhibits.

THE COURT: Let's find out how much more you have first, please.

MS. DUSTIN: Your Honor, I believe I have about ten minutes, I will be able to conclude.

THE COURT: That's fine. Just wanted to --

MS. DUSTIN: Ten, 15 minutes.

THE COURT: Just wanted to inquire.

MS. DUSTIN: Getting to the end.

BY MS. DUSTIN:

Q. Let me show you Exhibit 536. You know what, before you go from the red flag chart, I don't think we showed you the graph. Let's go back to the red flag chart for one moment, 923, all the way at the bottom.

And you also prepared a graph of Nathan's red flags?

A. Yes, correct. Yes, this is an indication, as we've seen previously, on the red flags of abhorrent behavior and events on the top and injections on the bottom, and then at the very bottom there's a line of the Morphine equivalency the patient was receiving.

Q. And the second page?
A. And the second page takes us from 2014 through 2019.
Q. Thank you. So looking at Exhibit 536 -- I'm sorry, 5 -- 547.
A. 547, excuse me, is a prescription issued to Nathan by Dr. Bauer dated 2-16-18. The prescription is for Oxycodone 15-milligrams every four hours -- excuse me, four times a day.
Q. And then Exhibit 548?
A. This is a prescription issued to Nathan by Dr. Bauer on 2-16-18 for Oxycodone 15-milligrams to be taken four times a day.
Q. And Exhibit 549?
A. This is a prescription issued to Nathan by Dr. Bauer on 2-16-18 for Oxycodone 15-milligrams to be taken every -- four times a day.
Q. And Exhibit 550?
A. This is a prescription issued to Nathan by Dr. Bauer on 2-16-18 for Oxycontin, 30-milligrams to be taken three times a day.
Q. Exhibit 551?
A. This is a prescription issued to Nathan on -- by Dr. Bauer on 2-16-18 for Oxycontin, 30-milligrams to be taken three times a day.

Q. And Exhibit 52?
A. This is a prescription issued to Nathan by Dr. Bauer on 5-24-19 for Oxycontin 30-milligrams, the extended release, Oxycontin to be taken twice a day.
Q. Dr. King, were the opioid prescriptions Dr. Bauer wrote for Nathan on February 16th of 2018 and May 24th, 2019, dispensed with a legitimate medical purpose and within the course of professional medical practice?
A. They were not.
Q. Why not?
A. First of all, that time frame was the issuance of medications after the patient had been discharged by Dr. Bauer for recognition of doctor shopping, and -- and for doctor shopping, early refills and other abhorrent behaviors, so it was recognized that Nathan was in a state of addiction. So any further opioids prescribed would have been in support of addiction, not in support of a legitimate medical diagnosis.
Secondly, Dr. Bauer continued to prescription opioids for Nathan, despite the fact that for many years they had been ineffective and had not offered any improvement in the VAS pain score or in function of the patient.
And thirdly, there were significant indications because of his -- his wife, Bethanee, and the things that

we reviewed with regard to his grandfather, Dale, that there were significant acts of diversion going on during this time, so it's not only a situation of addiction and abuse, but of diversion. Opioids were not prescribed by Dr. Bauer for legitimate medical purpose. A reasonable physician would not have continued to prescribe opioids under these circumstances.

Q. What would you have expected a doctor acting within the usual course of professional medical practice to do in the situation with Nathan?

A. Nathan is a known opioid abuser. Illegal drugs, in all likelihood, as well as prescription drugs. He reasonably needs to be referred to an addictionologist for treatment of his addiction and his dependency, and to address some of the psycho social conditions related to his -- his opioid addiction. He needed to be referred to a psychiatrist for treatment of addiction.

Q. Based on your review of the 14 patient files in this case, did Dr. Bauer cause harm to any of the patients?

A. Yes, he caused harm.

Q. How so?

A. To begin with, he didn't establish appropriate diagnosis, and without having established a diagnosis, the conditions these patients presented with could not be treated, so he did harm by not acting as a physician and

performing a diagnosis to treat what the patients came to him for to have addressed.

Secondly, he ignored indications of mental health of psycho social stressor, of co-morbid illnesses that contributed to the mental illness and addiction that we see again and again as we review these patients care. These patients were dependent on Controlled Substances, in some cases were getting illegal drugs as well. None of the patients we reviewed demonstrated any improvement as a result of multiple opioid trials, sometimes before they came to Dr. Bauer, and at all times after they came to Dr. Bauer. We see no indications of improvement in pain nor improvements in terms of functional improvement. These patients were prescribed opioids in most cases, in support of addiction and dependency, and as such, they were prescribed without a legitimate medical purpose.

Additionally, Dr. Bauer was not acting as a physician, he was prescribing outside the usual course of medical care by doing this. A prudent physician would not have continued prescribing Controlled Substances under these circumstances.

Q. You said that the defendant caused -- that Dr. Bauer caused harm to the patients. Is it unusual for a patient who becomes an addicted to support the doctors that give them the prescriptions and the pills they crave?

MR. GIBBONS: Objection, Your Honor.

THE COURT: Overruled.

A. What you're addressing is the one C that I referred to in addiction which is compulsion and/or the control. The -- the addict does not have control of what he does. He can't stop. And he has compulsion in the sense that he's always going to be thinking about where can I get my next fix, where can I get my next medication. Those two things, loss of control and compulsion, will cause the addicted patient to do whatever it takes to get the medication, and that means if they're getting their medications from someone like Dr. Bauer, they will continue to praise Dr. Bauer and tell him that he's doing a good thing, and we saw that in some of the notes from Nathan, as an example, that he was very pleased with Dr. Bauer's care because Dr. Bauer provided the medications. So, no, we would expect an addict to work in his own best interest or his perceived best interest and to do whatever that takes and say whatever is necessary to keep his medications coming. So yes, I would expect an addict to support the provision of opioids from Dr. Bauer.

Q. And are you familiar with Dr. Bauer's CV or resume?

A. I have reviewed it, yes.

Q. Okay. And are you aware that he has a Ph.D in

Neuroscience in neuropathic pain?

A. I'm aware that he has a Ph.D. in Neuroscience. The neuropathic pain I interpreted it as his area of interest within the larger field of Neuroscience.

Q. Does having a Ph.D., in of itself, qualify a physician to treat long-term management of pain?

A. No, it does not. A Ph.D. is a research degree, and a research degree is granted because a -- an individual, could be a doctor, usually it's not, is interested in pursuing a certain part of experimental research in a particular area, in this case Neuroscience. But it has nothing to do with the clinical practice of pain management. It has nothing to do with how to treat patients. A Ph.D. is a separate research or experimental degree, an M.D. is a medical degree that allows us, as physicians, to actually treat patients. The two are separate, they're separate words essentially.

Q. What's the difference between clinical and in the lab?

A. Okay. Fair question. In general, when we look at research, and I don't mean to get eccentric at this hour of the day, but, by and large, research can be divided into three large categories.

We have the experimental or in-the-lab research where we're feeling with mice and rats, or we're dealing

with specific situations where, judging by some of the papers Dr. Bauer authored, he was using functional MRI studies to evaluate patients' brains and the way they worked under certain circumstances. Those weren't clinical patients. Those weren't patients that we would see in the clinic. Functional MRIs aren't even tests that I can order because they aren't covered by insurance, and we don't understand diagnostically in the real world how to use it. So that's the experimental side of things in the lab, if you will. And those are important studies. They're important because long term they'll help us understand pain and other things better. They don't have a direct route to how to take patients in the office, take care of patients in the office.

So then the second category are as medical research where we might say, well, I'm going to put this medication or this patient on Neurontin, let's say, and see how he does. So we do medical studies, medical research having to do with real patients doing very controlled and well thought-out studies that we look at to see how patients respond to various treatments, interventions or perhaps to better define certain types of disease. That's where we work with actual patients in -- in the -- in the clinic.

And then the third one I'm not going to talk to

you about, but that's the epidemiological thing where we look at large populations and we go from basic science, clinical, and then large populations.

MS. DUSTIN: May I have just a moment, Your Honor?

(Government counsel conferring off the record.)

MS. DUSTIN: Your Honor, nothing further.

THE COURT: We're going to quit for the day, ladies and gentlemen, and appreciate, once again, your attention. Unless you choose otherwise, we'll start at 9:00 a.m. again tomorrow, and we'll invite the doctor back, give his voice a rest over the evening for cross-examination tomorrow morning. And I'll talk to you at the end of the day tomorrow about next week's schedule.

Please remember all the rules. We're adjourned.)

(Jury excused at 5:05 p.m.)

C E R T I F I C A T E

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

S:/Angela D. Nixon September 8, 2021

Angela D. Nixon, RMR, CRR Date

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