1 THE COURT: All right. We're going to bring up the
2 jury. We had a juror with a family emergency this morning
3 which is why we are running late, but they are here now,
4 full -- full panel, so we'll get going but that's why we're a
5 little tardy this morning. He just arrived.
6 COURT SECURITY OFFICER: All rise for the jury.
7 Jury in.
8 THE COURT: All right, ladies and gentlemen. I know
9 we're getting a little bit of a late start. I know we had an
10 issue with one of the jurors and I'm so sorry about that. I
11 know that is stressful, so hopefully everything is okay. I'm
12 glad everybody is here. I know we also have a birthday in the
13 jury. Yes? Yes? So I believe he's appropriately fed his
14 fellow jurors which was very kind, so happy birthday. Get all
15 your notebooks out we're going to continue on this morning
16 with cross-examination of this witness. Mr. Chapman, go
17 ahead.
18 MR. CHAPMAN: Thank you, Your Honor.
19 Q. Good morning, Doctor.
20 A. Good morning, sir.
21 Q. Yesterday during your testimony on direct examination you
22 mentioned a few guidelines that you applied to your review in
23 this case, correct?
24 A. That's correct.
25 Q. And one of them was the Federation of State Medical Board

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1 guidelines, correct?
2 A. Correct.
3 Q. They have gone through a few different revisions; is that
4 right?
5 A. They have gone through a few different publications and
6 built on the original publication.
7 Q. And which year guidelines did you apply in this case?
8 A. Well, they all were applicable, but beginning in 2007
9 foundationally those were applicable, and then from there,
10 there were -- excuse me -- 2007 I believe were the main ones.
11 And I believe there are 2004 guidelines as well. I don't
12 remember exactly the year that the second edition guidelines
13 came out but 2007 for sure. 2012 as well.
14 Q. There's also been a 2017 revision. Did you apply those in
15 this case?
16 A. No.
17 Q. Okay. And that's because those came into place after the
18 treatment in this case?
19 A. After the time frame of this case, correct.
20 Q. Okay. Now, the Federation of State Medical Boards is an
21 entity that essentially advises medical boards on certain
22 matters of policy, correct?
23 A. That's correct.
24 Q. Okay. And these guidelines were sent to the different
25 medical boards in the states in order to help them draft some

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1 sort of opiate policy?
2 A. That's correct.
3 Q. And the states could decide whether or not they wanted to
4 adopt or reject those guidelines, correct?
5 A. States and other organizations as well, but yes.
6 Q. Okay. And if a state adopted the guidelines, they could
7 adopt those guidelines in part or in full, correct?
8 A. Correct.
9 Q. And so it would be important then to look at whether or
10 not Kentucky and Indiana, the two states involved in this
11 case, fully adopted those guidelines, right?
12 A. Yes.
13 Q. Okay. Did you compare to determine whether or not Indiana
14 and Kentucky fully adopted those guidelines?
15 A. I looked at Indiana, I looked at Kentucky, I looked at the
16 American Academy of Family Medicine and applied that thought
17 process to those three organizations. Those three entities.
18 And to the extent I could tell they adopted them without
19 exclusion.
20 Q. So what you're telling us is you compared the Federation
21 of State Medical Board guidelines to let's start with the
22 Kentucky regulations and determined they adopted them in full?
23 A. What I did was noted that Indiana and Kentucky were
24 signatories to the Federation of State Medical Board
25 signifying they accepted the recommendations as printed. I

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1 did not go through -- if what you're asking, I did not go
2 through in terms of a point-by-point comparison.
3 Q. Okay. Wouldn't it just be better to look at the
4 individual guidelines that were put out by both boards?
5 A. Well, I think it's important to look at both to the extent
6 the state boards in Kentucky and Indiana are signatories to
7 the Federation of State Medical Boards. It would be
8 appropriate to look at both.
9 Q. Okay. But if an individual board adopted its own
10 guidelines and sent that to providers as a message of how
11 we're going to view these cases, isn't that really the
12 important thing to look at in this case?
13 A. Well, it's foundational. It's meant as a reference for
14 physicians, so physicians know how to act in this manner -- in
15 the proper manner, but we have to understand too that there
16 are also bibliographies and references associated with the
17 putting forth of the various guidelines and those guidelines
18 in both Indiana and Kentucky are referenced to try to reach
19 those state medical boards.
20 Q. Okay. So let's talk specifically about these type of
21 guidelines. First of all, a medical board in a state is the
22 entity that governs the licensing of physicians and other
23 practitioners, correct?
24 A. That's correct.
25 Q. And when they take action, they can determine whether or

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1 not a violation of their guidelines or recommendations has
2 occurred and then offer some sort of discipline to that --
3 that practitioner, correct?
4 A. Correct.
5 Q. All right. And that -- that discipline could be either a
6 suspension of their license or it could be probation or some
7 other intermediate kind of sanction, correct?
8 A. They have a number of options for sanction.
9 Q. All right. And the guidelines that you're referring to in
10 Indiana and Kentucky both apply to how a board would view
11 whether or not they should take professional action against a
12 practitioner, correct?
13 A. The guidelines in the Federation of State Medical Boards
14 put forth the criteria that define the proper use of opiates
15 and the treatment of chronic pain. The Federation of State
16 Medical Boards recommendation said nothing about sanction or
17 how the medical board should handle practitioners who are
18 outside those guidelines.
19 Q. Well, I think now we're really talking about the
20 individual guidelines in Kentucky and Indiana. Those
21 guidelines are a statement by the Board of how they will view
22 their decisions regarding licensure discipline of a
23 practitioner, correct?
24 A. They are foundational guidelines for going forth with
25 deciding how they like to proceed with sanction, yes.

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1 Q. These guidelines aren't something that has been put into
2 the form of a statute and made an absolute rule with the
3 potential for a criminal sanction, right?
4 A. That's correct.
5 Q. Okay. And so it's fair to say that violation of one of
6 these does not automatically trigger some criminal statute,
7 correct?
8 A. That's correct.
9 Q. Nor have these been put into the federal criminal code and
10 have been determined to trigger a criminal sanction if they're
11 violated, correct?
12 A. These are meant just to be guidelines and -- and not to
13 determine sanctions.
14 Q. Okay. And in fact the Kentucky regulations that we've
15 already gone over with the previous witness specifically state
16 that the opinion is not a statute administrative regulation
17 and does not have the force of law, correct?
18 A. That's correct.
19 Q. And that's in the very first paragraph of the Kentucky
20 2008 guidelines?
21 A. Correct.
22 Q. And that's under the paragraph that is labeled legal
23 authority, right?
24 A. Correct.
25 Q. All right. Further on the guidelines specifically state

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1 that these aren't a requirement to strictly adhere to them,
2 isn't that right?
3 A. Given that they were put forth as guidelines, that's
4 correct.
5 Q. In fact they say the board does not take disciplinary
6 action against a physician who fails to adhere strictly to the
7 provisions of this opinion if good cause is shown for a
8 deviation?
9 A. My recollection is that you're quoting that correctly.
10 Q. Okay. And if you need to see this at all, I would be more
11 than happy to show it to you.
12 A. If I had a copy for global review, that would be great if
13 you're going into some detail but so far we're okay.
14 Q. Okay. Well, let me get through one more sentence. They
15 also say the physician's conduct will be --
16 MR. ANSARI: May I approach, Judge?
17 THE COURT: Yeah. You have to object in the
18 microphone. I can't hear you.
19 (Bench conference on the record.)
20 MR. ANSARI: All right. My only objection -- I
21 think we need to be clear. I think this is a 2008 opinion and
22 we're saying guidelines as if it's House Bill One, so I think
23 he's -- I want to make sure he knows exactly what he's
24 answering. This is the opinion, not the House Bill One, I
25 assume, right?

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1 MR. CHAPMAN: I can clarify that with the witness.
2 THE COURT: Yeah. I'm sorry. I thought -- okay. I
3 thought it was the house bill too.
4 MR. CHAPMAN: I said 2008 guidelines.
5 THE COURT: So you're just going to clarify on the
6 record?
7 MR. CHAPMAN: Yeah, I'll clarify.
8 (End of bench conference.)
9 BY MR. CHAPMAN:
10 Q. Doctor, I just want to make sure that for the purposes of
11 the last few questions about the Kentucky Board opinion, I'm
12 referring to the 2008 opinion. Does that fact change any of
13 your previous answers?
14 A. No.
15 Q. Okay. So this board opinion in addition to saying that
16 they don't take disciplinary action for failure to strictly
17 adhere to the recommendations, it says the physician's conduct
18 will be evaluated to a great extent by the treatment outcome,
19 isn't that right?
20 A. That's correct.
21 Q. And with respect to the treatment outcome we're looking at
22 things such as condition of the patient and whether or not
23 there was any harm to the patient, right?
24 A. That's a pretty limited view. Actually this is where I
25 really need to see the document in order to answer precisely.

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1 Q. Sure. I would be happy to show it to you. Can we have
2 this just on the witness and counsel? And it's the second
3 highlighted sentence in the first paragraph, Doctor. When
4 you're done reading, feel free to look up and then we can
5 continue.
6 A. The answer in terms of what are the goals of -- I'm going
7 to say effective pain management based on what's presented
8 here are pretty well defined here and I'll -- can I just read
9 them off? I'll just read them as they're on here.
10 Q. Absolutely. Those were the next few questions, so if you
11 want to, feel free to read the three recommendations. That's
12 fine.
13 A. Sure. I'll read it in the entirety, so the jury knows the
14 context. The Board does not take disciplinary action against
15 a physician who fails to adhere strictly to the provisions of
16 this opinion if good cause is shown for such deviation. The
17 physician's conduct will be evaluated to a great extent by the
18 treatment outcome taking into accounting, one, whether or not
19 the drug used is medically or pharmacologically recognized to
20 be appropriate for the diagnosis. Number two, the patient's
21 individual needs including improvement in functioning. And
22 three, a recognition that some types of pain cannot be
23 relieved -- completely relieved.
24 The second of that, the beginning of that, is
25 germane as well. It states in its entirety here, The Board

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1 will judge the validity of prescribing based on the
2 physician's treatment of the patient and on available
3 documentation rather than only the quantity or chronicity of
4 prescribing. The goal is to control the patient's pain for
5 its duration while effectively addressing other aspects of the
6 patient's functioning, including physical, psychological,
7 social, and work-related factors. There's more to that
8 paragraph but that portion I read is the most germane part.
9 Q. Thank you for reading that for us, Doctor. So I think we
10 see a few interesting things here. First, the Board says very
11 clearly the goal is to control the patient's pain for its
12 duration but simultaneously to address those other aspects of
13 the patient's life that you read, is that right?
14 A. Again, I think you're paraphrasing it a little different
15 than the intent. My read on that as a physician would be that
16 there has to be an indication of an improvement in pain which
17 typically is like the VAS pain score and there has to be
18 improvement in function, and the function can be demonstrated
19 and proved by looking at the physical improvement of the
20 patient in terms of his ability to function as well as perhaps
21 return to work and improvement of various psychosocial issues.
22 Q. Doctor, where in this opinion does it say improvement of
23 functioning is a prerequisite for prescribing a controlled
24 substance?
25 A. If you put it back up again, I'll reread that portion.

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1 Q. I'd be happy to.
2 A. So on the second -- beginning of the second sentence in
3 the second paragraph it says, the goal is to control the
4 patient's pain -- and to a physician like myself that means
5 the VAS score -- for it's duration while effectively
6 addressing other aspects of the patient's functioning
7 including physical and work-related factors.
8 Q. And this indicates that you have to address it, but it
9 does not make improved functioning a prerequisite to a
10 controlled substance prescription; is that right?
11 A. For continuation of a controlled substance prescription it
12 is a prerequisite that we must demonstrate as providers an
13 improvement in both the pain score and the function of the
14 patient.
15 Q. So, Doctor, you're giving me your opinion, but what I'm
16 looking for is where that is stated on this document because
17 that's what we're talking about. Let me finish the question.
18 Where on this document does it say improvement of function as
19 you've testified to on the stand is a requirement for
20 prescribing a controlled substance?
21 A. Well, I'll read the second part of that paragraph then and
22 that will answer to the extent we can. The following opinion
23 is not intended to define complete or best practice, but
24 whether to communicate what the board considers to be within
25 acceptable boundaries of professional practice when

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1 prescribing for recurrent or persistent chronic pain. So
2 essentially what this is saying is that acceptable boundaries
3 from the Board's perspective requires an improvement in pain
4 and improvement ing function.
5 Q. I'm sorry, sir. I did not hear any aspect of what you
6 just read to the jury as requiring an improvement in pain. It
7 doesn't say that anywhere in the documents.
8 A. No. That's -- that -- I read what it said in the
9 document.
10 Q. But it doesn't say that improvement in functioning is a
11 prerequisite for a controlled substance prescription on this
12 document, isn't that right?
13 A. Well, it says that the Board considers acceptable
14 boundaries of professional practice to include pain and
15 function.
16 Q. Okay. In fact, Doctor, there are some patients whose
17 function may never actually be improved even though they're on
18 controlled substance medication; is that correct?
19 A. Well, if the function was on improve, that's an argument
20 to stop treatment with chronic opiates.
21 Q. So somebody should -- even though they're receiving a
22 reduction of pain under the VAS scale that you've testified
23 about but no improvement in functioning, your recommendation
24 would be to discontinue opiates and risk higher pain on the
25 VAS scale?

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1 A. Not my opinion. Standard of care states that if pain only
2 in terms of VAS is improved but function is not addressed,
3 then that is not acceptable for continuation of chronic opiate
4 therapy.
5 Q. So I go in a doctor's office and complain of pain level
6 nine, while the doctor's trying to figure out what's wrong
7 with me, they prescribe a medication that brings me down to a
8 pain level four. If they continue to test my function and
9 does not improve while I'm on that pain medication, are you
10 saying that the Board is requiring a physician to discontinue
11 that pain medication bringing me up to a higher pain score
12 because my functioning hasn't improved?
13 A. Well, as I mentioned earlier, the answer to that question
14 is yes because pain is a subjective response, and if someone
15 is suffering from psychogenic pain like we talked about
16 yesterday for which opiates are not appropriate, they
17 nevertheless will indicate to me their pain score's improved
18 because opiates are sedatives and it will address
19 psychosomatic pain but not in an effective or safe manner,
20 so --
21 Q. So pain -- pain that does not have a corresponding
22 increase -- prescribing pain medication without a
23 corresponding increase in functioning suggests to you that
24 pain is psychosomatic and in the head; is that right?
25 A. It suggests that the psychosomatic portion may be

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1 addressed by the opiate, but the function of the pain
2 management overall is to improve function, so function is not
3 correspondingly improved and there is not a foundation laid
4 for a continuation of opiates. And that's stated pretty
5 clearly there in the 2008 directive that we just looked at.
6 Q. Well, let's read another portion of this. Isn't it true,
7 sir, the Board also states it's the goal of the physician to
8 assist in the relief of suffering no matter the cause?
9 A. In order to answer that I would like to read that whole
10 paragraph, otherwise that's out of context.
11 Q. Sure.
12 A. So the paragraph reads as follows -- and, again, this is
13 out of the 2008 Kentucky Medical Board recommendation for the
14 use of opioids. By definition pain is a subjective statement
15 of a patient's perception of actual or potential tissue
16 damage. The distinction between pain and suffering should be
17 established. A patient may suffer due to pain but may have
18 other reasons for suffering as well. The assessment of a
19 patient's overall condition should be made at the initial
20 evaluation and thereafter. It is the goal of the physician to
21 assist in the relief of suffering no matter what the cause.
22 Financial, emotional, mental, physical, and spiritual factors
23 may contribute to the patient's suffering. Relief of the
24 underlying reasons for suffering as well as the pain will lead
25 to optimal treatment and utilization of controlled substances.

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1 Q. So despite the fact this Board's recommendation states the
2 goal of the physician is to relieve suffering, you believe
3 that it's appropriate to increase the suffering of a patient
4 by removing pain medication and therefore increasing their
5 pain level on a VAS scale simply because of lack of improved
6 functioning. Is that your testimony?
7 A. No, Counselor. You've taken that out of context. What
8 the Board says -- and they differentiate into what I just read
9 very clearly. There is a difference between suffering and
10 pain. We understand suffering for emotional, financial and
11 relationship issues, but pain is a separate issue. And what
12 they're saying is as a physician we should try to relieve
13 suffering, recognizing pain is perhaps a component of that
14 which perhaps we may need to use opiates, but they're not
15 saying use opiates for suffering in general recognizing that
16 that's a psychological issue that is treated differently.
17 Q. I feel like that was a very complicated answer to a very
18 simple question. Is it your testimony that a patient should
19 be removed from pain medication if they don't show a
20 corresponding improvement of function?
21 A. That is correct.
22 Q. In every case?
23 A. Well, I don't know that we can always say every case, but
24 the compelling argument is the prevailing argument. The
25 prevailing standard of care is that both pain and function

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1 have to improve. And failing to improve function, opiates
2 should be removed from a treatment option.
3 Q. Are you aware of any conditions out there that may subject
4 a patient to pain but could never be improved by other
5 modalities to increase functioning by a patient?
6 A. So say that question again.
7 Q. Are you aware of any conditioning out there that might
8 subject a patient to pain where corresponding functioning may
9 never be improved?
10 A. If we include function as -- as the medical board opinion
11 put there considering improvement in going back to some sort
12 of activity in the manner they described it, I'm not aware of
13 anything that -- any example that would fulfill your
14 hypothesis there. The function doesn't have to mean the
15 patient went back to work. It can mean they can function in
16 the household, they can walk a block, they can cook a meal,
17 they can go pick up their hobby. It doesn't have to be
18 dramatic, but it has to be relatable to function in some
19 manner. So the short answer is no, I'm not aware of any
20 examples where that does not exist.
21 Q. Let's talk about complex regional pain syndrome; the
22 syndrome that Brandon McDonald had. You indicated he was
23 diagnosed by Dr. Sepal; is that correct?
24 A. Dr. Sepal brought it up as a possible working diagnosis --
25 as a working diagnosis based on the examination that was

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1 documented by the Campbell Medical Group as well as Dr. -- I
2 remember saying the neurologist. There was not support for a
3 final diagnosis of RSD. It did not fulfill the criteria, so
4 we can assume that's a working diagnosis which was later
5 disproved, but go ahead with your question.
6 Q. Is it your belief that you can actually diagnosis complex
7 regional pain syndrome?
8 A. You can't diagnosis it positively. And I can talk to the
9 jury more about what that disease is because it's a rather odd
10 one, but what we can do is we can exclude it.
11 Q. This wasn't excluded at all, though, was it?
12 A. The physical exam did not demonstrate the three or four
13 parameters necessary to diagnosis it.
14 Q. Well, we'll get into Brandon McDonald in a bit. During
15 your testimony you also made reference to the 2016 Center for
16 Disease Control opiate guidelines; is that correct?
17 A. Say that question again.
18 Q. During your testimony yesterday you made reference to the
19 2016 CDC opiate guidelines; is that correct?
20 A. No, that's not correct.
21 Q. Didn't you -- didn't you say there's the principle of
22 start low, go slow?
23 A. That's a general principle of medicine that was taught to
24 us back in the 1970 s in our pharmacology class. That's not
25 something that has just newly come about.

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1 Q. You didn't testify that came from the CDC guidelines.
2 A. Well, the CDC adopted it and put it forth.
3 Q. My question was you didn't testify that came from the CDC
4 yesterday.
5 A. I did but not the 2016 CDC guidelines.
6 Q. Did you apply the 2016 CDC guidelines at all in this case?
7 A. No.
8 Q. Okay. So when you were reviewing the documents even
9 recently you didn't view that in mind of the CDC guidelines?
10 A. No -- well, the CDC -- there have been many CDC guidelines
11 and publications over the years. The big one that you're
12 referring to is 2016. That's after the time frame of the
13 course that we're reviewing now, so no I did not apply that to
14 my opinion.
15 Q. Okay. Well, let's talk a bit about those guidelines
16 though because I think it's important to discuss the
17 progression of the public view of --
18 MR. ANSARI: May we approach?
19 THE COURT: Yeah.
20 (Bench conference on the record.)
21 MR. ANSARI: We object this was the motion that we
22 filed preliminary, the motion in limine, about discussing
23 guidelines outside the indictment period. He did not apply
24 the 2016 guidelines. It's outside the indictment period and
25 irrelevant to this case.

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1 MR. CHAPMAN: Your Honor, he did make reference to
2 them a couple of times yesterday. In addition, I think it's
3 important to discuss through this witness the progression of
4 the public view of pain management and the development of a
5 lot of these regulations and how there has been a pull back
6 from the 2016 CDC guidelines and much of the policy that's
7 included in the two board recommendations that were made
8 previously.
9 THE COURT: What's the relevancy?
10 MR. CHAPMAN: The standard of care changes and
11 evolves when it comes to opiate and it's right now in a huge
12 period of evolution and I think that's important to talk
13 about.
14 MR. ANSARI: What matters is the standard of care
15 between 2010 and 2016 and specifically between '12 and '14.
16 MR. CHAPMAN: Well, I don't think a violation of the
17 standard of care triggers criminal culpability here. I think
18 the question is whether prescriptions were issued outside the
19 course of professional practice for other than a legitimate
20 medical purpose, so rigidly applying 2008 and 2014 Board
21 opinion as being the end-all be-all of that is not
22 appropriate. I think what we need to do is see how there's
23 been an evolution in the view of pain management and look at
24 some of the recent guidance in response to the guidelines.
25 THE COURT: I don't think this is what this jury's

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1 going to be -- or what this witness is applying. If he had
2 said he applied the 2016 guidelines, I'd be fine to go into
3 but if he hasn't applied them, then I think that's going to
4 get confusing because we're not applying 2016 to this case.
5 MR. CHAPMAN: Okay.
6 THE COURT: We've tried to stay inside the
7 indictment period although we've gone a little bit before it
8 and a little bit after it, but if he says he didn't apply
9 them, then they're going to have plenty of guidelines to be
10 thinking about in their head. I don't think we need to add
11 yet another one.
12 MR. CHAPMAN: The concern here is that the view of a
13 appropriate pain management has significantly changed and
14 evolved, just like the view of other matters of public policy.
15 And it's important for us to not just look at the rigid
16 application of guidelines that were in place at the time, but
17 look at this case through the lens of how we have reacted
18 since then. There's a lot of information that --
19 THE COURT: He wouldn't have known any of that at
20 the time he was -- at the time he was practicing, he would not
21 have known subsequent --
22 MR. ANSARI: Right. It goes to jury --
23 MR. CHAPMAN: That's true if it was a civil standard
24 of care case, but it's not. This case determining whether or
25 not there was a legitimate medical purpose and in order to

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1 understand whether or not there was a legitimate medical
2 purpose for medication, the common view of appropriate pain
3 management is just as important as what the view was then
4 especially if it changed the prior view of appropriate pain
5 management.
6 If there was a guideline in 2013 that has now been
7 significantly changed by public policy retraction of those
8 guidelines, that's important to discuss when we're determining
9 whether or not the guidelines that were applicable still
10 remain true or whether they're now kind of defunct and have
11 been questioned.
12 MR. ANSARI: The standard of care remain the same.
13 The CFR remain the same. The standard is what it is and
14 didn't change in 2016. 2016 is nothing but jury nullification
15 and irrelevant to this case.
16 MR. CHAPMAN: This is not a standard of care case,
17 Your Honor. This is a question of legitimate medical
18 treatment and we need to look at the full range of guidance
19 available in order to understand whether or not it was.
20 THE COURT: That guidance wasn't available to him at
21 the time at all.
22 MR. CHAPMAN: But, again, this is not civil standard
23 of care case, Your Honor. I would under if we're in a civil
24 malpractice case and we're determining whether a prescription
25 was appropriate, but that's not what we're here to do. If

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1 there was a guideline that said --
2 THE COURT: The standard of care is part, correct?
3 And he's only testifying to that part.
4 MR. CHAPMAN: That's true, yeah.
5 THE COURT: And he's only testifying to the standard
6 of care piece of it. I'm concerned that if you add yet
7 another guideline that we're going to confuse the issue seeing
8 he just said he didn't apply it. If this were a specific
9 guideline that he had applied, I would allow it in, but I
10 don't think we need to confuse the issue of what the
11 applicable standard of care was during a period.
12 MR. CHAPMAN: Well, he did apply it, Your Honor. He
13 said that dosages above 90 MME are disfavored, which is
14 something that was adopted first in the guidelines. He said
15 start low and go slow which he just admitted was something
16 that came directly from the guidelines.
17 THE COURT: That was an earlier guideline.
18 MR. ANSARI: Yeah. He's talking about standard of
19 care. The guidelines just adopted what was already in the
20 standard of care in the medical community.
21 MR. CHAPMAN: That's not something that has been --
22 the start low, go slow prior document he's referring to hasn't
23 been admitted, but that is something in the guidelines and now
24 that has been changed.
25 THE COURT: He indicated where he got that from. If

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1 he had no statement about where that came from, then I think
2 you could question him on it. You could probably question him
3 on it in anyway, but to the extent that he said he didn't
4 apply it, I mean, I don't think you can get into the specifics
5 of it. If he says he applies it or if he, you know, indicates
6 that something he said came from it and can't point to
7 something earlier, well, then he's inappropriately applied the
8 guideline, but I don't think he's indicated that as of yet.
9 MR. CHAPMAN: I think he really did apply the
10 guidelines and now he's backing away from it and that's what I
11 want to cross-examine him on.
12 THE COURT: Well, you say that, but there's nothing
13 yet that he's answered that he said he applied those
14 guidelines to.
15 MR. CHAPMAN: Yesterday he testified to a few things
16 that were in the guidelines which I just talked to him about.
17 Also his 90 morphine milligram equivalence guidance comes from
18 the guidelines. His opiates -- his opiates are an item of
19 last resort is testimony that came directly from the
20 guidelines. He's now saying he didn't apply the guidelines,
21 but he really did.
22 MR. ANSARI: All of those things were already in the
23 medical community way before the guidelines came out. That's
24 what guidelines do.
25 THE COURT: You can ask that question. I mean,

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1 that's a fine question, but if he says they were already in
2 the standard of care prior to that -- I mean, a lot of these
3 guidelines they don't just start something.
4 MR. CHAPMAN: Sure.
5 THE COURT: I mean, they come from something.
6 MR. CHAPMAN: It was a collection of documents that
7 created the CDC, I agree.
8 THE COURT: So to the extent he's using something
9 else that is just later codified in those guidelines, I don't
10 think that means we bring in a whole nother set of guidelines
11 to this jury, so let's -- I'm fine with you asking about
12 specific areas that you believe came from that, but if he
13 answers that that's not where he got them, then you need to
14 move on.
15 MR. CHAPMAN: Okay.
16 (End of bench conference.)
17 BY MR. CHAPMAN:
18 Q. Doctor, yesterday on the stand you testified that starting
19 a patient on opiate treatment should be an agent of last
20 resort; is that right?
21 A. Typically it should be a treatment of last resort,
22 correct.
23 Q. Okay. And that's how you treat your patients in your
24 practice as well?
25 A. Well, the way I treat my patients is according to what

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1 I've talked about is to do an evaluation first and then once
2 an evaluation -- an evaluation is performed and a diagnosis
3 determined, a treatment plan is formulated. Those three
4 things I talked about.
5 Q. Doctor, I did not ask you to reiterate the three things.
6 I was asking if you use that principle; opiates are a
7 treatment of last resort when you treat your patients?
8 A. Well, having gone through those three processes,
9 evaluation, diagnosis, and the treatment plan, I will use -- I
10 will consider opiates if appropriate after having gone through
11 those three processes. And I will -- and I will use them as a
12 last resort once having reached that point, but again there
13 is --
14 Q. Is it a yes, Doctor?
15 A. Well, it's a process. I can't answer yes or no based on
16 the way you phrased it.
17 Q. Is that something you consider when you're treating your
18 patients; I use opiates as a treatment of last resort?
19 A. No. The way I phrase it in my mind is it's not my first
20 choice. Perhaps that clarifies it.
21 Q. But you testified on this stand in this case that you
22 believe they should be treatments of last resort, correct?
23 A. They typically are thought of as treatments of last
24 resort, that's correct.
25 Q. Typically thought of. Is that how you typically think or

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1 is that what other people typically think?
2 A. That's not what other people typically think. We have
3 found -- we have not found any that opiates improve function
4 in the case of chronic pain.
5 Q. Is this a principle of opiates as treatment of last resort
6 that you applied in your review of Dr. Campbell's care?
7 A. It's not a principle. You phrase it as a principle and I
8 don't see it as a principle. It's a general knowledge that
9 opiates cause problems, so it's not the first thing we think
10 of. It's more towards the last thing we would think of
11 because of the harms associated with it.
12 Q. Okay. So, again, your testimony is that opiates should be
13 considered a treatment of last resort?
14 A. Well, it should not be the first thing that comes to mind.
15 It should be more towards the last thing that we might
16 consider.
17 Q. That's different than your testimony yesterday, isn't that
18 right?
19 A. Well, maybe it's a modification of what I said yesterday,
20 but within the context of what we're talking about now it's a
21 tool, but it's a tool that we don't reach for first. We tend
22 to reach for it at the end.
23 Q. This is very important, though. You told this jury
24 yesterday when talking about Dr. Campbell's care very
25 critically that he should consider opiates as a treatment of

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1 last resort, isn't that right?
2 A. In the context of what we talked about yesterday opiates
3 were the first choice and that's not correct. Opiates --
4 Q. That's not what you said yesterday, though, sir. It's
5 true that you told this jury Dr. Campbell should have
6 considered opiates as a last resort?
7 A. In the context of care he offered to these patients with
8 these diagnoses, that's correct.
9 Q. Okay. And that's how you reviewed his care, correct?
10 A. Well, I reviewed his care with a neutral approach and it
11 did not -- it did not indicate that he considered other
12 treatments -- did not emphasize other treatments prior to
13 going to opiates.
14 Q. Okay. Did you see -- that's interesting testimony because
15 did you see a single patient -- well, let me rephrase. Did
16 you testify yesterday about a single patient where
17 Dr. Campbell started an opiate trial?
18 A. I don't recall.
19 Q. Every single patient that you reviewed yesterday on the
20 stand was previously on opiates by a different provider; isn't
21 that right?
22 A. Again, I don't recall specifically. It could be, but I
23 don't recall specifically.
24 Q. Isn't that important? You testified about five files.
25 First one Brandon McDonald on opiate by a prior provider,

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1 isn't that right?
2 A. Again, if I had my reports here I could tell you
3 specifically.
4 Q. If you don't remember that's okay. The second patient,
5 Michelle Smith, on opiates from a different provider, do you
6 remember?
7 A. Again, if I have my files, Counselor, I could answer your
8 directly, but --
9 Q. Do you remember if Brenda Singleton was on opiates from a
10 different provider?
11 A. I -- I would have to look at the files.
12 Q. Christy Martin, do you remember that at all?
13 A. I would have to look at the files.
14 Q. Okay. Constance McFarland, do you recall?
15 A. Again, I would have to look at the files. I think as you
16 represent it certainly many of those patients were on opiates
17 prior, but you're asking me specifically, so I'd have to see
18 the -- my records on that.
19 Q. Well, it was just your testimony from your recollection
20 that Dr. Campbell didn't consider other treatments before
21 starting a patient on opiates. Isn't it strange that you can
22 remember that fact, but you can't remember whether or not any
23 of these patients came to Dr. Campbell without opiates in
24 their system?
25 A. Well, it's not strange. It begs the question of did the

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1 patient go through a successful opiate trial prior, and I
2 could elaborate on that if you would like, but that would be
3 my response to your questions.
4 Q. You said he should have considered other alternatives
5 prior to starting a patient on an opiate, wasn't that your
6 testimony?
7 A. In general that's true. I don't recall specifically what
8 I said verbiagewise.
9 Q. Well, with respect to opiates as a last resort, you
10 testified at least five times yesterday about a 2005 article
11 called Universal Precautions in pain medicine; is that right?
12 A. That's correct.
13 Q. Okay. And you used that document to help formulate your
14 idea of the standard of care in this case?
15 A. It was contributory to it, correct.
16 Q. Along with other sources, correct?
17 A. Yes.
18 Q. Okay. But you would agree with me that that was the
19 article that you most frequently talked about yesterday,
20 right?
21 A. Well, it was one that came up in discussion, sure.
22 Q. Okay. In that article isn't it true that that article
23 specifically disagrees with your assessment as opiates as a
24 last resort?
25 A. Again, your -- you're quoting out of context. If I had

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1 the document in front of me we would review it together.
2 Q. Well, let me read this portion of the document from the
3 2005 article that you referenced. Although opiates should not
4 routinely be thought of as a treatment of first choice, they
5 must also not be considered agents of last resort. Isn't that
6 what the article says?
7 A. Well, again, you're quoting it. I don't have it here in
8 front of me.
9 Q. Okay. I can show it to you. Paragraph six first -- first
10 part.
11 A. Okay. And, again, I think context is important. It's a
12 short paragraph, so perhaps I could read the whole thing.
13 Q. Doctor, my question is very specific. Isn't it true this
14 article, the one you cited, contradicts your opinion on the
15 stand yesterday that opiates should be treated as a treatment
16 of last resort?
17 A. You're taking it out of context. I'd like to read the
18 following two sentences.
19 Q. I'm talking about the first sentence, Doctor.
20 A. I know. And I'm talking about it being out of context
21 part of a single paragraph and I think the jury would
22 appreciate hearing the whole context.
23 Q. Dr. King, yes or no. The article specifically states
24 although opiates should not routinely be thought of as a
25 treatment of first choice, they must also not be considered

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1 agents of last resort. Does the article you cited say that?
2 A. The first sentence in that paragraph says that. Then it
3 goes on to explain that further.
4 Q. You think that the next few sentences qualify that and
5 make what you said to this jury yesterday true?
6 A. I'd be happy to read it and let the jury form their own
7 opinion.
8 Q. Let's read it and see if that happens.
9 A. So the context is important here. This is number six of
10 ten recommendations. And its under the subheading number six
11 that says, appropriate trial of opioid therapy plus minus
12 adjunctive medication and the paragraph reads as follows:
13 Although opioids should not routinely be thought of as
14 treatment of first choice, they must also not be considered as
15 agents of last resort. Pharmacologic regimens must be
16 individualized based on the subjective as well as objective
17 clinical findings. The appropriate combination of agents
18 including opioids and adjunctive medications may be seen as,
19 quote, rational pharmaco-therapy and provide a stable
20 therapeutic platform from which to base treatment changes.
21 Q. Thank you for taking the time to read that. Doctor, does
22 anything that you just read make your statement yesterday that
23 opiates should be considered a treatment of last resort
24 supported by this document?
25 A. Yesterday we were not talking about pharmacologic

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1 regimens. We were talking about opiates by themselves. This
2 is referencing opioids in the context of other adjunctive
3 medication. And in any event, as I said a little bit earlier
4 in our discussion, another way of looking at this is opioids
5 should not be routinely thought of as a first choice which is
6 what it says to lead off this paragraph.
7 Q. My question was very clear. Does anything about the
8 paragraph you just took the time to read to the jury support
9 your statement yesterday that --
10 MR. ANSARI: I think it's been asked and answered,
11 Judge.
12 MR. CHAPMAN: He's not answering the question,
13 Judge.
14 THE COURT: I think he has answered this particular
15 question.
16 BY MR. CHAPMAN:
17 Q. I'll move on. Doctor, additionally in the 2005 article
18 that you cited, it had a similar preamble to the 2008 board
19 note that states that these precautions are not rigid rules,
20 correct?
21 A. I'll take your summarization of that. Again, if I had it
22 we could read it directly, but in general that -- that
23 probably is correct.
24 Q. Isn't it true that the Universal Precautions document that
25 you cited says, The following universal precautions are

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1 recommended as a guide to start a discussion within the pain
2 management and addiction communities?
3 A. That sounds correct.
4 Q. Okay. It doesn't even say they are considered guidelines,
5 correct?
6 A. I'd have to review it to answer that specifically.
7 Q. Feel free to review it and then look up when you're done.
8 A. Well, in that one paragraph that you showed me there on --
9 I don't know what page it is but it says, the following -- and
10 again to quote part of what you said.
11 Q. Doctor, I didn't ask you to read it out loud. I wanted
12 you to read it to yourself and look up so I could ask you a
13 few questions.
14 A. Again, what you read was Universal Precautions are
15 recommended as a guide, so it is a guideline.
16 Q. To start a discussion within the pain management
17 community, correct?
18 A. Correct.
19 Q. It's a guide for a discussion, correct?
20 A. It's a guideline, yes.
21 Q. It's a guide for a discussion?
22 A. Well, we're parsing words, but I interpret it as a
23 physician, as a provider, as a guideline.
24 Q. Nowhere in this document does it say it sets the standard
25 of care for how a prescriber should prescribe opiate

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1 medications; is that right?
2 A. It does not define standard of care in and of itself,
3 that's correct.
4 Q. And in fact it says they are not proposed as a complete
5 but rather as a good starting point for those treating chronic
6 pain.
7 A. Well, I don't know if it states that, but it certainly
8 offers itself as a guideline.
9 Q. Despite the lack of any mention of this document setting
10 the standard of care, you've applied it to set the standard of
11 care; isn't that right?
12 A. This article has been a part and parcel of defining the
13 standard of care over the years.
14 Q. Doctor, again, you're answering a different question.
15 Despite any statement in this document that this defines the
16 standard of care, you have applied it as a standard of care;
17 isn't that right?
18 A. It has been formative in determining the standard of care.
19 Q. Okay. It was your testimony yesterday that if a patient
20 shows red flags of addictive behavior, a physician should
21 consider stopping opiate therapy; is that right?
22 A. I don't remember specifically what my -- what my testimony
23 was, but certainly a -- it would be a red flag and things
24 would need to be reconsidered very carefully.
25 Q. Okay. And isn't it true the Universal Precautions article

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1 only suggests that if an addictive disorder predominates
2 aggressive treatment, an underlying pain problem will likely
3 fail if not coordinated with treatment for the concurrent
4 addictive disorder; is that right?
5 A. My recollection is that's correct.
6 Q. And what that really means is that if a patient shows an
7 addictive disorder, concurrent treatment for that addictive
8 disorder should be combined with the pain management, isn't
9 that right?
10 A. No. What it says it should be addressed first. Generally
11 understood in the medical community and as put forth in that
12 triage caution there. If I recall correctly, unless we treat
13 the addictive disorder first, pain management is going to be
14 unsuccessful.
15 Q. Doctor, does anywhere in these document suggest that you
16 must treat the addictive disorder first before starting pain
17 management?
18 A. Let's go to the very end, if you would, Counselor, and
19 show me the last page.
20 Q. The very end of the document?
21 A. Yes.
22 Q. I'm specifically talking about paragraph nine, the part I
23 read to you. If a addictive disorder predominates aggressive
24 treatment of an underlying pain problem will fail if not
25 coordinated. Now, Doctor, I have a very specific question.

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1 "Coordinated" usually means to work together, right?
2 A. That's correct.
3 Q. Okay. And what they're saying here is that you should
4 coordinate treatment for the addictive disorder along with
5 appropriate pain management, isn't that right?
6 A. No, that's not what it's saying. It compliments that
7 comment at the very end when it talks about the various risk
8 areas. And if my recollections is correct, it talks about
9 coordination of care with an addictive counselor or a
10 psychiatrist2. And is generally recognized as it says here
11 that, quote, aggressive treatment of an underlying pain
12 problem -- and opiates are an aggressive treatment -- will
13 likely fail it not coordinated with treatment for the
14 addictive disorder. And later on towards the end here talks
15 about coordinated treatment being working closely with an
16 addiction counselor or a psychiatrist.
17 Q. This does not say stop opiate therapy if addictive
18 disorder is present, correct?
19 A. No, sir. It says pain problem will likely fail.
20 Q. Yes. If not coordinated?
21 A. If not coordinated, correct.
22 Q. In fact, the article cautions, It stands to reason that if
23 the patient is in recovery -- and I think this means recovery
24 for addiction -- and the pain is undertreated or not treated
25 at all, they may turn to the streets for elicit -- I'm

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1 sorry -- for licit or elicit drugs or may use legal drugs such
2 as alcohol to numb the pain, right?
3 A. Again, Counselor, I apologize, but you're taking this out
4 of context. They need to see it in context.
5 Q. I'm reading directly from a document. I'm not
6 paraphrasing at all. You agree the document says that, don't
7 you, sir?
8 A. No. I realize you're reading from the document, but it's
9 still out of context. So if we read that whole paragraph --
10 Q. Sir, I didn't ask you to read the whole paragraph. I just
11 read part of it to you and here's my question: Isn't it true
12 that the document says it stands to reason that if a patient
13 is in recovery -- recovery for addiction -- and the pain is
14 under treated or not treated at all they may turn to the
15 street for licit or elicit drugs or may use legal drugs such
16 as alcohol to numb the pain. Does the document say those
17 exact words, sir?
18 A. Those exact words are said, yes.
19 Q. Okay. Thank you very much. So it then stands to reason
20 that if somebody presents with an addictive disorder and we
21 refuse to provide something to adequately treat the pain the
22 Universal Precautions article suggests they may turn to the
23 street and engage in more dangerous activity, isn't that
24 right?
25 A. No. You have that exactly turned around.

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1 Q. Okay.
2 A. What it says is that the addiction needs to be treated
3 first. So if the addictive disorder is recognized it needs to
4 be treated before the pain can be effectively treated and
5 that's generally understood in the field of psychology and
6 psychiatry.
7 Q. Sir, doesn't the portion I just read to you specifically
8 say it stands to reason that if they're in their recovery and
9 pain is under treated or not treated at all?
10 A. Yes.
11 Q. If what you're suggesting is you must solve the addiction
12 first and leave the pain alone without prescribing opiates,
13 isn't that right?
14 A. No, I'm not saying that at all. What I'm saying is in the
15 part that you ignored here was it stands to reason that if the
16 patient is in recovery. The patients we reviewed yesterday
17 and today are not in recovery. They're showing signs of
18 active addiction or substance abuse disorder. They are not in
19 recovery. And because the addiction is -- is suggested and
20 the substance use dependency is shown, that needs to be
21 addressed. These patients are far from recovery and therefore
22 the latter part of what you read does not apply.
23 Q. Then I think it's necessary for us to go through this
24 whole paragraph starting from the word "however" all the why
25 through the highlighted portion. Can you please read that to

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1 the jury?
2 A. I agree. Yeah, that's what I suggested. So the paragraph
3 reads as follows: However, drug addiction is a chronic
4 relapsing disorder that involves multiple factors. The most
5 common triggers for release are states of stress, drug
6 availability, and reexposure to environmental clues such as
7 sight, sound and smells that are previously associated with
8 taking drugs.
9 Inadequate treatment or no treatment of pain is a
10 powerful stressor and can consequently trigger -- may trigger
11 relapse to addiction. It stands to reason that if the patient
12 is in recovery and the pain is under treated or not treated at
13 all, they may turn to the street for licit or elicit drugs or
14 may use legal drugs such as alcohol to numb the pain.
15 Q. Does this specifically rebut your notion that you must
16 resolve a problem with addiction before adequately treating
17 pain in a patient?
18 A. No, sir. Again, you turned that around. It states very
19 specifically there -- it's referencing the addiction being
20 under control.
21 Q. It also says that under treatment of pain can be a
22 powerful stressor for main patients, right?
23 A. If the patient is under control with regard to their
24 addiction, pain can be a stressor and reasonably needs to be
25 addressed, but it's all contingent on the fact the patient's

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1 addiction is under control and that's not what we see in these
2 cases.
3 Q. Doesn't it stand to reason, though, you cannot effectively
4 treat the addiction in a patient without first resolving the
5 pain?
6 A. That is a lay misconception. I understand why you might
7 say that but the medical truth is -- no, that's not true. The
8 addiction and mental illness needs to be optimized and
9 controlled before the pain can be addressed and we understand
10 that because psychological contradictions to pain are
11 overwhelming and if we don't address the psychological and
12 addiction concerns first, pain's not going to be controlled.
13 Q. And that's why in this document it makes it very clear
14 that the most common triggers for relapse in a patient are
15 states of stress, drug availability, reexposure, inadequate
16 treatment?
17 A. To patients who have their addiction under control which
18 is not the case we have here.
19 Q. And which patients are you referring to that did not have
20 their addiction under control, sir?
21 A. I would have to go back and look at them specifically, but
22 by in large all these patients had been trialed on opiates and
23 as you indicated -- I'll take your word for that -- and have
24 not responded and most of all -- maybe all of them had
25 indications that they were misusing opiates and had

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1 suggestions of what we call substance use disorder heading
2 towards addiction.
3 Q. Doctor, you just opined these patients didn't have
4 addiction under control, but when asked specifically to
5 identify which patients you don't have any recollection?
6 A. I'd have -- well, as I just told you, if you wanted me to
7 go through them one by one on my chart here, I can tell you.
8 Q. Is it strange you can have a recollection that some of
9 these patients don't have their addiction under control but
10 not be able to recall which specific ones sitting on the
11 stand?
12 A. No.
13 Q. Okay.
14 A. I want to be precise. Again, I can reference it and be
15 precise for you if you would like.
16 Q. Doctor, in this article Universal Precautions, does it
17 anywhere suggest that patients should be kept below a morphine
18 equivalence of 90 or that providers should be careful before
19 exceeding that morphine equivalence?
20 A. It does not address a threshold.
21 Q. Okay. In fact it doesn't refer to morphine equivalence at
22 all, correct?
23 A. That's correct.
24 Q. Okay. But the 2016 CDC guidelines do refer to morphine
25 equivalence correct?

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1 A. Again I didn't consider those guidelines in terms of my
2 opinion.
3 Q. No. I understand that but my question is do they?
4 A. They do, yes.
5 Q. Okay. Do any of the other guidelines that you referenced
6 make a suggestion that a patient should be kept below a 90
7 morphine equivalence?
8 A. The references I put forth there is a -- there is one from
9 the middle article that does suggest if I recall correctly a
10 hundred milligram morphine equivalence as a threshold that was
11 for -- for concern of overdose and problems. That's
12 incorporated into the guidelines. And I can be more specific
13 if you would like.
14 Q. Incorporated into what guidelines?
15 A. Into the guidelines that I reviewed and quoted to you.
16 Q. Do you know the name of the article that you're referring
17 to right now?
18 A. I do.
19 Q. And what's the name of it?
20 A. It was published in internal medicine by an author whose
21 last name DUNN that was published in I believe 2009, 2010. It
22 documented that increased -- increased morphine equivalence
23 were proportionate to an increased risk of morbidity,
24 overdose, and addiction, and is suggested the break point for
25 where there was a increase in risk of overdose and

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1 addiction -- well, overdose and death occurred around a
2 hundred morphine equivalence.
3 Q. And, Doctor, did that article ever make it into any of the
4 guidelines that you reviewed in preparation for this case?
5 And I'll list the ones that you've mentioned specifically.
6 The Federation of State Medical Boards guidelines prior to
7 2012, the 2008 Kentucky Board, I believe it was called a
8 letter, or the document 2005 Universal Precautions. Did that
9 90 morphine equivalence make it into any of those guidelines
10 that I've just discussed?
11 A. Okay. Well, first, it wasn't 90 milligrams. It was a
12 hundred milligrams. And secondly, I'd have to go back and
13 look at the bibliographies specifically and basically that was
14 well documented and well read by all of us in the pain
15 management world, so it was a well-recognized article but
16 specifically --
17 Q. Doctor, that's not my question. Did it ever make it into
18 the guidelines that you've referenced into the document? Did
19 it ever make it in there?
20 A. The actual hundred milligram -- morphine equivalence?
21 Q. That's my specific question, sir.
22 A. No. The actual hundred morphine equivalence did not make
23 it in there.
24 Q. Are you suggesting that because it maybe potentially made
25 it into the bibliography that would then be an applicable

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1 guideline to review in this case?
2 A. No. What I'm suggesting --
3 Q. You answered my question. Thank you, sir. In your review
4 of many of the cases and I'm talking historically over your
5 entire work for the Department of Justice since I believe 2012
6 until the present, you typically see and have the opportunity
7 to review undercover videos; is that right?
8 A. That's correct, yes.
9 Q. Okay. And in many cases what the -- what law enforcement
10 would do is put a camera or a microphone on a patient and send
11 them into the office; is that right?
12 A. Something like that, yes.
13 Q. And then that patient would attempt to get treatment from
14 a provider and determine whether or not that treat -- well law
15 enforcement would determine, but you would then determine
16 whether or not that treatment was for a legitimate medical
17 purpose or outside the course of professional practice, right?
18 A. Ultimately the Department of Justice asked me to opine on
19 whether medications were prescribed for a legitimate medical
20 purpose and for -- and in the usual course of medical
21 practice.
22 Q. But my question was more so about the videos. That video
23 would allow you to specifically see what's going on in the
24 patient's room between the doctor and patient and better
25 assess how that provider's treating a patient, right?

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1 A. It would be an added component to what I would review.
2 Q. Okay. Because documentation is only a snapshot of what
3 was written down. Viewing the actual patient care is more
4 helpful in understanding how a doctor operates, right?
5 A. No, I would disagree with your characterization of the --
6 the medical chart being a snapshot. It's supposed to be a
7 complete -- a complete documentation of all the elements that
8 go into the decisionmaking for the treatment and diagnosis of
9 the patient.
10 Q. Well, let me ask you this. If a provider saw a patient,
11 prescribes an opiate medication, and completely failed to
12 document anything about that, would you automatically
13 determine that prescription was written outside the course of
14 professional practice or for other than a legitimate medical
15 purpose?
16 A. I think I would not be an absolutist on that, but I would
17 suggest failing documentation of examination, evaluation, and
18 treatment plan formulation, that it did not occur. In
19 medicine we generally feel -- and this has been documented
20 many times -- if it is not documented, it didn't occur, so --
21 Q. So it's your belief that lack of evidence about something
22 is evidence that it didn't happen; is that right?
23 A. Well, over time. If the medical chart fails to show the
24 evidence to support a diagnosis or treatment plan, then the
25 failure to show that evidence means that there's a -- there's

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1 a concern. There's a problem.
2 Q. Okay. A concern. But you're not taking that as a
3 definitive statement of what happened in the treatment room,
4 right?
5 A. No. I am. The purpose of the medical chart -- and it's
6 generally understood and has been for a long time. Standard
7 of medical care is that the chart must be representative of
8 all the factors that go into the decisionmaking regarding the
9 diagnosis of a patient and the treatment plan.
10 Q. Well, let me give you an added part to the hypothetical.
11 Let's say that that doctor performed glowing treatment
12 consistent with every single guideline that you've referenced
13 here, the CDC guidelines, and even the most recent guidance
14 but there is absolutely no documentation available, would you
15 determine that that prescription was issued outside the course
16 of professional practice for other than a legitimate medical
17 purpose because if it wasn't documented it didn't happen?
18 A. I would concludes that, yes.
19 Q. You would conclude that? Okay. So we heard testimony
20 from a Dr. Baird who used to work at PPC. And Dr. Baird told
21 us that he had a power surge and all of his prior records were
22 deleted and that's one of the reasons why we can't look at his
23 treatment of Christy Martin. Okay? I'm just offering that to
24 you.
25 If looking at Dr. Baird's prior treatment of

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1 patients. You only had the fact that all of his records were
2 deleted and not available, would you opine that every
3 prescription Dr. Baird issued was outside the course of
4 professional practice or for other than a legitimate medical
5 purpose?
6 A. That hypothetical you put forth, I can't comment on. I
7 don't have enough information.
8 Q. Okay. That's fine. Now, if you had a video available to
9 you to help you understand what happened in a treatment room
10 even though some of the documentation was inadequate, you
11 would still use that video to inform your knowledge about
12 patient care; isn't that right?
13 A. It's a helpful tool, correct.
14 Q. Okay. So let's -- let's add to the hypothetical. We have
15 a physician who prescribes an opiate, no patient records
16 because they've been deleted like Dr. Baird's but we have a
17 video. Would you be able -- be able to watch that video and
18 if all of the patient care was glowing render the opinion that
19 patient care was for a legitimate medical purpose in the
20 course of professional practice?
21 A. If I was able to see -- and this never happens by the way.
22 If I was able to see the video interaction with the patient
23 over time a single video doesn't give me a whole lot of
24 information in order to make a final decision.
25 Q. Okay. Let's say that we have a video in this case where a

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1 patient came to the practice and wasn't on opiates and saw a
2 provider multiple times, right, and had the video and audio
3 running every moment they were in the practice -- and let's
4 assume again there's no documentation for that -- would you be
5 able to determine that the patient care was for a legitimate
6 medical purpose in the course of professional practice?
7 A. Possibly.
8 Q. Possibly? Okay. Great. Given any videos in this case?
9 A. I was not.
10 Q. Are you familiar with a patient Carrie Smith?
11 A. Not immediately, no.
12 Q. Okay. Now, I can't remember if you recall this, but the
13 five patients that you opined about were all on opiates prior
14 to coming to PPC; isn't that right?
15 A. Again, if I could look at my records I could be precise,
16 but I'll -- I'll take your representation for purposes of
17 discussion.
18 Q. Okay. Well, that's already in evidence and I think
19 that -- the evidence speaks for itself there but let's talk
20 about this -- this undercover patient.
21 MR. ANSARI: Can we approach?
22 THE COURT: You may.
23 (Bench conference on the record.)
24 MR. ANSARI: We object to the -- he hasn't reviewed
25 the --

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1 THE COURT: Wait a second.
2 MR. ANSARI: He has not reviewed the Carrie Smith
3 video. The -- the provider that Carrie Smith went to is not
4 charged here because she did not provide any opiates. This is
5 totally irrelevant line of questioning. He's already answered
6 he hasn't seen the video. We didn't provide the video because
7 we didn't indict this person.
8 MR. CHAPMAN: Well, here's where it's very relevant.
9 He's offering an opinion about the care of five patients and
10 generally speaking about the entire practice. This patient
11 was the only patient of the data set reviewed that was not on
12 opiates prior to coming to PPC. He testified that certain
13 principles should be used at this clinic such as start low and
14 go slow and these records have already been admitted into
15 evidence.
16 And I think it's fair to show him records that have
17 been admitted into evidence and determine whether or not the
18 care provided in those records rebut his assumptions his
19 practice was operating illegitimately.
20 MS. MCKEIVIER: He did that yesterday on direct.
21 He's exactly --
22 MR. CHAPMAN: Yeah. There were charts he reviewed
23 on direct exam yesterday that he didn't specifically offer an
24 opinion previously on as well.
25 MR. ANSARI: We only showed him the five patients

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1 charts that he's given an opinion on. We didn't show any
2 other charts.
3 THE COURT: I don't -- first of all, I'm unaware he
4 is offering an opinion other than for the 26 charts in there.
5 MR. ANSARI: Correct.
6 THE COURT: Okay. And presumably for the providers.
7 MR. ANSARI: That are on trial.
8 THE COURT: Right. The three -- these three. Is he
9 offering opinions on other providers?
10 MR. ANSARI: PPC's on trial, but the provider -- it
11 would -- it would be relevant if this undercover saw one of
12 these patients -- I mean, one of these providers that are on
13 trial. She saw Lecritia Huddle who is not charged in this
14 case and it's wholly irrelevant because she's not here on
15 trial.
16 MR. CHAPMAN: Dr. Campbell was a supervising
17 physician for this patient. By implicating Dr. Campbell and
18 prescriptions issued by Mark Dyer and all of other providers,
19 we need to defend the fact he was properly supervising his NPs
20 and Brigid Buckman and Lucretia were both his NPs and were
21 both properly trained on how to prescribe.
22 THE COURT: What are we wanting to show him?
23 MR. CHAPMAN: Just the glowing treatment that was
24 conducted on his record, Judge.
25 MS. MCKEIVIER: Patient records.

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1 THE COURT: We're not talking about a video.
2 MR. CHAPMAN: No. Just evidence that has already
3 been admitted is the only thing we want to show.
4 THE COURT: To the extent he states he doesn't or
5 hasn't reviewed this, I don't think he is -- to the extent he
6 hasn't reviewed this I don't think he can comment but to the
7 extent this is one that he was provided and reviewed, I think
8 he can -- yeah, answer whatever questions about what's in
9 there.
10 MR. CHAPMAN: I don't know if he was provided this,
11 no.
12 MR. ANSARI: No, we didn't provide it. We provided
13 it to Dr. Denham and that was it because we used --
14 THE COURT: Because his was a family practice one
15 and it had nothing --
16 MR. ANSARI: She didn't get any opiates. And we
17 only gave him the one to opine outside the usual course of
18 professional practice of prescribing, and she didn't
19 receive --
20 MR. CHAPMAN: Isn't that really the issue here?
21 This expert is suggesting this patient starts patients on
22 opiates and continues them on opiates for other than a
23 legitimate medical purpose and the government is trying to
24 prevent us from showing him a very good example that is
25 completely on video -- we're not going to show the video --

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1 but a very good example of an instance where that in fact did
2 not occur. It's an important contrast to be drawn, Judge.
3 MR. ANSARI: It would be if its one of these
4 providers, but it's not and that's why that provider's not
5 here.
6 THE COURT: To the extent PPC is on trial, I don't
7 have a problem with him being shown it to the extent he's
8 willing to render some sort of opinion, but I certainly think
9 on cross you have lot of latitude because if he's not reviewed
10 it before, I don't think it's -- I mean, he wasn't asked to
11 render an opinion on people who weren't on opioids.
12 MR. CHAPMAN: I'm not going to ask him his opinion
13 on them. I'm going to show him the records and we'll talk
14 about them.
15 THE COURT: You have to ask him questions.
16 MR. CHAPMAN: Well, sure.
17 THE COURT: This isn't just to get in somebody
18 else's file in front of him because he's not opining on it. I
19 mean, he's here for a purpose which is to opine on these
20 patients because it's the continued prescription of opioids,
21 but outside of that he's not --
22 MR. CHAPMAN: Your Honor, there are a lot more
23 questions other than an ultimate opinion I can draw out of
24 these patient records that would be helpful to the jury such
25 as the fact the patient had lower back pain and didn't receive

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1 an immediate opiate prescription and the testing that was
2 received and all of that. Plus it does set an important
3 contrast to his requirement that a patient have a plan of care
4 in order to make a prescription legitimate.
5 MR. ANSARI: Judge, none of this is relevant because
6 she's not here on trial. These records were not reviewed by
7 this expert.
8 MR. CHAPMAN: Again these providers were under the
9 supervision of Dr. Campbell and that is a very important issue
10 in this case because Dr. Campbell's on trial for the
11 prescriptions of others.
12 MR. ANSARI: He's on trial because he prescribed
13 personally. We showed that yesterday.
14 MR. CHAPMAN: He's charged with prescriptions
15 written and issued by other people and his supervision is very
16 important and this expert --
17 THE COURT: -- conspiracy.
18 MR. CHAPMAN: He's charged specifically with
19 substance prescription that were issued by Mark Dryer and the
20 date ranges.
21 MR. ANSARI: They were issued by him as well. We
22 showed it to him yesterday.
23 MR. CHAPMAN: And this goes back to a prior motion
24 proceeding. Let's take Brandon McDonald for instance. Dr.
25 Campbell is charged in a date range of --

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1 THE COURT: How about we let them take their morning
2 break?
3 (End of bench conference.)
4 THE COURT: All right. Ladies and gentlemen of the
5 jury, I'm going to give you your morning break at this point
6 and then we'll try to go through to lunch after that. Please
7 remember my admonition not to talk or communicate with one
8 another or anyone else about the case. Please don't do any
9 research on your cell phones or smart phones or communicate
10 with anyone on those devices in regards to this case. And
11 most importantly don't make up your mind about any of the
12 evidence until you've heard all of the evidence and you
13 finally retire to deliberate. Leave those notebooks on your
14 chairs, please.
15 COURT SECURITY OFFICER: All rise for the jury.
16 Jury out.
17 THE COURT: All right. You can step down as well,
18 sir. All right. Let's narrow this down a little. So the
19 request is to show an expert witness a file that he was not
20 provided in order to compare it presumably to files he was
21 provided.
22 MR. CHAPMAN: Yes, Your Honor.
23 THE COURT: I'm trying to simplify it.
24 MR. CHAPMAN: And also to rebut a very specific
25 opinion that providers should when they start a patient on an

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1 opiate trial, start slow and go low. That's one of the main
2 reasons we're bringing up this file is because this is the
3 only patient we have in this dataset that was not already on
4 controlled substances and it's important to show this expert
5 that as a matter of practice this -- this practice which has
6 been called a pill mill over and over again by the government
7 does not start patients on an opiate trial unless they have
8 significant conditions.
9 MR. ANSARI: This file was not shown to Dr. King,
10 this file went to a provider that's not been charged with
11 distributing narcotics outside the usual course of
12 professional practice. It is a hundred percent irrelevant to
13 show an expert that hasn't reviewed a file for another
14 provider that's thoughts on trial because she did not
15 prescribe narcotics. It makes -- it makes no sense for this
16 jury to do that in fact she followed -- that provider whose on
17 trial followed go low, go slow whatever he said his theme was
18 and so --
19 THE COURT: That is very challenging for all of us
20 to say accurately, I've noticed. Yes.
21 MR. CHAPMAN: Start slow, go slow.
22 MS. MCKEIVIER: Start low, go slow.
23 THE COURT: Start low, go slow.
24 MR. ANSARI: Start low, go slow. Dr. Campbell and
25 Mark Dyer for these patients she has to -- and both

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1 specifically prescribed the five patients we showed yesterday.
2 We have not argued yet that there's some sort of supervision
3 issue that links him in to the substantive counts of
4 trafficking and Carrie Smith doesn't help that at all.
5 MR. CHAPMAN: And Your Honor the point I was making
6 just before we had to leave the bench conference, Dr. Campbell
7 is specifically charged in substantive 841 counts with
8 prescriptions that were issued by Mark Dyer. There are
9 prescriptions within the date range that were issued by Mark
10 Dyer that has been part of the government's case and that he
11 is specifically charged with; therefore, the government is
12 making the argument that his supervision of a provider can
13 trigger 841 liability. An important aspect of this case is
14 all that all of the other providers he supervised including
15 many that will be called as witnesses in this case including
16 this provider who we're talk about now I think it was Lucretia
17 for this one -- yeah including Lucretia were properly trained
18 and properly advised on how to prescribe opiates this is an
19 very important aspect of this case for Dr. Campbell because
20 he's not only charged with the prescriptions he's authored,
21 but he's charged with the prescriptions to the five patients
22 he himself didn't write, I believe, including -- and I can't
23 recall specifically --
24 THE COURT: That he didn't write or sign?
25 MR. CHAPMAN: That he didn't sign or write. And

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1 supervision is a very important aspect of this case and it
2 needs to be shown and this witness should be cross-examined on
3 the fact that these providers were aware that when they're
4 starting a patient on an opiate trial they need to be very
5 careful.
6 MR. ANSARI: So within those counts -- like we
7 showed yesterday there are prescriptions written during those
8 counts in that time period by Dr. Campbell we showed that on
9 that screen yesterday. And again none of these prescriptions
10 are in Carrie Smith's file and she saw a different provider
11 that is not on trial and this expert has not reviewed her file
12 whatsoever, so it makes no sense to show this expert a file
13 that he has not reviewed or had an opinion on.
14 THE COURT: So the -- all right. I'm going to take
15 a minute to look back at the -- the indictment again. So the
16 government's argument is there are no prescriptions that Dr.
17 Campbell could be held liable for that he didn't write himself
18 pursuant to the indictment there are no prescriptions that Dr.
19 Campbell would be held liable for that he did not write
20 himself, similarly Ms. Davis would not be held liable for any
21 prescriptions she didn't write herself or Mr. Dyer is that
22 right?
23 MR. ANSARI: I could say from the indictment period
24 that -- those practitioners for the substantive counts did
25 write prescriptions during that time period. What I can't sit

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1 here and say right now to the court if I compare to the bill
2 of particulars we had to do each one of those dates to see if
3 Dr. Campbell wrote one on each one of those bill of particular
4 dates but assuming that the jury can still find him guilty,
5 can we argue for are instructions any of those bill of
6 particulars that were written during that indictment period?
7 We would show the ones that he specifically wrote which we
8 showed yesterday.
9 THE COURT: Okay. So let's not get billing
10 involved. Take -- put billing off to the side. That's a
11 whole other thing here.
12 MR. ANSARI: I'm talking about bill of particulars,
13 not billing.
14 THE COURT: Okay. Well, the bill of particulars,
15 all right, presumably is about who signed that, correct? Oh,
16 bill of particulars, not super bill?
17 MR. ANSARI: Correct.
18 THE COURT: The bill of particulars meaning like
19 what I get from my insurance company.
20 MR. ANSARI: The bill of particulars that we had to
21 file with the court to show --
22 THE COURT: Okay. On that you're just not sure
23 about the dates on there.
24 MR. ANSARI: I would have to go back to each date
25 within that bill of particulars to compare it to the

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1 prescription. All I know is from yesterday during the
2 indictment period for these patients Dr. Campbell did
3 prescribe prescriptions to all five of those patients
4 yesterday during the indictment time period.
5 THE COURT: And those are the only things you're
6 holding him liable for.
7 MR. ANSARI: Yes.
8 MR. CHAPMAN: Well we certainly would like to see a
9 motion to dismiss on those grounds because when you read the
10 indictment very clearly it says count -- let's just say count
11 two and it charges Dr. Campbell for an entire date range of
12 treatment of that patient. The government then filed a bill
13 of particulars included in that bill of particulars are
14 prescriptions written by Mark Dyer during that date range for
15 the drugs in question charged by the indictment.
16 The only reasonable way to read that is that Dr.
17 Campbell is not only charged as the person who wrote the
18 prescriptions but also as an accessory or accomplice to the
19 person -- I guess, I'm sorry, aiding and abetting is the right
20 word -- to the person who actually did write the
21 prescriptions.
22 The government had the ability when it filed its
23 bill of particulars to whittle down its charges against each
24 physician pursuant to the order of this court and only list in
25 the bill of particulars prescriptions issued by Dr. Campbell.

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1 It didn't do that. Instead it listed every
2 prescription for that substance within the date range in
3 question thereby making the bill of particulars essentially
4 not a bill of particulars and just sort of circumventing the
5 court's prior order which as you may recall required the jury
6 to find unanimously that a physician has prescribed unlawfully
7 a controlled substance for each element of the bill of
8 particulars.
9 So now we have a requirement for a unanimous jury
10 verdict on each prescription some of those are from Dr.
11 Campbell, some are those from Mark Dyer and if the government
12 wants to now change its theory after substantial motion
13 practice on this issue, we need to have a motion to dismiss
14 determining that Dr. Campbell is not liable for Mark Dyer's
15 prescriptions. Not to mention our theory of the case might
16 change quite a bill as well.
17 MR. ANSARI: Judge, what they're arguing is that we
18 are saying he's a supervising physician and therefore he can
19 be held vicariously liable. We are saying aiding and abetting
20 is totally different. If he aided and abetted -- so if Mark
21 Dyer wrote like a three day prescription in Kentucky and
22 Dr. Campbell filed a 30 day prescription that is aiding and
23 abetting that trafficking count that is different from are
24 vicarious liability.
25 THE COURT: So he's not being held liable for mark's

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1 three day -- I'm sorry to use your first name. Mr. Dyer's
2 three day prescription, he's only being held liable for the 30
3 day. I mean, that's what I hear you saying.
4 MR. ANSARI: Each defendant can be held for aiding
5 and abetting each other, so I don't want to say we're not
6 holding him liable for the three day prescription because if
7 he aided and abetted that, then he's liable for that. We're
8 saying -- we're not saying because he's a supervisor that he
9 somehow should have stopped -- he's not being held vicariously
10 liable for employer-employee relationship. He's being held
11 liable under aiding and abetting.
12 THE COURT: For prescriptions he may be tacked on
13 to?
14 MR. ANSARI: Yeah. And/or knew that Mark Dyer
15 was -- or allow him to prescribe those prescriptions knowing
16 what the patient -- and the patient file he would already
17 reviewed that's an aiding and abetting versus a civil
18 standard.
19 MR. CHAPMAN: That's supervisory theory, Your Honor.
20 Allowing him to prescribe because he's the owner of PPC
21 because he allowed Mr. Dyer to keep being employed there
22 because he was involved in the practice and in someway seeing
23 the patient. That is a theory of supervisory liability of Dr.
24 Campbell as a supervising physician. And that's why this
25 supervisory theory's important to defend against. This is the

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1 first time I'll hear the government has ever had a theory that
2 Dr. Campbell should only be held held liable for the
3 prescriptions he issued because you would think when they bill
4 the bill of particulars they would limit it to the
5 prescriptions he signed. Here's another important part
6 whether a physician has a DEA registration or a nurse
7 practitioner to prescribe certain controlled substances, its
8 their signature on the prescription form that is certifying
9 that this is for a legitimate medical purpose in the course of
10 professional practice.
11 If they have the registration, they have the
12 independent decision. So when you're talking about aiding and
13 abetting, it really doesn't make a lot of sense unless you're
14 talking about a supervisory theory of liability because if the
15 NP that has their own judgment to make on that prescription,
16 there is no aiding and abetting. This isn't like, you know,
17 you help them get the car to drive to the bank robbery sort of
18 thing. It's not like Dr. Campbell handed Mark Dyer the pen so
19 he could fill out the prescription.
20 The aiding and abetting theory only fits within the
21 context of supervisor liability here and I don't think it's
22 legally appropriate.
23 THE COURT: So the -- and I think generally what
24 we're talking about are the prescriptions that three-day
25 prescriptions pursuant to the regulations that were required

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1 that only allowed for that three-day prescription and then the
2 30 day had to come from a MD? Is that the world of
3 prescriptions we're talking about then because that's the
4 aiding and abetting you're talking about?
5 MR. ANSARI: Yes. It's whoever willfully caused and
6 actually done which if directly performed by him or another
7 would be the offense against the United States. I mean, Dr.
8 Campbell -- whether it's a supervisor or supervisee
9 relationship, it's his practice. He's allowed Mark Dyer to
10 practice in Kentucky, write a three-day script, then he
11 follows-up without seeing the patient for 30 days. And that's
12 aiding and abetting each other in the pursuit of unlawful
13 distribution.
14 THE COURT: Gotcha. Okay. Not totally sure I know
15 what the issue is, but I think I know enough of it to go take
16 a look at the indictment and stuff. And really the bottom
17 line is whether or not it's really appropriate for this
18 particular witness to comment on this and what is the exhibit
19 number of this patient file?
20 MR. CHAPMAN: I believe its 38A Your Honor. Am I
21 right about that?
22 THE COURT: You are right.
23 MR. CHAPMAN: Your Honor, I think it's important to
24 satisfy the threshold question of whether or not the
25 government is going forward on Mark Dyer's prescriptions

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1 against Dr. Campbell under his supervisory theory of
2 liability. I thought I heard the government say they weren't
3 and then they said they were and I think that needs to be
4 resolved before we get into the analysis of this patient
5 because if there's no supervisory liability against PPC or Dr.
6 Campbell, I really agree it's a moot point and we don't need
7 that testimony.
8 MR. ANSARI: We're not -- the government doesn't
9 have to state on the record that we're pursuing a supervisory
10 liability. That's not -- we are pursuing on 18 U.S.C. Section
11 2 which is aiding and abetting. If they want to interpret
12 that as supervisory liability, they can do that, but we're not
13 going to be hemmed into saying yes or no on supervisor
14 liability. We charged this under section two of 18 U.S.C.
15 which is aiding and abetting.
16 MR. CHAPMAN: I think in response to their own
17 objection, they should be able to support their theory to
18 argue that this testimony is irrelevant when I'm trying to
19 defend against a supervisory theory of liability. I mean,
20 their defending the objection by saying that they're not
21 pursuing a supervisory theory of liability in order to make my
22 testimony about supervisory liability irrelevant, right? And
23 I think they have to offer something to that end if they
24 maintain the objection.
25 THE COURT: Well --

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1 MR. ANSARI: That would be relevant if she was on
2 trial. She's not.
3 THE COURT: If it were his supervision of this
4 provider, then it would be relevant, but there's -- as I'm
5 understanding it, there are no prescriptions in this file
6 from --
7 MR. ANSARI: Lucretia Hubble. I think the last
8 prescription was issued was like tramadol on the last day. I
9 don't think there was any prescriptions before this.
10 MR. CHAPMAN: Tramadol is a controlled substance
11 obviously there's nothing charge we concede that however
12 because this expert has testified that this practice has
13 started patients on a trial of opiates it is important to show
14 these single government undercover that we have full video for
15 as this witness has already testified it's important to get a
16 good view of a practice with this sort of video its helpful to
17 him and I think that by -- I won't show him the video by at
18 least looking at the treatment of this patient it certainly
19 would be helpful to him in his assessment of the practice they
20 that being said, if the government wants to marijuana than
21 they are limiting Dr. King's testimony and its use to just the
22 five patients testified and will not extrapolate that
23 testimony to any other patient, then I think maybe we do have
24 a relevance issue but that wasn't my understanding of his
25 testimony. He's trying to dirty up the entire practice and I

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1 think we get to defend it.
2 MR. ANSARI: Well we're not extrapolating his
3 opinion to this patient that wasn't seen be any of these
4 providers that are indicted. We go back to good patient --
5 reverse 404(b). Again, you can bring in any patient in the
6 practice that wasn't reviewed by these practitioners or these
7 specific experts and say, Look, they didn't get it either.
8 But again that goes back to thousands -- according to them 64
9 thousand people. We have specific people that are named in
10 these counts in the indictment for specific patients for the
11 drug trafficking and Carrie Smith is not one of them. It's no
12 different than Tom Jones coming in here.
13 THE COURT: All right. So Carrie Smith not named in
14 any of the charges, correct.
15 MR. ANSARI: Not in the drug distribution charge.
16 MR. CHAPMAN: In the health care fraud charges.
17 THE COURT: Health care fraud charges.
18 MR. CHAPMAN: Yes.
19 THE COURT: About billing?
20 MR. CHAPMAN: Yes.
21 MS. MCKEIVIER: I would also like to just say that
22 in the government's bill of particulars for Brandon McDonald
23 they actually have a prescription that was issued by Denise
24 Willburn who is also not sitting up here, and so how do you
25 get to do a range and say this is Mark Dyer and this is

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1 Dr. Campbell when Denise Willburn is the one I'm looking at on
2 the INSPECT for that particular prescription that is in your
3 bill of particulars.
4 MR. ANSARI: I can't comment on that. I'd have to
5 look at the actual prescription and not the INSPECT and then
6 compare it to the bill of particulars, but if that was case,
7 we would also remove that bill of particulars. That was by
8 error.
9 THE COURT: Okay. You all work that out. You all
10 look at that patient 'cause that's a legitimate issue. You
11 all look at that patient. I'm going to go back and look at
12 the file and look at the -- the indictment in this case, so
13 let's all take our restroom break quickly and I'll come back.
14 (Recess at 11:17 a.m. until 11:52 a.m.)
15 THE COURT: All right. For starters I've let the
16 jury go to lunch. It would be start stop, start, stop. I
17 don't think that's worth while to them, so I already released
18 them and let them go to lunch. Where did we get to on the
19 bill of particulars prescriptions?
20 MS. MCKEIVIER: I retract what I said.
21 THE COURT: Okay. So as to the bill of particulars
22 we're golden, yes?
23 MS. MCKEIVIER: Well, I'm checking the amended, but
24 yes. That issue that I brought up was not on the --
25 THE COURT: On the amended?

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1 MS. MCKEIVIER: Yeah. We have one for Dr. Allen.
2 MR. CHAPMAN: Your Honor, just to be clear, Dr.
3 Campbell is still listed as being charged with prescriptions
4 written by Mark Dyer on the bill of particulars, but the other
5 provider, Lucretia hubal, was not included. There was a
6 amended bill of particulars that we weren't looking at when we
7 made that statement.
8 THE COURT: Okay. All right. Because I was trying
9 to match up prescription numbers which is somewhat difficult
10 to find, obviously, not being familiar with the documents,
11 it's a little difficult for me to find those.
12 All right. So here's where we are I think there are
13 a couple issues if we take the bill of particulars issue out
14 of it, first we'll talk about this -- I thought for a second
15 he was there this particular witness and whether or not this
16 particular witness can be shown a file that he did not review
17 and is not offering an opinion on.
18 Presumably it sounds like for the purpose almost
19 like a reverse 404(b) which would be where you're using
20 evidence for defensive purposes, evidence of a prior act or
21 acts but using it as exculpatory evidence instead of the
22 prosecution using it offensively. I think under the Sixth
23 Circuit law you would still need to show it's being offered
24 for a 404(b) appropriate purpose. I think the first step of
25 the Sixth Circuit test is -- I don't think there's any

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1 question that it actually took place. That this office
2 encounter actually took place so anything r that facture is
3 checked out.
4 I think the second facture would be whether or not
5 that evidence or that other file would be admissible for a
6 proper purpose under 404(b) being motive, opportunity intent
7 preparation, plan, that long list of things.
8 Here I'm not totally sure what it would be offered
9 for under the reverse 404(b) evidence theory. What I heard
10 was that it's being offered under a supervision aspect of
11 aiding and abetting. So the charge in the indictment -- you
12 were referencing counts two through five before.
13 MR. CHAPMAN: That's correct Your Honor.
14 THE COURT: Okay so two through five doesn't include
15 PPC at all. Two through five just includes Jeffrey Campbell
16 and Mark Dyer and just includes one, two, three, four -- four
17 patients.
18 MR. CHAPMAN: That's true Your Honor.
19 THE COURT: Okay so we're not talking about any of
20 those four patients, so I don't think it's relevant for that
21 purpose at all 'cause we're not talking about those
22 individuals. So then I think the question -- the second
23 argument was on count one presumably which did include PPC, is
24 that -- am I understanding it right?
25 MR. CHAPMAN: That would be the first yeah and then

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1 counts two through five with respect to supervisory liability.
2 THE COURT: Okay. Well, so reading counts two
3 through five. I see aided and abetted which is different than
4 supervision. Aided and abetted by definition is an act aiding
5 and abetting which as I understand it here we're r talking
6 only about prescriptions that were issued either by Jeffrey
7 Campbell or by Mark Dyer. These were prescriptions that as
8 somebody said your DEA number that you individually prescribe.
9 The aiding and abetting as I understand it -- and I
10 don't know what the aiding and abetting is other than signing
11 individual prescriptions themselves or else it doesn't really
12 make sense in the count. So unless somebody can clarify that
13 a little bit more, aiding and abetting is taking an act.
14 Taking an action. I don't know that that is supervisor
15 liability. That's being I am liable because my law clerk
16 messed up. Doesn't mean I did anything but I'm liable anyway
17 because the law clerk messed up.
18 MR. CHAPMAN: Can you offer something when we see
19 supervisor liability. We're not saying there could be some
20 vicarious liability under 841. I think what we're saying is
21 we believe the government's prosecution theory for aiding and
22 abetting is the fact that Dr. Campbell became Mark Dyer --
23 Mark Dyer's supervising physician through an act and therefore
24 permitted Mark Dyer to continue to prescribe in a manner that
25 the government deems inappropriate. That's the only way we

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1 could justify a government theory of charging somebody
2 substantively for prescriptions that they did not actually
3 authorize.
4 THE COURT: Okay. And my understanding is for each
5 of these four patients that were prescriptions written by Mark
6 Dyer, three-day prescriptions, that were later made into
7 30-day prescriptions.
8 MR. ANSARI: On some of those yes, ma'am. And so --
9 THE COURT: All right what's the other?
10 MR. ANSARI: Well because if the patient was seen in
11 Indiana, then Mark Dyer would write the full 30 days --
12 THE COURT: Okay.
13 MR. ANSARI: -- but both of them in each instance of
14 those patients both of home the wrote prescriptions and they
15 aided and abetted each other by writing those prescriptions to
16 this one patient or these five patients.
17 THE COURT: To continue prescribing that medication
18 to that patient.
19 MR. ANSARI: Yeah.
20 THE COURT: But to the defense point, each of them
21 is individually writing their name on a prescription - --
22 MR. ANSARI: Correct.
23 THE COURT: -- and so but that is their individual
24 prescription. That is -- they're aiding and abetting by each
25 writing subsequent prescriptions whether in Kentucky, three

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1 and 30 or in Indiana, just the 30.
2 MR. ANSARI: Yes.
3 THE COURT: Okay. That's the aiding and abetting.
4 MR. ANSARI: Yes, ma'am.
5 THE COURT: Okay. So then we move away from that
6 because I don't think this patient then who was not treated
7 by -- or who is not part of those four would matter for
8 purposes of that charge because whether or not somebody didn't
9 receive opioids on another occasion doesn't matter for these
10 four patients.
11 Count one is the conspiracy count. This is the one
12 where I think you were making the argument about PPC itself
13 being involved in the conspiracy. PPC is involved
14 specifically in a conspiracy with Dr. Campbell Mark Dyer and
15 Jacqueline Davis not with -- who's the other.
16 MR. CHAPMAN: Lucretia hubal.
17 THE COURT: Lucretia hubal. So I'm not seeing how
18 that applies. I'm looking -- let see here. This is a 2020
19 case. United States versus ruan. And I'm just going to read
20 this paragraph. It's 966 F.3d 1101. 2020 case. Ruan was not
21 prejudiced by the district court's exclusion of undercover
22 videos of DEA agents acting as patients seeking opioids from
23 him but being denied. As noted the government introduced
24 videos at trial from Officer Kelly's appointments with couch
25 at PPSA which comprised counts five through seven against him

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1 for illegal drug distribution. The DEA had also sent two
2 undercover patients to see rue an but neither received opioid
3 prescriptions. A nurse practitioner examined each patient and
4 each was then seen by Rena who told them that it was not
5 appropriate to prescribe controlled substances because of
6 better alternatives.
7 One was referred to surgery and another was given an
8 anti-inflammatory ointment at a pretrial conference the
9 government successfully moved to prevent Ruean from
10 introducing these videos at trial akin to other testimony.
11 These videos do not refute the inculpatory evidence against
12 ruin demonstrating other times Ruean did prescribe opioids to
13 patients outside the usual course of medical purpose or
14 without a legitimate medical purpose such as in the four
15 patient files reviewed by Dr. Greenburg specifically
16 comprising counts eight, nine, 11, and 12.
17 So as to counts five through seven I think that case
18 law is specifically on point as to this. I'm going to give
19 you the rest of lunch to explain to me how the conspiracy
20 might apply, but I'm having trouble with the conspiracy
21 because it's not with the particular practitioner in that
22 file. Certainly in your case in chief I think you can do
23 other things, but as to this witness who hasn't reviewed this
24 patient file, he's only offering opinions on certain files.
25 He's not specifically offered opinions outside of that that

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1 I've looked at and I haven't reviewed the whole transcript yet
2 on this -- on this issue or for this issue.
3 So I need you to give me something else on count one
4 that would make it relevant because right now it sounds like
5 reverse 404(b) evidence but I don't see a 404(b) specific
6 purpose under which it would get in.
7 I'm not saying this particular line of questioning
8 is not appropriate with some other witness in your direct
9 case, but -- or with your own expert on files that they've
10 reviewed, but as to this witness I'm not seeing the relevance.
11 MR. CHAPMAN: Your Honor, I certainly appreciate the
12 offer to take it to lunch, but I don't need that long. May I
13 show you something?
14 THE COURT: Sure.
15 MR. CHAPMAN: Okay. Again, with this issue of
16 supervisor liability not only has Dr. Campbell been charged
17 for prescriptions with respect to Mark Dyer, but he's also
18 being charged with signing prescriptions that were issued
19 based on the treatment notes of other providers.
20 THE COURT: Okay. Stop right there. Let's go back
21 to what had you just said. Not only has Dr. Campbell been
22 charged with bring prescriptions with respect Mark Dyer. Are
23 we talking about two through five?
24 MR. CHAPMAN: Yes. He is charged with prescriptions
25 Mark Dyer has issued in 2 through 5 and --

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1 THE COURT: That's not what I just heard. He's
2 charged with prescriptions he's signed himself that may have
3 aided and abetted Mark Dyer in prescribing a particular course
4 of opioids to patient.
5 MR. CHAPMAN: Your Honor he's also charged
6 specifically according to the bill of particulars for
7 prescriptions for patients that were seen only by Mark Dyer
8 and prescriptions that were issued only by Mark Dyer after
9 that date of treatment.
10 THE COURT: Which line items are those? Which bill
11 of particulars am I looking at?
12 MR. CHAPMAN: There's quite a few on Brandon
13 McDonald alone.
14 THE COURT: What's the document entry.
15 MS. MCKEIVIER: 139.
16 MR. CHAPMAN: So the first few prescriptions to
17 Brandon McDonald on the bill of particulars -- and I'm happy
18 to clear this up for the court -- were actually issued by Mark
19 Dyer and signed only by Mark Dyer. Dr. Campbell's sitting on
20 trial facing culpability for each one of those counts.
21 THE COURT: Under a theory of aiding and abetting?
22 MR. CHAPMAN: I don't know. That hasn't been
23 specified its listed as a substance charge against him.
24 MR. ANSARI: It's on the bill of particulars because
25 they both prescribed maybe not that specific prescription they

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1 both prescribed during that time period during that time
2 period so their both prescribing.
3 THE COURT: So under counts two through five count
4 two which is specific to Brandon McDonald.
5 MR. CHAPMAN: Yes.
6 THE COURT: Okay. Count two, the prescription is
7 for methadone from December 6, 2012, to April 19, 2014. Dr.
8 Campbell and Mark Dyer aided and abetted by others knowingly
9 and intentionally distributed and dispensed controlled
10 substances to the patients listed below.
11 MR. CHAPMAN: And the bill of particulars issued to
12 Dr. Campbell that lists his prescriptions pursuant to this
13 court's order that the government lists them continues to
14 include prescriptions issued by Mark Dyer in there. Meaning
15 the government is taking the theory that Dr. Campbell is
16 subject to a 20-year mandatory -- I'm sorry -- 20-year
17 statutory maximum for each one of those prescriptions even
18 though some were issued by Mark Dyer.
19 THE COURT: I'm going to let you address that, Mr.
20 Ansari.
21 MR. ANSARI: That's because they are working aiding
22 and abetting each other to write those prescriptions to that
23 patient. It would be different if Dr. Campbell had not
24 written any of those prescriptions of Brandon McDonald it was
25 only Mark Dyer. That would be separate and distinct. This is

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1 where they're both tag teaming the same patient writing
2 prescriptions back and forth. They are both running the same
3 prescriptions to that same patient over that same course of
4 time period and that's why it's aiding and abetting each other
5 to write those prescriptions.
6 MR. CHAPMAN: Your Honor there's absolutely no case
7 law or statutory support for the theory that prescribing to --
8 there would be no case law that suggests this that prescribing
9 to a patient on one day can -- can permit an aiding and
10 abetting theory for a subsequent prescription issued by
11 somebody else under their own registration. That's
12 preposterous. That's not an act that would be aiding Mark
13 Dyer's ability. The only theory here they're trying to escape
14 from is they charged him as supervisor of nurse practitioners
15 and the reason why I bring this up is because Lucretia howl --
16 the provider at issue here provides great care saw Brandon
17 McDonald. It is important for us to show the undercover video
18 with this provider and how she normally practices in a
19 recorded video setting to show that while there may be issues
20 with his view of the documentation, what happens in the
21 visited room is actually very, very comprehensive.
22 THE COURT: But this isn't a visit with Brandon
23 McDonald.
24 MR. CHAPMAN: No, I know. But it's Lucretia
25 performing the visit.

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1 THE COURT: But you're saying -- again, you're using
2 a good video of Lucretia -- let's call it a good video -- a
3 good video of Lucretia to prove what relevant fact?
4 MR. CHAPMAN: Well, this witness has already
5 established that -- in sense of documentation he believes its
6 helpful to say what happens in a provider's office he
7 established routinely he reviews these type of videos. He's
8 established the government has specifically not provided him
9 this video, which I think is a significant fact if his job --
10 THE COURT: Well, that's already in evidence.
11 MR. CHAPMAN: Sure. But then I think showing him a
12 video of how these people act in the office to see if that has
13 any bearing on the policies.
14 THE COURT: These people is what worries me.
15 MR. CHAPMAN: Providers in the office he gets to see
16 how MedFit work.
17 THE COURT: But Lucretia is not on trial.
18 MR. CHAPMAN: But PPC and Dr. Campbell are and Dr.
19 Campbell's supervising physician and Lucretia saw Brandon
20 McDonald.
21 THE COURT: But then under that theory Dr. Campbell
22 could be liable for absolutely everything that takes place in
23 that office.
24 MR. CHAPMAN: Well Dr. --
25 THE COURT: I'm sure you're not saying he's going to

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1 be liable for more things.
2 MR. CHAPMAN: Dr. Campbell specifically facing
3 liability for a prescription that was issued by him after
4 Lucretia saw the patient. That's a very important fact. I
5 think Lucretia's involved in the case very much.
6 MR. ANSARI: Judge, I think us a violation of the
7 reverse 404(b) because it goes specifically to show she acted
8 in conformity with.
9 THE COURT: All right. In this witness for this
10 witness, for the facts or the relevance of his opinion, I
11 don't think this patient file and his testimony regarding this
12 patient file has anything to do with a fact in evidence for
13 this jury to help decide whether or not for those four
14 patients Dr. Campbell properly supervised a different nurse
15 practitioner.
16 He's not on trial for supervising Lucretia with
17 however many patients she saw and he's not on trial for
18 however many patients anybody else saw. He's on trial for
19 just those prescriptions. So if this went to one of those
20 practitioner's treatments prior to these prescriptions, that
21 might be a little bit different because he would have been
22 supervising and that would be a supervision theory.
23 MR. CHAPMAN: I hope the court is mindful of this
24 fact. Throughout the trial when we try to offer evidence of
25 this patient's -- this patient's treatment, Carrie Smith was

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1 included in the indictment under the health care fraud counts
2 her video. The only undercover video in this case shows
3 absolutely glowing treatment. The documentation is spot on.
4 It shows how this practice runs.
5 After they put her into the office, they willingly
6 decided not to do any with additional physical-n cover visits
7 to see if they could obtain narcotics illicitly but instead
8 immediately use that information to pursue a search warrant in
9 the case this is a very important part of the defense theory
10 and where he will be seeking admissibility and further
11 discussion of that with the undercover and I don't think we
12 should be precluded from doing so. I respect the court's
13 ruling with respect to this witness, I understand, but this
14 patient has a major role in this case specifically because the
15 government elected to stop undercover visits when they
16 realized that this practice wasn't the caricature of a pill
17 mill that they thought it was.
18 MR. ANSARI: That would go to suppression of the
19 search warrant and there's plenty of PPC outside of what she
20 did to support the search warrant, so that's what Dr. Denham
21 reviewed it for specifically. And then, two, whether it stops
22 or not it's a different provider that's not on trial, so it's
23 wholly irrelevant to this case.
24 THE COURT: I think as to -- well, all right. I'm
25 not going to make a broad finding about this case in general.

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1 Okay. As to this witness there is nothing to show here that
2 he's going to be able by viewing this that he's not reviewed
3 help anything or determine anything relevant from that. You
4 would also have to give him -- I don't know how much time to
5 review the entirety of the file. I -- so I don't know that
6 we're in that kind of position here where we're asking him to
7 do a full view of a file he's never been given.
8 MR. CHAPMAN: I told you, Your Honor. I wasn't
9 looking for his opinions. I'm only wishing to show him
10 evidence that already been admitted to rebut specific facts
11 he's testified to on that stand and that is this practice
12 doesn't start low and go slow and a few other facts.
13 THE COURT: It doesn't start low and go slow. So
14 you're saying it starts high and goes fast?
15 MR. CHAPMAN: That was his opinion. His opinion was
16 that his practice starts patients on opiates too quickly and
17 those opiates lack a legitimate medical purpose.
18 THE COURT: As to the files that he's reviewing.
19 MR. ANSARI: Correct.
20 THE COURT: I don't think -- I don't think he's here
21 to make that statement for the 64 thousand files --
22 MR. CHAPMAN: Certainly not.
23 THE COURT: -- and I don't think any expert could be
24 required to opine on that. But I think he's opining on the
25 specific patient files in counts two through five because

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1 those are the ones he was showed.
2 MR. CHAPMAN: The government will saying that
3 testimony and extrapolate it to the conspiracy count in order
4 to prove a higher guideline level likely later on with respect
5 to the entire conspiracy. They're using five patients and the
6 opinions related to those five patients but you know very well
7 Your Honor when the time comes they will argue that this
8 practice because of those five patients was a pill mill and
9 they'll recall argue it to the jury in closing they'll say we
10 showed you five patients you need to see there was a
11 conspiracy inside of this practice and they'll likely argue
12 for a higher guideline determination, you know, if there's a
13 verdict in favor of them in this case.
14 It's very important for us to be able to rebut the
15 evidence related to the facts that these five patient files
16 suggest a larger conspiracy within the practice. This
17 expert's testimony is going to be used to show that. They
18 certainly will and I think if the government once to prohibit
19 this line of questioning -- if the judge does I understand but
20 I think you should also then prohibit their ability to
21 extrapolate this testimony and apply it to some larger sense
22 of the conspiracy to satisfy their belief of legitimate
23 patient treatment to larger data including those 26 that they
24 specifically avoided talking about.
25 MR. ANSARI: That would be relevant if she was

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1 included in the count one conspiracy but she's not.
2 MR. CHAPMAN: Well there's no limit on the count one
3 conspiracy. There's been a list of patients that have been
4 sent us which has a changed, but there has been no bill of
5 particulars specifically saying we are only going to seek --
6 THE COURT: Yeah. But it's not to this particular
7 provider who's in the patient file that we're talking about --
8 or the video, right?
9 MR. CHAPMAN: She has patients in the 26, Your
10 Honor. She has patients in the five charged count.
11 THE COURT: Right. But she is not in the conspiracy
12 count.
13 MR. CHAPMAN: It says "and others," Your Honor.
14 THE COURT: I understand that, but --
15 MR. CHAPMAN: She's not excluded.
16 THE COURT: She's not excluded. She's not charged,
17 though.
18 MR. CHAPMAN: Your Honor, uncharged coconspirators
19 are very common and the government by it's inclusion of the 26
20 patient files that they've used as their dataset for the
21 conspiracy have included her in the conspiracy because some of
22 her patients and some of the prescriptions that Dr. Campbell
23 issued as a result of the patients that she saw are listed in
24 those 26 files in the conspiracy. She's all over this
25 conspiracy, if there was one.

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1 THE COURT: So are five million other people too.
2 MR. CHAPMAN: I don't know about five million. I
3 think there may be five other providers, Your Honor, and I
4 think the testimony about them and video evidence of their
5 treatment is absolutely relevant for this jury.
6 MR. ANSARI: She didn't get any prescriptions that
7 satisfy count one. Two, Dr. Campbell would have written
8 prescription on his own DEA number regardless of what Lucretia
9 or Brigid Buckman would have done.
10 MR. CHAPMAN: She provided treatment that
11 established the diagnosis and treatment plan for Brandon
12 McDonald and other patients listed in the charged counts.
13 THE COURT: Okay.
14 MR. CHAPMAN: She's important.
15 THE COURT: Let's limit this a little bit. So is
16 there going to be an objection 'cause clearly they're going
17 to -- well, whose -- you already shown the video, right?
18 Didn't we show that.
19 MR. CHAPMAN: It hasn't been admitted.
20 MR. ANSARI: It was in opening, so it's not
21 evidence.
22 THE COURT: Right, but they've already shown it is
23 what I'm saying. Presumably they're going to move to bring
24 that in. Are you going to object to that?
25 MR. ANSARI: Likely so; yes, ma'am.

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1 MR. CHAPMAN: Your Honor, they charged health care
2 fraud related to these visits.
3 THE COURT: Okay. That issue is going to need to be
4 a little bit more --
5 MR. ANSARI: We understand.
6 THE COURT: -- given more clarity --
7 MR. ANSARI: Yes, ma'am.
8 THE COURT: -- 'cause right now, again, I don't know
9 what providers are in what files. I mean, I guess I can go
10 back there and look through all of them, but I really -- I
11 don't think that's my job.
12 MR. CHAPMAN: Dr. King's chronology is very helpful.
13 THE COURT: I want to know specifically what the
14 objection is. I want some case law on it in the same manner
15 that if somebody is going to try to admit reverse 404(b)
16 evidence I need to know which of the line items it goes under
17 other than -- I really need it for a specific argument in my
18 defense because there -- I mean, does it prove motive,
19 opportunity, intent, preparation, plan, knowledge. It sounds
20 like no and you seemed to have said to me the reason you
21 wanted to show it because that one was really good. That was
22 a good instance of a visit. That's sort of defining what this
23 reverse 404(b) is, so I want to make sure that there is an --
24 like what item are you introducing it under for what purpose.
25 I think there will be a time in this trial when you

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1 will be able to admit some of this. Not -- this witness is
2 not it. I mean he's not reviewed the file. There's nothing
3 relevant he can offer on it and particularly my understanding
4 is the prescriptions in this file are not at issue and he's
5 not giving opinion on it.
6 So I think your defensive arguments will be
7 available to you. It's just not on a cross-examine with this
8 witness.
9 MR. CHAPMAN: I understand Your Honor.
10 THE COURT: So that issue I think is behind us but I
11 see the next issue coming, so I'd like us to anticipate it,
12 get something on the record other than generalized arguments
13 with no citation. Get something a little bit more substantive
14 with some understanding of what is in those files that you're
15 wanting to admit, who saw them, and those type of things, so
16 we can make an actual decision on it before we get to the
17 moment of trial where I have to send the jury out for an hour,
18 okay? So let's anticipate it. And if the government is going
19 to object and you're going to enter it, let's figure out when
20 that's going to happen so we can anticipate it and get some
21 case law on it and have it researched. I think that will make
22 it a little more efficient.
23 MR. CHAPMAN: I understand, Your Honor, but one
24 issue is the court's called this 404(b) repeatedly. We're
25 talking in the context of just the opiate charges, but when

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1 you expand this to the entire case, we have to point out the
2 government has admitted her patient file into evidence already
3 and they've also charge her as a substantive count for --
4 well, her visits as substantive counts under health care
5 fraud, I believe, and she's included in the health care fraud
6 conspiracy count.
7 MR. ANSARI: It's not in the substantive counts.
8 MR. CHAPMAN: Then it's the conspiracy count. It's
9 not 404(b) Your Honor if the video is analyzed under 404(b)
10 we're not looking at the whole picture. Dr. Campbell and PPC
11 are charged with treatment that is depicted on the video.
12 This isn't action and conformity so I don't think we need to
13 brief the issue I think it comes up.
14 THE COURT: You're not showing it for action and
15 conformity for the prescribing of opioids?
16 MR. CHAPMAN: No. Like I said, the conversation
17 about opiates was where we were talk about 404(b) that's
18 purchased for this but when we expand this issue and look at
19 the larger case it's not 404(b) because Dr. Campbell has been
20 charged with ordering the tests and PPC has been charged with
21 conducting the tests related to this patient. She's in a
22 substantive charge.
23 THE COURT: Okay.
24 MR. CHAPMAN: Okay. So I don't think we need to
25 brief the issue of whether or not this is 404(b) because the

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1 evidence is already coming in and getting shown to the jury.
2 MR. ANSARI: It's not a substantive charge. She's
3 not in counts 11 through 21.
4 MR. CHAPMAN: She's in the conspiracy count. Her
5 patient file's included in one of the 26, I believe.
6 MS. MCKEIVIER: Yeah. It's going to come in under
7 count ten where they -- where they have -- have the conspiracy
8 for the health care fraud. But more importantly the actual
9 substantive counts of health care fraud are going to be
10 related to providers outside of these three. So counts 11
11 through 21 are in regards to the MedFit, the counseling
12 programs, like that which were being ordered, or by other
13 providers outside of three that are sitting right here which
14 thereby brings in hubal and Buckman and others treatments.
15 MR. CHAPMAN: Who also can very clearly see how
16 MedFit operates. You can clearly see the exercises she does.
17 It's absolutely the best evidence of how these tests and these
18 visits were conducted at this practice. I don't think there's
19 any 404(b) here Your Honor its.
20 MR. ANSARI: As it relates to that practitioner
21 who's not been charged.
22 THE COURT: I'm sorry.
23 MR. ANSARI: As it relates to that practitioner.
24 That visit they're talking about is not charged. That would
25 not be in any kind of conspiracy count either. She had a

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1 visit with a provider on video where the provider sat down and
2 probably did everything appropriately. And we are not -- we
3 don't plan to introduce the video unless we're told to or
4 the -- I mean, patient file came in just because it was part
5 of that, you know, we agreed to put it in and make her
6 available, the UCD, but we are not using that to prove any of
7 the conspiracy in this case.
8 THE COURT: So as far as the direct case in chief,
9 it's not being used?
10 MR. ANSARI: Correct.
11 MR. CHAPMAN: Part of the charges, Your Honor. The
12 treatment occurred during the conspiracy time frame. It
13 relates to the same programs applicable at PPC that were
14 during the conspiracy time frame.
15 MS. MCKEIVIER: Same testing.
16 MR. CHAPMAN: It's related to employees of PPC who
17 are charged in the indictment. It's a nurse practitioner
18 whose supervised by Dr. Campbell during the time period of
19 indictment for the purpose of testing. It is the best
20 evidence of what happened in the treatment room in the testing
21 area of the MedFit program if this jury is denied that
22 opportunities, they're not seeing the full truth of what
23 happened here and allowing the government to hide behind
24 documents and some very specifically guided witness said to
25 share an untrue picture about PPC. This video is the best

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1 evidence of what really went on there.

2 MR. ANSARI: Best evidence for that one specific

3 provider for that one specific innocence which is not on

4 trial.

5 THE COURT: Yeah. Okay. Let's take our lunch

6 break. We'll come back about 1:00ish or so. I let them go I

7 think it was like quarter of, so they'll have about an hour

8 and 15 minutes for lunch. All right?

9 (Recess at 12:24 a.m. until.^)

10

11 THE COURT: All right. The jury's being brought up.

12 Taken a look at the video issue. I think the video -- I mean,

13 to the extent it can be authenticated, obviously, can come in

14 at the appropriate time down the road.

15 The questioning, though, to get to the relevancy

16 it's going to have to be shown to be relevant at the start. I

17 think there's a limited relevancy purpose. To the extent

18 you're saying it's exculpatory on the conspiracy charges so to

19 that extent that will come in.

20 As to this witness, this file, you're going to have

21 your own experts. I think showing this file bits and pieces

22 to this expert and trying to force him into your expert isn't

23 appropriate. He's already indicated he hasn't viewed it, so

24 I'm going to stick with that. We're are not going to try to

25 force this down this particular witness's throat because I --

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1 it -- he's already said he hasn't looked at it, so we're going
2 to leave that one. To the extent the video can later be
3 authenticated in your case in chief, you want to use it as an
4 exculpatory, I think that is reasonable, but obviously that's
5 a little bit down the road.
6 MR. CHAPMAN: Understood, Your Honor. Thank you.
7 THE COURT: Hopefully not weeks down the road but
8 maybe down the road.
9 MS. MCKEIVIER: Just to make the court aware in
10 terms of the video, we provided I want to say last Sunday
11 because there are multiple videos -- there are multiple videos
12 from September and November, in order to cut the timing down
13 for the jury, if we were to be able to show the video, we had
14 it edited. I also provided a log of the time codes from what
15 parts of the video came from the actual videos provided in
16 Jencks that was provided to the government last Sunday so the
17 court is discussing the issue of authentication. I just want
18 to make the court aware we have provided an edited for time
19 video to the government. We have not heard back on what their
20 position would be with regards to that edited time-coded
21 video, but --
22 THE COURT: I suspect they haven't looked at it yet.
23 MR. ANSARI: I have not looked at it. Been a little
24 busy.
25 THE COURT: I suspect they will. Let's not wait

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1 till the last moment, shall we.
2 MR. ANSARI: I'll get to it this weekend.
3 THE COURT: Is it Friday?
4 MS. MCKEIVIER: Your Honor, they would like to know
5 if the witness can take the stand.
6 THE COURT: Yeah. Let him come on in.
7 Jury in
8 All right. Ladies and gentlemen, if you'll grab
9 your notepads we're going to continue on with the
10 cross-examination of this witness. Sir, I'll remind you you
11 remain under oath. Mr. Chapman, your witness.
12 MR. CHAPMAN: Thank you, Your Honor.
13 Q. Doctor, we went through your forensic chronology yesterday
14 a bit, but I understand you also provided an updated forensic
15 chronology to the government in this case is that right?
16 A. That's correct. Yes.
17 Q. Okay. And did you do that approximately a week ago?
18 A. I don't remember what the timing was. It was produced
19 after I was given additional chart information.
20 Q. And one of the things that you did as you went through
21 your forensic chronology and cleared up any errors in the
22 first part of the summary? Is that right.
23 A. I don't know that it cleared up any errors. What I did
24 was to try to clarify it such that it would read in more, you
25 know, quickly interpreted fashion.

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1 Q. And how much additional documentation did you receive from
2 the government prior to updating your chart?
3 A. I don't really recall. I could make a guess but you don't
4 want me to make a guess I don't recall it was a fairly large
5 amount of pages.
6 Q. Are we talking in the thousand of pages? I don't want you
7 to guess. A range would be helpful.
8 A. I'm not really sure. Yeah, I'm not really sure.
9 Q. Did those records include additional urinalysis testing
10 that applied to the patients in this case?
11 A. They did yes.
12 Q. And you did you review those and make up dates to your
13 chronology?
14 A. I did.
15 Q. Okay. And did you update those chronologies with the same
16 rigor that you updated -- or I'm sorry -- that you create
17 under prior chronologies? I guess what I mean to ask is did
18 you use the same method that you would generally use in
19 creating a chronology?
20 A. I was aware that there were quite a number of additional
21 urine toxicologies that were presented with the new data so I
22 went back through and reviewed all those to try to make sure I
23 understood the larger picture of what was going on the short
24 answer to your question is yes I used the same rigor but I
25 looked at it in a little more detail on the urine toxicologies

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1 because there were so many new ones as part of the package.
2 Q. I know you testified that in some cases you had nurses
3 assisting you with the creation of the chronologies, but I
4 just want to ask, did you yourself update these chronologies
5 when you provided the updates to the government?
6 A. I did, yes.
7 Q. Okay. I'd like to show you your updated chronology for
8 Brenda Singleton I do not have a government marking on this
9 because it was recently produced. It's the same as the old.
10 MR. CHAPMAN: It's the same.
11 THE COURT: Do you have that number?
12 THE COURT: Its 77 --
13 MR. CHAPMAN: O I think.
14 THE COURT: Well -- yeah.
15 MR. ANSARI: U.
16 Q. I'm showing you what's been marked for identification as
17 77U and this will be just for the witness. Does this appear
18 to be your updated chorology?
19 A. The black and whited version of it, yes.
20 Q. Okay. I notice the date here says 4-17-2017, is that
21 right?
22 A. That's correct, yes.
23 Q. Does that just mean the date wasn't updated from the
24 original date of your chronology?
25 A. Correct. Yes.

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1 Q. Okay. So I'd like to look at the very first urinary drug
2 screen that you note on the chronology, the updated one, and
3 here you say that on 7-12-2013 Brenda Singleton had an
4 inconsistent urinary drug screen because she was positive for
5 cocaine, is that right?
6 A. Counselor, I wonder if you could adjust that focus a
7 little bit.
8 Q. More than happy to. I'm sorry that was quite small.
9 A. It was mainly the focus that was out. Okay that's fine.
10 Q. It should auto focus if we wait a second. Yeah, that's
11 about as good as it's going to get so again 7-12-2013 this
12 says there's an inconsistent urinary drug screen because
13 Brenda Singleton was positive for cocaine; is that right?
14 A. Yeah. I remember that specific one. There was some
15 question about that. I put it there because there was the
16 question.
17 Q. Okay. And then you cite to page 144 of the record as
18 evidence of that?
19 A. Correct, yes.
20 Q. And there's no other pages cited on that line, right?
21 A. Not on that line, no.
22 Q. Okay. And I'm gonna show you page 147 of Brenda
23 Singleton's file. And this can be shown to the jury as well.
24 It's been admitted. And it's hard to read the writing here
25 but would you agree with me that that says 7-12-2013?

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1 A. If appears to.
2 Q. And the issue was that she appeared to be positive for
3 cocaine and you are in fact correct in your summary right that
4 she was positive for cocaine?
5 A. That's what it indicates, yes.
6 Q. Okay. And this appears to be a urine dipstick result,
7 right?
8 A. That would be correct. Yes, a point of care test.
9 Q. And you testified previously that those point of care
10 tests can be inaccurate?
11 A. There are false positives and false negatives yes.
12 Q. I'd like to show you page 144 of her file. Does this
13 appear to be another result on 7-12-13?
14 A. Yes. That's one I wasn't sure how to interpret.
15 Q. Okay. Now, yesterday we had some colloquy about this
16 Roche Cobas. Did you have a chance over the evening to look
17 up what that is to clear up any misconceptions about that
18 machine?
19 A. I didn't feel like that was part my responsibility, so the
20 short answer is no, I didn't.
21 Q. Okay. So you're still not aware of exactly what type of
22 test this is, right?
23 A. That's correct.
24 Q. Okay. But on this test we see that the result appears to
25 be nine nanograms a milliliter for cocaine, right?

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1 A. That's what it says, yes.
2 Q. All right. And it appears that the expected value
3 according to this test is zero to 299 right?
4 A. And that's where it gets confusing because I don't know
5 what expected value means. We usually have it expressed as a
6 threshold value. That would be the usual and common way of
7 doing it. Expected value is not a term that we -- we use in a
8 manner that it's reasonably interpreted. I just didn't know
9 what expected value was.
10 Q. It appears to be a term that toxicologists use at least on
11 this machine right sir?
12 A. I don't know. As I say I'm not sure what this represents.
13 Its -- in every test I've ever seen in the past it's always
14 expressed as a threshold value. And then if the amount is
15 below that threshold value we don't form a conclusion. If
16 it's above that threshold value, we assume its positive.
17 Q. Well, let me show you a few things that may help you out
18 here. First of all, you're familiar with the concept of
19 cut-off levels, right?
20 A. That would be what I'm referring to; a threshold value or
21 a cut-off, yes.
22 Q. And cut-off levels are in place because the way that urine
23 samples are tested, there are some potential error rate in the
24 test?
25 A. Correct. It depends on the sensitivity of the test. That

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1 would be the correct term to use.
2 Q. My only question is there is some error rate in the test,
3 right?
4 A. It's not an error rate. It's a sensitivity issue.
5 Q. Okay. So in some cases, if a patient doesn't have a high
6 enough of the certain metabolite or drug in their system, the
7 result is reported as a negative result, correct?
8 A. Well, you say a high enough level. From a toxicological
9 standpoint, that's not correct. It's the sensitivity of the
10 reagent or the chemical reaction. So it's -- threshold value
11 is defined as a value above which we can be sure that the
12 compound was present.
13 Q. Okay. We see some interesting numbers here on this sheet.
14 This Cobas form under the column expected value, there is zero
15 between a certain number almost consistently until we get down
16 to the -- creatinine level, but then that number appears to be
17 reflected on the drug as one digit higher. Do you see that?
18 A. I do.
19 Q. Okay. And what this means to a reasonable professional
20 who's reviewing this report is that if the value does not meet
21 this threshold, it should be reported as a negative value,
22 don't you agree?
23 A. No, I don't agree. I'm a reasonable reviewer and I didn't
24 see that at all. I'd be glad to tell you what I did see if
25 you would like me to tell the jury.

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1 Q. Do you see there's a signature on this document?
2 A. I do.
3 Q. And do you see there's appears to be a mark above the
4 cocaine level?
5 A. The star there, yes.
6 Q. Yeah. And it's a star or it could maybe be okay somebody
7 writing okay?
8 A. That's illegible if from that standpoint.
9 Q. Okay. But it appears this result was reviewed by somebody
10 at the practice, right?
11 A. It appears so.
12 Q. You would agree that nine is lower than 299 right?
13 A. Yeah. But I don't know what that 299 represents. We go
14 around the circle.
15 Q. My only question was: Nine is lower than 299, you would
16 agree with that?
17 A. In the context we're talking about, I have no idea what
18 that means.
19 Q. Context is something you can clarify with the government,
20 but I'm asking you specific questions, okay.
21 A. If you're comparing mathematically is nine less than 299,
22 that's obviously true, but in the context of this, I have no
23 idea what it means.
24 Q. Okay. Well, that was specifically my question, sir. Did
25 you ever look to see what the cut-off level for a cocaine

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1 result would generally be on a test?
2 A. There's no generally it would be. That will be taking
3 into account too much assumptions. That's why its already
4 listed specifically as part of the report for the urinary drug
5 screen.
6 Q. Are you familiar with the federal register, sir?
7 A. Not specifically, no.
8 Q. Well, are you aware there's something called a federal
9 register where the government puts registrations for
10 publication?
11 A. Yes.
12 Q. Okay. And in that federal register are you aware that
13 there is a federal register entry that lists the specific cut
14 off values for certain types of substances?
15 A. I'm not aware that there are cut-off values in that
16 manner, no.
17 Q. Okay. And you didn't research that when looking at this
18 result and noting that you had questions about it?
19 A. I didn't know what type of urinary drug screen this was.
20 Q. It's true looking at your chronology, though, that instead
21 of saying that you had questions about that to the government,
22 you creating the chronology, you simply reported that it was
23 positive for cocaine citing only the dipstick and made
24 absolutely no reference to the COBIAS sample; is that right?
25 A. That positive cocaine was referencing the urinary drug

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1 screen the presumptive sample as you presented.
2 Q. You made no reference to the additional document we looked
3 at, right?
4 A. No. That reference -- that document was referenced in the
5 scheme of the chronology, but it was -- and again I don't have
6 my full report in front of me, but it may not have been
7 referenced up in that column because that column was basically
8 for urinary drug screen inconsistencies.
9 Q. And you believe that something is inconsistent even though
10 there's another report that shows the sample was below the
11 cut-off value?
12 A. Well, Counselor, we went through this yesterday. There's
13 conflict there. Some of the tests are positive, some are
14 negative. My job -- as part of my notes because this did
15 reflect me note-taking -- as I went -- as I went through the
16 record was to simply report all the inconsistent values.
17 Q. Okay. So are you saying that this -- this top sheet of
18 your forensic chronology is simply your personal notes?
19 A. Those are my personal notes, yes.
20 Q. Okay. All right. Let's look at another sample. Again,
21 Brenda Singleton?
22 THE COURT: Are we just on the witness?
23 MR. CHAPMAN: Oh, yes. I'm sorry.
24 THE COURT: Okay.
25 MR. ANSARI: This is the old one correct?

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1 MR. CHAPMAN: This is the new one.
2 Q. And on October 14, 2013, you believe that she's negative
3 for benzodiazepines and cite to the urine dipstick; is that
4 right?
5 A. Well, I don't know if it's urine dipstick. I cited to a
6 reference there, but I don't know what the technology was
7 to -- for the toxicology.
8 Q. And that's page 147?
9 A. It's referenced in 147 correct.
10 Q. Okay. And this next document can be shown to the jury.
11 I'm going to show you -- we will skip directly to the COBIAS
12 result page 53 of this patient's medical record. On that same
13 day, 10-16-2013, we see that she has a benzodiazepine level of
14 375; is that right?
15 A. That's correct. For this particular sample which may or
16 may not be the one I referenced.
17 Q. And you didn't reference this sample in your chronology,
18 you reference page 144, but this test was taken on the same
19 day that your -- that you note a urinary drug screen was
20 inconsistent; is that right?
21 A. I can't answer that without looking at my records because
22 I bates stamped the records and I would have to look at it to
23 and your questions accurately.
24 Q. Well, I'm showing you the record, sir. You state Brenda
25 Singleton had a negative benzodiazepine test on 10-14-13,

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1 correct?
2 A. That's correct.
3 Q. Okay. And the draw date on this sample is 10-14-13,,
4 correct?
5 A. Yeah. But counselor this isn't the one I was referencing
6 for that inconsistent result.
7 Q. I understand that. But this is from the exact same date,
8 isn't it, sir?
9 A. It's from the same date, yes.
10 Q. And it does show she did have benzodiazepine in her
11 system?
12 A. I'm assuming so. Again there's some question about how to
13 interpret this particular test.
14 Q. Sir you said you assume so but you previously testified
15 yesterday that you thought this H meant high; isn't that
16 right?
17 A. That's correct.
18 Q. So now it's your testimony that you're not sure if he had
19 some medication in you system even though you previously
20 thought this H meant high?
21 A. No. I believe the H does represent that she has
22 benzodiazepine, but in terms of the amount and so on, there's
23 still some confusing issue such that I overall don't know how
24 to interpret it.
25 Q. Do you see a checkmark on this document, sir?

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1 A. I do.
2 Q. Would that suggest to a reasonable provider that this
3 sample has been reviewed and checked and there's no
4 inconsistencies with it?
5 A. I wouldn't know what that checkmark represented
6 previously. There was a signature this was just a checkmark.
7 Q. Okay. So when your reviewing files, if you saw that there
8 was a checkmark on a document, you just assumed it meant
9 nothing because you don't know what it is instead of assuming
10 this means a provider looked at it and is okay with the
11 sample?
12 A. As you correctly say, we don't want to assume so I don't
13 want to assume its insignificant but I have no evidence to
14 assume it is significant either.
15 Q. Okay.
16 THE COURT: What page was that.
17 MR. CHAPMAN: 53, Your Honor.
18 Q. And I'd like to show this just to the -- the next one I
19 would like to show just to the witness. Yesterday we talked
20 about your old chronology for Michelle Smith and we talked
21 about a sample that you said was negative for opiates on
22 January 20, 2014. Do you recall that?
23 A. I don't recall it specifically.
24 Q. Okay. Well, this is the updated chronology and would you
25 agree with me that it still indicates that this patient was

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1 negative for opiates on January 20, 2014?
2 A. Based on that bates reference, yes.
3 Q. And you reference page 203, right?
4 A. Correct.
5 Q. And you reference no additional pages on the initial sheet
6 of your report?
7 A. Correct.
8 Q. Okay. And let's look at 203 and this can be shown to the
9 jury. It appears sir once again by reviewing only the
10 dipstick you are correct that this patient did not appear to
11 have opiates in her system when we look at the point of care
12 cup on January 20, 2014, right?
13 A. And that's what was referenced that's correct.
14 Q. And one of the reasons we have confirmation tests
15 available is so we can determine if the urinary drug screen
16 was correct. And I'd like to show you the confirmation which
17 is Michelle Smith's file page 55. Just showing the bottom
18 there. Hydrocodone is an opiate, sir?
19 A. That's correct.
20 Q. This sample appears to be -- I'm sorry. This document
21 appears to be a confirmation test on January 20, 2014, is that
22 right?
23 A. Correct.
24 Q. And that is for the same date of the original entry in the
25 report that we just looked at, right?

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1 A. Correct.
2 Q. And does it appear this patient's sample was positive for
3 hydrocodone, right?
4 A. On the confirmatory but not on the presumptive, correct.
5 Q. And nowhere in the report does it say this test was
6 actually consistent because of a confirmed test showing
7 opiates in her system?
8 A. No. Actually it was. It was an entry in the -- in the
9 forensic chronology. It just wasn't listed in the column that
10 you're looking at.
11 Q. Okay. And you still reported it as an inconsistency to
12 the government and the top part of your spreadsheet?
13 A. And it was. As referenced there the presumptive was
14 inconsistent.
15 Q. And I'd like to go back to showing the chronology just to
16 the witness. Let's look back again at Michelle Smith's file.
17 4-16-14 on your report. You say that she was negative for
18 methadone and opiates and you cite page 203; is that right?
19 A. Correct.
20 Q. And I'm showing you page 27 of that file. And this was a
21 test from a sample that was collected on April 16, 2014 that's
22 the same date as the entry on you your report, correct?
23 A. Correct.
24 Q. And does it appear that is different on the entry on you
25 report? She actually did test positive for the methadone and

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1 did test positive for opiates, right?
2 A. On this particular one, but this is not the test I was
3 referencing on that particular bates number.
4 Q. Okay.
5 A. The one I was referencing was indeed inconsistent.
6 Q. You would agree if a inconsistent urine dipstick is later
7 confirmed to be consistent, it should be considered a
8 consistent result?
9 A. Correct.
10 Q. Just go over one more with respect to Brandon McDonald.
11 And this is just for the witness. This is your chronology for
12 Brandon McDonald?
13 A. It is.
14 Q. And 7-19-2013 we have a string of results here positive
15 for oxycodone, TCA, negative for methadone. Citing page 92,
16 right?
17 A. That's correct.
18 Q. And this is Brandon McDonald's file, page 992, which has
19 already been admitted. And let's look at 92. And it appears
20 that on 7-19-2013, right here, that your findings were
21 absolutely correct, right?
22 A. That's correct, yes.
23 Q. But then when we look at page 53 -- sorry. I have the
24 wrong one. Page 86 this is another COBIAS result which seems
25 to contradict those original findings, correct?

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1 A. Correct. It reports different values.
2 Q. Different values?
3 MR. CHAPMAN: Your Honor, similar to what we did
4 yesterday, I would like to show his entire spreadsheet
5 chronology for patient Constance McFarland as a demonstrative
6 aid. Happy to approach if we need to.
7 MR. ANSARI: No objection.
8 THE COURT: Okay. You can approach.
9 (Bench conference on the record.)
10 MR. ANSARI: I said no objection.
11 THE COURT: Oh. I thought you said objection.
12 MR. ANSARI: I said no objection. Sorry. But while
13 we're up here 'cause I'm going to do the same thing with his
14 chronology, the same one Mr. Chapman was doing I'm going to go
15 through.
16 THE COURT: What's good for the goose is good for
17 the gander.
18 (End of bench conference.)
19 THE COURT: All right, members of the jury. I
20 thought I heard the word objection. There was really no
21 objection. Told them to go away. That was my fault.
22 (End of bench conference.)
23 BY MR. CHAPMAN:
24 Q. All right. So I'd like to show you now Government Exhibit
25 77Q for the purposes of a demonstrative aid only. And can we

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1 have it on defense table, please? And, Doctor, can you please
2 identify this? Is this it top page of your chronology?
3 A JUROR: Are we supposed to be seeing this?
4 THE COURT: They've allowed it as a demonstrative
5 aid.
6 A JUROR: Oh, I'm sorry.
7 THE COURT: Thank you for keeping track.
8 A JUROR: I wanted to make sure I wasn't seeing
9 something I shouldn't.
10 THE COURT: That's an honest juror right there.
11 A. Could you scroll down a little bit? Okay. Yes. That's
12 my old chronology, yes.
13 Q. Are you sure it's your old one, sir?
14 A. Well, scroll up again. No, I'm sorry. Yeah, that's the
15 old one.
16 Q. And how do you know it's the old one?
17 A. Because I -- I added some additional things with the new
18 material and it's not there.
19 MS. MCKEIVIER: Ron?
20 A. Actually, Counselor, if you scroll down again let me take
21 another look at that.
22 MR. CHAPMAN: Your Honor, may we approach?
23 THE COURT: Yeah.
24 (Bench conference on the record.)
25 MR. CHAPMAN: We weren't provided a new Constance

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1 McFarland update and I just wanted to let the government know
2 that at a sidebar before we move forward.
3 THE COURT: How about this. I think he just wanted
4 you to scroll somewhere else because -- did you hear him
5 before you came up?
6 MR. CHAPMAN: No. I heard him say this wasn't his
7 new one and we don't have a new one.
8 THE COURT: I'm going to quickly ask him if he
9 needed to see something else.
10 (End of bench conference.)
11 THE COURT: Did you need to see something else?
12 Scroll down for him, please.
13 MS. MCKEIVIER: To where?
14 THE WITNESS: Just keep going. That's the old
15 chronology.
16 THE COURT: Okay.
17 MS. MCKEIVIER: Actually Your Honor if I could show
18 him again. I cleared the filters.
19 THE WITNESS: Other direction.
20 THE COURT: She said she had filters on. That's the
21 old chronology. Okay.
22 MR. ANSARI: So what he sent me what I wrote -- the
23 same day, he sent me or the next day, U.S. affixed all of this
24 chronologies to me. I didn't go through each one of them and
25 I sent them over to them. And then I have a hard copy buying

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1 one from the five we used the five patient files he went
2 through so I haven't compared that hard copy to the electronic
3 version he provided that -- I think we're good on everything
4 else. I think it's this patient that we're unsure of whether
5 he gave us an electronic version of a an updated version.
6 THE COURT: Oh, he updated but didn't send it to
7 you.
8 MR. ANSARI: I think so.
9 THE COURT: You don't have it either.
10 MR. CHAPMAN: I would like to proceed with the old
11 one if that's okay because I don't have a new one.
12 THE COURT: Proceed with the old one, and if he says
13 something's not there, it's not there.
14 (End of bench conference.)
15 BY MR. CHAPMAN:
16 Q. Okay, sir. This is the old version of your forensic
17 chronology. And it's the front page which gives you a brief
18 summary of everything that is in the entire file; is that
19 right?
20 A. That's correct.
21 Q. Okay. And one of the things that you and your assistants
22 do is go through the entire chart and put a number of entries
23 into a spreadsheet that you can later filter, correct?
24 A. I can later review. I'm not sure what you mean by filter
25 but yes.

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1 Q. By filter, I mean in a spreadsheet format you can click a
2 tab and -- why don't we go through and filter urinary drug
3 screen to see how it's done. On Excel you can filter the
4 information to show only the inconsistent urinary drug screen;
5 is that correct?
6 A. Not just inconsistent. It will show all urine drug
7 screens.
8 Q. So this filter that we put on urinary drug screen, you're
9 saying will show all of the urinary drug screen for that
10 patient Constance McFarland?
11 A. That's correct.
12 Q. Okay. And there are some entries -- well, there's one
13 entry that shows consistent; is that right?
14 A. Yes, there is. Well -- well, there's at least one. I
15 haven't looked at it carefully, but -- yes. Looks like there
16 may be a couple.
17 Q. Okay. So let's look at page 162. You indicate that the
18 urinary drug screen on page 162 -- I don't know if I can --
19 right there -- is inconsistent is that right?
20 A. The point of care is negative for benzodiazepine which
21 would be inconsistent.
22 Q. And you report that as an inconsistency?
23 A. Yes.
24 Q. Okay. And if we can scroll back up to the top. And here
25 162 is reported -- page 162 I'm going to circle it -- or

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1 actually summer can highlight it -- is reported under the
2 heading UDS inconsistencies is that right?
3 A. That's correct.
4 Q. Okay. And so this indicates to anybody who's reviewing
5 very quickly that there was an inconsistent urinary drug
6 screen on January 20, 2014, correct?
7 A. Yes. That's not in my updated chronology, but yes.
8 Q. Okay. But this is in the one you provided to the
9 government up approximately 2017?
10 A. Correct.
11 Q. Okay. And the government would have reviewed this top
12 sheet in making a determination about Dr. Campbell; is that
13 right?
14 A. No. They would have looked to my opinion, my written
15 opinion. As I see these are just my notes.
16 Q. Okay. But these notes were provided to the government for
17 the purposes of providing them information about the treatment
18 at PPC and the treatment by Dr. Campbell, correct?
19 A. I gave them all my notes, yes.
20 Q. Okay. Now, I'd like to show you page 162 and I'm sorry
21 we'll have to flip to the ELMO. And 11-1-2013 your chart
22 appears to be correct and she appeared to be negative for
23 benzodiazepine, correct?
24 A. That is correct yes.
25 Q. Okay. However on that same day I'm showing you page 3,

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1 11-1-13, we have a confirmation test that actually shows that
2 she was positive on that day for benzodiazepine, correct?
3 A. Actually we have two tests being reported here. The one
4 you are pointing to which correctly is the confirmation, but
5 if you go up a little bit in that right-hand corner where it
6 says benzodiazepines reports it as negative, so again we have
7 a situation here where we have three urinary drug screen two
8 of which are negative one of which is positive there's
9 conflict there and there in lies the problem and that's why I
10 put all the inconsistencies up here because there is a
11 conflict issue on the reported results there.
12 Q. So is it your opinion that if a patient provides a
13 urinalysis sample and less reliable equipment such as a urine
14 dipstick shows negative, but then more reliable equipment that
15 you've testified about an LCMS shows positive, it's your
16 opinion that there's still some medical question as to whether
17 or not that patient has a benzodiazepine in their system?
18 A. When the results are repetitively inconsistent over time
19 which is what we see here it raises a question as to the
20 validity of testing.
21 Q. Okay sure that might raise a question as to the
22 manufacturer of the point of care up and its reporting
23 mechanism, correct?
24 A. Well, no. Because the one here was not a point of care
25 cup. It was actually done on Dr. Campbell's equipment.

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1 Q. A chemistry analyzer?
2 A. I don't know what it was specifically.
3 Q. How do you know it was Dr. Campbell's equipment?
4 Previously we just heard testimony from you that you had no
5 idea what this result was reported.
6 A. Well, if we go back to that last report you just showed me
7 we can answer that.
8 Q. Showing you page 3.
9 A. And if you go down a little bit. So we see the top there,
10 the header. Look at the header.
11 Q. Which header?
12 A. The header of this particular piece of paper.
13 THE COURT: Sir, you're able to circle on your
14 screen.
15 A. Okay.
16 Q. I'll zoom out so you can get the whole page there. Feel
17 free to circle what you think the shows that the Rosch Cobias
18 machine is on Dr. Campbell's --
19 A. I don't know about the Rosch Cobias machine, but I do know
20 this is printed on the letterhead of Physicians Primary Care
21 which is Dr. Campbell's organization. And on this report we
22 have a drug screen right here which shows benzodiazepines as
23 negative. And then down at the bottom we have a report of a
24 benzodiazepine positive.
25 Q. Would you like me to move up so you can see that?

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1 A. The jury understands part of this is reporting it as
2 positive and part is reporting it as negative. And this is
3 all on the header on the report from Physicians Primary Care,
4 so as I indicated you asked me how I knew it was his, it's
5 because it's got his header on it.
6 Q. And let's go back to the chronology form.
7 MR. CHAPMAN: Defense table, please. Thank you.
8 Q. Okay. So we've determined that your report page 162 is
9 inconsistent and populate that up in the header form and then
10 there appears to be one mention of a consistent urinary drug
11 screen with the remainder being inconsistent correct?
12 A. I'm not sure I followed what the had you said.
13 Q. You report here in one consistent drug screen pages 151
14 through 152, but the rest appear to be inconsistent; is that
15 right?
16 A. I don't know what you mean by the rest. There's a point
17 of care done on 11-1-13 which is reported inconsistent.
18 Q. All right. The rest on the page. Let's filter this for
19 the term inconsistent. All right. So your report shows
20 inconsistencies on 6-24, 11-1, 12 -- 12-2, 12-17, 1-3. And
21 let's stop there and scroll all the way up to the top and see
22 what we see. And all of those inconsistencies even from the
23 urine dipsticks that I just mentioned are included in the
24 urinary drug screen inconsistency column at the header,
25 correct?

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1 A. Again, I'd have to go through them one by one, but if you
2 did the math on that, then it should be correct.
3 Q. Okay. And there's no mention of any consistent urinary
4 drug screens up in this header. Those have been excluded
5 correct?
6 A. Correct.
7 Q. Okay. So you report the urine dipstick as being
8 inconsistent, but if it's later confirmed, you don't report it
9 at the top part of this form as consistent, correct?
10 A. Not on the top part of this form. I record it in the body
11 of the chronology.
12 Q. Okay. Isn't it true that what you do during your review
13 is have your assistants go through the medical records and
14 create these charts and then have them filter for certain
15 information that is consistent with your findings here and
16 then report that as the top part of your chart for you review?
17 A. No.
18 Q. Okay. Sir, have you ever filed anything before the United
19 States patent and trademark office?
20 A. I have.
21 Q. Okay. And the patent that you filed was done on May 7,
22 2020, correct?
23 A. I don't know what the date was.
24 Q. The patent that you filed was for a forensic system and
25 method for detecting fraud abuse and diversion and the

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1 prescriptive use of controlled substances is that right?
2 A. That would be about right.
3 Q. Okay. And you drafted or at least were involved in
4 drafting the patent application for this method is that right?
5 A. I certainly didn't draft it. It had more verbiage than I
6 knew what to do with, but attorneys did it.
7 Q. An attorney's office drafted it? Okay. Now, you're
8 familiar though with a purpose of the patent application
9 right?
10 A. Yes.
11 Q. Okay. The reason why we have patents in this country is
12 so that people can develop new technologies and then claim
13 those technologies as their own to the exclusion of all
14 others, correct?
15 A. Correct.
16 Q. And now 80 to 90 percent of your work in the medical field
17 is actually this sort of forensic work testifying for the
18 Department of Justice, correct?
19 A. That's correct.
20 Q. And throughout your time doing that 80 to 90 percent of
21 work you found that a lot of governmental agencies and
22 prosecutor's offices are sending you a large volume of medical
23 records for your careful review, correct?
24 A. Correct.
25 Q. And one of the things you decided to do was develop a

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1 patent to create a system so that you could filter through
2 this information quickly and efficiently and determine whether
3 or not somebody was unlawfully prescribing isn't that right?
4 A. Part two is not correct. Basically I did put it together
5 as a methodology. A great deal of work and effort and
6 evolution went into this over the years, so yes, I did put in
7 for a patent application for the methodology.
8 Q. Sir, do you believe that it is possible to use a formula
9 to determine whether or not a patient needs a controlled
10 substance in a particular case?
11 A. No.
12 Q. Okay. Because the practice of medicine should be
13 individualized, correct?
14 A. Correct.
15 Q. And that therefore the review of medical care should be
16 individualized?
17 A. Yeah. This represents the organizations of medical
18 documentation.
19 Q. Okay. But the review of medical care should be
20 individualized, correct?
21 A. That's correct.
22 Q. When you review these cases you think it's very important
23 to ensure not just that the document supports it but from a
24 individual standpoint each patient was receiving care that was
25 medically appropriate and legitimate right?

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1 A. That's correct, yes.
2 Q. From an individual perspective?
3 A. From an individual perspective, yes.
4 Q. But that's now what your patent application does is it?
5 A. No. The patent application's for the methodology here so
6 we can analyze patient charts that has a lot of different
7 types of data in it, so basically it's a organizational
8 document; the methodology. It's just for organizational.
9 Q. It's organizational, not for the purposes of making any
10 determination?
11 A. The -- once it's organized, it will be used to individual
12 lies the evaluation and make a determination, but in and of
13 itself it makes no determination.
14 Q. Okay. I'm going to read the first sentence of your patent
15 application, okay? The present invention relates to a
16 forensic system and method including a methodology for
17 analyzing medical and pharmacy data to determine the
18 legitimacy of controlled substance prescription and use it to
19 detect fraud, abuse and/or diversion. Right?
20 A. It can be used for that yes.
21 Q. Okay. So what you are saying in this first sentence is
22 you have developed a method that you would like to patent to
23 the exclusion of all others that will determine if a physician
24 is illegitimately writing controlled substance prescriptions,
25 right?

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1 A. No, that would be an incorrect statement.
2 Q. Okay. Let's go forth into the patent application.
3 MR. ANSARI: May we approach?
4 THE COURT: Yeah you may.
5 (Bench conference on the record.)
6 MR. ANSARI: He testified he didn't draft this
7 document. The attorney's drafted it and so I don't think it's
8 relevant its post indictment. It's current it was filed in
9 2020.
10 MR. CHAPMAN: 2020.
11 MR. ANSARI: Way outside the scope of the indictment
12 and way outside the scope of when he first provided his
13 reports and only amended them based on the old reports. I
14 don't think it's relevant.
15 MR. CHAPMAN: The -- the work product in this case
16 was drafted in -- was created in 2017 and also just recently.
17 It was using the exact formula method that is described
18 further in the patent application that we will get to. This
19 is the system that he used and this is clearly showing he's
20 using a formulaic methodology to determine illegitimate
21 prescribing which is contrary to his testimony that review of
22 care needs to be individualized.
23 MR. ANSARI: We're just talking about the chronology
24 and he already said the chronology are his notes. He has
25 given a separate report.

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1 THE COURT: Yeah. I mean, I'm going to give you a
2 limited bit on this, but what he said is this is the
3 organizational method for the information from the documents.
4 MR. CHAPMAN: That's not true, Your Honor, and I'll
5 show it.
6 THE COURT: Which is why I'm giving you a reasonable
7 way to go, but to the extent that you're trying to show
8 something that he's already said is not the case here, I have
9 a problem with that.
10 MR. ANSARI: This is evidence to impeach.
11 MR. CHAPMAN: I'm not introducing it into evidence,,
12 Your Honor. I'm asking him about a document he signed.
13 THE COURT: I have a little trouble reading it,
14 okay, if he said he didn't write it. You should ask him
15 questions about what his patent does certainly.
16 MR. CHAPMAN: He's adopted the document, Your Honor.
17 It's his patent. It's got his name on it and he signed it.
18 THE COURT: He just told you an attorney drafted it,
19 so I'm fine with you questioning him about it, but I don't
20 think reading it if it's not his -- he told you he didn't
21 write it. Is not helpful.
22 MR. CHAPMAN: Your Honor, every statement in this
23 patent application is his statement. While he hired somebody
24 to write it they're still his statements. He submitted it
25 under his own name to the U.S. patent application and likely

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1 signed a certification somewhere that his statements are true.
2 THE COURT: Do you have the certification.
3 MR. CHAPMAN: I don't have the certification but
4 that's how patent applications work.
5 THE COURT: I understand that.
6 MR. CHAPMAN: It's a statement to the federal
7 government under his name.
8 THE COURT: Okay. I don't know what you're looking
9 at okay.
10 MR. CHAPMAN: I can show it to you.
11 THE COURT: What I am telling you is to the extent
12 he said he didn't write it, you can certainly question him
13 that he signed it, okay, that's fine. But I wouldn't go into
14 reading it if he just told you he didn't write it. To the
15 extent you want to ask him questions about his patent, I'm
16 fine with that. There's a limited -- limited scope to that,
17 obviously, but I mean to the extent he says he -- he used it
18 to organize his thoughts and all that stuff fine. That's
19 perfectly within the scope.
20 I don't think the time period matters other than you
21 can get up and certainly point out this is post indictment
22 period but I don't think this pertains to the charges at all.
23 (End of bench conference.)
24 Q. Dr. King, this patent application, did you read it and
25 ultimately sign it before it was submitted?

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1 A. Well, as I say I didn't write it. The attorneys put it
2 together and I looked through it, but there was so much
3 verbiage there that was beyond me. It didn't mean a lot but
4 yes, I did sign it.
5 Q. Okay. And did you adopt this statement on your own behalf
6 and submit it to the U.S. patent office had -- U.S. patent and
7 trademark office?
8 A. Adopt which statement?
9 Q. This statement in the patent application?
10 A. Well, they submitted the patent application.
11 Q. Okay. But it was filed under your name, correct?
12 A. Correct.
13 Q. All right. And you reviewed and agreed with the
14 information that was submitted in the patent application
15 right?
16 A. Well, I signed it. You know, assuming it was all
17 representative of the way I had described it to them.
18 Q. You ensured that the document was representative of your
19 vision for this patent, right?
20 A. Well, as I said I didn't understand most of the verbiage.
21 They said it had to be presented and put together in this
22 fashion. I said okay. I don't get all of it, but okay.
23 Q. Okay. Do you agree that your method -- the forensic
24 chronology method that you claim in the patent application,
25 that it provides objective evidentiary data that shows with a

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1 high certainty whether a suspected medical practitioner has
2 been issuing controlled substance prescriptions outside the
3 usual course of medical purpose?
4 A. No. In and of itself it doesn't provide that conclusion.
5 Q. Okay. But it's true in the patent application that it
6 states, that you can use this method to determine with high
7 certainty --
8 A. Well, it's a tool. It's a tool that will allow you to do
9 a specific review and put things together in a manner that's
10 clear. It's an organizational methodology for the huge number
11 of files that we go through. So it doesn't provide a
12 conclusion. It just provides a framework.
13 Q. Your patent application also states that using this
14 forensic method you can create a concise one-page document
15 from which legal determination can be made as to whether or
16 not state laws -- state or federal laws have been violated,
17 right?
18 A. That's a bit of an overstatement but if that's what it
19 says, that's what it says.
20 Q. Would you like me to show you it?
21 A. I'll assume you're representing it correctly.
22 Q. That concise one page statement is that first page that we
23 saw on the top of your chronology?
24 A. Actually it's not.
25 Q. It's not? All right. Dr. King, has this patent been

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1 approved?
2 A. No, it has not.
3 Q. Okay. And your goal with the patent is not to use this
4 for your own personal use, correct?
5 A. No. I've offered to share with other colleagues.
6 Q. You intend to license this format so other people can use
7 it and pay you for that privilege, right?
8 A. No. That's indeterminate. I'm more interested in putting
9 out a uniform methodology that can be used. As I say, I've
10 shared this with several colleagues and there's no licensing
11 or charges involved.
12 Q. A uniform methodology that you believe can objectively
13 determine whether or not someone has unlawfully prescribed?
14 A. Well, I think what it does is it presents a framework so
15 we can analyze the data and ultimately come to a conclusion,
16 but as I emphasize all the conclusions are individualized.
17 Q. You realize that this patent application does claim to
18 provide an objective process, right?
19 A. Well, to the extent that it's a forensic chronology, it is
20 objective.
21 Q. Okay. And you're familiar with the difference between
22 subjective and objective, correct?
23 A. Yes.
24 Q. Okay. And subjective generally means that it's up to the
25 determination of whoever's reviewing it right?

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1 A. Subjective would be personal interpretation.
2 Q. Personal interpretation? Okay. And objective means I
3 guess in this context that your process will show the result,
4 right, whether somebody is unlawfully prescribing?
5 A. No, Counselor. You said that many times. That's not it
6 at all. What this does is put all the data into an
7 organizational format that's easy to read. It's color-coded.
8 It's chronologically oriented so the hundreds and sometimes
9 thousands of pages of documents that pertain to a specific
10 patient can be organized so a story can be told about their
11 clinical care. That's the purpose of this methodology.
12 So then instead of going through a packet of records
13 that aren't organized, we can look at it as a spreadsheet and
14 determine what's going on.
15 Q. In the preamble in this patent application, don't you
16 state that one of the issues with prosecutions of a provider
17 related to controlled substances is that there is no current
18 way to objectively determine whether or not they're unlawfully
19 prescribing?
20 A. There's no current way to organize the data for objective
21 review.
22 Q. I don't know that that answers my question. Don't you say
23 in this application that currently there is no way to
24 objectively determine whether or not a provider has prescribed
25 an elicit controlled substance?

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1 A. I don't know if that's what it says or not. Again, what
2 this refers to is a methodology.
3 Q. Well, if I showed you the application and a portion of it
4 would that help refresh your memory?
5 A. Well, I assume your reading it correctly, but again you're
6 an attorney and you understand what's there in the context. I
7 don't know whether it's in context -- I don't know if it's in
8 context or out of context, but it's a lengthy and complicated
9 document. And if you're asking me to interpret certain parts
10 of it and I didn't write it, I probably would not be
11 well-advised to comment on specific outtakes.
12 Q. Well, let's dive into this deeper. In the top part of
13 this document you say there are nor objective switches,
14 defined sets of criteria or generally accepted medical
15 protocols that conclude whether a specific medical
16 practitioner has issued a controlled substance outside the
17 usual course of professional practice. And then you moved on
18 later in the document to say in view of the forgoing
19 especially regarding the urgent need to combat and curtail the
20 epidemic of prescription drug abuse, a forensic product is
21 needed that provides an objective data-based methodology based
22 on a clear set of criteria to help determine if a practitioner
23 is suspected of promoting fraud, abuse, or diversion. Isn't
24 that your statement?
25 A. It provides the methodology, so it can be interpreted and

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1 a conclusion can come to but it doesn't direct the conclusion.
2 Q. But, Doctor, you say here that we have a problem in this
3 country right now. You can't objectively determine whether or
4 not a doctor has unlawfully prescribed and you're going to
5 meet that problem by creating a spreadsheet where you can
6 clearly see on it whether or not a doctor has unlawfully
7 prescribed. Isn't that right, Dr. King?
8 A. No, Counselor. You've misrepresented that yet again.
9 It's simply a methodology. It does not come to a conclusion.
10 MR. CHAPMAN: May I have a moment, Your Honor? I
11 don't have any further questions thank you. Thank you,
12 doctor.
13 THE COURT: All right Mr. Butler?
14 MR. BUTLER: Thank you.
15 CROSS-EXAMINATION
16 BY MR. BUTLER:
17 Q. Dr. King, my name's Mr. Butler. I represent Mark Dyer,
18 nurse practitioner. Yesterday I believe I heard you say that
19 you were not a, quote, ivory tower doctor, you were down in
20 the trenches; is that correct?
21 A. That's correct yes.
22 Q. Now, would you agree with me that a good definition of
23 ivory tower would be, quote, a metaphysial place where a
24 person is not -- where a person is disconnected from the
25 concerns of everyday life. Don't you think that would be a

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1 reasonable definition of an ivory tower?
2 A. Well, in the context that I presented that definition
3 probably would not apply.
4 Q. Okay. Now, we've heard you testify yesterday that for the
5 last six or eight years you have earned 90 percent of your
6 income from the Department of Justice, the DEA, the FBI,
7 correct?
8 A. 90 percent of my consulting income --
9 Q. Okay.
10 A. -- but not my total income, no.
11 Q. And you testified yesterday that you're on a sabbatical
12 from your medical practice, correct?
13 A. Correct.
14 Q. So am I right in assuming or believing that actually this
15 last year maybe more than 90 percent of your income came from
16 working from the government?
17 A. This last year, that's correct. During times of COVID we
18 had as every one did a significant disruption of our business
19 and we had to get up and going on telehealth. We couldn't see
20 patients personally. We couldn't see patients in the surgery
21 center. We couldn't do procedures, so -- yes, that pretty
22 much came to a grinding halt except for telehealth, so -- yes.
23 Q. And how -- exactly how much telehealth did you do?
24 A. Do I do?
25 Q. Yeah.

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1 A. Well, probably in terms of patient care, probably about 95
2 percent of it's telehealth which is part of the reason why I
3 went on sabbatical waiting until such time the COVID situation
4 settles down a bit.
5 Q. Okay. So now your practice is not like the practice that
6 Physicians Primary Care has which is a very, very large
7 practice, isn't that right?
8 A. Well, our practice is pain management and we typically
9 limit ourselves because of the complexity of the patients to
10 you know no more than sort of ten to 20 patients per day again
11 because of their medical complexity, so if you're asking is
12 that like a family practice that might see many more, there is
13 a difference.
14 Q. Okay. A family type practice would see many more patients
15 than what you would normally see, correct?
16 A. Right. From problems that are not as complex or
17 concerning.
18 Q. Okay. Now, moving on to your -- your testimony from
19 yesterday, I think that you said that you and your assistants
20 earned 82,000 dollars analyzing the 25 files that the
21 government gave you on this case, correct?
22 A. Well, they did the clerical work. I did the analysis but
23 yes.
24 Q. And does the clerical work they do -- we just heard about
25 the methodology that you incorporated in your patent

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1 application. Did that 40 thousand dollars worth of clerical
2 work was that using your patent application methodology?
3 A. It was using the forensic chronology methodology but it
4 was also organizing records, binding records, and pulling them
5 together into a cloud storage device and bates stamping those.
6 As you know in your law office, there's a great deal of
7 background that goes on for organization. Was part of it the
8 chronology? Yes. Were there other aspects of what they did?
9 Yes.
10 Q. So you're saying that part of it was -- did deal with what
11 you put in your patent application, correct?
12 A. It was org -- it was part of the organization of all the
13 material that was coming in.
14 Q. Now, did these individuals that -- that were paid the
15 $40,000 apart from the 42,000 you earned, were those
16 individuals -- were they actually nurses or were they clerical
17 personnel that was looking through the patient files -- the 25
18 patient files that you were given?
19 A. They were registered nurses.
20 Q. Okay. So these registered nurses applied the patent
21 methodology that you had and came up with -- I guess
22 spreadsheets or -- is that what had you want to call them?
23 A. I think that's a fair way to reference it because that's
24 what the forensic chronology is it's a giant spreadsheet.
25 Q. Then you took a look at that and came to your conclusion,

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1 right?
2 A. That's correctly represented, yes.
3 Q. Now, since you only saw 25 patient files and you have
4 agreed with me as you understand that Physicians Primary Care
5 is a very, very large practice. Do you know how many patient
6 files were out there at Physicians Primary Care?
7 A. I do not.
8 Q. So you wouldn't know what percentage those 25 files
9 represented, would you?
10 A. I would not.
11 Q. Thank you.
12 THE COURT: Mr. Pence?
13 MR. PENCE: Your Honor I don't have any questions
14 for this witness.
15 THE COURT: Okay. Mr. Ansari?
16 MR. ANSARI: Yes, ma'am.
17 REDIRECT EXAMINATION
18 BY MR. ANSARI:
19 Q. Dr. King, you just talking about your payment of roughly
20 80 thousand dollars in this case and I know that's what you
21 testified to yesterday. Is it possible that you were in error
22 on this specific case for the 80 thousand dollars?
23 A. It's possible because I looked at those figures as part of
24 a program that had been off on my computer for a while and I
25 was reaching back in time when there was a different billing

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1 system, so I would have to say yes there could be an error on
2 that.
3 Q. Is it possible the Department of Justice in this case paid
4 you $46,750?
5 A. Yes, it's possible.
6 Q. Is it possible the other conflated amount would have been
7 for other cases?
8 A. Yes. It would make more sense actually as I think about
9 it. Yes.
10 Q. Now, let me try to go back to yesterday. You were asked
11 specifically about Dr. Denham and he's a family practitioner,
12 is what you know of him?
13 A. That's all I know of him, yes.
14 Q. Do family practitioners look at files differently than
15 someone with your credentials?
16 A. Well, based on background training there may be things
17 that I or he would look for that would be different.
18 Q. Would you look at this from an eye of acute or chronic
19 pain with opioid use?
20 A. That's the way I would look at it, yes.
21 Q. And when you reviewed these files did these files appear
22 to be a family practice or pain management?
23 A. They appeared to be family practice.
24 Q. Was there a lot of pain management going on?
25 A. There was a lot of pain management going on.

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1 Q. And that's more your wheelhouse than Dr. Denham?
2 A. That would be correct yes.
3 Q. You went through these -- I don't want to painstakingly go
4 through them, but I'm going to look at your forensic
5 chronology and see if I can -- if I can explain this I'm going
6 to look at Brandon McDonald which is 77P and you were shown --
7 this is the revised version. Can we show the witness, please?
8 These are your notes; is that right?
9 A. It is correct.
10 Q. And this is a summary page we're looking at?
11 A. It is yes.
12 Q. And then underneath the summary page, aren't there a lot
13 of pages through the chronology?
14 A. Yes. The additional pages are -- of the spreadsheet
15 actually tell the story of all the visits and tests and images
16 and other notes.
17 Q. You were specifically asked about January 3, 2014. And at
18 the top of your sheet it lists -- do you see what it lists
19 there 1-3-14. Is that negative methadone?
20 A. Correct. Negative opiate, yes.
21 Q. And when you flip through your chronology on the 1-3-14
22 entry, what does that say?
23 A. I'm only seeing part of that.
24 THE COURT: You're going to have to zoom out, Mr.
25 Ansari.

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1 MR. ANSARI: Okay. Yes, ma'am.
2 THE COURT: There we go.
3 A. And -- I'm sorry. What was the question?
4 Q. On 1-3-14 what does your chronology show?
5 A. It shows two entries on 1-3-14 both are urinary drug
6 screen the urinary drug screen on the top line is point of
7 care or dipstick and it's consistent. And then the second
8 line is -- the same date 1-3-14 it's the LCMS urinary drug
9 screen by Physicians Primary Care and its negative for
10 hydrochloride hydromorphone.
11 Q. Let's look at Brenda Singleton.
12 THE COURT: Was this the demonstrative one or no.
13 MR. ANSARI: I'm going to go back to it, ma'am. I'm
14 going to hit two patients and then go back. I'll move to
15 publish this to the jury for demonstrative purposes.
16 THE COURT: This is the one you showed the other
17 day.
18 MR. CHAPMAN: It's already in for demonstrative,
19 right, Your Honor.
20 THE COURT: Yeah. I'm just waiting for her to
21 switch it. All right. We're good.
22 Q. Dr. King, can you explain that again so the jury can see
23 it?
24 A. Sure. This is one of the -- well, many pages in the
25 chronology. At the very top there again looking on the

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1 left-hand side at the dates, 1-3-14. And those are
2 color-coded green. Green is the color I use to denote urinary
3 drug screens so the first line 1-3-14 reads UDS POC which is a
4 point of care urinary drug screen UDS results positive for
5 amphetamine, benzodiazepine, opiate, and methadone. That's
6 what those three letter configurations stand for.
7 Then the next line -- and because it's all in black,
8 there was demarked as -- as normal or as consistent. There
9 wasn't anything wrong there. And then the next line
10 underneath that 1-3-14 says LCMS primary -- Physicians Primary
11 Care LCMS liquid chromatography mass spec which is what we
12 call the definitive test that looks at specific drugs or
13 specific substances as opposed to classes of substances. And
14 so that has a lengthy UDS result box there that shows positive
15 for a lot of things and negative for the last substance there
16 hydromorphone which is in red. That would be inconsistent.
17 Q. Why is it important -- why do you list it the point of
18 care UDS inconsistencies? Why do those matter?
19 A. Well, it's important -- okay. And this is a good point.
20 The reason we do a urinary drug screen point of care because
21 that's the pointer for deciding whether we go forth to do a
22 confirmatory. In other words, if the urinary drug screen
23 point of care -- the dipstick -- is normal, then unless we
24 have a specific reason, there's no medical necessity to go
25 ahead and do a confirmation test which is more complicated and

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1 takes days to weeks to do and is vastly more expensive. Well,
2 I don't know about vastly more expensive, but it's more
3 expense. So if the urine drug screen point of care is normal
4 then there's no reason no medical necessity to go any further.
5 We just leave it at that.
6 Q. And if we can, we'll go to Ms. Singleton. This is 77U.
7 Again, you were shown this already, but this is your front
8 page or your summary page.
9 A. Correct, yes.
10 Q. And I think you were shown 9-13 -- 9-13-13.
11 A. Correct, yes.
12 Q. And what does that first one show?
13 A. The first line, 9-13-13, again, it's marked in red the
14 inconsistencies, positive for opiates, TCA, stands for
15 tricyclic antidepressants, and negative for oxy or oxycodone.
16 So it showed three inconsistent results on that -- on that
17 particular entry.
18 Q. And what's second one?
19 A. The second one says clinical indeterminate toxicology and
20 I guess I might suggest for the jury's edification if we could
21 turn to the 9-13-13 and the chronology it might be easier to
22 understand. And again I apologize to the jury on the
23 complexity of this but again green denotes a urinary drug
24 screen entry, so on 9-13-13 there are two green entries there.
25 The first one says UDS POC point of care urinary

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1 drug screen and it indicates results positive for opy and
2 negative for oxy those are the two that are in red. And those
3 would be denoting inconsistencies. So the urinary drug
4 screen -- the point of care test, indicates that opiates are
5 present and oxycodone is not present, so that's an
6 inconsistency that would be normally indicative that in order
7 to resolve that a confirmatory should be done. And on 9-13-13
8 just below that the line says clinical indeterminate
9 toxicology.
10 You've heard me talk with Mr. Chapman about that.
11 The -- the way that's presented and I don't know maybe we want
12 to show the jury even the actual entry on that page, but it's
13 confusing to me. It's not obvious that on that second urinary
14 drug screen that I've labeled clinical indeterminate. It's
15 not clear to me what's being said or what the results are
16 indicating, so I labeled that accordingly.
17 Q. We have that. It was Defense Exhibit 104D -- or 0006.
18 THE COURT: Are we switching to prosecution table?
19 Yes, this one's been admitted.
20 Q. So this is the one you were shown previously, Dr. King.
21 A. It is correct, yes.
22 Q. And explain to us your reasoning behind that you don't
23 think -- or it is clinical indeterminate. And I assume you're
24 talking about the expected values. And if you could
25 specifically explain why a range of values is different from a

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1 confirmation test.
2 A. I sure will. So from -- someone may say to the jury here
3 for our purposes there are two types of urinary drug screens.
4 There's initial test comes a dipstick and it will either show
5 a positive or negative. And then there are the confirmatory
6 tests that will actually read out the number, the
7 concentration of that particular -- of each substance. Not
8 just present or nonpresent but what's the concentration.
9 Q. So on the dipstick test, in addition to just -- if we can
10 go back to that a second. The dipstick will do either yes or
11 no, but it also only measures classes of medicine. What does
12 that mean? That means it will measure for all opiates. It
13 won't separate out morphine or codeine or hydrocodone. It
14 will just say opiates.
15 When we get to the confirmatory it will tell us the
16 actual concentrations of the morphine, the codeine, the
17 hydrocodone, so we get more detailed results with the
18 confirmatory. So with that sort of understanding in mind, if
19 we look at this we see that under the test column there,
20 there -- there are groups of medicine, not individual
21 substances. So right out of the bat, that tells me this is
22 more of a point of care dipstick type -- type test because it
23 doesn't tell me which benzodiazepines are being tested, which
24 barbiturates are being tested or which opiates are being
25 tested so the first column there would tell me or reasonable

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1 practitioner that this is more on the presumptive or dipstick
2 side of the equation.
3 Next we have results there that next column and
4 there are numbers there. And I look at that and say why are
5 those numbers there if its dipstick it should be yes or no not
6 a number. So we look at the numbers and they say huh those
7 look like they could be concentrations because it is listed in
8 units of nanograms per milliliter. And so I go to the next
9 column that says expected value and I ask myself what is is an
10 a expected value? That's not a standard term in urine
11 toxicology. Expected value is a term we sometimes use if
12 we're looking for what concentration in the blood -- let's say
13 an antibiotic or an anticancer drug might need to achieve for
14 efficacy but we don't have those values for controlled
15 substances.
16 Certainly not for opiates. And the other -- so I
17 look at this and I say I don't know whether this is a point of
18 care type test or confirmatory test and -- and sort of put an
19 exclamation mark on that there's nothing here that tells me
20 what the cut-off value is and you heard me talk about that
21 with Mr. Chapman.
22 There should be a cut-off value if it's a
23 confirmatory test that would define where -- where the present
24 or absence of a substance becomes valid. So I'm sorry I gave
25 you a lot of detail, TMI, but the fact is I don't know what

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1 this is saying. I don't know what kind of test it is 'cause
2 it's got one foot here and one foot there and it is not
3 helpful.
4 Q. So regardless of all these tests in your report -- or your
5 notes, this is --
6 A. Those are my notes, correct.
7 Q. You provided the United States a report; is that right?
8 A. Correct.
9 Q. Okay. So in your notes you summarize as we've already
10 seen the inconsistencies on page 1; is that right?
11 A. That's correct.
12 Q. But throughout the chronology in Singleton's 22 pages you
13 show all the results; is that right?
14 A. I show all the results, correct.
15 Q. So you're not just showing me inconsistencies, right?
16 A. I'm not -- no correct. I'm showing you the whole picture.
17 Q. And are you basing your entire opinion on point of care
18 urinary drug screen?
19 A. No, I'm not.
20 Q. Are drug tests just one thing you looked at?
21 A. It's just one element, one tool that helps in the
22 determination, yes.
23 Q. And in fact yesterday when you were testifying I think we
24 covered one point of care test; is that right -- on the
25 direct -- on my direct examination of you?

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1 A. I think that's correct, yes.
2 Q. What were all the other ones we looked at?
3 A. They were true confirmatory results.
4 Q. Okay. Ones we are looking at, those were inconsistent
5 LCMS confirmatory results, right?
6 A. There were inconsistent confirmatory results, correct.
7 Q. And after we saw that, did you also see narcotics being
8 prescribed after those LCMS confirmatory results?
9 A. Yes. The narcotics were prescribed despite inconsistent
10 confirmatory results.
11 Q. So all these point of care stuff we've been talking about,
12 how important is that?
13 A. In terms of my ultimate opinion it's not important.
14 Q. You were asked about some guidelines. And I think today
15 you mainly went over 20 -- well, for Kentucky you went over
16 the 2008 KMLB opinion; is that right?
17 A. That's correct.
18 Q. And I think the question and answer was dealing with
19 treatment plans and goals.
20 A. Correct.
21 Q. And if I could -- you were asked specifically about
22 functional goals; is that right?
23 A. That's right.
24 Q. And I'm going to look at -- I'm going to show you -- what
25 I'm showing you --

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1 THE COURT: Does this get published, Mr. Ansari?
2 MR. ANSARI: Just for the witness, please.
3 Q. What am I looking at Dr. King?
4 A. This is a copy and I'll read the title. Opinion regarding
5 the use of controlled substances in pain treatment. And this
6 is the -- my recollection and memory, this is the 2008
7 Kentucky Board of Medical Licensing documents that defines
8 the -- the proper use of opioids in the treatment of chronic
9 pain.
10 Q. Okay. And what is paragraph two under treatment plan?
11 A. Paragraph two under -- shall and read it? Its probably
12 the most effect way.
13 Q. Yes, sir.
14 A. Point number two under treatment plan says: The written
15 treatment plan should state objectives that will be used to
16 determine treatment such as pain relief, and improved physical
17 and psychosocial function and should indicate if any further
18 diagnostic evaluations, consultations, or other treatments are
19 planned.
20 Q. In the records that we look at yesterday together, did any
21 of those records have that written treatment plan in there?
22 A. There was no written treatment plan correct.
23 Q. And so are you telling us -- what are you telling us about
24 the KMLB 2008 opinion?
25 A. Well their correct I agree with them they've been

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1 maintained by other organizations and so foundationally
2 they're correct.
3 Q. Did House Bill One go further?
4 A. House Bill One further elucidated the requirements, yes.
5 Q. Did House Bill One adopt much of the 2008 opinion?
6 A. Yes, it was built on the 2008 foundation.
7 Q. Is what I'm showing you House Bill 1 --
8 A. Yes.
9 Q. -- which became codified as house bill one?
10 A. Yes.
11 Q. Can you tell us what this paragraph is?
12 A. Again, section two I'll just read it professional --
13 references professional standards for documentation of patient
14 assessment education, treatment agreement and informed consent
15 action plans outcomes and monitoring. Number one, each
16 licensee prescribing dispensing or administering a controlled
17 substance shall obtain and document all relevant information
18 in a patient's medical record in a legible manner and in
19 sufficient detail to enable the board to determine whether the
20 licensee is conforming to professional standards for
21 prescribing dispensing or administering controlled substances
22 and other relevant professional standards.
23 Q. And what's -- what's D?
24 A. D reference -- okay. So right after what I just read it
25 says relative information meaning what should be included in

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1 the medical record shall include as appropriate and then there
2 are a number of things there but one of them is D as you
3 reference which is treatment objectives.
4 Q. Would that include functional goals?
5 A. It is specifically functional goals yes. Functional goals
6 and VAS pain scores.
7 Q. And prior to the -- or even during this time period, the
8 '08 opinion or the 2013 Do No Harm in Indiana guidelines or
9 House Bill One, was there already a standard of care in the
10 medical community regarding treatment plans and functional
11 goals?
12 A. There definitely was, yes.
13 Q. And what was that?
14 A. The standard of care has been that in order to support the
15 use of chronic opioid therapy and chronic pain there must be a
16 demonstration of improvement in pain and function. And the
17 standard went on to indicate you know even prior to 2008 there
18 was an understanding that if the goals were not met then
19 support for opioids was not there and the patient should --
20 and other types of treatment should be considered opioid
21 should not be used long term.
22 Q. And does -- do the Indiana guidelines also address
23 functional goals or I guess functional domain, physical
24 domain, those type of -- that type of terminology?
25 A. They do. And if I may just say this -- yes, Indiana

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1 reflects the same things. If we understand that pain
2 management is to try to optimize function and as part of that
3 you want to reduce pain but the primary goal is to optimize
4 function, it is not a surprise to understand that success for
5 pain management and the rationale for continued use of opiates
6 is linked to improvement in function as well as pain score.
7 Q. What am I showing you right now?
8 THE COURT: Is this published or not?
9 MR. ANSARI: It's not been published. It's the
10 Indiana guidelines.
11 A. This is a copy of one page of the Indiana opiate
12 guidelines of 2013.
13 Q. You don't have to read it, but read it to yourself but
14 take a look down here.
15 A. It might be worthwhile reading that to the jury.
16 Q. Go ahead, sir.
17 A. So --
18 MR. CHAPMAN: Objection, Your Honor.
19 THE COURT: We'd be reading these all afternoon.
20 Why don't you ask a question first?
21 Q. So what does the Indiana guidelines say in reference to
22 functional goals or physical goals?
23 A. The guidelines indicate Indiana that based on
24 international association for the study of pain what had we
25 refer to as the IASP and that's our go-to source for many of

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1 the standards and protocols -- that they -- based on the IASP
2 activity should be set in three different domains. Physical
3 domain, functional domain and social domain.
4 Q. And what do those mean?
5 A. Well, that really means that if -- as providers going to
6 rationalize the use of chronic opiate therapy, we have to
7 demonstrate improvement in function and we've discussed that.
8 And what this is saying is improvement in function includes --
9 okay. The physical domain which references exercise programs
10 in a very specific manner, functional domain involving
11 everyday tasks such as housework or hobbies, and then social
12 domain such as participating in social activities, visiting
13 friends, going to church, going to the movies, going for a
14 walk. And it indicates here that -- well, these are the
15 goals. It defines these as the goals.
16 Q. You were asked specifically about -- you know, opioids
17 being a tool or you know I think you testified to it it's a
18 tool of maybe not last resort but not the first thing you grab
19 out of the toolbox. Does the Indiana guidelines -- or do the
20 Indiana guidelines agree with you?
21 A. They do agree with me, yes.
22 Q. And did the Indiana guidelines also agree with you on
23 whether fibromyalgia should be treated with opioids?
24 A. They agree that fibromyalgia is not a treatment -- excuse
25 me -- not a diagnosis that is reasonably treated with opioids.

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1 Q. And what about low back pain?
2 A. Low back pain and total body pain are two other diagnoses
3 that do not qualify as generally accepted diagnoses to be
4 treated with chronic opioid therapy.
5 Q. You were asked specifically about, you know, the patient
6 files that we looked at, patients were coming to PPC on
7 opioids. But what's the significance of after they get there
8 and before they leave, what are you looking at during this
9 again trial period?
10 A. Okay. So I will answer that in two parts. First of all
11 the predicate they are coming in having tried opioids before,
12 that's suffices as an opioid trial, so as a provider one would
13 want to review those records to see if the patient had
14 improved with the trial of opiates they had before the came to
15 my office.
16 If they got better then where he would consider
17 continuing them. But assuming -- so part two of your question
18 is what do I look at -- what do we look at as pain providers?
19 During the duration of our care we look for improvement in
20 function. We look for improvement in pain. We look for a lot
21 of other things too in terms of aberrant behaviors and
22 compliance and treatment and so on and so forth, but the
23 bottom line is if -- if the provider cannot demonstrate
24 improvement in pain and function, then as I said before
25 that's -- that means there's good reason to stop the opiates

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1 or as we put it exercise an opiate exit strategy and put the
2 patient on different treatment options.
3 Q. You were asked about specifically addiction and recovery
4 and whether people in addiction therapy should receive
5 opioids. And can you kind of explain that a little more? So
6 someone is coming to a practice they're not in addiction
7 therapy versus they are in addiction therapy, kind of explain
8 the difference.
9 A. Okay. So let's look at the first part of that. When you
10 say addiction therapy, assuming if they a history of
11 addiction?
12 Q. Yes.
13 A. Would that -- okay.
14 Q. Yes, sir. That's fine.
15 A. My interpretation.
16 Q. It probably wasn't mine, but that's the way you took it so
17 go ahead and answer that.
18 A. Okay. So if a patient comes in with a history of
19 addiction a prudent practitioner would say recognizing that
20 addiction is a reoccurring problem I would not want to tempt
21 that patient or -- or risk taking that patient out of his
22 world of addiction control by exposing him to opiates or
23 benzos or other addiction -- addictive substances that would
24 be the same as saying look I know your an alcoholic but come
25 sit down and have dinner with me. One glass of wine won't

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1 cause a problem. No, it will cause a problem. Recognizing
2 addiction is a recurrent problem, you don't want to tempt the
3 devil.
4 So if a patient had an history of addiction, a
5 reasonable provider would look at non-opiate treatment options
6 first and maybe just leave it at that. So I'm not exactly
7 sure where you wanted me to go with this.
8 Q. So are -- if someone is in dire pain but they're also
9 addicted, what do you do there?
10 A. Oh, okay. Well, okay. The answer to that if somebody's
11 got coexisting addiction and pain, basically what you're
12 saying coexisting addiction and pain. We have to get the --
13 okay so we will treat the pain with non-opiate treatment
14 options and we have a lot. We have a lot of them. We just
15 want to use opiates. We don't want to use controlled
16 substance. We also recognize that treatment of the addiction
17 is tantamount before we can effectively get control of the
18 pain. Why is that? Because you recall I told you earlier or
19 yesterday that up to about 80 percent of chronic pain is
20 psychological, so whether it's addiction or mental illness,
21 those psychological components need to be brought under
22 control before pain can be effectively controlled.
23 So in the scenario Mr. Ansari just put to me, we
24 would work with the patient with non-controlled substance --
25 treatment for the pain but also would team that patient up

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1 with treatment for the addiction and mental health. That
2 would be primary. We would have to get that under control
3 because -- before we could become effective with the other
4 options we might choose.
5 Q. Is that a multidisciplinary approach?
6 A. That's the definition of a multidisciplinary approach we
7 also refer to it as a you know personal approach. Every
8 patient's different and we use all the tools we got.
9 Q. You were asked about the number of a hundred morphine
10 equivalence level and you I thin was cited to a 2009, 2010
11 article. During this time period -- past 2010 between 2012,
12 2014, did that become the standard of care in the medical
13 community?
14 A. It did. If I can make a comment on that. It isn't the
15 magic number of -- okay so on that 2009, 2010 article what did
16 that article do it put down in black and white the
17 relationship that we already knew in the clinic and had for
18 years and years and years the higher the dose of opioid the
19 more likely chance there's going to be of overdose death and
20 addiction. It's common sense, right? The more you put out
21 the more like ly there's going to be a problem. We always
22 knew that that article quantified that and it said at about a
23 hundred morphine equivalence there's an order of magnitude
24 increase in the risk of overdose and death ten times.
25 So yes, that's where that hundred milligram came

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1 from, but it formalized the concept of the more you prescribe,
2 the worse the adverse side effects and the increased chance of
3 death, so -- yes, that became codified in terms of a number.
4 The CDC in 2016 said 90, but back then it was a hundred.
5 Q. You were asked about your patent. Are you patent -- I
6 don't know if that's the a word.
7 A. Say the question again.
8 Q. Your patent, are you attempting to protect your
9 development of this chronology?
10 A. When you say protect, I'm not sure what you mean. I want
11 it to be an instrument that can be formally defined. I've
12 used -- I've used it for many, many, many years to and so --
13 there's no intent to sort of keep it to myself. I shared it
14 with -- with the government and with other colleagues. I'm
15 not sure where you're going with that.
16 Q. Yeah. No, that's fine. So you're not -- you didn't file
17 a patent on your reports, right?
18 A. Oh, no. Not on the reports, just the methodology.
19 Q. On the methodology of this chronology?
20 A. Correct.
21 Q. Is that just putting things in logical order?
22 A. Yes.
23 Q. And the placing things in logical order, is that an
24 objective method?
25 A. That is an objective method, yes.

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1 Q. Are you saying that if you put everything in an -- this
2 objective order that I can just pick this up and a make
3 determination whether a doctor has prescribed outside the
4 usual course of professional practice?
5 A. No, can't do that.
6 Q. What else does it take to make that determination?
7 A. That takes the review by an expert to individualize to --
8 well, to review the report in an individualized manner and
9 make determinations based on standard of care.
10 Q. Thank you, sir.
11 THE COURT: Anything further, Mr. Butler -- or I'm
12 sorry, Mr. Chapman?
13 MR. CHAPMAN: Just briefly, Your Honor.
14 Is your screen back on Mr. Pence?
15 MR. PENCE: It is at this moment.
16 RECROSS-EXAMINATION
17
18 BY MR. CHAPMAN:
19 Q. Doctor, just a few brief questions. And I'd like to show
20 this just to the witness. Recall earlier you testified
21 January 3, 2014, Brandon McDonald had an inconsistent urinary
22 drug screen because he was negative for methadone and opiates.
23 A. If that's what was testified. I'll take your word for it.
24 Q. Okay. Then your revised report you indicate page 92 is
25 the urine dipstick result for that.

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1 A. I don't know if its urine dipstick. I'd have to go to the
2 reference to verify.
3 Q. Okay. Let me show you page 92 that you referenced. Is
4 that the urine dipstick result for Brandon McDonald?
5 A. It is.
6 Q. Okay. Can we please swipe over to defense table? 1-3-20.
7 And, Dr. King, 1-3-14 is this being shown to the jury? 1-3-14
8 you indicate on your report and therefore indicate in the
9 statement made to the federal government that Brandon McDonald
10 had an inconsistent urinary drug screen on that day correct?
11 A. Correct.
12 Q. Okay. And you cite in there page 53 and 54 correct?
13 A. Right. And 320.
14 Q. All right. And that's your statement that that was an
15 inconsistent urinary drug screen, right?
16 A. That's the source where this was referenced, yes.
17 Q. Can I please have it back on ELMO for the jury and the
18 witness? Now, previously the top page of your chronology said
19 1-3-14 was inconsistent because it was negative for methadone
20 and opiates. Your report also indicates that that was an
21 inconsistent urinary drug screen down at the bottom where you
22 say that you actually report the truthful results, but isn't
23 it true, sir, that there are opiates and methadone in this
24 sample making this urinary drug screen consistent?
25 A. Okay. So on the bottom part there where we have the

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1 confirmatory result there, that's referencing the -- that's --
2 it's representing the absence of morphine and hydromorphone.
3 Q. I'm sorry. I said morphine, not methadone. I meant to
4 say methadone. Isn't it true this report shows methadone in
5 Brandon McDonald's system?
6 A. It does show methadone, yes.
7 Q. In your chronology you say it's inconsistent because it
8 lacked methadone; is that correct?
9 A. Again, I'd have to go back and find out what I was
10 referencing. You just pull up a confirmatory but there are
11 several bates there that need to be looked at.
12 Q. Sir, let me show you the chronology again and I'll have it
13 just back on the witness. We'll go through this slow this
14 time. Your chronology inconsistent urinary drug screen on
15 January 3, 2014, says the urinary drug screen is inconsistent
16 because it was negative for methadone and opiates isn't that
17 right?
18 A. I'm doing a cross-comparison. Stand by for just a second.
19 Q. I'm just asking you go about chronology and whether or not
20 the language there is correct.
21 A. That's not in the updated chronology.
22 Q. Okay. So you removed that because it was a mistake?
23 A. Again, I don't know if it was a mistake. I had new
24 records, so I melded them together.
25 Q. So showing you -- can we go back to defense table, please?

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1 Showing you your updated chronology, you still list January 3,
2 2014, as an inconsistent urinary drug screen result, correct?
3 A. For the confirmatory yes.
4 Q. Okay. And I'm going to show you that confirmatory result
5 back on the witness. And you see this is time there is
6 methadone in this patient's system as confirmed by a LCMS,
7 correct?
8 A. That's correct.
9 Q. And there is hydrocodone in this patient's system as
10 confirmed by an LCMS?
11 A. There is no hydrocodone. I'm sorry. There is no --
12 that's correct. There's hydrocodone. There's no
13 hydromorphone.
14 Q. Okay. But hydromorphone is traditionally it comes from --
15 well, the medication would be Dilaudid that causes a positive
16 result but also hydrocodone can be metabolized into
17 hydromorphone; is that right?
18 A. Well, you use double speak there. Hydrocodone is
19 metabolized hydromorphone.
20 Q. Okay. But the fact that there was no hydromorphone in
21 this urinalysis sample is wholly irrelevant because this
22 patient wasn't prescribed Dilaudid, correct?
23 A. No. It's not wholly irrelevant at all. It's very
24 relevant and here's why. If a patient were taking hydrocodone
25 what we look at in the urinary drug screen is the present of

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1 the parent drug which is hydrocodone and the metabolic
2 breakdown products to show the patients be taking the drug and
3 breaking it down in this case the hydromorphone which is the
4 breakdown product is absent, what does that tell us? That
5 tells us that even though hydrocodone shows up, he hasn't been
6 taking it very long, maybe just took it that day or maybe
7 scraped off some of the pill into urine, but there's no
8 indication the patient's been on that pill, on that
9 medication, the hydrocodone, for any length of time.
10 Q. It's interesting that you mention scraping because you've
11 seen patients who scrape before, correct?
12 A. I don't know that I've seen them. I know it occurs.
13 Q. Okay. And you're aware that when patients scrape what
14 they do is take some of the pill and actually scrape it into
15 the sample, correct?
16 A. That's one option, yes.
17 Q. And that gets tested, right?
18 A. Well, the sample gets tested, sure.
19 Q. And one reason why you're saying that this could
20 potentially be scraping is because when you scrape, the drug
21 hasn't processed through the body and therefore the metabolite
22 isn't also excreted with the medication, right?
23 A. That's correct.
24 Q. But you're also familiar with the fact when a patient
25 scrapes, the levels in their system of the drug are incredibly

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1 high, aren't they?
2 A. Well, they're -- they generally are, yes.
3 Q. Yes. Because in an instance where somebody is scraping,
4 they're actually putting the pill directly into the sample as
5 opposed to ingesting it, having it spread throughout the body,
6 and then secreting it slowly over the course of hours or a
7 couple of days, right?
8 A. That's correct. And that's what this demonstrates here.
9 Q. This isn't consistent with scraping, is it, sir?
10 A. It certainly could be. The hydrocodone value is listed
11 greater than 5,000 which means that's the max apparently that
12 this machine will measure. It looks like it's been maxed out,
13 so yeah. It's a pretty high value.
14 Q. It says it's positive for hydrocodone. This would lead a
15 reasonable provider to believe the patient was ingesting
16 hydrocodone, correct?
17 A. No, it's not. There's no metabolic product shown and the
18 level the concentration is greater than 5,000 which is a very,
19 very high amount, so -- yes, it could be consistent with
20 scraping.
21 Q. You have no evidence to suggest that Brandon McDonald was
22 not taking his medication and was scraping, is that correct?
23 A. I don't know about scraping, but this is an indication
24 he's not taking his medication.
25 Q. Looking very quickly at this, you said the maximum amount

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1 could potentially be 5,000, so you don't what the ceiling on
2 this sample is, was that your prior testimony?
3 A. What I'm saying is it says greater than 5,000. When we
4 see a greater than sign, that usually means that's the highest
5 the machine can measure.
6 Q. Greater than means that you believe that this patient was
7 scraping a drug into a sample because he wasn't taking it and
8 was instead selling it on the street, is that what your
9 saying?
10 A. I don't know whether he was scraping it or took it the day
11 he came in. What I do know is the concentration is high only
12 for the hydrocodone and there's no indication of the metabolic
13 product, so he hasn't been taking it.
14 Q. Let's look at the reported result. 5,272 do you see that
15 there?
16 A. Yes.
17 Q. Do you have any information to suggest that a result at
18 5,272 is consistent with scraping as opposed to -- as opposed
19 to being consistent with use of the medication?
20 A. Yeah. I don't know about the scraping. I just offered
21 that as a possibility. I'm not opining that that's what
22 happened.
23 Q. Is it your habit to offer possibilities of potential
24 conduct like scraping to this jury as an explanation for
25 inconsistent urine drug screen absent --

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1 MS. MCKEIVIER: Can this be shown to the jury,
2 please? This is part of the --
3 MR. CHAPMAN: My mistake. I failed to realize that
4 it wasn't.
5 Q. Let me just go over this briefly because the jury didn't
6 have an opportunity to see it. Doctor, it's true that this
7 result was positive for hydrocodone, correct?
8 A. Correct.
9 Q. That is a medication that was prescribed to Brandon
10 McDonald, correct?
11 A. Correct.
12 Q. Okay. It's also true that -- here it says greater than
13 5,000 nanograms a milliliter, correct?
14 A. Correct.
15 Q. All right. But also up here it indicates the result was
16 actually 5272 correct?
17 A. Correct.
18 Q. With a cut-off value of a 300 nanograms a milliliter,
19 correct?
20 A. Right.
21 Q. And you also see the hydromorphone here is circled dated
22 and signed by somebody, correct?
23 A. I can't see the little thing, but I think -- yeah, right.
24 Q. Okay. That would indicate to you that somebody was aware
25 of the possibility that you suggested we don't see the

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1 metabolite hydromorphone in the system and is indicating that
2 they've noted that, at least, right?
3 A. I noted it, but no indication that any action has been
4 taken.
5 Q. Is it your belief that a patient should be refused
6 medication because they don't have the metabolite in their
7 system but have the active drug?
8 A. Well, that's a rather binary statement. Here's what my
9 thought is. This is an indication that the patient's not
10 taking his medicine. It's a formal statement here that the
11 hydromorphone is not present which tells us the patient's not
12 taking his medicine. That needs to be acted upon, needs to be
13 addressed.
14 Q. It could also mean the patient has just recently taken his
15 medication and the metabolite hasn't processed through his
16 system yet, correct?
17 A. No. Because if he was on -- and I believe he was on
18 hydrocodone on a regular basis, then the metabolic product
19 would be expected to be present.
20 Q. Sir, are you aware -- you just testified to this jury a
21 few minutes ago not having the active metabolite in your
22 system could suggest you just recently took the medication?
23 A. Right. And point of fact have not been taking the
24 medication.
25 Q. Okay. I don't have any further questions. Thank you,

DRAFT

1 Your Honor.

2 THE COURT: All right. Mr. Butler? Okay.

3 Mr. Ansari?

4 MR. ANSARI: Half a one.

5 THE COURT: Half a one.

6 REDIRECT EXAMINATION

7 Q. Sir, do you see a date on that?

8 A. I'm sorry. You weren't at the microphone.

9 Q. Sorry. Did you see the date that hydromorphone was

10 circled, a line drawn out, some initials and a date. Do you

11 remember that date?

12 A. I don't remember the date.

13 Q. You don't remember the date?

14 A. Perhaps we can take a look at it again.

15 Q. I don't remember the exhibit number. Can I borrow yours?

16 If I told you 4-17 would you remember that?

17 A. 4 -- 4-17? That would be -- well, that would be more than

18 three months after the test.

19 Q. Thank you, sir.

20 THE COURT: All right. We're calling it a day, sir.

21 You can step down now.

22 THE WITNESS: Thank you.

23

24

25

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