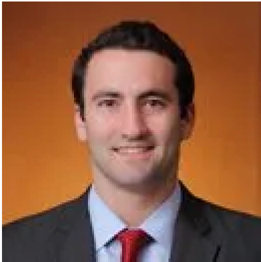
Exhibit
9

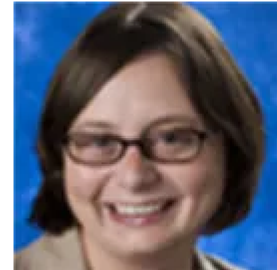
Charles Szyman, MD Acquitted by Jury in Wisconsin

by Linda Cheek, MD | Nov, Mon, 2017 | Acquitted | 2 comments

Charles R. Szyman, MD a pain specialist from Manitowoc, WI, accused of over-prescribing narcotic medications, was found not guilty of all charges by a jury Nov 17, 2017.

> “I think what this verdict ultimately proves is that the United States government’s attempt to scapegoat and paper over the opioid crisis by blaming doctors who are just trying to do their job for people who are suffering from pain, that’s not going to work,” said Beau Brindley, lead counsel for Dr. Szyman’s defense. “We do not go after doctors and blame them for a bigger problem, as opposed to actually deal with and treat that problem,” Brindley said. “Dr. Szyman worked hard to take care of his patients for years and years and years, and this jury validated that.”





The trial lasted only five days. On the side of evil stood Assistant U.S. Attorney Matthew Jacobs and Laura Schulteis Kwaterski. In his closing, Mr.Jacobs said that Dr. Szyman failed in his duty to protect his patients when he prescribed them ever-increasing doses of narcotics without understanding the source of the patients’ pain and properly monitoring their use.

Really? And where is your medical degree, Mr. Jacobs? And how do you come up with such lies and sleep at night? Oh—that’s right—it’s the money.

Beau Brindley did what every defense attorney should do. He pointed out that the government’s case was not about medical malpractice, not about negligence, but was a criminal case.

> “They are not calling Charles Szyman a doctor, they are calling him a criminal,” Brindley said. This is a point that every defense attorney in the country should be bringing home to the juries—that a doctor working in his office treating pain is not criminal.

According to Brindley, Szyman acted in good faith and truly believed he was prescribing appropriate amounts of medication to address the debilitating pain many of the patients

complained of. He also said there was no reason for Szyman to knowingly give patients more narcotics than they needed.

> "Where is the bad faith?" Brindley asked. "I'm not talking about if he should have been more skeptical. I'm talking about bad faith, bad intention."

Dr. Szyman was a pain specialist for Holy Family Memorial in Manitowoc until he was terminated in October 2015 after his medical license was suspended by the Wisconsin Medical Examination Board as a result of an investigation into his practice. This shows how the state Boards of Medicine are simply henchmen of the US Attorney's and States' Attorney's offices.

In June, 2016, he was indicted for 19 counts of drug trafficking for allegedly over-prescribing narcotic medications and pleaded "not guilty" to each of the charges. The indictment stated the usual misuse of the exemption phrase in the Controlled Substance Act—that Dr. Szyman "knowingly and intentionally distributed unlawfully a controlled substance outside of his professional practice and not for a legitimate purpose".

On the witness stand, Dr. Szyman described his practice as a normal pain clinic with the aim to help people with their suffering while taking the necessary precautions.

> "When people speak of pain and the treatment of pain, we talk about the complications of treating the pain, but we rarely speak of the complications of not treating the pain," he said.

Szyman said he was seeing 350 to 400 patients and only a small percentage were on what he called high-dose opioid therapy. He said he first encountered the therapy, using high dosages of opioids to treat non-malignant chronic pain, in a seminar in the early 1990s and it seemed practical to him.

> "To me, it made sense," Szyman said. "Why does a human being have to suffer just because they don't have cancer?"

He said he would typically start by finding alternative options for the patient, but when treatment with opioids became inevitable, he would start them on a low dose and eventually increase it until the patient reported they were functional in their daily lives.

> "Trying to help these people was labor intensive and emotionally draining … because I was concerned for them," Szyman said.

According to Szyman, he had no indication some of his patients were lying to him to obtain ever-increasing amounts of narcotics. He said he always believed he was prescribing medication for a "legitimate medical purpose," and to prescribe medication without a purpose was unethical.

The prosecution's evil PAID TO LIE "expert" witness was Dr. Timothy King, a pain specialist and anesthesiologist from Indianapolis. Stay away from him as a doctor. As usual, though, his testimony about Dr. Szyman's patients was limited to the information included in their medical files. He looked at several patients who were on high doses of opioids due to years of treatment and the usual opioid tolerance, and called the amounts "egregious". I remember that term being used by the lying expert witness in my case as well, Dr. Marc Swanson of Roanoke, VA. I guess this 4 dollar word is something they learn in the "How to Lie 101" class for prosecutorial expert witnessing.

The prosecution also used the testimony from two DEA agents, Greg Connor and Kelsey Knaup, who obtained prescriptions from Dr. Szyman fraudulently. They are the REAL criminals. They complained about pain they didn't really have, and Dr. Szyman believed them and treated them appropriately for the pain they described.

> Mr. Thompson told the jury "There are two things about this case that are true. The first is that Charles Szyman is a physician … the second is that Charles Szyman did his job."

Yeah for the people of Wisconsin. Possibly some of them have been following American Pain Institute, or this website. But whatever the reason, good job, Wisconsin.

However, Dr. Szyman is not finished with the attacks. He is also facing a wrongful deaths lawsuit with Holy Family Memorial in Manitowoc County Circuit Court. The lawsuit, filed Oct. 4, 2016, alleges he caused the deaths of Heidi Buretta, Monica Debot, Mark Gagnon and Alan Eggert through his practice and prescription of narcotics. But again, if he prescribed in good faith and had professional decision making, he should be declared innocent.

Charles Szyman, MD Addendum

Dr. Szyman was never able to recoup from the depression the attack on him caused. In February, 2018, he committed suicide. And instead of writing about him as a physician doing his job and helping his patients, the unethical media still just wrote about the charges against him in their announcements of his death. This alone should show the world that the standard media/government arrangement isn't to spread the truth, but to spread the government propaganda. It's too bad that Dr. Szyman has to wait for God to render judgement on these propaganda moguls.

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About the Author Linda Cheek, MD

Linda Cheek is a teacher and disenfranchised medical doctor, turned activist, author, and speaker. A victim of prosecutorial misconduct and outright law-breaking of the government agencies DEA, DHHS, and DOJ, she hopes to be a part of exonerating all doctors illegally attacked through the Controlled Substance Act. She holds the key to success, as she can offset the government propaganda that drugs cause addiction with the truth: The REAL Cause of Drug Abuse.
Get a free gift to learn how the government is breaking the law to attack your doctor: Click here to get my free gift

2 Comments

Bella Szyman on June 6, 2019 at 4:08 pm

this was my uncle, he is actually dead now, he hung himself

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Reply

Linda Cheek, MD on June 6, 2019 at 7:08 pm

I am so sorry for your loss. But the fact remains that doctors are being attacked in greater numbers than ever before. Everyone in Dr. Szyman's family and his friends and patients should be active members of DoC to stop this horrendous government Hitlerism. So can you tell me why you aren't a member? Feel free to email me instead of putting it in a comment. lindacheekmd@gmail.com

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Get your T-shirt to tell the world the truth about pain and the War on Doctors! Doctors of Courage is the ultimate source for information people need to know.
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UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF WISCONSIN

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	Case No. CR 16-00095-WCG-1
	)	Milwaukee, Wisconsin
vs.	)	
	)	November 15, 2017
CHARLES R. SZYMAN,	)	11:36 a.m.
	)	
Defendant.	)	

TRANSCRIPT OF JURY TRIAL EXCERPT
TESTIMONY OF DR. TIMOTHY KING - PART 1 OF 2
BEFORE THE HONORABLE WILLIAM C. GRIESBACH
UNITED STATES CHIEF DISTRICT JUDGE

APPEARANCES:

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transcript produced by computer aided transcription.

1 TRANSCRIPT OF JURY TRIAL EXCERPT

2 **TESTIMONY OF DR. TIMOTHY KING**

3 Transcribed From Audio Recording

4 * * *

5 THE COURT: Next witness.

6 MR. JACOBS: Your Honor, we're going to call

7 Dr. Timothy King.

8 THE COURT: Okay.

9 MR. JACOBS: Sir, step up to the witness stand, remain

10 standing. You'll be placed under oath.

11 THE CLERK: Do you solemnly swear the testimony you

12 are about to give will be the truth, the whole truth and nothing

13 but the truth so help you God?

14 THE WITNESS: Yes.

15 THE CLERK: Please be seated. Please state your full

16 name for the record. Please spell both your first and last

17 names.

18 THE WITNESS: Timothy E. King, K-I-N-G. First name

19 Timothy, T-I-M-O-T-H-Y.

20 THE COURT: Thank you, Dr. King.

21 Go ahead, Mr. Jacobs.

22 DR. TIMOTHY KING, GOVERNMENT WITNESS, DULY SWORN

23 DIRECT EXAMINATION

24 BY MR. JACOBS:

25 Q. Good morning, Dr. King. How old are you?

1 A. I'm 68 years old.
2 Q. And where were you born?
3 A. I was born in South Bend, Indiana.
4 Q. And in what city do you currently reside?
5 A. Currently I still reside in Indiana and I reside in
6 Indianapolis.
7 Q. All right. How long have you been living there?
8 A. I have been in Indianapolis approximately four years.
9 Q. Are you married?
10 A. Yes, sir.
11 Q. Any kids?
12 A. Several kids. Three girls and a boy.
13 Q. Any grand kids?
14 A. Several grand kids.
15 Q. Can you tell me -- I want to discuss your educational
16 background. Can you tell me how far you went in school?
17 A. Well, I went through post-graduate training in medicine. I
18 also did some post-graduate training as part of my Ph.D. program
19 in medical biophysics. So that would include college, medical
20 school, graduate school.
21 Q. Where did you go to college?
22 A. I attended college at Indiana University in Bloomington,
23 Indiana and to some extent Indiana University in South Bend
24 during the summers.
25 Q. What did you major in in college?

1 A. I was a science major. I was a pre-med major. I majored in
2 chemistry, mathematics, and physics.
3 Q. And you received a degree from Indiana?
4 A. Yes, sir, I did.
5 Q. And when was that?
6 A. All these dates run together. I have to reference it here.
7 I graduated from Indiana University in 1970.
8 Q. Okay. And you went to medical school after that?
9 A. I did. After Indiana University Bloomington I applied for
10 and attended medical school at Indiana University School of
11 Medicine, Indianapolis.
12 Q. And did you graduate from that medical school?
13 A. Yes, I did.
14 Q. And what degree did you receive upon graduation?
15 A. A medical degree, M.D. degree.
16 Q. And did you also do post-graduate work while either
17 attending college and medical school?
18 A. I was involved in several basic science research programs
19 while I was attending college. And when I entered into medical
20 school I entered into what's called the combined degree program.
21 It was a program just being initiated at that time where an
22 individual who has an interest in clinical research would also
23 obtain a Ph.D. as part of the M.D. training program.
24 Q. What was the field of study that you worked towards a Ph.D.?
25 A. The field of study was basically pharmacology. It had to do

1 with membrane transport. It had to do with chemicals that
2 affected antibiotics and in general the basic concept of how do
3 drugs work in the body, how are they transported, what do they
4 do.
5 Q. Okay. And how long is medical school?
6 A. As part of the combined-degree program the medical school
7 lasted for me a little over five years.
8 Q. And after graduating from medical school did you do a
9 residency somewhere?
10 A. Yes. After I was done with medical school I attended the
11 University of Washington-Seattle for a residency in anesthesia
12 and pain management.
13 Q. How long was that residency?
14 A. That residency was three years.
15 Q. And can you explain to the jury what do you do during a
16 residency?
17 A. A residency basically is an area of subspecialty training.
18 After one comes out of medical school with basic concepts of how
19 to deal with human disease and how to diagnose and treat basic
20 concepts of human disease, one usually has an idea of a
21 specialty.
22 In my case I was so very interested in pharmacology
23 and in anesthesiology, the art and science of taking care of
24 people in pain. So my anesthesia and pain management residency
25 was a further specialty training where I served an internship

1 for a year and then two years' time intensely spent in the
2 operating room or in the pain clinic.
3 Q. So you actually treat patients during that internship and
4 residency?
5 A. Yes.
6 Q. And how long did that combined internship and residency
7 last?
8 A. That was a three-year timeframe.
9 Q. All right. And when did you complete that? What year was
10 that? Sorry.
11 A. Checking my notes here.
12 Q. Yeah.
13 A. I finished my residency in 1978.
14 Q. And what did you do at that time?
15 A. After completion of the residency and medical training
16 program I took a job in Washington State and worked as an
17 anesthesiologist and pain management physician out of Spokane,
18 Washington.
19 Q. And what did that involve?
20 A. That involved time in the operating room administering
21 anesthesia for various operative intervention, operative cases.
22 It also involved taking care of patients who had typically at
23 that time spine pain issues.
24 So I acted as an interventionalist offering both
25 medical management but primarily interventional pain management

1 such as epidurals.
2 Q. And how long did you do that?
3 A. I did that for a number of years. If my memory is correct
4 it was on the order of about five years or so in Spokane,
5 Washington. And at that point we moved further north to Alaska
6 where I practiced for about another five years doing both
7 anesthesia and pain management.
8 Q. All right. So I think you said Alaska for five years. What
9 did you do after that?
10 A. After our Alaska journey my folks were aging and I needed to
11 come back home to them. So we moved back to the midwest and
12 moved back to my hometown area of Northern Indiana and we set up
13 practice there and that's where I've been for the last couple
14 decades.
15 Q. Do you know approximately when you returned to Indiana?
16 A. I don't have that date, but it would have been -- I don't
17 have that date.
18 Q. Somewhere in the late 1980s?
19 A. That would be about right.
20 Q. So since that time have you been practicing medicine?
21 A. Yes. I've been in the continual practice of medicine since
22 that time.
23 Q. And could you describe what your practice of medicine has
24 been since that time, since returning to Indiana?
25 A. Since having returned to Indiana the art and science of pain

1 management has continued to define itself and has become a
2 separate specialty.
3 When I returned to Indiana it was my intent to do
4 about 50 percent of my time as an anesthesiologist in the
5 operating room and about 50 percent of my time as a chronic pain
6 management and acute pain management physician. As the years
7 went on I spent a little less than half my time in the operating
8 room.
9 As the understanding of the complex pharmacology and
10 interventional treatment options for chronic pain continued to
11 evolve I, like most of my colleagues, became a pain management
12 physician exclusively. So over the course of the decade or so
13 that I was back in the midwest, back in Indiana, I evolved into
14 not much operating room work at all and I exclusively took care
15 of chronic pain management issues in the clinic.
16 Q. And is there a date post you could give for when the bulk of
17 your practice, majority of your practice transitioned from some
18 surgery work as an anesthesiologist to primarily a pain
19 management doctor?
20 A. I haven't actually been asked that question before so I
21 can't give you an exact date, but I would say it happened fairly
22 quickly. Within the first five years or so after I returned to
23 the midwest I was practicing pain management on a ninety to a
24 hundred percent basis.
25 Q. In what context were you practicing pain management? Were

1 you in a clinic standalone, with a hospital?
2 A. As an anesthesiologist I was very interested and well
3 trained in interventional pain medicine. That is to say, I knew
4 how to give blocks, I knew how to give spinal blocks, epidural
5 blocks, extremity blocks, facial blocks, that sort of thing.
6 So from a diagnostic standpoint approximately I would
7 say once I was in full-time pain management I would say maybe
8 20 percent of my time was actually spent in the procedure room
9 where I would offer patients diagnostic and therapeutic
10 treatment options and then the other 80 percent of the time was
11 actually in the clinic sitting in front of a patient, talking to
12 a patient, examining a patient, putting together a diagnosis and
13 a treatment plan or following up with patients for whom we had
14 started on various treatment options.
15 Q. And during the time you were practicing primarily in the
16 pain management area, do you know approximately how many
17 patients you would see on a weekly basis or a monthly basis?
18 A. The pain management clinic was unlike family practice in
19 orthopedics and other areas where you can move through patients
20 fairly quickly. You cannot do that with pain management. The
21 cases are too complex and too many variables and too many things
22 you need to sort out. That limited the number of patients.
23 So typically I would say the average number of
24 patients that I would see and still see actually on a daily
25 basis are on the order of about 20 to 25 patients.

1 Q. On a daily basis?
2 A. Per day, yes.
3 Q. Per day. I'm sorry. I didn't hear that part. And I'm not
4 sure I completely understand the distinction between
5 anesthesiology and pain management. Can you explain that?
6 A. Anesthesiology and pain management I would suggest are
7 really continuums of each other.
8 If we ask the question why are so many
9 anesthesiologists involved in pain management, it's because as
10 part of the anesthesiology training program and practice of
11 anesthesiology we learn how to use medications, we learn how to
12 use opiates and sedatives and barbiturates to make people
13 unconscious and unconscious of pain.
14 And it's not too much of an exaggeration to then say
15 with that degree of training and understanding of the
16 pharmacology and how to do injections, that we would then go
17 into pain clinics.
18 So essentially pain medicine is an extension, it's an
19 arm if you will of the anesthesiology. Anesthesiology one might
20 say is pain management in a situation where somebody's going to
21 intentionally have something done to their body and needs to be
22 made pain insensible.
23 Chronic pain management is sort of the other end of
24 that spectrum but still on the same spectrum where we take care
25 of individuals whose pain has persisted for whatever reason and

1 needs to be addressed with various techniques. So it's
2 basically a continuum; one end is more of acute pain, the other
3 is more chronic pain treatment.
4 Q. And did you -- or have you continued to practice in the area
5 of pain management since that time --
6 A. Yes.
7 Q. -- to the present?
8 A. Yes, I have.
9 Q. Still practicing in the clinical area?
10 A. Yes, sir, I am.
11 Q. And do you know what the term "board certified" means?
12 A. Yes.
13 Q. Or is? Do you know that term?
14 A. Yes.
15 Q. Okay. What does that mean? Can you explain that to the
16 jury?
17 A. Board certification is what we might call the gold standard
18 of a specialty. As physicians we enter into the clinical
19 workplace with licensure, which is sort of a base level. If you
20 get your medical license to practice in the state of Wisconsin
21 or the state of Indiana, that allows you entry to be a doctor,
22 but it doesn't really say anything about your -- about your
23 background and about your skills.
24 So the board certification was put forth as an
25 examination or a series of examinations that would set apart

1 those individuals who were just freshly trained and maybe
2 haven't honed their skills or developed them compared to those
3 who have achieved a certain gold standard, have passed through
4 some peer-reviewed exams, some written exams, and have shown
5 mastery of the topic. That would be what board certification
6 would entail.
7 Q. And is the testing a written exam, an oral exam?
8 A. The testing is actually quite rigorous, it's both. There is
9 a written exam and there is an oral exam and then, thirdly,
10 there is a practice requirement.
11 In other Words, you can't just take a board
12 examination without having been in practice for a certain period
13 of time and having performed certain things as part of your
14 specialty. So it's a three-part process and then you're not
15 even done at that point.
16 Typically these days we have what's called a MOCA or a
17 maintenance certification. So even though one might be board
18 certified at a given timeframe -- and I was board certified, and
19 I have to check my records here, back in 1982, for -- for pain
20 management -- sorry -- for anesthesiology I was board certified.
21 I was board certified in pain management in 1984, but
22 the requirements now are that every 10 years you have to be
23 recertified. So most of us having gone through that initial
24 walk have to re-walk and re-take that examination every 10
25 years.

1 Q. And who issues those certifications?
2 A. The certifications are issued by the board of your
3 specialty. In my case I'm an anesthesiologist, so the American
4 Board of Anesthesiology issued the board examination for both
5 anesthesiology and pain management again in my case.
6 Q. And who makes up the board? Where does that come from? Is
7 that a governmental agency, a state agency? What is that?
8 A. The board of the specialists is not a government agency.
9 It's made up of university professors, individuals who have
10 shown expertise in that particular area who may have published
11 and who are teaching. The board is a separate private
12 organization that represents the best of the best essentially in
13 that specialty.
14 Q. Okay. I think you've mentioned this, but do you have any
15 board certifications?
16 A. I do.
17 Q. And how many do you have?
18 A. Technically I have four board certifications. I am board
19 certified and anesthesiology is my home certification.
20 I'm also board certified through the American Board of
21 Anesthesiology with what are called extended qualifications in
22 pain management. That's my second board examination -- board
23 certification. I have been board certified through the American
24 Academy of Pain Medicine for a second board certification in
25 pain management.

1 And then I am certified by the American Academy --
2 American Board of Addiction Medicine with board certification in
3 addiction medicine.
4 Q. Okay. And I think you've mentioned this, your board
5 certification in anesthesiology, you obtained that in 1982?
6 A. Correct, 1982.
7 Q. And then board certification in pain management in 1984?
8 A. That's correct.
9 Q. And when did you obtain your board certification in
10 addiction medicine?
11 A. The addiction medicine board certification was attained in
12 2015.
13 Q. Maybe -- I want to show you what has been marked for
14 identification as Exhibit 104. Maybe this will help you.
15 Do you recognize what Exhibit 104 is, Dr. King?
16 A. I do, yes.
17 Q. And what is that? Is that your curriculum vitae or your
18 resume?
19 A. It is, yes.
20 Q. Okay. And does it accurately reflect your education,
21 training, your employment and accomplishments?
22 A. Yes, sir, it does.
23 MR. JACOBS: Your Honor, I'd move into evidence
24 Exhibit 104.
25 MR. BRINDLEY: No objection, Judge.

1 THE COURT: 104 is received.
2 (Exhibit 104 received in evidence.)
3 BY MR. JACOBS:
4 Q. And how did it come about that you received board
5 certification -- or why did it come about that you received
6 board certification in the area of addiction medicine?
7 A. As the years began to show that the chronic pain was a major
8 problem, perhaps larger than what we had thought initially, and
9 as we began to see that the pharmacology -- the pharmacologic
10 treatment of chronic pain had significant dependency and
11 addiction side effects associated with it, it became obvious
12 that to continue to be an expert in this area, to continue to be
13 able to make the best treatment and diagnostic decisions for
14 patients, it was in my mind to address that head on.
15 So I decided in order to best do no harm and best
16 protect my patients and give them the best service, I went
17 forth, studied for, prepared for and ultimately achieved board
18 certification in addiction medicine.
19 Q. And could you describe that field? How does that -- what
20 does that practice entail?
21 A. And to be fair, I don't practice addiction medicine, but I
22 wanted to attain that level of knowledge so I could best serve
23 our patients in chronic pain.
24 But addiction medicine basically is a recognition of
25 the fact that a lot of the common tools that we might use in the

1 pharmacologic treatment of patients under anesthesia or patients
2 having acute pain treatment for a broken leg, that there are
3 concerns, there are costs that are associated with the use of
4 opioids or narcotics. There are costs associated with the use
5 of sedatives and hypnotics like benzodiazepines.
6 Those costs sometimes become even more concerned when
7 the patients come in with an alcohol background or an illegal
8 drug-use background. There's a very complex and a very
9 dangerous series of pharmacologic events that can occur if the
10 choice is made to use controlled substances like opiates for the
11 treatment of our patients.
12 So addiction medicine addressed all that. It
13 addressed who are the patients, what are the pharmacologic
14 interactions that we need to be aware of, how do we address
15 them, how do we treat them, and specifically how do we treat
16 them in the context of chronic issues like pain management.
17 Q. Now, in addition to your medical practice have you done any
18 teaching in the medical area?
19 A. I have.
20 Q. Can you describe the teaching you've done?
21 A. I'm not an ivory tower doctor. I'm what has been referred
22 to as an in-the-trenches doctor. I take care of real people
23 with real pain management issues.
24 But recognizing that it's important to be involved in
25 the latest of what's going on in this field, it's important I

1 think to maintain a foothold in the academic environment which
2 is what I've done over the years.
3 So my teaching has been involved in several levels.
4 One is, I've typically always had an appointment to one of the
5 local medical schools. In the past it was Indiana University or
6 University of Washington in Seattle or Rush University in
7 Chicago. Or currently I'm on the associate staff at the
8 University of Chicago.
9 So I do teaching occasionally to residents who are
10 training in similar and near similar fields, say rehabilitation
11 or pain management.
12 I lecture to young doctors and to nursing staff a
13 great deal as a senior physician in our fairly large practice
14 group. I spend a great deal of time mentoring our new young
15 doctors and our new young medical people.
16 This morning before I came in I had two conversations,
17 one with a doctor, one with a nurse practitioner who were
18 calling me up this morning asking for guidance in the treatment
19 of a complex pain management case.
20 I also teach/instruct law enforcement. I do a lot of
21 lectures to law enforcement to help them understand the basics
22 of pharmacology, the basics of pain management, and the basic
23 understanding of what's involved in addiction so that they could
24 better address their duties when they're out on the streets or
25 working on specific cases.

1 I also do some lecturing, some teaching to the public.
2 I do a number of public service discussions with lay
3 people, whether it be with the YMCA or various other charity
4 organizations. We all are very well aware that the opioid
5 clinic is front and center in the headlines and has been
6 actually for a number of years. So I get a number of requests
7 to teach and to talk to lay groups about the problem.
8 Q. And have you also done consulting --
9 THE COURT: When it's an appropriate spot to take a
10 break you can -- whenever. If you have a few more --
11 MR. JACOBS: Okay. Just a couple more and then I'll
12 be done with this area of background.
13 THE COURT: Okay, go ahead.
14 BY MR. JACOBS:
15 Q. Have you done any consulting in the area of pain management
16 and opioid use and abuse?
17 A. By consulting -- the answer is yes, I have. I do consulting
18 on the topic with various agencies, yes.
19 Q. And in particular have you consulted with various law
20 enforcement agencies?
21 A. Yes, I have.
22 Q. And with whom have you consulted?
23 A. I've consulted on the state level with various state
24 attorney generals. Indiana is where I invested a lot of time
25 working with the attorney general's office in Indiana. But also

1 with other states' attorney generals' offices by giving them
2 lectures or working on cases. And it isn't always working on
3 cases, sometimes I come in to give them lectures and help orient
4 them to, you know, current appropriate topics.
5 I also work a great deal with the federal government.
6 I work with not only yourself and the State of Wisconsin, but I
7 work with several other states with regard to consultation on
8 various pill mill and physician overprescribing cases that they
9 would like to talk about and have some guidance on.
10 And then I also do consulting in the private sector.
11 There are a number of physician groups who have called me and
12 asked me to review hospital practices or group practices. It
13 has nothing to do with law enforcement, it's just that they
14 would like to have some insight as to whether they're practicing
15 appropriate pain management and following the right protocols.
16 So the one area that I don't do much consulting with
17 is I don't do much malpractice at all. I might do one
18 occasionally, but typically that's a very small minority of the
19 larger consulting part of what I do.
20 Q. And are you currently licensed to practice medicine in
21 various states in the United States?
22 A. Yes.
23 Q. And have you ever testified in connection with an opinion
24 about the legitimacy of prescriptions for controlled substances,
25 opioids, narcotics?

1 A. Yes, I have.
2 Q. On how many occasions?
3 A. Again, I haven't tallied them so I'm going to give you an
4 estimate. But I am going to suggest that maybe -- maybe 30
5 cases over the last five years, something of that sort.
6 Q. And that would be both federal cases; is that right?
7 A. Yes.
8 Q. State cases?
9 A. Yes.
10 Q. And administrative cases, maybe before licensing boards?
11 A. Correct.
12 Q. Any other type of proceedings in which you've testified in
13 this area?
14 A. With regard to the legitimate use of opiates and the
15 standard of care of medical practice, those would be the three
16 areas — medical boards, state authorities, and federal
17 authorities.
18 Q. Okay.
19 MR. JACOBS: That's all I have as to the witness's
20 background and qualifications, Judge, so this might be an
21 appropriate time --
22 THE COURT: Okay. We'll take our noon recess then.
23 Please be back in the jury room a little after 1:00. We'll
24 start right away then. By five after.
25 (Jury out.)

1 THE COURT: Anything to place on the record?
2 MR. BRINDLEY: No, Your Honor.
3 MR. JACOBS: No.
4 THE COURT: Okay. We have a short telephone hearing
5 we're going to do on another case so -- we're in recess.
6 In that case you can step down, Dr. King. All right.
7 (Lunch recess taken at 12:08 p.m., until 1:05 p.m.)
8 THE COURT: Are we going to have some presentation on
9 the screen?
10 MR. JACOBS: There will be some.
11 THE COURT: I don't want people to think we're leaving
12 them in the dark.
13 (Jury in.)
14 THE COURT: Okay. And at this point maybe we could
15 collect the transcripts that were handed out earlier. We're
16 done with that witness? If you would just pass them down to
17 this end we can pick them up there.
18 Okay. Then go ahead and be seated, ladies and
19 gentlemen.
20 Okay. Go ahead. Then you can proceed with your
21 direct examination of Dr. King.
22 (Witness resumes the stand.)
23 BY MR. JACOBS:
24 Q. All right, Dr. King, I think we had gone over your
25 background prior to lunch, so I'd like to turn more

1 substantively to your testimony.
2 Could you describe for me, what is the practice of
3 medicine? What is the goals and what are the considerations in
4 the practice of medicine?
5 A. The practice of medicine, of course, is defined with a lot
6 of highfalutin words in the administrative code and in the law.
7 But when it comes down to it the practice of medicine, as we
8 were taught in medical school, is fourfold:
9 To be a physician, to practice medicine a patient is
10 evaluated, a diagnosis is defined, a treatment plan is
11 formulated, and then the patient is reviewed for outcome,
12 compliance, enforcement of the treatment plan.
13 Then that becomes an iterative process in the sense
14 that the practice of medicine means once you have -- once I as a
15 physician have treated a patient and I see them back next, I
16 reevaluate them for those four things.
17 But that would be I guess how I would put it from a
18 practical standpoint.
19 Q. Are there any overarching concerns that physicians should
20 have when going through the practice of medicine?
21 A. What we all take an oath for, from a medical standpoint, is
22 to do no harm. So frequently when I'm lecturing to my
23 colleagues or mentoring my colleagues, I will emphasize to them
24 that this last step in the four that I mentioned, that is to say
25 how does the patient do, what is the outcome, that's what I

1 sometimes call the "do no harm" step. We need to make sure
2 we're treating the patient, the patient's getting better, but
3 overall I need to make sure that we're doing no harm.
4 Q. All right. Now, I'd like to focus in on when we're talking
5 the practice of medicine the practice of pain medicine. And I
6 think you've mentioned that you're board certified in that area?
7 A. Yes, sir.
8 Q. Do you want some water or something?
9 A. I've got some. It's the dry air. But that's okay.
10 Q. Sure. So in the area of pain management, first of all, what
11 is pain?
12 A. It's a fair question to ask, what is pain, because it's
13 sometimes very difficult to articulate.
14 Pain is, at its very base, an unpleasant sensation.
15 It's an unpleasant sensation that may be emotional or it may be
16 real or really in most cases it's both and it's described in
17 those terms.
18 So pain is anything that is unpleasant. And then it
19 becomes up to the physician. Specifically it's up to the pain
20 physician to decide how much of that pain is an emotional
21 concern, an emotional etiology or mental health etiology, and
22 how much of it is something's really broken, something needs to
23 be addressed what we call somatically. Something's broken that
24 can be addressed with other types of treatment that we might not
25 choose if the pain were primarily a mental health or an

1 emotional issue.
2 Q. All right. And what is the role of the pain management
3 physician in addressing pain then?
4 A. If we combine the concept of what is pain with what we
5 expect of a physician, the pain management doctor is asked to do
6 these things:
7 Pain management doctor is asked first to examine the
8 patient. An examination of the patient becomes not only the
9 history and physical, but it also becomes an examination of past
10 medical treatment. What has the patient had done to them prior.
11 What has worked, what has not worked. What MRI's are available,
12 what x-rays are available, what lab tests, what
13 electrodiagnostic tests are, like EMGs or nerve conduction
14 studies.
15 So the evaluation is number one. We do a complete
16 evaluation which includes primarily history and physical and
17 what we call past medical history.
18 The second thing that a pain physician would be
19 expected to do based on standard of care would be to make a
20 diagnosis. One would expect that the history and physical and
21 workup and past medical records would support, would help form,
22 would help define a specific diagnosis.
23 And again a diagnosis is not simply what the patient
24 complained of. You may come in and complain to me of back pain.
25 That's what we call your chief complaint. But I as a physician

1 have to discern based on the examination what is causing the
2 back pain. Have you got a herniated disk. Is there a nerve
3 compression. Is there a facet arthropathy.
4 So the second thing that a pain physician would do
5 would be to make an appropriate diagnosis. And it can be a
6 working diagnosis. We can come back and alter that as we see
7 the patient back. But there has to be a diagnosis.
8 The third thing would be formulation of a treatment
9 plan. And the treatment plan has two components to it. It has
10 to be individualized. It can't be the same thing for everybody
11 that walks in the door. That would not be medically correct.
12 And it has to be -- in the field of pain management it
13 has to be multidisciplinary. One treatment option does not
14 address all concerns.
15 So the treatment formulation is individualized for
16 that particular person and it has to be multidisciplinary.
17 Meaning I'm not going to use narcotics every time and I'm not
18 going to use epidurals each time, but I'm going to look at other
19 things like physical therapy, psychologic assistance, coping
20 assistance, non-opiate-type drugs.
21 And then the fourth thing which I termed the do no
22 harm part of things, is I look to see what's going on. As a
23 pain management physician we reasonably need to ask:
24 Is the patient getting better?
25 Is the treatment plan formulation that I put together,

1 is it working?
2 Is the patient getting better?
3 Is the patient getting worse?
4 Is there no change?
5 Is the patient compliant?
6 Is the patient doing what I asked them to do?
7 Are they taking their medications appropriately?
8 Are they showing up for the tests that I ordered?
9 Are they avoiding physical therapy or are they
10 attending physical therapy like I requested?
11 So this last part, this do no harm part is what we
12 call the compliance enforcement and outcome phase.
13 In other words, the outcome. How's the patient doing?
14 Enforcement. If the patient's not doing what I tell
15 him to, am I enforcing that?
16 And is the patient in general compliant with their
17 treatment plan?
18 So it was those four areas.
19 Q. And you use the term "standard of care." What do you mean
20 by that?
21 A. Again the standard of care has many definitions, but the way
22 I'd describe it is as such.
23 The standard of care is the level of watchfulness,
24 attention, caution and prudence that a prudent physician would
25 put forth in the care of this patient under same or similar

1 circumstances — again, watchfulness, attention, caution, and
2 prudence — that another physician in the same or similar
3 circumstances would exercise.
4 Q. And does that vary by geographical location?
5 A. The standard of care does not vary with regard to location.
6 The standard of care is sort of the basal level of care that we
7 would expect whether we were addressing a patient in this
8 geographical area or that geographical area. The standard of
9 care would be the same across the country.
10 Q. Because, let me ask you, you've never practiced in
11 Wisconsin; is that right?
12 A. That's correct, I've not practiced in Wisconsin.
13 Q. And you're not licensed to practice medicine in Wisconsin.
14 A. Correct.
15 Q. Are you licensed to practice medicine in any other
16 midwestern states?
17 A. I am. I have a license to practice medicine in Illinois,
18 Michigan. Indiana, of course. Those would be the three
19 midwestern states.
20 Q. Okay. And I gather other states as well.
21 A. Correct. Yes.
22 Q. All right. And so would your opinion about the legitimacy
23 of a medical practice, whether it met the standard of care, be
24 different whether the care was rendered in Manitowoc, Wisconsin
25 or was rendered in Indianapolis, Indiana?

1 A. There would be no difference in the standard of care.
2 Q. How about the period during which the care was rendered?
3 A. Uh-huh. The standard of care can change with regard to the
4 timeframe. We do realize that as new concepts become available
5 and new knowledge, new scientific knowledge, new ways of
6 medically addressing chronic pain or other aspects of medicine,
7 those -- those new discoveries, those new medications, those new
8 techniques can change and do change the standard of care.
9 So whereas the standard of care may not change
10 regardless of whether we're talking about this geography or that
11 geography, the standard of care may change depending on whether
12 we're talking about 1990 or 2000 or 2010.
13 Q. Now, in this case, and we'll get into this in more detail,
14 you were asked to review a series of patient files; is that
15 right?
16 A. That's correct.
17 Q. And do you know roughly the period of time covered by those
18 patient files?
19 A. There were 13 patients that I reviewed the files on. And as
20 I recall, the earliest records in some of those files were
21 dating back to 2004.
22 And as I recall the latest -- and this is going by
23 memory, I may be off a little bit on this. But as we talk about
24 it now the latest I think was 2013, possibly 2014. We'll
25 address that specifically I'm sure as we go through the cases,

1 but that's ballpark the timeframe.
2 Q. Okay. And the type of care that we're talking about is pain
3 management; is that right?
4 A. That's correct.
5 Q. Can you tell me did the standard of care change over the
6 period of time of the records you reviewed, that is, from 2004
7 to even the present?
8 A. The standard of care did not change. Our understanding with
9 regard to how do you use opiates, how to use controlled
10 substances was well defined during that timeframe.
11 Q. And is it still the same today as it was during the
12 timeframe of the patient files you've reviewed?
13 A. Yes, it is.
14 Q. And I just want to ask you a quick little question.
15 You mentioned that the fourth tenet or the fourth
16 aspect of treatment was do no harm and the question of whether
17 the patient was getting better.
18 Is that still a goal of pain management, that is, is
19 the patient getting better?
20 A. The goal of pain management, since we're dealing with a
21 chronic disease, since we're dealing with a problem that none of
22 us have a cure to, is based on three things. Our outcome from
23 the clinical standpoint is based on three things.
24 We ask the question, is the patient having an improved
25 pain relief? Basically we ask them their pain score. If it was

1 a seven out of ten to begin with is it now perhaps a three out
2 of ten or two out of ten.
3 The second criteria we look at, and this is the gold
4 standard, this is the primary gold standard for pain management,
5 is has the patient improved their function. Have they improved
6 their function specifically in a measurable objective way and a
7 meaningful way.
8 Not just I feel better, I feel like I can do things a
9 little bit better. We ask the question: Are you able to climb
10 up and down stairs?
11 Are you able to go to school?
12 Are you able to go to your job?
13 Are you able -- to be able to do your woodworking
14 hobbies or work out in the garage?
15 So we have to have something from a functional
16 standpoint that's measurable, meaningful, and objective.
17 And then the third thing -- again, we've got pain
18 relief, function, the third thing would be quality of life. In
19 some cases where we're dealing with individuals who may not be
20 terribly active, we nevertheless ask the question:
21 Has your quality of life improved?
22 Are you still constrained to sit in a chair and watch
23 TV all day, or has your quality of life improved such that you
24 can get up, cook a meal for your spouse, fend for yourself?
25 Those are the three things we look at — pain score,

1 meaningful functional improvement, and quality of life
2 improvement.
3 Q. Okay. Now, is there an accepted methodology to evaluate a
4 pain patient?
5 A. We are taught as physicians to look at the individual as a
6 whole.
7 I'm not sure I can give you one, two, three as an
8 answer to that question. But when we evaluate a patient there
9 are many things that we need to answer.
10 For instance, on the history, when we talk to a
11 patient we look at and verify and analyze past medical history.
12 Again, as I mentioned previously, what has the patient had done
13 before? What has worked, what has not worked? What has been
14 tried, what has not been tried?
15 It's important as a specialist, as an anesthesia and
16 pain management doctor that I review what has been done to look
17 for deficits, to look for things that haven't been tried, or to
18 look for things that perhaps were not invested in as well as
19 they could, we may need to repeat those.
20 We look at the past medical history. We look at past
21 imaging. Certainly when we're dealing with spine pain, when
22 we're dealing with headache issues, when we're dealing with
23 painful joints, we as pain physicians, as good physicians are
24 going to want to see what the imaging is. Was there an MRI
25 done? Was there a CAT scan done? Were their x-rays done? Does

1 it show a normal back or a normal-for-age back which is the way
2 we refer to it because nobody's got a normal back after they've
3 passed the age of 18. But we look to see is the back normal for
4 age or is there something really there that is identified as a
5 pain source.
6 We also look -- in addition to imaging we look at
7 electrodiagnostic studies. Often as not we're dealing with
8 nerve injury problems. If a patient has a diagnosis of what we
9 call a neuropathic pain or nerve related pain, we're going to
10 want to know what nerve is it and how bad is it injured.
11 And we'll have a number of tests that will help us
12 with that, tests that we call EMGs. Or nerve conduction
13 studies, NCS. And we often enlist the aid of our neurology
14 colleagues to help us out with that part of things.
15 So a past medical history, testing, imaging. I didn't
16 go into detail on the physical examination, but there are
17 specific issues with regard to physical exam that we would look
18 at such as a good musculoskeletal exam, a good neurological
19 exam.
20 Again recognizing that the majority of what we deal
21 with are spine issues and headache issues. We have to do a good
22 musculoskeletal exam because a lot of what we deal with are
23 joint issues or muscle-related pain.
24 So the history becomes -- or, excuse me, the physical
25 exam becomes important. And there are targeted ways, accepted

1 ways, medical standard ways of documenting that.
2 Q. And are there specific tools or methodologies that a pain
3 management doctor uses to treat patients?
4 A. If you're asking me how do we treat a patient in chronic
5 pain?
6 Q. Yes.
7 A. How do we treat a patient in chronic pain. Well, again,
8 I'll go back to the concept that I said that it's an
9 individualized treatment plan and it's a multidisciplinary
10 treatment plan.
11 Frequently we hear today that opiates are a
12 last-resort treatment. That's not exactly true. Opiates are a
13 tool and they are one of the tools that we may or may not use in
14 the treatment of a chronic pain problem.
15 The reality is the multidisciplinary part of the
16 question opens us to a number of treatment options. If it's a
17 musculoskeletal issue, for instance, if it's a joint issue, we
18 may deal with physical therapy. We may bring a rehab doctor in
19 to assist us in treatment of this patient. We may use a TENS
20 unit. We may use acupuncture. We may use massage. We may use
21 any of a whole host of what we call physical medicine modalities
22 or physical medicine treatment options of which physical therapy
23 might be one.
24 So that's one category. Another category or treatment
25 option would be non-opiate medications. Certainly in the

1 pharmacologic world we have a lot of options. We have a lot of
2 options. We don't just jump to the narcotics. Narcotics are a
3 Band-Aid. They really don't cure anything.
4 So we may look at non-narcotic options like Lyrica,
5 like Gabapentin or Neurontin, antidepressants,
6 antiinflammatories, muscle relaxers, sleep assist aids, and we
7 may choose from that large group of medications carefully
8 something that may apply to the patient and use that as part
9 of -- part of our multidisciplinary treatment plan.
10 So the second option -- you know, again we got the
11 physical medicine, we've got the non-opiate pharmacologic
12 options, we've got the psychology options.
13 Because as I mentioned earlier, what is pain? Pain is
14 always emotional and sensory. Which means there is always an
15 emotional component to chronic pain. To chronic pain. There
16 may be depression, there may be anxiety, there may be
17 post-traumatic stress syndrome, there may be schizophrenia,
18 there may be attention deficit disorder.
19 All these mental diagnoses, if you will, are
20 legitimate and they are an inherent part of chronic pain
21 management. If we don't recognize those, if we don't treat
22 those, then we might as well not be taking care of the patient
23 at all. We have to treat both the emotional as well as the
24 sensory component of what might be broken.
25 So we have that as our third category. Bringing in a

1 psychologist, bringing in a psychiatrist, using cognitive
2 behavorial therapy, relaxation therapy, stress therapy,
3 counseling, social counseling. Sometimes there are family
4 dynamics that need to be addressed with all this.
5 And lastly -- I say lastly just for the purposes of
6 this discussion -- we have the narcotics. But the narcotics are
7 a Band-Aid. They are a Band-Aid. They don't cure anything. We
8 use them -- in our world we use it to buy time. We use it to
9 buy time perhaps while the patient's undergoing some counseling
10 or undergoing some conditioning or some weight loss or some
11 physical therapy, but we typically don't think of opiates as the
12 first line of defense. They're not. We don't think of them as
13 a long-term defense because they really don't work very well
14 particularly at higher doses. They have side effects that
15 causes problems. And we don't think of them as a last resort.
16 We think of the opiates as a tool to be used at the proper time,
17 the proper place, in the proper amount.
18 I could go on more and more, but I think you get the
19 idea. It's a multidisciplinary approach to treatment of chronic
20 pain.
21 Q. And you mentioned opioids, can you explain, what are
22 opioids?
23 A. We sometimes get a little confused about the terminology.
24 For the sake of what we're talking about today opioids or --
25 Opiates or narcotics I'm going to say are the same

1 thing again for the purposes of our discussion today. Opiates
2 are pain relievers. They act on the pain receptors in the body.
3 They are almost all derivatives of the opium plant, thus the
4 word opiate.
5 Some of them are synthetic, some of them are naturally
6 occurring. Morphine and codeine are naturally occurring in
7 opium. But there is also a thebaine, which we had never heard
8 of before, which is one of the opiates in opium. And from that
9 we synthesize hydrocodone, oxycodone, OxyContin, Dilaudid,
10 methadone, and all of the others that we see and hear of as
11 synthetic opioids, but they're pain-relieving medicines.
12 Q. And how do they work? How do they relieve pain?
13 A. They relieve pain by acting on the pain receptors of the
14 body.
15 Again without going into a lot of detail, we have
16 learned as the years have gone on that there are pain receptors
17 in our body. Those pain receptors are in the brain, they're in
18 the spinal cord, they're in our periphery in the skin. And
19 those receptors, once stimulated, cause --
20 Or, sorry, not those receptors. When pain is being
21 felt in the body these receptors are sometimes acted upon either
22 by endogenous morphine in the body -- you've heard of endorphins
23 before. We really have morphine-like molecules in our body
24 naturally. So when we have pain the endorphins come and
25 stimulate these receptors that quiets the pain response down a

1 little bit. Modifies it.
2 We find that from a medical standpoint I could do the
3 same thing by giving you not sort of a modest dose of what your
4 body might cause to be released when you're having a painful
5 experience, I can come in and I can give you IV morphine.
6 As an anesthesiologist I give IV morphine to stop the
7 pain that would be caused otherwise by an incision. And orally
8 we could provide morphine to our patients as an option, a tool
9 if we're treating a long-term pain syndrome that we think is not
10 emotional but may actually be sensory. In other words,
11 something might be broken. So it acts by stimulating a
12 circuitry that quiets the pain response so the pain doesn't
13 completely take over the brain so that the pain condition is
14 better tolerated.
15 Q. And are opiates available to everybody?
16 A. Well, they're not available to everybody. As you know -- as
17 you all know, there are certain medications that are only
18 available by a prescription. We call those legend drugs.
19 Legend drugs are available by a prescription because
20 there are concerns about the drugs such that a medical
21 professional will have to check you out and examine you and make
22 a diagnosis before they might give them to you.
23 If you've got a sore throat and penicillin might be a
24 reasonable treatment option, that's a legend drug, it has to be
25 written out, the doctor having made the appropriate diagnosis of

1 an infection for you.
2 But on the other hand, you're going beyond that, we
3 have controlled substances. And the opiates are controlled
4 substances. They have such potential significant danger
5 associated with them that you have to have a special license to
6 write a prescription for the opiates.
7 So they are what we call "controlled" because there
8 are even more safeguards that have to be addressed prior to
9 distributing them or giving them out to an individual.
10 Q. And with respect to opiates what are those concerns? What
11 are those risks?
12 A. Opiates have a number of short-term and long-term effects.
13 As I talk to patients in the clinic and they ask me
14 that question, the way I describe it is, look, I say there are
15 basically three different types of opiate side effects.
16 I say on the one end of the spectrum there are what I
17 call the misery side effects. The misery side effects. The
18 misery sides effects are those that are just going to make you
19 feel crummy.
20 They include nausea and vomiting because morphine and
21 codeine and a lot of these really cause nausea problems. They
22 cause headaches. And up to about 50 percent of our patients who
23 are even on low-dose opiates, headaches are a very frequent
24 response.
25 They cause constipation. Constipation, while we may

1 laugh about it a little bit, tends to be the most limiting
2 factor with regard to the use of any opiates. And if you're
3 constipated and you can't eat and you start getting nauseated
4 and throwing up because you're having a bowel movement once
5 every two to three weeks — which is what one of the patients
6 here manifest — then that's one of the misery side effects as I
7 call it.
8 Also you get a depression of sexual hormones of
9 testosterone and estrogen. So as one of the misery side effects
10 you have a decrease in sexual function.
11 There's -- and along with that is sort of a laziness,
12 a lack of energy because your hormones are depressed. So that's
13 one end of the side-effect spectrum.
14 The second set of three of the side effects that I
15 talk to our patients about are the ones that may aggravate
16 certain coexisting problems.
17 For instance, in the patient suffering from depression
18 or anxiety, the opiates will have side effects that will make
19 that worse. Will make that worse. Opiates will make depression
20 worse. Opiates will make panic attacks more frequent.
21 And the biggie in all this, as if those weren't
22 enough, the opiates will cause insomnia. Opiates will cause
23 insomnia. So if you can't sleep, you can't cope. And if you
24 can't cope and you're not sleeping, your mental illness,
25 whatever it is, whether it's depression, anxiety, PTSD,

1 attention deficit disorder, it's going to get worse.
2 The third set of side effects, the ones that sort of
3 put all this in the headline, are what we call the death side
4 effects. But it isn't only death. We know that the opiates
5 certainly can cause death. But also the opiates can cause
6 dependency and opiates can cause addiction. And arguably, as
7 bad as it is when a person dies as a result of an overdose of
8 opiates or controlled substance combination, it is a horrible
9 situation to make a patient addicted.
10 Addiction changes the mind. It rewires the brain in a
11 way that we think right now is fairly permanent. It's a little
12 bit like when an alcoholic gets control of his alcohol disorder,
13 but he always has to fight that alcoholic tendency every single
14 day because he was addicted to alcohol. He's now got his life
15 under control but he needs to be aware that he's only one drink
16 away from reactivating that again.
17 That's the same thing with regard to the opiates. So
18 the third part of that is addiction because once a person is
19 addicted to the opiates, and sometimes it doesn't take much,
20 that person has a life-long diagnosis that has to be addressed,
21 has to be fought, has to be watched for so the things aren't
22 reactivated causing the fall into the horrible problems that
23 they had to begin with.
24 So those three areas.
25 Q. And in the pain management field were these three areas of

1 side effects well known throughout the time period you were
2 examining the patient files?
3 A. These three sets of side effects were well-known throughout
4 this timeframe.
5 And I'm sorry, if I may, there was one other side
6 effect that I didn't mention that falls in that middle category.
7 And that's -- this is an important one so if I may update my
8 list there, it's called opioid-induced hyperalgesia. OIH.
9 That's a mouthful. That's a mouthful. But we'll call
10 it OIH, opioid-induced hyperalgesia. What is that? That means
11 that we actually -- if we keep using these opiates, these
12 Band-Aids on the patient, particularly if they're at high
13 levels, we're going to actually hypersensitize the body and
14 cause the pain to be worse.
15 So we find that the more we use the opiates -- again,
16 at the high end of the spectrum anything over arguably sort of
17 50 to 100 milligrams of morphine equivalent -- if we start to go
18 above that we actually start doing harm. We actually start
19 sensitizing the body such that even normal touch or normal
20 existence is painful. And the more -- the longer that exists,
21 the more opiates we use, the more we hypersensitize the body and
22 the more the pain gets worse.
23 And we think that this is the reason why in a lot of
24 patients why, as we increase their opiates because their pain is
25 increasing, we as physicians if we're writing those scrips are

1 actually the cause. We're actually doing harm. We're actually
2 causing that pain to get worse.
3 So the OIH, opioid-induced hyperalgesia is one of the
4 side effects.
5 Q. And all of those side effects then, are those considerations
6 that a physician would have to be aware of and take into
7 consideration if he or she was legitimately practicing medicine
8 during the period from 2004 to 2015?
9 A. Yes.
10 Q. Now, when a pain management physician sees a patient on a
11 regular basis is there a certain protocol for examining the
12 patient to evaluate how the treatment -- you said monitoring --
13 are there certain things you evaluate -- you know, whether
14 they're getting pain relief or improving -- is there a series of
15 factors that a doctor has to consider on each visit?
16 A. A number of years ago as we began to be acutely aware in the
17 opioid crisis, the fact that people were dying of overdose and
18 getting addicted and getting dependent, in 2005 a seminal
19 article came out that was called "Universal Precautions."
20 Again, 2005.
21 And that article, in answer to your question, said
22 that as a pain physician, as an individual who is prescribing
23 chronic opiates to a patient, there are four things that have to
24 be checked each time the patient comes in. Four things that
25 have to be documented. Four things that have to be looked at as

1 part of the decisionmaking process regarding how to continue to
2 treat that patient. Those four things we refer to as the four
3 A's. The four A's. The four A's are as follows:
4 The first one is analgesia. Is the patient getting
5 better? Is he telling you that his or her painless level is
6 improving?
7 So the first thing you ask is, you know, can you --
8 what's the analgesic issue here? Is your pain getting better or
9 is it getting worse?
10 The second A is activity. Remember I told you that
11 the gold standard is for success of opioid use there has to be
12 an actionable, measurable, meaningful improvement in activity.
13 So as a physician I ask that:
14 Are you back at work?
15 Are you back driving your car?
16 Are you back to volunteering? Lot of my patients
17 volunteer at the hospital. So if we can get them at a good pain
18 control they could push a wheelchair and help other people.
19 But we have to have something that's meaningful. So
20 the second A is activity, which means function.
21 The third A is adverse side effects. The adverse side
22 effects, we just went through that. I gave you the sort of the
23 misery index.
24 And the -- and the middle index and then the far index
25 which involves am I causing the patient to be dependent or

1 addicted or have I killed them.
2 So we ask about adverse side effects. You know, are
3 you constipated? Are you sleeping? Is your depression getting
4 better or worse? Are you fatigued? How's your sexual function
5 going? Those sorts of things.
6 The fourth A. The fourth A is addiction behaviors.
7 And addiction behaviors becomes very, very important here
8 because we're looking at the behavior of the patient. I will
9 believe you when you come in and tell me that you're hurting,
10 but it's my job as a physician to make sure that I look beyond
11 that and find out about your behaviors to see if that holds up
12 to what you're telling me.
13 What does that mean? That means if I do a urine drug
14 screen, is it consistent? Is it showing what it should?
15 If I do a prescription drug monitoring survey on you
16 am I going to find that you're getting drugs from other doctors
17 that I don't know about?
18 It means that if I ask you to come in for a pill count
19 because I want to make sure that you're taking your pills
20 properly, do you have the right pill count?
21 It means that if I really have a concern maybe I'll
22 ask you to bring in one of your relatives, maybe your brother or
23 your sister or your spouse, so I can verify, so I can trust you
24 but I can verify.
25 It means that if I get a call from a third party,

1 whether that third party is a pharmacist who says, hey, I'm not
2 prescribing to this patient anymore because of what I've
3 observed, am I paying attention to that as a physician?
4 So those are the addiction behaviors that is the
5 fourth of the four A's.
6 Now, having said that, there is occasionally a fifth
7 one that I would be incomplete if I didn't tell you about. The
8 fifth one is affect. Affect really refers to mental illness.
9 It refers to emotion. It refers to depression. And it goes to
10 the point that mental illness is frequently and generally made
11 worse with opiate use, particularly a high opiate use. So of
12 the four A's we have a fifth which is affect. Am I making your
13 depression or your anxiety, your panic attacks worse?
14 So we've got: analgesia, activity, adverse side
15 effects, addiction behavior, affect.
16 Q. Great. And are those evaluations that a pain management
17 doctor acting in the legitimate scope of his practice would have
18 to consider on each appointment?
19 A. Yes, they are.
20 Q. Can't a patient just come in, not make any complaints, just
21 give him one, two, three prescriptions for more opioids, more
22 OxyContin, oxycodone?
23 A. That question is asked frequently and my answer is this.
24 I'm not a vending machine. I'm not a vending machine. I'm
25 not -- I'm not there where you put a quarter into, pull the

1 lever, get your Milky-Way or your oxycodone or your OxyContin
2 and go on your way.
3 My job is, as a professional, to act as a specialist,
4 to act as a physician, to do the four things that we talked
5 about:
6 To examine and evaluate you.
7 To come to a diagnosis, a legitimate objective
8 diagnosis.
9 To formulate a multidiscipline individualized
10 treatment plan.
11 And then to monitor the outcome so that I do no harm.
12 So, no, a patient cannot come into me and simply say,
13 hey, you know what, I felt good when I went to my previous
14 doctor when I was getting morphine, would you just write for it
15 again? No.
16 My job is to do a independent medical evaluation. An
17 independent medical evaluation. Not simply to take the word of
18 what went before. And then to monitor you with regard to did I
19 make the right diagnosis, did I put together the right treatment
20 plan. I am not a vending machine.
21 Q. Now, with respect to prescribing opioids, is there a way
22 that the dosages of opioids is measured so that you can compare
23 it or keep track of it?
24 A. You're asking me, of course, a very legitimate question, one
25 that allows us [Indiscernible] and when I talk to our patients

1 on this, it's a way of comparing apples to apples.
2 What do I mean by that? Let's say you come in to see
3 me and you're on Dilaudid and I determine that maybe Dilaudid
4 isn't the best choice for you.
5 And let's say I determine that opiates are appropriate
6 for you, but I want to change your opiate dose to morphine or to
7 hydrocodone or to oxycodone but the morphine equivalency dose
8 is --
9 The MEQ, the morphine equivalency. Sometimes referred
10 to as MED, morphine equivalent dose. Everything's compared to
11 morphine. And this came about in the cancer world where we had
12 people at end-of-life scenarios that weren't doing too good on
13 one medicine and we needed to convert them from, you know, a
14 Dilaudid or a methadone to morphine. So these are factors such
15 that we can compare equivalent doses, equivalent doses. So if
16 you're on 40 milligrams of oxycodone I know that that's
17 equivalent to 40 milligrams of morphine. If you're on 10
18 milligrams of oxycodone I know that's equivalent to 15
19 milligrams of morphine.
20 So it's a way of doing the apples-and-apples
21 comparison of different narcotics. And, of course, there's a
22 significance, there's a reason why we pull this concept
23 together. But in terms of what is morphine equivalency, that's
24 what it is.
25 Q. All right. And in the practice of pain management are there

1 certain standards of how much opiates, what level of ME,
2 morphine equivalencies should be prescribed before certain
3 concerns arise?
4 A. Morphine equivalency becomes important, indeed it becomes a
5 critical part of what we do in pain medicine because there are
6 levels, there are danger levels involved.
7 We found many years ago -- beginning in the mid 2000s
8 and 2007, the first formal papers began to be published on this.
9 We found that there are danger levels associated with the
10 morphine equivalency.
11 Let me give you an example. If you come in with a
12 sprained ankle and I deem it appropriate to give you some
13 hydrocodone for a couple days, just a couple days to get you
14 into rehab or over the acute phase of this, I may give you a
15 Norco, 7.5 milligrams twice a day. That's equivalent to 15
16 morphine equivalents. 15.
17 We generally recognize that somewhere between 15 and
18 30 milligrams is the green zone. So if we kinda think of it as
19 a green light, yellow light, red light. So the green light zone
20 is somewhere between let's say 5 milligrams to 30 milligrams of
21 morphine is safe. That's not to mean that I can't stop. If I
22 identify some problems I can get you off of it like that and we
23 can try something else. So that's a safe zone.
24 Q. And is that a daily dosage?
25 A. That is a daily dosage, yes. I'm sorry. It's a daily

1 dosage. So a daily dosage for chronic pain, if we're looking
2 at -- well, for any kind of pain, that green zone is something
3 that we can work with, we feel safe in the sense that we can
4 stop it and substitute things without causing withdrawal issues
5 and all kinds of problems.
6 The yellow zone sort of starts about 30 morphine
7 equivalents. And as you correctly say, this is per day. So a
8 30 mill equivalence up to arguably about a hundred to 120
9 milligrams. We say a hundred just because it's easier to
10 remember.
11 So somewhere between 30 and a hundred milligrams is
12 what we call the danger zone. It's a yellow -- sort of yellow
13 light if you go in an intersection and you got a light.
14 Why do we consider that a yellow zone? Because we
15 found that as the morphine equivalency dose goes up, so does the
16 chance of side effects. So does the chance of diversion and
17 abuse. So does the chance of death and overdose.
18 Such that when we hit the beginning of the red zone,
19 which we call the region of extreme concern -- so the red light
20 starts at about 100 to 120. When we enter into that zone at
21 about a hundred, again just for ease of talking here, we find
22 something very traumatic occurs. At a hundred to 120 mill
23 equivalents of morphine, morphine equivalents per day, the
24 chance of overdose is about 10 times what it was down at the
25 lower dose.

1 So we get kind of this linear line here. So, no
2 surprise. It sort of makes common sense when you think about
3 it. The higher the dose the more likely the patient is either
4 going to be diverting or abusing, the more likely the patient's
5 going to be having significant side effects, and the more likely
6 they are to come into the emergency room for an overdose.
7 So it's sort of generally been looked at anything
8 above a hundred, except for terminally ill hospice patients,
9 end-of-life scenarios, but except for those situations for
10 chronic pain management anything above a hundred it's almost
11 impossible to justify.
12 And so we stay down into the safer zones looking for
13 improvement in function but at lower levels so we don't get into
14 trouble.
15 Q. You mentioned the use of opioids with terminally ill
16 individuals in hospice or end-of-life care, have you ever worked
17 in that area?
18 A. I have, yes. In the beginning days -- beginning days
19 probably not over the last decade or so -- because palliative
20 care has come into the scene as a separate specialty they deal
21 with end-of-life scenarios so I don't do that so much anymore.
22 But in the beginning cancer pain management was a very large
23 part because of our knowledge of opiates and various other
24 interventions that could help someone in a terminal state.
25 Q. We were saying that that's sort of a unique case when it

1 comes to the various danger zones for morphine equivalency
2 doses?
3 A. Yes.
4 Q. Do you know, what type of daily morphine equivalencies are
5 you familiar with being given to these terminally ill hospice
6 end-of-life care patients?
7 A. When we're dealing with an end-of-life scenario we're not
8 worried so much about addiction dependency because typically we
9 realize the individual's not going to survive more than days,
10 weeks or maybe a month or two. So those -- that long-term
11 concern we don't worry about so much.
12 But nevertheless, we want to have the patient
13 cognizant, we want them to be aware so that they can enjoy their
14 families during their last days. So we don't want to snow them
15 either. We don't want to make them a zombie and we don't want
16 to give them constipation that's going to make them feel
17 horrible. And nausea and vomiting which are part of what we
18 worry about.
19 So typically because of those side-effect issues we
20 generally find that we get up to doses for terminal patients
21 using oral or IV narcotic equivalents. We usually get up to
22 maybe a couple hundred max per day. Occasionally we might go
23 above that, but if we do we know we start snowing the patient,
24 we start making them zombies, we start making them so they can't
25 interact with their family, or we start getting nausea side

1 effects or one thing or another.
2 So typically for end-of-life scenarios we might be
3 talking about max a couple hundred. Maybe every now and then
4 once in a blue moon we might go above that, but in my experience
5 I've not seen it go above that.
6 Q. All right. And you used the phrases "addiction" and
7 "dependency," are those the same thing?
8 A. They are not the same thing. We recognized over the last
9 several years that -- well, we recognize -- let me put it this
10 way. It's been defined that there's a difference from a
11 diagnostic standpoint.
12 The DSM, Diagnostic Statistical Manual put out by the
13 American Society of Psychiatry, has redefined these two things
14 so that they are separate diagnoses. If you will, there's a
15 spectrum. At one end of the spectrum where things are not too
16 severe you and I might say we're addicted to Cinnabuns or we're
17 addicted to coffee or something of that sort.
18 That's not really a true addiction. But you can have
19 at the lower end of the spectrum a dependency on such things as
20 tobacco or caffein or morphine or other opiates. What that
21 really means is that you're using them in a manner that you're
22 not really able to control your use. You still have a craving
23 for them, but perhaps your life is not totally destroyed.
24 You're not having destructive consequences.
25 But as you go on, and let's just pick morphine as an

1 example, so a dependency as at one end of the spectrum that can
2 increase and you may get up to a point where your use of
3 morphine because of your craving and your loss of control is
4 creating problems, maybe you lost your job because of it, maybe
5 you lost your spouse, maybe you're living out on the street or
6 maybe you're in trouble with law enforcement. Once you get up
7 to that upper end of dependency that becomes addiction.
8 Addiction by definition -- not necessarily by
9 definition, but the easy way to think about it is you got the
10 three C's. You've lost control, you've got craving that you
11 can't control, and you've got consequences, negative
12 consequences that are occurring as a result of your behaviors.
13 So you have dependency that kinda goes up like this.
14 And when you get so dependent on it that your world's falling
15 apart, that's addiction.
16 Q. And is that a risk with opioids?
17 A. It is definitely a risk with opioids, yes.
18 Q. And is the risk of abuse, of a diversion also a known risk
19 with opioids?
20 A. Yes. Yes. The risk of abuse and diversion. And there's,
21 of course, a difference between those two terms. But yes, it's
22 a risk with opioids.
23 Q. And what is the difference?
24 A. Abuse is when if I prescribe you some Norco, and abuse would
25 be if you don't take it as I prescribed it, you decide you're

1 going to take maybe more than I prescribed you or you're going
2 to chop it up and make it into a solution and inject it because
3 you want the high from it. So abuse is using the medicine for
4 other -- by yourself for other than prescribed reasons.
5 Diversion means you're gonna share it with somebody.
6 You're going to sell it. You're going to trade it. You're
7 going to loan it out. So diversion goes beyond your use.
8 Diversion goes to the point that you're going to be putting it
9 into the general population, if you will. You're going to be
10 selling it, maybe trading it for your favorite drug that maybe I
11 didn't prescribe for you. Or just as a way to make money
12 perhaps.
13 So abuse is if you misuse it on yourself, a simple way
14 of putting it. And then diversion would be if you use it for
15 purposes beyond what it was prescribed for for -- with somebody
16 else.
17 Q. Is there a market for these prescription opioids?
18 A. We all are regrettably aware that there is quite a big
19 market for this. And it changes a little bit in terms of the
20 value or the street value you can get on these drugs. But there
21 is a big market for the opioids, whether you're going to use
22 them for yourself or not. A lot of our folks, unfortunately
23 they use some for themselves and they will sell or trade the
24 rest and they can get good money for it.
25 Q. And are these concerns — addiction, dependency, abuse,

1 diversion, are these factors considerations that a doctor of
2 pain management has to have taken into consideration to be
3 practicing within the legitimate bounds of professional
4 practice?
5 A. Yes.
6 Q. And given these concerns — addiction, dependency, abuse,
7 diversion by patients, does that impact on a pain management
8 doctor's ability to just rely on a patient's statements?
9 A. It does.
10 We want to believe our patients when they come in.
11 You know, it's a foundational relationship, Doctor/patient
12 relationship. I want to believe you when you come in and talk
13 to me. And I will. I will believe you, but I will verify that.
14 As I talked earlier, there are various tools. We have
15 various ways of examining you, various ways of getting past
16 medical history, testing. There are various things that I can
17 use to verify that.
18 So, yes, I will tell you it is not easy being a
19 doctor. It is not easy being a doctor. And it is not easy
20 being a pain doctor because upon us is put the responsibility --
21 along with pharmacists by the way who have a corresponding legal
22 responsibility in all this -- but it is put upon us to be
23 proactive, to practice what I referred to as universal
24 precautions, the four A's.
25 And we have to do that each time. We believe the

1 patient, we believe our patients, but we have to verify that
2 because if we don't the consequences are huge. The consequences
3 are huge.
4 Q. And are there certain red flags that a pain management
5 physician must be aware of or pay attention to?
6 A. There are red flags. Again I mentioned some of them from a
7 behavior standpoint.
8 Let me give you a couple of examples here. If your
9 urine drug screen shows up heroin and I've only been prescribing
10 oxycodone to you and maybe oxycodone doesn't show up but heroin
11 does, we got a problem.
12 If I'm prescribing morphine to you and maybe you have
13 the morphine molecule showing up in your drug screen but you
14 don't have any metabolites, meaning that maybe you just shaved a
15 little morphine in that urine drug sample that I took from you
16 that morning and you're trying to put one over on me.
17 Maybe when you get your drug sample because you knew
18 you were taking drugs that were illegal maybe you put something
19 into your urine sample, an adulterant as we call it, so that I
20 can't test for it and it comes back indeterminate.
21 So from an objective standpoint I look at the red
22 flags from the urine drug screen standpoint.
23 Secondly, I look for a urine -- I look for behavioral
24 issues with regard to pill counts. The only reason pill counts
25 work is that I know how much you should be taking. And if you

1 come in and bring in all your pills and I count them out and
2 find than you've got too many or too few, we've got a problem
3 that needs to be explained.
4 Well, if you say, hey, I'm not coming in because --
5 you know, and then there's whatever excuse, but the agreement --
6 And we do have opioids agreements with our patients
7 because we know this is a high-risk thing. So you have to agree
8 to work with me so we can stay safe and I do no harm to you.
9 But, you know, so if patients don't come in, if they
10 refuse to come in for whatever reason then they violated their
11 agreement. So we look at violation of the agreement as well as
12 pill count issues.
13 We look at other issues going on. Are we getting
14 reports from third parties?
15 Again, I mentioned that I have a responsibility to
16 make sure that you are taking the medication as prescribed and
17 that I'm causing no harm. The pharmacist, the pharmacist has
18 the same responsibility.
19 Pharmacist legally has a corresponding responsibility
20 to make sure that the medication, the controlled substance is
21 being used for a legitimate medical purpose. If the pharmacist
22 calls me up and says, you know what, I just saw Mr. Smith and he
23 came in with wads of cash and some shady individuals and, oh, by
24 the way, he looked like he was inebriated, looked like he could
25 barely walk, then I need to pay attention to my pharmacy

1 colleague who is passing this independent information to me.
2 Or maybe somebody's mother will call and say, hey,
3 you're making my son addicted. And I say, why do you say that?
4 Well, because he's on the street buying drugs because he's
5 selling the drugs that you're giving him. I need to listen to
6 that.
7 So there are various objective ways that we look at in
8 terms of behaviors. Some of them I test for, some of them I get
9 for third parties.
10 Insurance companies sometimes will cue me in in case
11 my patient is getting drugs from multiple other providers.
12 But those are some of the objective things I look for
13 that are major, major red flags. That goes to that fourth "A"
14 that I mentioned which is addiction behaviors.
15 BY MR. JACOBS:
16 Q. How about patients seeking early refills of their medication
17 or claiming their meds are stolen, is that anything a pain
18 management doctor has to pay attention to?
19 A. Early refills are a concern. As a matter of fact, so much a
20 concern that we have a name for it. If a patient is -- is
21 coming in for an early refill, has called several times to say
22 that they're out early because they took too many medications
23 and is having a history of stolen or lost medications, those
24 three items — that is to say, lost or stolen meds, early refills
25 and early-outs, we call that the abuse triad.

1 And, okay, sometimes maybe legitimately that happens.
2 Not usually. We see it often enough, that's what we call it.
3 But when it's -- but if we see an abuse triad, that's a red
4 flag. If we see two of them, we got a problem.
5 Q. And I think you mentioned are things like -- are the -- what
6 are called -- what is a comorbidity? What is comorbidity? I'll
7 go that way and have you get to the adjective.
8 A. A comorbidity. Comorbidity really means are there any other
9 morbid situations existing. Meaning does the patient have lung
10 disease, do they have heart disease, do they have kidney
11 disease. Are there any other medical issues that are going on
12 that I need to be aware of so that I can do no harm.
13 Again if I'm giving opiates as one of my tools, I know
14 what happens with opiates is that it depresses respiration, it
15 makes your breathing go down like this.
16 So what would be a comorbidity that I would be worried
17 about? I would be worried about sleep apnea. If you're
18 stopping your sleep -- if you're not breathing in your sleep
19 because you've got sleep apnea and then I add a respiratory
20 depressant on top of that, I'm likely to kill you.
21 If you have heart disease, if you've got blood
22 pressure issues, maybe you've got a stent, maybe you've got
23 hypertension and I add opiates to your regimen, I have to be
24 careful that I don't change your blood pressure. Because
25 opiates can cause blood pressure to drop, opiates can cause

1 heart rate to slow down. That would be a comorbidity I would
2 watch out for.
3 Q. How about -- now, those are all physical comorbitities, are
4 there psychological comorbidities?
5 A. There are psychological comorbidities and sometimes we refer
6 to it as mental health risk factors. But as you correctly
7 suggested, it really is a comorbidity. What does that mean?
8 That means, like I've referenced before, our patients
9 have coexistent depression, anxiety, panic attacks, PTSD,
10 schizophrenia, attention deficit disorder. There are a host
11 of -- OCD. A lot of just -- repetitively we see these. Bipolar
12 disorder. The three that we see more commonly than anything
13 else are depression, anxiety, and bipolar which is really a
14 combination of those two.
15 Why do we worry about that? We worry about that
16 because those are comorbidities, comorbid diagnoses that exist
17 in addition to the chronic pain. And we know that if we choose
18 to use opiates it's going to make those mental illness issues
19 worse. It's going to make it worse. In addition to causing
20 insomnia.
21 And we also know that those comorbidities sometimes
22 can modify and in some cases can actually cause the pain, can
23 actually be the source of the pain. So if I get a patient in
24 who's complaining of sort of vague symptoms of headache,
25 abdominal pain, back pain, muscle pain or some combination

1 thereof -- those are the common ones. Those are the common
2 ones. So if I see a patient coming in with those complaints and
3 I do an MRI and their back is normal, I do a physical exam and
4 there's nothing to be found, then I worry that maybe it is the
5 mental illness that is contributing to or causing that pain
6 complaint by the patient, in which case for me to choose an
7 opiate treatment regimen would not be appropriate. I would be
8 doing harm. It's going to make those mental illnesses worse.
9 I have to make the right diagnosis. So comorbidities
10 help us with -- identification of comorbidities are required so
11 that not only can I make the right diagnosis, but so I can
12 choose the right treatment formulation that will do no harm.
13 Q. And in the pain management area are there certain
14 combination of drugs that set off red flags, are indicative of
15 non-legitimate medical use?
16 A. Sometimes -- sometimes we think that, okay, maybe I'll avoid
17 the opiates or maybe I'll just give them at a low dose. But as
18 you referenced, the concern -- the other concern that's very
19 real, very real that we have is that there are combinations in
20 medications that cause us significant problems.
21 For instance, I may offer -- I may offer you some
22 low-dose narco and thinking that that may be okay, but you may
23 be also getting -- perhaps from your family doctor, perhaps from
24 your psychiatrist you may be also be getting a benzodiazepine
25 like Valium or Xanax and you may be getting Adderall which is an

1 amphetamine. And if I don't know about those, if I don't do my
2 required standard of care evaluation, if I don't do the past
3 medical history on you and I just summarily give you the
4 narcotics without looking at this combination, we get into
5 trouble.
6 And these drugs when added together don't cause just
7 sort of additive problems, they cause an exponential increase in
8 problems.
9 Let me give you some examples. Whenever we combine an
10 opiate with a benzodiazepine like Valium or Xanax, we
11 exponentially increase the risk of overdose death.
12 If I prescribe an opiate with Adderall, that's what we
13 call a prescription speedball. What's a speedball? A speedball
14 is cocaine plus heroin. And we know how deadly that is. How
15 deadly that is.
16 Okay. So if I give you not heroin, if I give you
17 Norco or methadone, and instead of giving you cocaine if I give
18 you Adderall, we got a prescription speedball that may not be
19 quite as dangerous as the cocaine/heroin, but it is dangerous
20 and it causes all kinds of problems and it causes death.
21 Q. Now, why is that? How does that work? That speedball.
22 A. Well, the speedball is a particularly concerning issue
23 because it's a -- it's an upper and a downer and they both are
24 very potent and they both affect the blood pressure and
25 breathing.

1 The downer will cause you to not breathe and lower
2 your blood pressure and the upper will cause you to breathe a
3 lot and increases your catecholamines and your blood pressure
4 will go up. But they don't last the same timeframe. So if one
5 wears off before the other one does you're either going to have
6 a heart attack or you're going to have respiratory depression
7 and die. Which is why the heroin/cocaine speedball is so
8 dangerous, different timings. They're metabolized at different
9 rates.
10 The same thing occurs when I -- if a patient is taking
11 a prescriptive speedball, different rates in metabolism. So you
12 may suddenly find as one wears off and the other is still in
13 effect the patient could die of an overdose. They were doing
14 fine till the stimulant wore off and all of the sudden they died
15 in their sleep.
16 Or you may find the other way around. You may find
17 that the stimulant is taking over and now you've got high blood
18 pressure issues and tachycardia issues which may cause a heart
19 attack. So that's why it's so dangerous.
20 Q. Now, that's -- that's not what a benzodiazepine does, like
21 the Valium and the Xanax, right?
22 A. No, correct.
23 Q. So what is the problem there?
24 A. A Valium and a Xanax is part of the pharmacologic group that
25 we would call sedatives. No surprise, they're sedatives. And

1 the problem with the sedatives is -- well, not the problem --
2 the recognition of the sedatives is that they act through the
3 same chemical pathway.
4 And give me a little liberty here, I'm just going to
5 use this to make the point for you.
6 They use the same metabolic pathway that alcohol uses.
7 So if I were to tell you, look, I'm going to give you some
8 opiates but I don't want you to drink alcohol. And believe me,
9 that is a really bad interaction between the two of them. It
10 causes respiratory depression and death. But if I were to give
11 you a benzodiazepine after having told you not to take the
12 alcohol, if I were to say here's some Xanax, here are
13 three-a-day Xanax, here are four-a-day Clonazepam, which is
14 another one, then I essentially have made the situation very
15 dangerous for you because either one of those medications on its
16 own, whether it's the opiate, whether it's the sedative or the
17 benzodiazepine, has a tremendous risk not only of addiction but
18 has a risk of respiratory depression and death.
19 So if I say, hey, don't take alcohol but here, I'm
20 going to give you this one, I've just double teamed you and I
21 have put you in danger of overdose death.
22 So the risk of the sedative is that it is not merely
23 additive to the opiate, it's exponentially worse in terms of the
24 risk of death.
25 Q. And when you say respiratory depression, what does that

1 mean?
2 A. Stop breathing. Stop breathing.
3 Remember I mentioned to you that there were -- you
4 asked me are the receptors -- well, you asked me that and I
5 answered there are receptors in the body, there are receptors in
6 the brain, and in the brainstem the brainstem receptors or the
7 opiate receptors are the ones that also cause respiratory
8 depression.
9 If I'm taking care of you in the operating room and I
10 give you some IV morphine, your breathing is going to go down,
11 down, down, down, down, down. Now, why do you survive in the
12 operating room? Because I'm there as your anesthesiologist. So
13 I generally put a mask on you with oxygen and I'll ventilate for
14 you. So we can use these opiates in an operative room setting,
15 but we can't use them safely in an outpatient setting without
16 being careful about what's the dose we're using, what are the
17 side effects that they're causing, and am I double-teaming you
18 by adding other medications in combination like the sedatives,
19 like the Xanaxes that will cause you to stop breathing and not
20 recover because I'm not there to take care of you when you do
21 stop breathing.
22 Q. All right. Now, Dr. King, did you in preparation for your
23 testimony have occasion to review a total of 13 patient files?
24 A. I did, yes.
25 Q. Okay. And those are the patient files that have been

1 previously admitted in this case as Exhibits 1 through 13. Did
2 you also have occasion to review what are known as PDMP records?
3 A. I did, yes.
4 Q. And what are PDMP records?
5 A. PDMP is a prescription drug monitoring program. PDMP,
6 prescription drug monitoring program.
7 The PDMP basically is a list of all the medications
8 that a patient is on as registered through the pharmacies. The
9 pharmacies are required by law to enter in the date it was
10 filled, the medication, how many, the strength and other
11 factors.
12 But from my perspective those are the important ones.
13 And I can get -- as a physician I can get a copy of the PDMP
14 which tells me what this patient is receiving from all
15 caregivers. All caregivers. It's not just me.
16 So it's a way that I have a window into what
17 medications are being prescribed across the board, what
18 controlled substance medications are being prescribed for this
19 patient.
20 Q. And did you also have occasion to review those PDMP records
21 for those same 13 patients?
22 A. I did, yes.
23 Q. And those PDMP records have been admitted into trial here as
24 Exhibits 105 through 116. And using those records, Dr. King,
25 did you prepare a chronology for each of the 13 patients based

1 solely on the information from those patient files and the PDMP
2 records?
3 A. I did, yes.
4 Q. And do you have those chronologies or a copy of them with
5 you here today?
6 A. I do.
7 Q. Do you have them in front of you?
8 A. I do.
9 Q. And I think I handed you also an accordion file that's
10 marked as Exhibits 90 through 102. Do you have that in front of
11 you?
12 A. I do.
13 Q. And is that also a photocopy of those chronologies for the
14 13 patients that you examined and reviewed in this case?
15 A. They are.
16 Q. And so all of the information in there, the factual
17 information, comes from the patient records and the PDMP
18 records?
19 A. That's correct.
20 MR. JACOBS: Your Honor, I would move into evidence
21 Exhibits 90 through 102, the chronologies prepared by Dr. King
22 for the 13 patients involved in this case.
23 THE COURT: Any objection?
24 MR. BRINDLEY: No, Your Honor.
25 THE COURT: 90 to 102 are received.

1 (Exhibits 90-102 received in evidence.)
2 BY MR. JACOBS:
3 Q. And am I correct that the chronologies, in total they are
4 themselves several hundred pages long?
5 A. Yes, they are.
6 Q. And the patient files do you know offhand, how many total
7 pages of patient files did you review?
8 A. I typically don't add them up, but an individual patient
9 file might be anywhere from at the low end maybe 50 pages, at
10 the high end maybe over a thousand. So there were several
11 thousand pages of patient file.
12 Q. And so did you then evaluate -- were each of those patients
13 treated by a Dr. Charles Szyman?
14 A. That's correct.
15 Q. And did you evaluate the legitimacy of the medical care
16 provided by Dr. Szyman to each of those patients?
17 A. I did.
18 Q. And were each of those patients prescribed opioids,
19 controlled substances, narcotics by Dr. Szyman?
20 A. Yes, they were.
21 Q. And did you evaluate whether Dr. Szyman's prescribing of
22 those narcotics/controlled substances was the practice of
23 legitimate medicine?
24 A. I found that the medications were not prescribed for
25 legitimate medical purpose. I found that the medications were

1 used outside the usual course of medical care.
2 Q. And is that with respect to all of the 13 patients you
3 reviewed?
4 A. Yes.
5 Q. Okay. And so did you then prepare a summary grid of your
6 analysis for purposes of your testimony here today?
7 A. I did.
8 Q. And do you have a copy of what's been marked as Exhibit 103
9 in front of you?
10 A. I do.
11 Q. Okay. And is this that summary of your findings with
12 respect to the 13 patients here?
13 A. Yes.
14 MR. JACOBS: Your Honor, I'd like to be able to
15 provide the jury -- each of the jurors with a copy of that. I
16 had provided a copy of the summary grid to defense counsel to
17 facilitate Dr. King's further testimony.
18 THE COURT: Any objection?
19 (Pause.)
20 MR. BRINDLEY: Judge, could we be heard at side bar?
21 (Non-recorded discussion at side bar.)
22 THE COURT: Okay. The exhibit is received for
23 demonstrative purposes for now and copies can be distributed to
24 the jury so they can follow the testimony.
25 (Exhibit 103 received for demonstrative purposes.)

1 BY MR. JACOBS:
2 Q. And, Dr. King, do you have that exhibit in front of you?
3 A. Yes, sir, I do.
4 Q. Okay. Just gotta take a minute to make sure I've given
5 enough to -- okay. I think we're good.
6 MR. JACOBS: And, Judge, if I could also -- we'd also
7 display it to help follow along as well.
8 THE COURT: You may.
9 BY MR. JACOBS:
10 Q. And I wondered, just to help follow along if we could
11 describe what information is contained --
12 I'm going to have to do this in smaller bits. I
13 suppose they have a copy so -- to help your attention, I'm going
14 to start in the upper left-hand side, all right?
15 A. Yes.
16 Q. Thanks. And if you could describe first what information is
17 contained in each of the columns? And then we'll go down
18 different rows.
19 A. The initial question asked, the large question is -- as we
20 had described is: Was an evaluation performed by the physician?
21 Was a diagnosis established? Was a treatment plan formulated?
22 And was outcome monitored?
23 So those are the four large categories across the top.
24 And then under each of those categories where I have outlined in
25 blue, and then I have outlined in light green, I break that

1 question down into further detail.
2 Such that in the blue I ask -- under "diagnosis" I ask
3 the question: Was an objective medical diagnosis established?
4 And under that in the green is what I look for when I
5 actually look at the chart from a pain management standpoint.
6 And I ask the question: Was a legitimate diagnosis
7 established or is it just subjectively based? That is to say,
8 is it just what the patient said.
9 So as we go from the blue to the green, the green are
10 the questions that I asked and documented based on what the
11 chart actually said.
12 Q. All right. So first column, "objective medical diagnosis,"
13 second column, "pertinent clinical history." So what questions
14 are you asking then?
15 A. As far as the pertinent clinical history I'm asking was the
16 past medical history -- that is to say previous treatment of the
17 patient -- secured, obtained, reviewed, considered.
18 Q. So that's what "PMHX" is, past medical history?
19 A. Correct.
20 Q. And the next column, "targeted physical exam," what is that?
21 A. And I'm really asking the question: Was an objective
22 physical exam performed? Was any physical exam performed? And
23 if it was, was it repetitive or rote or did it really address
24 the diagnosis to support the diagnosis?
25 Q. Well, let me just ask you. If a pain management doctor gets

1 a referral from a treating physician or some other physician and
2 they've done a targeted physical exam, is it required that the
3 pain management doctor do his own physical exam?
4 A. It is required. My job as a physician, my job as a pain
5 management specialist is to perform an independent medical exam
6 and to come up with an independent medical diagnosis.
7 It might be the same as what was put forth regarding
8 the patient when a previous doctor looked at him. But
9 essentially, like we talked earlier, I'm not a vending machine.
10 I don't just take somebody in through the door, say, hey, you're
11 on this, I'm gonna continue it.
12 My job -- my job is required to do a complete
13 evaluation and to establish the diagnosis and treatment plan
14 such that we can go forth in an objective manner and not just
15 take somebody's word for it. So, yes, it is required.
16 Q. The next column is "clinical workup." What is that?
17 A. That's the evaluation. And again we're in the evaluation
18 larger overview on this.
19 And as I talked about, a -- the evaluation, the
20 clinical workup, was [Indiscernible] done, were there MRI's,
21 were there x-rays, were there EMG's, nerve conduction studies,
22 electrodiagnostic studies, were there any other second opinions.
23 Very frequently these patients come in having seen a
24 host of other doctors and sometimes other pain doctors and
25 sometimes multiple times, multiple pain doctors. So I want to

1 know what those other pain doctors had to say and what their
2 conclusion was as much as I want to know what the latest MRI
3 showed.
4 So the clinical workup involves looking at those
5 items.
6 Q. All right. The area to the right it says "risk assessment."
7 What is that?
8 A. Risk assessment is, along with the supported diagnosis,
9 that's the evaluation phase of those four things I talked about.
10 Risk assessment I pulled out separately because as we discussed,
11 there are mental health comorbidities and there are medical
12 comorbidities.
13 I need to find out whether the patient is or has been
14 under psychiatric care, is there a history of alcohol or
15 previous substance abuse, and I need to find out who treated, is
16 the patient still being treated, or did the patient just leave
17 their psychiatric care.
18 Similarly from a medical comorbidity standpoint, as we
19 talked about, there's significant comorbid conditions that
20 patients have, other diagnoses that could cause me to kill them
21 if I'm not careful. I need to find out whether they have any --
22 you know, are they on home oxygen because their respiratory
23 status is so bad, do they have severe chronic obstructive lung
24 disease, do they have asthma, do they have renal or kidney
25 problems, do they have cardiac problems. I need to know

1 objectively and inquire into that.
2 Q. All right. We move to the next area, "treatment plan." Can
3 you explain those columns?
4 A. The treatment plan has several different -- four different
5 items there.
6 First of all, is there a treatment plan, period. Did
7 the doctor establish a treatment plan or was there just a
8 [Indiscernible] narcotics and we keep on going.
9 We need -- the treatment plan from the standard of
10 care standpoint needs to be written, needs to be defined, and it
11 needs to be discussed with the patient. So I look to see if
12 there is a documented treatment plan.
13 The second is the multidisciplinary aspect of it, is
14 the treatment plan opiate centric. Meaning are narcotics just
15 the focal point or is it -- as I've talked over the last bit of
16 time here, is the treatment plan really multidisciplinary. Are
17 those other treatment options being looked at and is it
18 individualized or am I using -- or is the physician using just
19 the same treatment plan for everybody. Because not all patients
20 are the same.
21 Q. Well, isn't a treatment plan for a pain doctor sufficient if
22 they have pain and you're going to give them the Band-Aid of
23 opioids and let's just go with that?
24 A. No, it's not sufficient. The opioid Band-Aid thing, you
25 know, even Band-Aids get dirty and have to be taken off

1 sometimes. Band-Aid doesn't cure anything, it just buys you a
2 little bit of time.
3 The real question is what are you doing with that time
4 if you do decide to use opioids. And the whole issue is that
5 because we don't have a cure for chronic pain we have to look at
6 the long term. We have to do no harm. We have to make sure
7 we've got a treatment plan that's not just opioids but is trying
8 to optimize the patient's quality of life and optimize their
9 ability to function.
10 Q. Okay. What's the next column in red there, "MEQ over a
11 hundred"?
12 A. As we talked regarding the morphine equivalency, MEQ,
13 morphine equivalency, once we get to about a hundred to 120
14 there's a 10X increase in overdose.
15 So it's generally recognized that there's really no
16 medical justification -- really no medical justification for
17 using morphine equivalencies above a hundred. So I looked to
18 see if there are morphine equivalencies above a hundred because
19 that implicates safety and overdose risk.
20 It also has a great deal to do with street value. I
21 didn't say earlier but I will now, typically if you're saying,
22 well, what's the value of my pills if I decide to sell them,
23 it's about more or less one dollar per milligram.
24 So if somebody's taking a hundred milligrams, that's
25 equal to about a hundred dollars. If you've got a couple

1 hundred pills like that in your bottle and you're getting them
2 every month, that's a lot of money potentially to sell out on
3 the street. So we look at greater than a hundred milligrams
4 both from a street value standpoint and an overdose risk
5 standpoint.
6 Q. And is that a similar concern you have here under "high-risk
7 drug/combos"?
8 A. Well, they're referencing what I talked about in terms of is
9 the patient being prescribed a recognized high-risk combination
10 like -- for instance, like the Adderall and the opiate or the
11 prescription speedball as I referred to it, or is there a
12 combination of opiate and sedatives which has a huge increased
13 risk of overdose because of the sedation side effects.
14 There are other combinations too. Those are the two
15 big ones that we look for, the combinations.
16 Q. All right. And then we move to the third area, the
17 "compliance enforcement outcome," can you explain what that is?
18 A. That's the "do no harm" column. And basically as we've
19 talked about here, first --
20 Well, one of the things, look, we look at the PDMP,
21 the prescription drug monitoring program, find out are there
22 multiple providers, are there multiple pharmacies. Sometimes
23 patients shop multiple pharmacies hoping not to get discovered
24 in the sense that they're getting a lot of narcotics. Maybe
25 they'll split it up amongst pharmacies.

1 And again I'll be looking for risky drug combos. The
2 doctor may not be prescribing all the components of a given bad
3 combination, he may be only prescribing one of them. But he has
4 to be aware -- it's incumbent that he be aware of standard of
5 care that other doctors may be prescribing other elements of
6 the -- of that combination that could cause problems. So the
7 PDMP helps us discern that.
8 Do you want me to just go down the --
9 Q. To the right --
10 A. -- to the right there?
11 Q. The next column.
12 A. The "UDS" is urine drug screen. And again as we've given
13 several discussion points on, that refers -- what we're looking
14 for are inconsistencies.
15 If I'm prescribing to you fentanyl and there's no
16 fentanyl in your drug screen, then that tells me that that
17 fentanyl is either being abused or diverted because it is not in
18 your body. So something has to have happened to it. So we look
19 for inconsistencies.
20 We also look for illegal drugs. We look for
21 marijuana, we look for cocaine, we look for methamphetamine.
22 All the ones that we know unfortunately in the news today we
23 look for those, because those drugs do not play well with our
24 very potent narcotics and sedatives.
25 I need to know if somebody is on marijuana. You may

1 argue marijuana is good, bad or otherwise, but the fact is it's
2 still what we call a psychotropic drug and it affects judgment
3 and it affects thinking, it affects cognition. And when I start
4 adding other very potent narcotics to that we've got a
5 combination that could cause harm. So I need to know what
6 illegal drugs the patient's on.
7 And then the other thing too is not only do I need to
8 know what patient's on or not on, sometimes we see things
9 showing up in the urine drug screen that are not illegal but
10 it's not what I prescribed. Maybe I didn't prescribe Valium but
11 Valium shows up and I need to know that. So the urine drug
12 screen helps us look at compliance, medication compliance.
13 "Clinical improvement."
14 Basically we're looking to see if we've got that gold
15 standard. Is the pain improved? Is quality of life -- that's
16 "QOL" -- quality of life improved? Is function improved?
17 Function's the gold standard. Is there any indication that
18 actionable, meaningful, objective function is improved?
19 "Critical behaviors."
20 These are the addictive behaviors. That's one of the
21 four A's that I talked to you about. I've expanded on this a
22 little bit here.
23 Are there ER visits?
24 Is the patient being admitted to the emergency room
25 because they're [Indiscernible] withdrawals. Which by

1 definition tells me they're not taking the medication as
2 prescribed.
3 Is the patient even worse coming into the emergency
4 room because they're OD'd? Which really tells us they're not
5 taking the medications as prescribed.
6 Are there hospitalizations for respiratory depression?
7 Meaning, oh, I better take a look at this again. Patient has
8 asthma and has COPD of a severe nature and I'm prescribing narcs
9 that might be putting that patient into the hospital.
10 And are there any arrests? Are there any arrests?
11 Are there any interactions with law enforcement that would
12 suggest that the patient is -- has been selling their drugs or
13 is trading their drugs or was arrested for drug related
14 infractions?
15 So all these things go to the adverse consequences
16 part of addiction or they go to the diversion part of things
17 that I need to be aware of as a physician.
18 And then the very last column there is "death and
19 discharge." As physicians we need to monitor our patients, we
20 need to know what's going on. If the patient dies I need to
21 know about that because I have to ask the question did I have a
22 hand in that. Did I have a hand in that. And I need to feed
23 back and then ask myself the question. Maybe I ought to change
24 the way I do business, the way I treat patients, the way I
25 diagnose patients if I got patients who are dying.

1 Now, similarly, was the patient discharged. I may
2 discharge the patient at some point because I feel that they're
3 not with the program. They're not participating. Maybe I feel
4 they're abusing or diverting their drugs. But I should know
5 that up front. I should know that up front.
6 If I'm going to discharge a patient because they
7 didn't do well on their narcotics and they have a lot of
8 suspicious behaviors, I don't want to wait till years down the
9 line before I pull that plug. I need to be watching these
10 patients and seeing what the overall behavior is. I need to
11 know if the patient's been discharged from other pain doctors
12 before they came to me. Very frequently that's the case. In
13 which case why do I want to try that experiment again?
14 So death and discharge are two areas that I look at
15 for each patient to find out if there's anything there that may
16 be of help in discerning the legitimacy of opiate use.
17 Q. All right. So I gather those are the areas that you
18 considered and the factors that you considered to evaluate
19 Dr. Szyman's treatment of these patients?
20 A. That's correct.
21 Q. And so I'd like to turn to the first of those patients. I
22 think at least in your chart the first you examined was a woman
23 named Heidi Buretta?
24 A. That's correct.
25 Q. And so let me -- I know the jury has this but I'm going

1 to -- if we could then move to the row that says "Buretta."
2 And I'd like you to apply those factors that you said
3 you used to evaluate Dr. Szyman's treatment of a patient to
4 Ms. Buretta. So if we could start with the first column,
5 "diagnosis." How did you evaluate Dr. Szyman's meeting the need
6 for an objective medical diagnosis?
7 THE COURT: Before we begin --
8 MR. JACOBS: Sure.
9 THE COURT: -- this specific analysis let's take our
10 afternoon recess. Then we won't break up. Okay?
11 (Jury out at 2:32 p.m.)
12 THE COURT: I just want to note for the record that
13 our side bar involved the Exhibit 103. And as I recall, the
14 objection from the defense was to receiving it as an evidentiary
15 exhibit and then sending it into the jury room during
16 deliberations. But there's no disagreement with allowing the
17 exhibit to be used demonstratively at this point and to allow
18 the jury to follow the testimony on individual handouts.
19 Anything to add, Mr. Brindley?
20 MR. BRINDLEY: No, that's correct, Your Honor.
21 THE COURT: Mr. Jacobs?
22 Anything else we should put on the record that I've
23 forgotten in the meantime?
24 MR. BRINDLEY: No, Your Honor.
25 THE COURT: Okay. We'll take our break then.

1 MR. JACOBS: Thank you.
2 THE COURT: Mr. Jacobs, what do you think, how much
3 longer?
4 MR. JACOBS: An hour to go through -- I mean it's
5 really just to go through this chart, the 13 patients, the
6 factors in each one of them.
7 THE COURT: Okay. Okay. Well, whatever you need to
8 do.
9 MR. JACOBS: Yeah.
10 (Recess taken at 2:34 p.m., until 2:50 p.m.)
11 THE COURT: Is it fair to say that we're -- I hope we
12 can finish the evidence tomorrow and probably close on Friday?
13 Does that kinda look where we're going, like where we're going?
14 Or is there a possibility we could close tomorrow?
15 MR. BRINDLEY: I don't think that's plausible, Judge.
16 With what Mr. Jacobs indicated they have, there's a substantial
17 cross. I don't know whether we'll finish that today or not.
18 THE COURT: Yeah. I'm just going to give the jury a
19 ballpark.
20 MR. BRINDLEY: So I would hope -- I would think that
21 we could finish the evidence tomorrow. I don't think we could
22 get to closing arguments before Friday.
23 THE COURT: Okay. Let's bring the jury in.
24 (Jury in at 2 :52 p.m.)
25 THE COURT: Okay. Please be seated, ladies and

1 gentlemen.
2 By way of further schedule, it looks like the best
3 we're going to be able to do is finish the evidence tomorrow.
4 We may finish a little before the end of the day. The plan is
5 probably -- and this is subject to change as things change but
6 we'll likely close on Friday. But hopefully first thing Friday
7 you'll come back for closing arguments and deliberations. But
8 it looks like we won't be able to finish the evidence until
9 probably too late tomorrow to submit the case to you and I don't
10 want to break it up. So that's what it looks like for now. All
11 right?
12 All right. Go ahead, Mr. Jacobs, you can proceed with
13 your direct exam.
14 MR. JACOBS: Great.
15 BY MR. JACOBS:
16 Q. Dr. King, we were focusing first on patient Heidi Buretta,
17 and I wondered if you would explain your assessment of
18 Dr. Szyman's treatment of Ms. Buretta and his prescribing of
19 prescription narcotics.
20 A. Let me try to put it into a concise format here.
21 The concern I had about Ms. Buretta was that she
22 presented as a young 48-year-old woman. She was under treatment
23 with Dr. Szyman for 10 years. At no time did she have any
24 indication of any improvement either functionally, quality of
25 life or pain management.

1 She had significant -- a significant number of opiates
2 prescribed to her. As you see in the total there, she had in
3 excess of 11,000 -- 11,000 morphine equivalents.
4 And remember what I was talking about in terms of the
5 area of extreme concern beginning at 100. She had over 11,000.
6 She was being treated with -- for back pain, but the back pain
7 essentially was never documented. There was no imaging, there
8 were no physical exam findings. The MRI that she did have of
9 her low back just showed appropriate-for-age degenerative disk
10 disease.
11 On the flip side she had significant problems with
12 regard to mental health comorbidities and medical comorbidities.
13 Again these are very dangerous issues in both counts. She had
14 severe chronic obstructive lung disease, she was an ongoing
15 smoker. Ultimately she was put on home oxygen.
16 Additionally, she had hepatitis C. Hepatitis C is a
17 marker that we use to not always but in general to suggest that
18 we've got a history of IV drug diversion in the past.
19 So there are a number of warning factors here and
20 safety concerns. She was under psychiatric care prior to being
21 transferred to Dr. Szyman. She had significant psyche issues
22 with regard to depression, anxiety, and possibly ADHD. It was
23 not clear to me she had ADHD, but I inferred that because she
24 was being treated with amphetamines. Adderall specifically.
25 So she was being treated with what we call the

1 prescriptive speedball. She was on multiple high-risk
2 medications in addition to that, exceptionally high dose
3 morphine equivalency for many, many years. She was treated with
4 morphine, hydrocodone, Fiorinal, Robaxin which is a muscle
5 relaxant, Valium which is a benzodiazapine, and then the
6 combination of Adderall and Ziram. Ziram is another medication
7 that is very close to -- it's a GHB-type medication.
8 [Indiscernible] is what we commonly know as the date-rape drug.
9 She also had illegal substances. She had cannabis,
10 tetrahydrocannabinol in her bloodstream. Excuse me, in her
11 urine drug screen.
12 And at least at one point she had -- she was positive
13 for codeine that had not been prescribed. So in essence I would
14 say this woman because of her severe medical comorbidities,
15 mental health comorbidities and exceptionally, exceptionally
16 high opiate dose by orders of magnitude was inappropriately
17 treated for 10 years.
18 Again there was -- we don't need 10 years to determine
19 that the regimen is not working. Maybe a couple weeks, but not
20 10 years. This was an incredibly dangerous combination of
21 comorbidities and medication. And I suggested in my narrative
22 report that she was unlikely taking all those medications as
23 prescribed, otherwise she would be dead.
24 Q. One thing -- a couple things, Dr. King. First of all, you
25 mentioned that Ms. Buretta was being prescribed Adderall. Who

1 was prescribing the Adderall?
2 A. Dr. Szyman did not prescribe the Adderall. As I recall that
3 was being prescribed by another physician. But actually having
4 said that, let me double-check so I can be sure.
5 (Brief pause.)
6 A. I'm looking back at the PDMP. And --
7 (Brief pause.)
8 A. I'm sorry, there are many pages on this, of course.
9 (Brief pause.)
10 A. The amphetamine salts as is listed here were being
11 prescribed by Dr. Szyman.
12 BY MR. JACOBS:
13 Q. Because again you look at that -- your chronology I gather?
14 A. Yes.
15 Q. And if we look even at the last page of your chronology on
16 the -- I don't know what you have as the last entry there.
17 A. She's being prescribed Adderall by Dr. Szyman. So he is
18 prescribing it.
19 Q. And what do you have as the last entry on your chronology?
20 A. Dated 11/3/14.
21 Q. So November --
22 A. Office visit.
23 Q. I'm sorry.
24 A. The office visit, yes.
25 Q. November 3rd of 2014?

1 A. Correct.
2 Q. Okay. So it was Dr. Szyman prescribing both the opiates and
3 the amphetamine Adderall.
4 A. That's correct.
5 Q. Now, when you did your review were you provided any
6 information about Ms. Buretta's current status?
7 A. I was not, no. Just the chart.
8 Q. Okay. And would the fact that Ms. Buretta was found dead of
9 a mixed drug toxicity on December 5th of 2014, in any way affect
10 your conclusion about Dr. Szyman's treatment of her?
11 A. Well, no. I have never seen -- in all the years I've been
12 doing this I've never seen a -- an opiate dose as high as this
13 one was. And in combination with multiple high-risk
14 medications, regrettably it does not surprise me that she did
15 not survive.
16 Q. And based on your medical opinion, Doctor, did Dr. Szyman's
17 prescription of opioids to Ms. Buretta, was that for a
18 legitimate medical purpose?
19 A. No, it was not.
20 Q. Was it within professional -- was it in the realm of
21 professional practice to prescribe these opioids to Ms. Buretta?
22 A. No, it was outside of the usual course of medical practice.
23 Q. All right. Next you have on your list I think Sean Conway.
24 Do you see Mr. Conway there?
25 A. Yes.

1 Q. All right. And did you again review Mr. Conway's medical
2 file?
3 A. I did.
4 Q. And what was your assessment of Dr. Szyman on's treatment of
5 Mr. Conway?
6 A. Mr. Conway was a 24-year-old healthy individual who was
7 treated for six years. Young man treated for six years with,
8 again, exceptionally high-dose opiates.
9 If we look at again 100 milligrams as being the
10 beginning of the red zone, he was prescribed at his max dose
11 7,460 milligrams per day.
12 So I found there were exceptionally medically
13 non-defensible amounts of narcotic prescribed. He manifest what
14 we talked about earlier on going abuse triad of early-out,
15 early-refill and lost and stolen medications. There were
16 multiple third-party notifications of concern with regard to
17 cognitive deficits and appearing under the influence. Those
18 came from pharmacists and were documented in the chart.
19 There were no indications of any significant findings
20 on physical exam or imaging. He was complaining of what we call
21 subjective back pain. He had had a previous laminectomy or a
22 small operation on his back years before, but there was no --
23 but there was no hardware, there was no neurologic complication
24 documented in the chart, there was no foundational diagnosis to
25 support the use of opiates.

1 Q. And Dr. King, you mentioned that there were third-party
2 warnings provided to Dr. Szyman?
3 A. Yes.
4 Q. And I turn your attention -- and again, this information
5 comes from Dr. Szyman's medical file for Mr. Conway; is that
6 right?
7 A. That's correct.
8 Q. And if I could turn your attention to page 728 of
9 Mr. Conway's medical file which is already in evidence.
10 I'm sorry.
11 I'm going to first turn to go page 648 I think. And
12 bring up on the screen --
13 Well, that's not gonna work as well I think up on that
14 screen, is it. Just bear with me. For some reason it's not
15 displaying.
16 Do you recognize this page from Mr. Conway's medical
17 file?
18 A. I do, yes.
19 Q. And what is this?
20 A. Basically this is a nursing note. Could you give me the
21 Bates number on that again, please?
22 Q. I'm sorry. 648.
23 A. Okay, 640 -- yes. This is a nursing note whereby the
24 following bullet points were noted by the nurse and placed in
25 the chart.

1 The first, that there was an early -- the patient was
2 asking for an early refill on his narcotics because he, quote,
3 lost his fentanyl patches.
4 Secondly, the pharmacy called and was very concerned
5 about abuse. They said they didn't want to refill the
6 medications and so the patient went to Walgreen's the next day
7 and they refilled them.
8 Q. And I gather the note indicates that the pharmacy --
9 A. The pharmacy is concerned that he was abusing his
10 medications.
11 Q. And if we turn to I think the other Bates number -- the
12 other page that you were referring to. 728. This is also a
13 page from Mr. --
14 A. Yes. This is another nursing note that was in the chart
15 whereby it was documented with: "Pharmacy called once again
16 with an explicit warning about overuse. The pharmacist noted
17 and made the call saying that the patient can't talk clearly,
18 falls asleep, and is obtunded. And as a result the pharmacist
19 no longer is going to fill the prescriptions because of concern
20 about legal liability."
21 Q. And again this is information contained in the patient file
22 for Mr. Conway maintained by Dr. Szyman's office?
23 A. That's correct. It's in the chart.
24 Q. All right. And turning back to your summary grid, were
25 there other factors as you identified that supported your

1 conclusion regarding Dr. Szyman's treatment of Mr. Conway?
2 A. There were a number of urine drug screens inconsistent. And
3 as I've put here, there were multiple ones for the absence of
4 prescribed morphine and fentanyl, oxycodone, and Xanax.
5 In other words, at different times urine drug screens
6 showed that the patient was not taking the medications that were
7 prescribed which suggests that they were either being abused or
8 diverted, one of those two things, not once but several times.
9 Q. And in light of that information from the pharmacy that
10 Mr. Conway -- that they didn't want to fill it, would it be
11 appropriate to continue to prescribe opioids to Mr. Conway or to
12 increase the quantities of opioids he was receiving?
13 A. It would be outside the usual course of medical care for
14 continuation of the opiates under the circumstances, let alone
15 increasing the dose.
16 Q. Now, given that Dr. Szyman is prescribing opioids to
17 Mr. Conway, is it appropriate that Dr. Szyman would simply rely
18 on Mr. Conway's statements that he's got more pain and he wants
19 more drugs?
20 A. Well, as we talked, that's certainly where we start. We
21 want to believe our patients, but I'm going to then ask you
22 to -- you know, to -- then I'm going to go ahead and do things
23 to prove that, to verify it.
24 And in this case even though we want to start by
25 believing our patient, there are multiple indicators, objective

1 indicators that the patient was -- was lying, Mr. Conway simply
2 was not telling the truth.
3 Q. And you mentioned the daily morphine equivalency that
4 Mr. Conway was receiving from Dr. Szyman. Were there -- would
5 there be risks or side effects associated with that level of
6 opiates being consumed by an individual?
7 A. At its height Mr. Conway allegedly --
8 Well, let me put it this way. He was prescribed 7,400
9 morphine equivalents. I don't think there's any way that he
10 could be taking those and survive. As I say, end-of-care
11 scenarios we might use a couple hundred, but not 7,000 in a
12 healthy young guy who has no indication of any disease, any
13 chronic pain etiology.
14 So I would not expect he would survive. There would
15 be side effects that would take effect at the lower levels, at
16 the 10, 20, 30, 40, 50 milligram level, let alone the 7,000
17 milligram level.
18 We do, however, see that there are a number of notes
19 here not only by the pharmacist but also by the nursing staff
20 that the patient was obtunded, sedate, and lethargic. So we
21 have multiple inputs that the patient was at least taking
22 excessive medication, probably not 7,000 morphine equivalents,
23 but was certainly taking too much because we were seeing side
24 effects of -- of sedation and overuse of medication.
25 Q. What does obtunded mean?

1 A. Obtunded? Obtunded means you're a zombie. Just
2 [Indiscernible] you're a zombie.
3 Obtunded means you're tired, you're not responsive and
4 just not making sense. We'll call it cognitively impaired. But
5 that's really what it means. You are overdosed, basically.
6 Q. And could you expect a patient like that to feel loyalty to
7 Dr. Szyman?
8 MR. BRINDLEY: Objection. Outside of the --
9 objection.
10 THE COURT: Overruled.
11 MR. JACOBS: I'm sorry.
12 BY MR. JACOBS:
13 Q. Would you expect a patient like that to feel loyalty to
14 Dr. Szyman?
15 A. I would, yes. Yes.
16 Q. Why is that?
17 A. These patients, Mr. Conway in specific, is clearly -- if not
18 addicted he's dependent and if not diverting he's at least
19 abusing the medications. His whole intent is to get the
20 medications. So he's going to do what he can to put forth a
21 story to allow the doctor to make the doctor give him his
22 narcotics.
23 So the patients can put together a good story. And
24 again we always want to believe the patient, but why would he
25 leave Dr. Szyman? He's giving him everything he wants. Why

1 would he go somewhere else? He's getting everything he wants in
2 spite of the fact that he's testing inconsistent on the urine
3 drug screens and in spite of the fact that he's showing no
4 significant improvement. He keeps saying his pain is worsening
5 and he's getting more and more medications, why would he leave?
6 He's got what he wants.
7 And we do see this. We do see this. And that's why
8 as a physician we have to hold the line, we have to do a careful
9 examination, we have to use universal precautions which were not
10 done in this case. This was a candy-store situation. Of
11 course, he enjoyed seeing Dr. Szyman, he was getting everything
12 he wanted.
13 Q. And were there some psychological comorbidities as well from
14 Mr. Conway?
15 A. Mr. Conway suffered from depression, anxiety, ADHD and
16 bipolar disorder. Again the three more -- most common ones that
17 we see as comorbidities that either modify or cause chronic pain
18 are depression, anxiety and bipolar disorder and he had those.
19 Q. How do you know that?
20 A. Well, it was in the chart.
21 Q. I mean that's not your diagnosis.
22 A. No, that's not my diagnosis. I just took it right out of
23 the chart. It was listed in the chart.
24 Q. And why would that impact upon the opioids that Dr. Szyman
25 was giving him?

1 A. We would expect that depression, anxiety and bipolar
2 disorder would worsen with -- with opioids and we would
3 particularly expect those diagnoses to get worse with high
4 doses.
5 He was taking as many as 94 pills per day. 94 pills
6 per day at a greater than 7,000 milligram morphine equivalency.
7 That would be expected to make any kind of mental illness worse.
8 Q. The next patient on your chart I think is Anna Kingston; is
9 that right?
10 A. Yes.
11 Q. Okay. And did you find Dr. Szyman's treatment of
12 Ms. Kingston, the practice of legitimate medicine within
13 professional medical bounds?
14 A. I did not.
15 Q. And why is that?
16 A. Ms. Kingston presented as a walk-in patient. She was 22
17 years old, healthy young woman with a normal physical exam
18 complaining of vague, subjective shoulder pain.
19 As I indicated earlier, shoulder pain, joint pain
20 should be treated with physical therapy or physical therapy
21 modalities, not with high-dose narcotics on the first visit. So
22 she was -- she had no past medical records. She was very honest
23 in indicating she just wanted narcotics to take care of her
24 subjective pain, and she got them.
25 And she didn't even get modest narcotics, she got a

1 significant dose. She got 30 milligram oxycodone tablets, three
2 a day on the first visit and for several visits thereafter.
3 And -- I'm sorry.
4 Q. Go ahead. I'm sorry.
5 A. 30 milligrams is important. 30 milligram oxycodone is the
6 most street-valued narcotic from a prescriptive standpoint
7 arguably. It's the highest dose of unadulterated oxycodone.
8 It's extremely popular out on the street because it can be
9 crushed and then snorted or injected. It has the highest
10 per-milligram value. 30-milligram oxycodones are known to be
11 the highest risk of single pain medication in that group.
12 Q. And can I ask, Dr. Szyman, in doing your evaluation were you
13 provided with any information concerning the identity of
14 Ms. Kingston?
15 A. No.
16 Q. You were told she was just another patient of Dr. Szyman's.
17 A. Correct.
18 Q. Okay. And did you find that Dr. Szyman's prescribing of
19 opioids, in this case 30 milligram oxycodone, 90 capsules -- or
20 90 tablets, was for a legitimate medical purpose?
21 A. I did not.
22 Q. Within the bounds of professional medical conduct?
23 A. Outside the usual course of medical practice. I saw no
24 foundational acceptability, no foundation for the use of
25 narcotics in this patient.

1 Q. Would it be enough though that the patient comes in and
2 says, you know, I had some pain in the past, I might have some
3 pain in the future, can I have some opioids?
4 A. That goes back to the vending machine analogy. I'm not a
5 vending machine. Doctors should not be a vending machine.
6 If they examine the patient and they find something
7 focal, a deficit that needs to be addressed, then it should be
8 addressed. In this case it's an intermittent shoulder issue.
9 The multidisciplinary individualized approach to this patient
10 should have been physical therapy and/or imaging, but certainly
11 not high-dose dangerous street value 30 milligram oxycodone on
12 the first visit.
13 Q. Well, how about if the patient says, well, I don't want
14 physical therapy, I want narcotics?
15 A. That happens. The patients come in and say I just want
16 narcotics. At which point I say, you know, that's not
17 appropriate. It may be, but in this case it was not.
18 I would indicate to this patient look, you don't have
19 anything that serves as a foundational diagnosis for the
20 legitimate use of opiates. If your shoulder is a problem we'll
21 get it X-rayed, may send you to a specialist or do some physical
22 therapy. But if you choose, if you choose as a patient to say I
23 don't want that, I want narcotics, then I say we don't have a
24 meeting of the minds. Medically it does not make sense for me
25 to prescribe the opiates. I will take care of you, but opiates

1 are off the table. That would be the appropriate way to handle
2 a case like this.
3 Q. All right. I'd like to next turn to your evaluation of the
4 patient file for Alexandra Krizizke I think it's pronounced?
5 A. Uh-huh.
6 Q. And did you find Dr. Szyman's treatment of Miss Krizizke to
7 be appropriate?
8 A. I did not.
9 Q. And did you find that he prescribed controlled substances
10 within his professional practice for a legitimate medical
11 purpose?
12 A. I did not.
13 Q. And could you explain to the jury the basis of your
14 conclusion with respect to Ms. Krizizke?
15 A. I may call her Alexandra because I can't pronounce the last
16 name either.
17 Alexandra was 18 years old. 18 years old when she
18 presented to Dr. Szyman. And she stayed with him for four years
19 complaining of a headache. In no case really are headaches
20 acceptable diagnoses for the use of opiates. And in her case
21 she nevertheless received opiates aggressively for four years
22 with no improvement.
23 There was no diagnosis. Her chief complaint was
24 headache and it was treated by Dr. Szyman with high-dose
25 opiates. Her dose was 652 morphine equivalents, well above the

1 red zone of a hundred. He -- the patient had been through
2 treatments prior and had been under Dr. Szyman's hands treated
3 with hydrocodone, Dilaudid, morphine, and Toradol.
4 So she got multiple medications none of which were
5 helpful. There was no indication of any abnormality on
6 neurologic exam. There was no indication of any imaging. She
7 had multiple early refills, multiple early-out scenarios.
8 She did have one urine drug screen that was negative
9 for prescribed hydrocodone, but no action was taken on that.
10 And it was noted from a behavorial standpoint that she visited
11 the ER frequently for headaches and it was a, quote, common
12 complaint for her, suggesting that she was going there just to
13 get narcotics.
14 Q. Is the fact that prior physicians had prescribed pain
15 medication, narcotic pain medication a basis for Dr. Szyman to
16 say, well, they've done it before I'll continue to do that?
17 A. No, it's not a legitimate position. Again, as I've stated,
18 it's up to us as physicians to be gatekeepers. That's probably
19 a good way to look at it, we're gatekeepers.
20 And if I refer a patient to a specialist, an
21 orthopedic doctor for a spine evaluation, I don't expect that a
22 spine physician to simply parrot what I said, I expect him to
23 give an independent review of the circumstances and a diagnosis
24 based on his independent evaluation.
25 Similarly, when a patient presents to me for pain

1 management, even though that individual may have been receiving
2 narcotics from another doctor it's up to me to be the
3 gatekeeper, to do an independent medical evaluation to determine
4 the diagnosis and to determine an appropriate treatment plan.
5 So, no, we don't just accept trading one patient to
6 another and maintaining the narcotics.
7 Q. Is the prior use of opioids and the fact that a referral is
8 made some indication that it didn't work?
9 A. It is absolutely an indication that it didn't work. The
10 trial had been done.
11 Many times we'll trial a patient on opiates, and
12 that's okay. That's okay. When you try somebody or another
13 doctor may try somebody on opiates, and maybe I don't agree but
14 it's okay. The thing is the opiate trial, the opiate trials,
15 which is acceptable, should be done with specific goals in mind,
16 specific functions in mind. And it should be done from a time
17 standpoint of a couple weeks, maybe four weeks, maybe even six
18 weeks, but not a year, not two years, not four years, not 10
19 years. By the time you get to that point you're well into the
20 area of causing harm.
21 So a trial of a couple weeks, okay. And then if the
22 patient has not significantly improved you exercise an opiate
23 exit strategy and you get out of the opiate business.
24 Q. Is there a concern with high levels of opioid prescriptions
25 that the exit strategy will result in withdrawal?

1 A. The exit strategy depending on the dose of opiates could
2 have withdrawals. And those can be treated and should be
3 treated by the physician who is prescribing.
4 But again this is a proactive issue. We don't want to
5 suddenly as a physician find ourselves default in the situation
6 where we've got the patient on high-dose narcs and now we've
7 gotta decide what to do with that. We want to have that careful
8 proactive formulation of treatment plan in conjunction with the
9 patient before we even do the trial, the opiate trial.
10 We want to make sure that the patient understands
11 we're going to go this far and no further unless there is
12 absolute objective improvement that we can demonstrate. And
13 typically we do that short of getting into the -- into trouble
14 with withdrawals. If we're in the withdrawal end of the world
15 we've gone too far.
16 Q. Now, you've mentioned a number of high levels of morphine
17 equivalency, I think for Alexandra 652, but Mr. Conway in excess
18 of 7,000, Ms. Buretta in excess of 11,000. Is it possible that
19 that just resulted because of a tolerance the body develops?
20 A. The body does develop a tolerance over time, but in these
21 cases the doses are so egregious that this is not a tolerance
22 issue, it's more likely a situation of abuse and diversion.
23 The reason we say that is because we can look back and
24 we can see urine drug screen inconsistencies, we can see
25 addictive behaviors, or we can see evidence that the medications

1 are not being taken as prescribed. So the risk is if the
2 patient does take them as prescribed they might die.
3 So these doses are egregious. They aren't even just
4 high, they're egregious. They're way outside the usual course
5 of medical practice.
6 Q. And when we talk about tolerance, is the body -- it's
7 developing a tolerance to the pain relief aspect of the opioids?
8 A. The body can develop a tolerance to the pain relief aspects.
9 But once -- as I talked earlier, as we get up to these really
10 high doses, then we have to worry about the opioid-induced
11 hyperalgesia or the OIH.
12 In other words, at these real high doses the pain may
13 be worse as a result of the narcotics. So in these cases I feel
14 confident that the increase in narcotics were being used --
15 there was a lot of abuse and diversion going on as a result of
16 the behaviors. But in all likelihood there was opioid-induced
17 hyperalgesia going on which would more likely count for some of
18 the legitimate cases where the patients might have been
19 requesting higher opiates. In other words, it was iatrogenic,
20 the doctor was causing it. He was making the pain worse. He
21 was doing harm.
22 Q. Have you ever heard the term "rebound headache"?
23 A. Yes.
24 Q. Is that a medical condition?
25 A. That is a medical condition.

1 Q. And what is that?
2 A. A rebound headache is a condition where, again, it's another
3 way where we as doctors can make the pain worse -- headaches in
4 this case -- by prescribing a lot of short-acting medications,
5 whether they're narcotics or over-the-counter analgesics.
6 It comes from the fact that if we take a Tylenol we'll
7 get a blood level that'll go up and then down over the course of
8 a couple of hours. So if we add some narcotic to that, a
9 Percocet or an oxycodone or a Dilaudid, we're still getting a
10 short-acting response of a couple hours.
11 So what we see and when the patient starts taking a
12 lot of short-acting medications over the course of the day, we
13 see up/down, up/down, up/down, up/down, up/down, and that has
14 the effect of causing what you referred to as a rebound
15 headache.
16 We actually caused the headache because of the varying
17 rates of change and the varying blood levels of medication. So
18 a rebound headache can -- some of the times the patient causes
19 it just because they're taking too much over-the-counter
20 short-acting medication, sometimes we cause it because we
21 prescribe too much.
22 Q. And how about, have you ever heard the term "medication
23 hangover"?
24 A. I think I've heard patients reference that. Certainly not a
25 medical term, but yes.

1 Q. Okay. Do you know what that refers to? Is there a medical
2 term to what that refers to?
3 A. The closest I would probably approximate the definition to
4 would be the patient, obtunded or zombie-like as a leftover
5 sedation -- because the medicine doesn't wear off.
6 We've all been -- well, I don't know if we've all
7 been. I'm trying to think of a good analogy. But basically
8 it's leftover sedation such that the patient feels like they're
9 waking up with a hangover, like an alcohol hangover let's say.
10 They're just not with it, they're not functioning right. In
11 this case they're obtunded, they're zombie-like as a result of
12 their prescribed medication.
13 Q. All right. So let's move on again to the next patient you
14 have on your summary here, I think it's Mr. Orth. And did you
15 find Dr. Szyman's treatment of Mr. Orth to be within his
16 professional practice and that his prescribing medication was
17 for a legitimate medical purpose?
18 A. I did not.
19 Q. And could you explain to the jury the basis of your
20 conclusion.
21 A. Mr. Orth again was another young man, he was 36 years old.
22 He was treated by Dr. Szyman for four years. Not a couple
23 weeks, not a month, but four years with no indication of any
24 improvement whatsoever.
25 He was prescribed up to 2,400 morphine equivalents.

1 Again, well above our red zone area beginning at about a
2 hundred.
3 He complained of neck pain. He had his neck pain
4 operated on. He had an anterior cervical effusion during the
5 course of care with Dr. Szyman, but it didn't help, didn't do
6 anything, and the medication continued by Dr. Szyman.
7 My concern about -- additional concern about the care
8 of Mr. Orth was the fact that there were multiple early-out,
9 overtaking and lost medication issues, what we've referred to as
10 the abuse triad.
11 There were multiple inconsistent urine drug screens.
12 Multiple ones. The patient had -- Mr. Orth had a history of
13 illegal drug use — that is to say, marijuana.
14 He was still using alcohol and yet we had
15 documentation that he has a history of operating while
16 intoxicated.
17 So he's using illegal substances, he's got an alcohol
18 abuse/use issue. He's also under psychiatric care. He is also
19 being prescribed as it turns out a combination of a prescription
20 speedball. He's on amphetamines. He's on Adderall.
21 So I have a concern with regard to Mr. Orth in the
22 sense that he's got abuse and diversion behaviors. He failed
23 four years of care with no exit strategy being exercised. He
24 was on excessive medications, up to 2400 morphine equivalents.
25 And I find --

1 And one last thing, I should mention this. His first
2 urine drug screen when he presented to Dr. Szyman in 2011, his
3 first -- very first urine drug screen had marijuana,
4 buprenorphine, which is Suboxone, and methadone in it. And
5 there's no indication that he was being prescribed those for
6 legitimate basis.
7 As a matter of fact, buprenorphine -- or Suboxone --
8 and methadone are medications we use to treat addiction. The
9 very first question that should have been asked at that point
10 is, are you under treatment for addiction from somewhere you're
11 not telling me?
12 So there were major red flags in the case of Mr. Orth
13 starting at the very beginning.
14 Q. And with those major red flags did Dr. Szyman's treatment of
15 Mr. Orth change in light of those red flags?
16 A. It did not change, no.
17 Q. Now, you mentioned the body may have some tolerance to the
18 pain-relieving effect of these opioids. Does the body develop
19 tolerance to the side effects, to the reduction in testosterone,
20 to the constipation, to the nausea?
21 A. To some extent the body will accommodate to the side
22 effects. The last one to be moderated is constipation. A
23 constipation, as I say, is usually the end point for our
24 escalation of narcotics. But if you keep ramping it up high
25 enough the body can't accommodate and at some point the body

1 becomes overwhelmed not only with constipation but with sedation
2 or I think you called it a hangover effect or a obtundation from
3 a medical standpoint. Nausea, vomiting.
4 A number of these patients were being prescribed
5 antinausea medications on a regular basis ostensibly so they
6 could tolerate the opiates. But that's inappropriate. If we've
7 got that degree of side effect profile going on an opiate exit
8 strategy should be exercised.
9 Q. I don't recall if I asked you so maybe I'll repeat myself.
10 Do you find Dr. Szyman's prescribing of opioids to Mr. Orth to
11 be within his professional practice and for legitimate medical
12 purpose?
13 A. I do not.
14 Q. I'd like to next turn your attention to Dabian Peterson.
15 Did you review Mr. Peterson's patient file reflecting
16 Dr. Szyman's treatment of him?
17 A. I did.
18 Q. And did you find Dr. Szyman's treatment of Mr. Peterson to
19 be within his professional practice and his prescribing of
20 medication to be for a legitimate medical purpose?
21 A. I did not.
22 Q. And could you explain to the jury the basis of your
23 conclusion?
24 A. Mr. Peterson was a 45-year-old gentleman who was under care
25 of Dr. Szyman for seven years. The opiates prescribed at a high

1 dose initially. They were ramped up to a dose, max dose of
2 2,910 morphine equivalents, which again is well above the 100
3 milligram red zone.
4 There was no indication that the opiates were
5 successful in addressing Mr. Peterson's pain. There were
6 instances of the abuse triad where there were early refills,
7 early-outs, and stolen medications.
8 There were instances in this case of very significant
9 prior history of addiction and substance abuse which are pretty
10 significant contraindications for the use of high-dose opioids
11 on a chronic basis --
12 Q. Can you explain --
13 A. -- specifically.
14 Q. Can you explain what you mean by that when you say a history
15 of --
16 A. Of addiction, substance abuse? Yeah.
17 Q. -- substance abuse? Yes.
18 A. Basically, I guess the easiest analogy is if an individual
19 is an alcoholic he's essentially an alcoholic for life in the
20 sense that he has to be careful about being tempted to overuse
21 alcohol. So an alcoholic is always going to have to be very
22 careful not to trigger over drinking.
23 In the same sense if somebody is addicted -- and in
24 this case Mr. Peterson has a history -- not subtly, he has a
25 significant history of IV cocaine use, current marijuana use and

1 current alcohol use.
2 So if a patient has a history of addiction treatment
3 as it is here on multiple substances, and this is all in the
4 chart, then it is not appropriate medically, it's not within the
5 usual course of medical practice to give that person with the
6 history of addiction high dose additional narcotics. It just
7 doesn't make sense.
8 Particularly given the fact that Mr. Peterson had been
9 in prison for no less than five DWIs. He had a very
10 significant, a very objective history of alcohol abuse. So why
11 would an individual want to prescribe to him additional
12 narcotics, additional addictive medications knowing that there's
13 a history of IV cocaine use, current marijuana use, and
14 imprisonment for alcohol abuse? It doesn't make sense. It's
15 outside the usual course of medical practice.
16 Q. Did Dr. Szyman's file also reflect that he had received
17 warnings from third parties concerning Mr. Peterson?
18 A. Yes, he did. And I suspect you may be showing that. If not
19 I can just address it here and describe it.
20 Q. I'd like to show you what's part of an exhibit, Exhibit 5.
21 It's Bates No. 361, I believe.
22 I don't know why I'm having a problem on that screen.
23 Can you see the full on your monitor?
24 A. Yes.
25 Q. This is a page of the patient file for Mr. Peterson; is that

1 right?
2 A. That's correct.
3 Q. Okay. Could you tell the jury, what does the note indicate?
4 A. This is a nursing note that's in the chart and that
5 basically indicates that the office received an anonymous call
6 from the female who wishes to remain anonymous.
7 She reports that this patient, Mr. Peterson, and his
8 wife, are selling his narcotic medication. He has offered his
9 meds to her son to sell. She has witnessed this.
10 She reports the patient calls the police and reports
11 meds stolen, but they were not stolen, they were sold.
12 Caller --
13 And then it goes on to say that the nurse advises the
14 caller to make an anonymous call to the metro drug unit. But it
15 goes on to indicate that this phone call would be reported to
16 Dr. Szyman and that the patient would be brought in for a pill
17 count.
18 Q. All right. And did your review of the patient file, in
19 fact, reflect that Mr. Peterson had made reports of lost or
20 destroyed medication?
21 A. Yes.
22 Q. And despite receiving this anonymous report did Dr. Szyman
23 continue to prescribe controlled substances, opioids, narcotics
24 to Mr. Peterson?
25 A. Yes, he did.

1 Q. Were there any other factors that affected your conclusion
2 regarding Dr. Szyman's treatment of Mr. Peterson?
3 A. Mr. Peterson actually did come in for a pill count after
4 that notification and there are a number of nursing notes
5 addressing it. And there were a number of inconsistencies found
6 with that pill count.
7 But when the day is done the -- Dr. Szyman indicated
8 that, "I am satisfied that this phone call was malicious," and
9 he took no action on that.
10 I think that's misguided. That doesn't make logical
11 sense. It certainly doesn't make medical sense. We've got too
12 many other behaviors here that suggests that the patient
13 actually is abusing or diverting. We as physicians need to take
14 seriously these phone calls when they come in. Sometimes
15 they're from pharmacists, sometimes they are anonymous.
16 Sometimes they're from patients' mothers or relatives. But the
17 fact that somebody took the time to call in and make a lengthy
18 entry saying, you know, not just I saw somebody diverting the
19 drugs, no, I saw this patient selling them to my son, trying to
20 get my son to sell them, I witnessed this. This is pretty
21 detailed and needs to be taken seriously.
22 Q. I note on your summary sheet you indicate that one of the
23 issues is multiple formulations, 80 milligram, 40 milligram,
24 30 milligram. Can you explain why that's significant to you?
25 A. If we're going to prescribe an opiate to a patient then we

1 pick the opiate and we prescribe it accordingly.
2 In this particular case there were multiple
3 formulations. And by that we mean multiple strengths.
4 I'm looking for the exact date here to give you an
5 example. But I'll pick one here where, for instance, right
6 after the phone call was made Dr. Szyman prescribed this patient
7 three different oxycodones: 80 milligram, 30 milligram, and 40
8 milligram.
9 Why? Why? Each one of those has the -- has the risk
10 that it's going to be put out on the street. If we're going to
11 prescribe a medication to a patient, an opioid medication, one
12 is all that's necessary. When we start prescribing multiple
13 formulations, different strengths, it makes no medical sense.
14 First of all, it hasn't done anything to help the
15 patient in this case. He's got up to -- I don't know what the
16 morphine equivalency is at that particular time, but it's very
17 high. He's taking 30 to 40 pills per day. Even if you had a
18 patient that was doing that, the compliance would probably not
19 be good.
20 So the use of multiple formulations does not make
21 medical sense. One narcotic, one dose, and let's see -- and
22 then show that that's working. That did not occur in this case.
23 Q. And was there any evidence over the seven years that
24 Mr. Peterson got better?
25 A. There was no indication. There was no objective description

1 that function, pain control or quality of life improved.
2 Q. So again was the prescribing of opioids by Dr. Szyman to
3 Mr. Peterson outside of his professional practice and not for a
4 legitimate medical purpose?
5 A. That's correct.
6 Q. If we could next turn to Ms. Tanya Pivonka-Dewane. If you
7 have that there.
8 A. Yes.
9 Q. Can you describe your analysis of Dr. Szyman's treatment of
10 Ms. Pivonka-Dewane?
11 A. I'm sorry, was that a question?
12 Q. Sure. I just want you to describe your assessment.
13 A. My -- again, Ms. Pivonka is a 34-year-old woman who was
14 under treatment with Dr. Szyman for six years. Six years of
15 failed opiate therapy.
16 But in this case, prior to that there were three years
17 of opiate therapy failed before she even saw Dr. Szyman. So
18 she's been through -- well, at the end of her time with
19 Dr. Szyman she's been through nine years of failed therapy.
20 That does not make medical sense. She was prescribed
21 up to several thousand, 2,540 morphine equivalents for
22 subjective back and abdominal pain. There was nothing that
23 indicated that she had any deficits on physical exam to support
24 a source for her back pain or abdominal pain.
25 She had severe mental health risk factors. She was --

1 she had urine drug screens that were positive for heroin. She
2 had a normal physical exam. She had eight hospitalizations,
3 eight hospitalizations for mental illness. She was prescribed a
4 prescriptive feed ball. And she exhibited the opiate -- the
5 abuse triad of early-out medication, overuse medication and
6 lost-and-stolen medication.
7 Additionally, she exhibited what we call doctor
8 shopping. That is to say, she was getting different controlled
9 substances from different doctors.
10 She had illegal substances in her urine. She had not
11 only dipstick positive for heroin, but she also had marijuana
12 and she also had several urine drug screens that did not show
13 presence of her prescribed medication of oxycodone and
14 benzodiazepine.
15 So with multiple behaviors, multiple objective
16 indications, the medication was being abused or diverted. It
17 was being nevertheless prescribed at a very high dose after the
18 patient had failed the trial of ultimately nine years. The
19 medications were prescribed without a legitimate medical purpose
20 and outside the usual course of medical care.
21 Q. Did Dr. Szyman also receive warnings from third parties
22 about Ms. Pivonka?
23 A. Yes, he did. He -- I'll go back in the beginning and say as
24 early as 2004, she was discharged or left two pain clinics that
25 were unable to help her.

1 And again we don't have any history as to whether
2 there was any urine drug screen issues, but she had seen two
3 previous pain clinics before. And she had a third-party report,
4 again it's in the form of a nursing note in the chart. The --
5 Q. And what's the date of that nursing note?
6 A. 7/7/09.
7 Q. And who is the third party?
8 A. The third party are the police. The patient had indicated
9 theft of the medications and notified the police to make a
10 report. But she according to the nurses' note became so
11 distressed that she rolled up in a ball and goes to bed,
12 complains of being very depressed.
13 When the clinic -- presumably Dr. Szyman's clinic --
14 contacted the officer, he expressed that there are some family
15 concerns regarding the patient's med use.
16 Officer stated that he has numerous questions to ask
17 patient. She had not made a bona fide statement. And the info
18 given to him was "vague at best." The officer states it is his
19 gut feeling that more is going on here.
20 As a result of that interaction -- or I should say
21 despite that interaction, medications continued to be prescribed
22 and increased as time went on.
23 Q. Did Dr. Szyman's office receive additional warnings from
24 third parties such as a pharmacy suggesting that Ms. Pebamca was
25 abusing her medication or diverting her medication?

1 A. (No audible response.)
2 Q. Maybe if I can turn your attention to Bates 504 -- this is
3 part of Exhibit 4.
4 A. Yes. I have it. Okay.
5 Q. I don't know if that's up on the screen. You can read it
6 there.
7 A. Yes.
8 Q. It cuts off over there.
9 A. No, it shows it. It looks good there. That nursing note on
10 9/16/2013 is from the pharmacist. The pharmacist states that
11 they only gave the patient a hundred [Indiscernible] pills.
12 States one bottle costs $4,600 and they didn't want to
13 write the other bottle if the patient didn't do well on this
14 med.
15 But it goes on to say there are expressed concerns
16 regarding the patient presenting to the pharmacy has large rolls
17 of cash. Is always with a different young man. She questioned
18 our monitoring system. I explained it to her. And
19 Dr. Szyman's --
20 So -- yeah, so the patient -- so the pharmacist was
21 very reasonable, he's saying this doesn't look right so made the
22 step to call Dr. Szyman.
23 Dr. Szyman says have her come in for a pill count.
24 And the pill count indicated that she was overusing her
25 medications.

1 And it also notes on that same follow-up appointment
2 that the urine drug screen was negative for the prescribed
3 hydrocodone. So things didn't make sense. She was, quote,
4 overusing it, but her urine drug screen was negative for it.
5 What's the conclusion? She's not taking it. She's
6 either abusing it, in which case probably not because the urine
7 drug screen is negative, she's probably diverting it, selling
8 it, giving it away, wherever.
9 But it doesn't add up. The medication is not being
10 used for a legitimate medical purpose.
11 Q. So what should a reasonable pain management doctor have
12 done?
13 A. A reasonable pain management doctor would have recognized
14 that the drugs were being to some extent abused but certainly
15 diverted based on this information. A reasonable pain doctor
16 would have said no more. No more. And would have stopped it.
17 And would have gotten the patient the appropriate care she
18 needed which in all likelihood was a mental health issue to
19 address her pain management.
20 But a reasonable doctor should not have continued the
21 opiates which reasonably would have been expected to make it
22 worse or to contribute to ongoing diversion.
23 Q. Well, what if the patient comes in and says I'm still in
24 pain, it hurts?
25 A. Patient probably still is in pain. We can accept that at

1 face value. But she's not in the kind of pain that requires
2 narcotics.
3 In all likelihood her pain is what we call
4 psychosomatic. She may not be making it up, but it still may be
5 a psychosomatic manifestation of suffering and these would be
6 treated with other than opiates. It needs to be treated with a
7 psychiatric foundation and psychiatric counseling modalities.
8 Q. So is Dr. Szyman helping her by giving her 2,540 morphine
9 equivalency units a day of opiates?
10 A. Dr. Szyman is materially contributing to doing harm with
11 this patient. This patient is not being helped in either her
12 practice of diversion or her pain management. She is not being
13 helped at all by the use of continued high-dose opiates by
14 Dr. Szyman.
15 Q. Well, maybe in her practice of diversion it might be helping
16 her sales, right?
17 MR. BRINDLEY: Objection, Judge.
18 THE COURT: Sustained.
19 MR. BRINDLEY: Argumentative.
20 MR. JACOBS: Sorry. I'll move on.
21 BY MR. JACOBS:
22 Q. Let's move to the next patient if we could. That's
23 Ms. Ramirez. Did you review Dr. Szyman's patient file for
24 Ms. Ramirez?
25 A. I did.

1 Q. And what did you conclude about Dr. Szyman's treatment of
2 Ms. Ramirez?
3 A. Ms. Ramirez presented Dr. Szyman's care for nine years, who
4 had nine years of failed therapy. She had nine years of failed
5 therapy with Dr. Szyman.
6 She had a huge dose of morphine equivalents. Her dose
7 was up as high as 2,880. She was complaining of headaches,
8 headaches as a result of a motor vehicle accident that happened
9 a few years prior. But her physical exam was normal. There was
10 no imaging that indicated anything was broken.
11 There were multiple letters -- while there were
12 letters written by Sigma Healthcare indicating that she was
13 doctor shopping, getting her medications from different sources.
14 She was also testing positive for heroin in her urine drug
15 screens.
16 She's an addict. She's an addict. She needs help,
17 but she certainly doesn't need additional narcotics from
18 Dr. Szyman to facilitate further addiction.
19 She had multiple inconsistent urine drug screens. The
20 insurance companies in addition to showing doctor shopping
21 said -- noted that she was taking excessive controlled
22 substances and she was still disabled. She was taking four
23 different strengths of morphine at once and two different
24 benzodiazepine sedatives at once. She was taking -- assuming
25 that she was taking all these -- a total of 39 pills per day.

1 That's a lot of pills. We wouldn't expect patients to be
2 compliant with that.
3 And in addition to that she's got significant risk
4 factors. She's obese. She has obstructive sleep apnea, asthma,
5 chronic bronchitis, COPD. She's a smoker and she has angina,
6 heart disease. She's a setup to not survive this treatment
7 regimen of high-dose multiple narcotics.
8 Narcotics in this case were prescribed without a
9 legitimate purpose. Eventually, in the end --
10 By the way, she also has a history of alcohol and
11 marijuana abuse. And she's noncompliant with her use of
12 medications. And eventually she's arrested for first degree
13 reckless homicide with delivery of drugs and negligent
14 manslaughter and was subsequently discharged from the practice.
15 But these sort of things should have been foreseen
16 much earlier.
17 Q. And so is Dr. Szyman's prescribing of controlled substances
18 for Ms. Ramirez outside of his professional practice and not for
19 a legitimate medical purpose?
20 A. Correct.
21 Q. I'm going to turn you next to your analysis, the analysis
22 you did for Mr. Russo. Did you review the patient file --
23 Dr. Szyman's patient file for Mr. Russo?
24 A. I did.
25 Q. And what was your conclusion regarding Dr. Szyman's

1 treatment of Mr. Russo?
2 A. I was quite concerned about Mr. Russo for reasons I'll tell
3 you in a moment.
4 Mr. Russo was a healthy 49-year-old gentleman with a
5 subjective history of lower neck and upper thoracic back pain.
6 He alleged he was a cement finisher and was being referred for
7 an evaluation relative to periodic opioid therapy.
8 But we don't know who referred him. There's no
9 documentation here as to who the referral doctor was. We have
10 no indication that he has seen any pain doctor in the past.
11 He nevertheless receives opiates on the first visit
12 without verification of any diagnosis, without obtaining past
13 medical records, without having anything abnormal on the
14 physical exam. He was just given opiates right off the bat. No
15 urine drug screen, no legitimate diagnosis.
16 What happened on this gentleman was that he had a
17 musculoskeletal pain. And physical therapy is indicated for
18 musculoskeletal or joint pain, not high-dose opiates.
19 Ultimately, of course, this patient was discharged,
20 but not until -- not until this patient had received seven
21 months of high-dose oxycodone prescriptions.
22 If we do the calculation here, Dr. Szyman issued 690
23 oxycodone pills for a total of over 13,000 milligrams over 10
24 months. That computes to over 20,000 morphine equivalents.
25 Now, this patient did not show up with a urine screen

1 that confirmed he was taking his medications. So where did
2 these medications go? Where did these 20,000 morphine
3 equivalents go? They went out into the community. They fed the
4 opiate crisis.
5 MR. BRINDLEY: Objection, Judge. That's speculative
6 and demonstrably false.
7 THE COURT: Sustained. Your objection is to the
8 answer --
9 MR. BRINDLEY: Yeah, it is.
10 THE COURT: You know, the jury knows that Mr. Russo
11 was an undercover officer so they didn't go --
12 But, Doctor, please confine your answer to the
13 question and only within your personal knowledge or your
14 opinion, of course --
15 THE WITNESS: Yes, sir.
16 BY MR. JACOBS:
17 Q. You didn't know who Mr. Russo was, right?
18 A. I did not, no.
19 Q. You don't know if he's a legitimate patient or an undercover
20 law enforcement officer.
21 A. I assumed he was a legitimate patient.
22 Q. But you also don't know where the meds went. Maybe he just
23 stashed them, maybe he just threw them away. Who knows.
24 A. I don't know where the meds went.
25 Q. Right. But based on that review of Mr. Russo's medical

1 file, that is, Dr. Szyman's medical file for Mr. Russo, was his
2 treatment of Mr. Russo in his prescribing of controlled
3 substances outside of his professional practice and not for
4 legitimate medical purpose?
5 A. Yes.
6 Q. Let's turn next to Ms. Valdez. Do you have that there?
7 A. I do.
8 Q. And did you review Dr. Szyman's medical file for Ms. Valdez?
9 A. I did.
10 Q. And what was your conclusion regarding Dr. Szyman's
11 treatment of Ms. Valdez and his prescribing of controlled
12 substances to her?
13 A. I concluded it was outside the usual course of medical
14 practice.
15 I did not see indications that the medications were
16 prescribed for a legitimate medical purpose. Specifically, she
17 was under care for 20 months, 20 months of failed opiate therapy
18 in the sense that there was no indication of any improvement.
19 She was prescribed a very, very large amount. Again,
20 up to 1,140 morphine equivalents. The unique thing about this
21 case is that she was referred to Dr. Szyman from the Wisconsin
22 Circuit Court Access -- I assume that's a program -- where it
23 was noted that she had used excessive Percocet and yet her pain
24 had remained way out of control.
25 When she came in her main complaint was knee pain.

1 She indicated she had had a knee replacement. But the workup,
2 the examination did not show any specific deficit. There was
3 just a subjective patient complaint of knee pain.
4 She received significant opiates that did not offer
5 any improvement in her pain. She had at one point five
6 different strengths of OxyContin prescribed all at once, five
7 different strengths all at once.
8 She had her doses escalated over time despite showing
9 no significant improvement. And in the end, after 20 months of
10 failed improvement, she was sent back to jail for violation of
11 parole and shoplifting. And at that point we learn that she had
12 past charges of drug possession, drug paraphernalia, and
13 delivering oxycodone, the very medication that she was being
14 prescribed.
15 Q. Based on your review of the patient file should that
16 information have come as a surprise to the person writing
17 prescriptions for her?
18 A. Well, I like to think that when we exercise as physicians
19 universal precautions, we ask the question of why are you in
20 jail. Because we're interested in the psychosocial aspects of
21 the patient's care.
22 And if the patient was just -- if you were just
23 referred to me from the jail it would make sense for me to ask
24 why are you in jail. That would have to do with the total care
25 of the patient and would modify in all likelihood what I would

1 do for you from a pain management standpoint.
2 Q. And did the patient file include records to indicate why
3 Ms. Valdez had been in jail?
4 And if I could just turn your attention to Exhibit 3.
5 I think it's page 175.
6 (Brief pause.)
7 BY MR. JACOBS:
8 Q. No. I think wrong.
9 A. Actually that -- I'm sorry. I think that maybe does address
10 it in the lower part of that larger paragraph.
11 Q. Well -- I think what I was trying to get at was --
12 This page. I'm sorry, it's page 13. Do you recognize
13 this document from Ms. Valdez's patient file?
14 A. Yes. This was in the patient file, yes.
15 Q. And it indicates that Ms. Valdez was found guilty of
16 conspiracy to deliver THC, a Class C felony here in Wisconsin?
17 A. Yes, that's what it says.
18 Q. And this would have preceded her treatment by Dr. Szyman?
19 A. It would have accompanied the initial visit so he would have
20 been aware of this.
21 Q. And should that have affected a reasonable pain management
22 physician's treatment of a given patient as regards to
23 prescribing opioids or controlled substances?
24 A. Yes, it would affect decision-making and treatment plan
25 formulation.

1 Q. In what way?
2 A. Two factors. One is, she's taking an illegal substance so
3 we have to be concerned about her judgment and whether we can
4 trust her to take any controlled substances.
5 And secondly, not only do we have to be concerned
6 about trust, we have to be concerned about whether she's going
7 to use the medications illegally and divert them in the same
8 manner that she is now under arrest for I will say diverting
9 the -- the marijuana.
10 So we have two major risk factors, two major red flags
11 that would speak against using opioids of any type early on this
12 patient.
13 Q. I'm not sure what you mean by diverting the marijuana.
14 A. Well, perhaps that's a bad choice of words. What I really
15 mean to say is that she was -- I'm looking for that entry one
16 more time.
17 Q. I'm sorry. Sometimes it's just hard to do.
18 No, can't do it.
19 A. That's okay. I think by memory I recall what it said was
20 "conspiracy to deliver THC." So perhaps I was speaking a little
21 bit too loosely.
22 But conspiracy to deliver THC suggests to me that she
23 was selling it, which essentially is diversion. It's an illegal
24 drug so, you know, it's -- so by definition I guess it's
25 illegal.

1 But I would be concerned if I prescribed her a legal
2 drug like oxycodone, that she would sell that as well. That's
3 the point I mean to make.
4 Q. Okay. So that's in her history. How about during
5 Dr. Szyman's treatment of Ms. Valdez, were there any indications
6 that she might be diverting the prescription drugs he was
7 prescribing?
8 A. There are many notes including nursing notes as early as
9 2010, the first part of her care, suggesting that she was
10 overtaking her medications. She was asking for early refill
11 requests. And nevertheless there were continuing prescriptions
12 and escalation of medication.
13 She also has an inconsistent urine drug screen at one
14 point which fails to show her prescribed medication of fentanyl,
15 which should have been an indication that there were problems.
16 Q. Were there any comorbidities that also suggest that
17 prescribing controlled substances, narcotics was not for a
18 legitimate purpose and not within professional practice?
19 A. There were significant comorbidities including obesity and
20 asthma. We would worry about respiratory depression in cases
21 like that.
22 Q. And what type of quantities did Dr. Szyman prescribe for
23 Ms. Valdez nonetheless?
24 A. He continued to prescribe well over a thousand morphine
25 equivalents per day for this patient.

1 Q. And so was Dr. Szyman's prescribing of those controlled
2 substances outside of his professional practice and not for a
3 legitimate medical purpose?
4 A. Yes.
5 Q. Let's move next to Ms. Walt. Did you review Nancy Walt's
6 patient file that Dr. Szyman had -- sorry -- Dr. Szyman's
7 patient file for Ms. Walt?
8 A. I did.
9 Q. And what was your assessment of his treatment, that is,
10 Dr. Szyman's treatment of Ms. Walt?
11 A. Ms. Walt was a 44-year-old woman and she was treated for
12 11 years. And her morphine equivalency got up to as high as
13 well over 3,000, 3,720 morphine equivalents.
14 He had failed therapy during that time. She did not
15 improve. She was taking up to 49 analgesic or pain pills per
16 day, which I would not expect a patient to -- to be able to do
17 on a regular basis.
18 Her main complaint was arthritic knee pain. You
19 simply do not address arthritic knee pain with hundreds and
20 hundreds and hundreds morphine equivalents per day. It just
21 doesn't make sense.
22 Q. Why is that?
23 A. Knee pain, again, as we've talked, is a joint issue. How do
24 we address joint issues? We address joint issues with
25 specialized physical therapy or physical medicine modalities.

1 If the knee is bad enough we might consider a knee
2 replacement or injection of an artificial joint fluid or
3 cortisone in the knee. But we don't prescribe with over a
4 thousand, almost 2,000 morphine equivalents. The way to treat
5 joint pain is with physical medicine options, physical therapy
6 and so on.
7 She manifests -- getting back to the original thought,
8 she manifests risk behaviors. She had early refills requesting
9 additional oxycodone and OxyContin.
10 She was in the emergency room for withdrawal. She
11 took too much of her medication and ran short. She had to go to
12 the emergency room for withdrawals. She was also in the
13 hospital emergency room for overdose. She took too much and had
14 to go in and was treated for overdose. When confronted about
15 some of this she admits to lying about how she takes her
16 medications.
17 So on summary here we have an individual with
18 inconsistent pill counts, early-out medication, ER visits for
19 overdose, ER visits for withdrawal, admissions of lying about
20 her medication, inconsistent urine drug screens, and she has a
21 third-party observation here that the opioid side effects that
22 she's having are related to the opioids and they probably ought
23 to be stopped or at least slowed down.
24 So we have a patient here who is not a candidate for
25 opioid therapy. Too many red flags.

1 Q. Would you expect someone taking that quantity of opioids to
2 have side effects such that they'd be like in a zombie state?
3 A. I would expect it, yes.
4 Q. Would they walk around perhaps looking as if they were
5 drunk?
6 A. Yes. That would be a good explanation. And indeed that was
7 noted. She did not -- well, she exhibited significant side
8 effects of fatigue and sedation or zombie-like effect.
9 Q. So was Dr. Szyman's prescribing of controlled substances for
10 Nancy Walt outside of his professional practice and not for a
11 legitimate medical purpose?
12 A. Yes.
13 Q. Finally, I'd like to have you address the patient file for
14 Chad Wenzel. Did you review Mr. Wenzel's patient file?
15 A. I did.
16 Q. And did you find Dr. Szyman's treatment of Mr. Wenzel to be
17 appropriate?
18 A. I found it to be inappropriate.
19 Q. Could you explain to the jury your assessment?
20 A. Mr. Wenzel is a 30-year-old gentleman. And his primary
21 concern was related to a traumatic amputation of his arm that
22 had occurred years prior as a result of a motorcycle accident.
23 He was under care with Dr. Szyman for five years and
24 at no time during that five years did he show any indication of
25 improvement. He was nevertheless treated with significant

1 amounts of medication, multiple medications up to a dose of
2 2,892 morphine equivalents. Again, a huge amount. Huge amount.
3 He had multiple instances of medication overuse,
4 early-out medication and doctor shopping. Doctor shopping
5 meaning he's getting his medications from multiple doctors.
6 There is in this case multiple third-party
7 notifications of problems. Those third-party notifications came
8 from insurance companies, pharmacies, and the patient's mother.
9 But in all cases they were ignored. As were ignored
10 inconsistent urine drug screens one of which showed active
11 taking of cocaine.
12 So we have a young individual here who's got a history
13 of OWIs, alcohol abuse. He has an admitted history of
14 recreational drug use. He's using illegal substances,
15 marijuana. Doctor shopping. Inconsistent urine drug screens
16 showing cocaine use.
17 He's not a candidate for narcotics. He's addicted.
18 He's a multiple-substance abuser. We would not want to for the
19 sake of the patient give him additional narcotics. It would be
20 fueling the addiction fire.
21 The addiction -- or the opiates use in this case
22 because of his history of alcohol, illegal substance,
23 recreational drug abuse, the use of opiates in this case is not
24 for a legitimate medical purpose. It's outside the usual course
25 of medical care.

1 Q. I want to turn you -- you mentioned third-party warnings
2 that Dr. Szyman received. I want to turn your attention to
3 page 959 of Exhibit 11 that was previously admitted. This is
4 patient note dated November 22nd of 2013. Can you see it up
5 there?
6 A. I can.
7 Q. Can you read to the jury what is contained in Dr. Szyman's
8 medical file for Mr. Wenzel?
9 A. This note indicates that, quote, Mr. Wenzel's mother is
10 listed as okay to contact and she was called. She reports that
11 her son [Indiscernible] -- so this was initiated I presume by
12 the clinic.
13 But she reports that Chad is, quote, slowly getting
14 eaten up by the drugs. He is addicted. He told her the pain
15 pump is doing nothing for him. He had a trial pain pump
16 implanted.
17 He told her he would buy drugs off the street. She
18 feels he is doing this. He told her he does not care about
19 anything anymore.
20 His mother is upset, feels she needs to go for
21 counseling due to her son's issues. She is worried about his
22 welfare as well as the two grandsons that are living with Chad.
23 And leaves a number that Dr. Szyman can call her back.
24 Q. All right. And after Dr. Szyman received that information
25 did he continue to prescribe high levels of controlled

1 substances, opioids, narcotics for Mr. Wenzel?
2 A. He did. Continued to prescribe despite that note and that
3 warning.
4 Q. And I gather Dr. Szyman's office received warnings from
5 other third parties?
6 A. Yes.
7 Q. And based on your review of the patient file and the PDMP
8 records for Mr. Wenzel, was Dr. Szyman's prescribing of
9 controlled substances for Mr. Wenzel outside of his professional
10 practice and not for a legitimate medical purpose?
11 A. Yes.
12 Q. I was wrong, there was one more. I neglected that
13 Ms. Wolf -- I think is the last patient on your summary; is that
14 right?
15 A. That is correct, yes.
16 Q. So if I could turn to that entry. I think I have it now.
17 Did you review the patient file for Ms. Wolf, that is,
18 Dr. Szyman's patient file for Ms. Wolf?
19 A. I did.
20 Q. And did you find Dr. Szyman's treatment in prescribing of
21 narcotics for Ms. Wolf to be appropriate?
22 A. I found it to be inappropriate.
23 Q. And can you explain the basis of your conclusion?
24 A. Ms. Wolf was a 51-year-old woman who indicated that she had
25 shoulder pain and low-back pain. Again, subjective complaints

1 that were never verified. No imaging was done. Physical exam,
2 such as it was, was normal. She declined a referral to an
3 orthopedic doctor, she just wanted narcotics.
4 So she received narcotics for four years. Four years
5 of unsuccessful treatment. Her morphine equivalency got up to
6 at least 800, perhaps higher. 800 morphine equivalents per day.
7 Again, well above the 100 red level -- red zone.
8 She had significant anxiety and depression. I wanted
9 to talk about the risk factors on this patient for just a
10 moment. She had significant anxiety and depression that
11 resulted in all likelihood from the history of preadolescent
12 sexual abuse.
13 Q. How do you know that?
14 A. That's in the chart. It's in the chart.
15 Q. Why is that significant?
16 A. We are unfortunately aware that preadolescent sexual abuse,
17 particularly in women, young girls, is probably one of the major
18 predictive factors for drug abuse.
19 If we look at the individuals, let's say the women who
20 are participating in a drug rehab program, we are likely to find
21 in excess of three-quarters of them with the history of
22 preadolescent sexual or physical abuse.
23 Other indications -- the studies are hard to do, but
24 other indications suggest that perhaps the risk of preadolescent
25 sexual abuse will increase the risk of drug abuse by four or

1 five times.
2 If we're talking about red flags, if we're talking
3 about as a doctor how to best help the patient and not make it
4 worse particularly from a pain management standpoint, we have to
5 identify risks that have to do with emotional, physical or
6 sexual abuse, particularly in women -- also men, but also in
7 women.
8 In this case her history, preadolescent sexual abuse
9 and subsequent anxiety and depression, is consistent with the
10 pain that she complains of. It's a vague pain. It's a vague
11 pain that nothing on physical exam or imaging shows broken. She
12 had an MRI of her low back, it's normal. It's normal.
13 So again, she's suffering. She's suffering from pain
14 as a result of an emotional trauma. And that needs to be
15 identified. Why does that need to be identified? Because
16 opiates are going to make that worse. Again, make that worse.
17 But she was prescribed opiates right off the bat.
18 Significantly escalated. She had inconsistent urine drug
19 screens, she had pill-count inconsistencies. Doctor shopping
20 behaviors were documented. She was at one point terminated by
21 Dr. Szyman, terminated from care, but he continued prescribing
22 for the next seven months anyway. And I don't understand that.
23 He terminated her from care but kept prescribing opiates. So
24 there's an inconsistency there.
25 Q. And I'd also like to show you what's been previously

1 admitted as page 226 of Exhibit 6 -- I think that's right. This
2 is a note, again [Indiscernible].
3 Do you recognize this note in Dr. Szyman's patient
4 file for Ms. Wolf?
5 A. I do.
6 Q. And can you tell the jury, what does it say?
7 A. It says: Received a call from Manitowoc metro drug unit
8 detective that they received information from another detective
9 through a confidential informant that patient is selling her
10 Morphine-ER, extended release, hundred-milligram tabs. She last
11 refilled this on 12/10/14, and gets 210 tablets. They are
12 reporting that she sells them for $4,000 a month.
13 So this is a report basically from the police, from
14 the drug unit.
15 Q. And did Dr. Szyman after receiving this note continue to
16 prescribe narcotics to Ms. Wolf?
17 A. Yes, he continued to prescribe.
18 Q. Based upon your review of the patient file was Dr. Szyman's
19 describing of controlled substances to Ms. Wolf outside of his
20 professional practice and not for a legitimate medical purpose?
21 A. Yes.
22 MR. JACOBS: Judge, that's all I have for this
23 witness.
24 THE COURT: Okay. Mr. Brindley?
25 MR. BRINDLEY: Thank you, Your Honor.

1 CROSS-EXAMINATION
2 BY MR. BRINDLEY:
3 Q. Dr. King, people who suffer from alcohol addiction issues
4 can also have pain, right?
5 A. Yes.
6 Q. People who use marijuana can also have pain, right?
7 A. They can be suffering from pain, yes. It's our job to
8 determine what's the source of that pain.
9 Q. All right. My question is -- try to limit it just to the
10 question I ask. I'm asking you, people who use marijuana can
11 have pain. That's true, isn't it?
12 A. Yes.
13 Q. And people who have been in jail can have pain, right?
14 A. Yes.
15 Q. People who sold marijuana can have pain, right?
16 A. Yes.
17 Q. People who have used cocaine or have a history of cocaine
18 use can have pain, right?
19 A. Yes.
20 Q. People who have had preadolescent sexual abuse, they can
21 have pain, right?
22 A. Yes.
23 Q. And people who have been accused of selling their pain
24 pills, those people can actually still have pain, right?
25 A. Yes.

1 Q. Pain is a subjective sensation, right?
2 A. Pain has a subjective sensation, correct.
3 Q. Okay. And the person who can best advise on how a
4 medication impacts his or her pain is the person feeling the
5 pain. Fair to say?
6 A. No, that's incorrect.
7 Q. You think that someone other than the person feeling --
8 well, let me change the form of my question.
9 A person who's actually feeling the pain and takes
10 medication, that person then feels less pain, that person could
11 report that, right?
12 A. Would you like me to explain why I think that's incorrect?
13 Q. No, I'd like you to answer the questions and only the
14 questions I ask. All right?
15 A. Okay.
16 Q. My question is this. A person who is in pain and takes
17 medicine and then feels less pain can report that, right?
18 A. Can report that?
19 Q. Yes.
20 A. I don't understand what you mean.
21 Q. Report that to a doctor. Report that to a jury.
22 A. Sure. That's what we call a subjective statement, yes.
23 Q. Yes. The subjective statement of the person feeling the
24 subjective pain. Right?
25 A. Correct.

1 Q. All right. And long after -- you were talking about -- I
2 believe you were talking about Mr. Conway and why would he be so
3 loyal to Dr. Szyman because he'd still want to be keeping,
4 getting his medications, but Dr. King, long after these patients
5 stop seeing Dr. Szyman at all, long after Dr. Szyman had any
6 ability to prescribe medications for them at all, you never --
7 have never heard how those people would under oath describe the
8 impact of his treatment on their pain. You haven't heard that,
9 have you?
10 A. I was not present during the initial testimony on that,
11 correct.
12 Q. Okay. And you didn't talk to any of these people after --
13 long after they had anything they could get from Dr. Szyman
14 after he stopped treating, you haven't talked to these people
15 about their interactions with him and how it may have helped
16 them, have you?
17 A. I have not, no.
18 Q. Okay. You would agree with me certainly that some doctors
19 are more compassionate than others, right?
20 A. Some doctors are more compassionate than others, I would
21 agree with that.
22 Q. Some doctors are more forgiving of patients' actions than
23 others, right?
24 A. I would agree with that.
25 Q. Now, Dr. King, you have certainly an impressive amount of

1 medical credentials, right?
2 A. (No audible response).
3 Q. You would agree with that, right? It's pretty substantial.
4 A. I'm very proud of them, yes.
5 Q. Okay. And you got your original medical degree from Indiana
6 University, right?
7 A. Correct.
8 Q. And then you got your residency at the University of
9 Washington, right?
10 A. Correct.
11 Q. And you know that Dr. Szyman, he also has a medical degree,
12 right?
13 A. Yes.
14 Q. And you said that you were board certified in
15 anesthesiology, right?
16 A. That's correct.
17 Q. Board certification you said is the gold standard by which
18 one's peers in the medical community acknowledge expertise,
19 right?
20 A. Correct.
21 Q. And you know that Dr. Szyman was also board certified in
22 anesthesiology by his peers, right?
23 A. I'm not aware of whether he was or was not.
24 Q. About you have more board certifications than just
25 anesthesiology, right?

1 A. Yes.
2 Q. You're board certified in pain management, right?
3 A. Correct.
4 Q. You're board certified in pain medicine. That's different,
5 right? The management and the medicine, those two, those are
6 two different tests you had to take, right?
7 A. Two different exams, correct.
8 Q. Yes. And you're board certified in addiction medicine too,
9 right?
10 A. Correct.
11 Q. Okay. So you have a lot more education and certification
12 than most practitioners of pain management, right?
13 A. Probably so.
14 Q. And your opinions are impacted by your degree of education
15 and your degree of certification in your field, right?
16 A. No.
17 Q. Your opinions aren't impacted by your degree of education?
18 A. I'm not sure what you mean by impact. I'm testifying as to
19 standard of care, not as to my opinion with regard to the
20 highest level of care.
21 Q. You're testifying about your opinion about the standard of
22 care, right?
23 A. Correct.
24 Q. Okay. And certainly your opinions are impacted by your
25 education, right?

1 A. My education helped give me an understanding, a perspective,
2 but, again, I don't know what you mean by "impacted."
3 Q. Okay.
4 A. My opinions are based on what the standard of care is at
5 this time for these patients.
6 Q. But you were giving us your opinion on the standard of care,
7 right?
8 A. I'm sorry, say that again?
9 Q. I'll come back to it. I'm going to come back to it.
10 You would agree --
11 Well, I guess I'll say it this way. You've provided
12 your opinion on what the standard of care should be in treating
13 pain management patients, right?
14 A. That's correct.
15 Q. You and I can agree, Dr. King, though, that sometimes
16 doctors have differing opinions about how treatment should be
17 done, right?
18 A. Treatment can vary but standard of care does not.
19 Q. Doctors have different opinion -- different philosophies
20 about how to treat patients sometimes, don't they?
21 A. Philosophies can change but standard of care does not.
22 Q. Wait. The question I'm asking is about philosophy. You
23 keep talking about something else. I'm talking about
24 philosophies regarding how to treat patients. Philosophies
25 about how to treat patients, doctors can have different ones,

1 right?
2 A. There are different philosophies, different approaches that
3 could be acceptable within the standard of care.
4 Q. Yes. And you keep talking about the standard of care. And
5 you talked about what you said were requirements, requirements
6 that you would have to do at each appointment when a pain
7 patient comes in, right?
8 A. I referenced the four A's, if that's what you're referring
9 to.
10 Q. And you called them requirements, right?
11 A. I don't have an independent recollection of what I said, but
12 certainly they are the four elements. They go out into doing
13 inpatient review on each follow-up.
14 Q. And you're saying in your opinion those are the required
15 things you need to do, right?
16 A. Well, those are standard of care items.
17 Q. That's your opinion those are the things you need to do,
18 right?
19 A. No, that's not -- I'm expressing my opinion based on the
20 literature. The literature as I indicated have shown that those
21 are standard-of-care items that need to be addressed.
22 Q. Okay. So you're telling me about the literature. I'm
23 asking so your opinion is these are the things that need to be
24 done, right?
25 A. Based on a review of the literature and practice standards,

1 yes.
2 Q. All right. And you talked about the requirements for opioid
3 prescription decisions, right?
4 A. I'm not sure what you're referencing.
5 Q. Well, doctors make decisions about how much opioid should be
6 prescribed and you talked about the amount that was the yellow
7 zone and the red zone. Do you remember all that?
8 A. Well, I remember discussing that and teaching about that,
9 yes.
10 Q. I'm talking about your testimony today. I'm not talking
11 about anybody getting taught. I'm talking about right now here
12 in this court what you talked about is the red zone and the
13 yellow zone and what amounts can be prescribed, right?
14 A. Clearly discussed those items, of course.
15 Q. Okay. And you are giving us -- you're telling us that those
16 things -- that's what you have to do, that's the standard of
17 care, right?
18 A. Well, I am giving him my opinion on the standard of care
19 based on the literature and practice, yes.
20 Q. Your opinion -- informed by literature and practice and
21 whatever else, your opinion is that this is what the amount
22 should be in terms of prescription, right?
23 A. That's What's out there supporting -- supporting the
24 [Indiscernible], yes.
25 Q. Okay. But, Dr. King, there is no written set of standard

1 requirements or guidelines that all pain management doctors have
2 to agree to before they prescribe pain medication, is there?
3 A. Well, you're asking me if there is a specific set of
4 requirements that's out there, just one set we can refer to, and
5 the answer is no.
6 Q. Okay.
7 A. We compile those from the current literature, from current
8 consensus and from publications and from training.
9 Q. Right so --
10 A. And so you pull those together, then I give you my opinion
11 as to what the standard of care is.
12 Q. All right. Are you done?
13 So you rely on the literature and your experiences and
14 your I suppose discussions with your colleagues in order to come
15 up with your opinion about what the standard of care is, right?
16 A. Well, you keep emphasizing "your" as if this is something
17 that's unique or isolated.
18 The reality is our literature, our publications, our
19 journals, our meetings across the country, our communal inputs,
20 our consensus is broad. It's across the U.S. It's not just
21 something that I do in my clinic.
22 Q. All right. But you're the only one here testifying for us
23 today, right?
24 A. (No audible response.)
25 Q. In terms of experts sitting up here talking --

1 A. I don't know if they have other experts or not, but
2 certainly I'm here.
3 Q. You didn't bring with you any literature that you're putting
4 into evidence and reading to the jury, right?
5 A. I can certainly quote the literature if you like.
6 Q. I asked whether you brought it to put into evidence and read
7 to the jury. Did you or not? I take it that you did not.
8 A. I did not bring it to put into evidence, no.
9 Q. All right. Then what we're talking to you is about your
10 opinion. You're the person who is here, right?
11 A. I'm not sure where you're going. My opinions are based on
12 the current literature and standards that were put forth by
13 individuals, not myself. I'm just compiling them and telling
14 you what they say.
15 Q. So you're telling me what other people say.
16 A. I'm telling you what the current literature and experience
17 and consensus says. I'm telling you what the Federation of
18 State Medical Boards says. I'm telling you what medical boards
19 say. I'm telling you what the American Board of Anesthesiology
20 says. I'm telling you what the American Pain Society says, what
21 the American Academy of Pain Management says, what the American
22 Board of Addiction Medicine says.
23 Those statements, those white papers, those practice
24 items are all consistent and I am -- having reviewed those,
25 that's the opinion that I'm giving you.

1 Q. Okay. But you didn't bring any of that stuff with you so
2 we've gotta just rely on you, right?
3 A. I can give you the quotations and you can look them up if
4 you like. I mean that's a voluminous amount of information.
5 But I could certainly very specifically tell you what those
6 papers are.
7 Q. All right. Okay. So in your view -- so no doctors disagree
8 with your assessment on high-dose opioid treatment; is that
9 right?
10 A. I'm telling you that a prudent physician would not use these
11 doses.
12 Q. No, no, I'm not talking about any particular doses. Are you
13 telling me that no -- there's no group of doctors out there that
14 have a different opinion about the use of high-dose opiates than
15 what you're saying? Is that really what you're saying?
16 A. There clearly are doctors out there who consider it
17 differently and that is some of the problem that we're wrestling
18 with.
19 Q. Okay. So there is a difference of opinion out there, right?
20 A. Well, we wouldn't be here today if there were not a
21 difference of opinion.
22 Q. Okay. And one doctor may have one opinion and another one
23 may have another. That's always true, isn't it?
24 A. Well, again, I think you're trying to oversimplify that.
25 We're talking about standard of care. We're not talking about

1 opinions.
2 Q. Well, you said you were giving us your opinion on the
3 standard of care just a minute ago I think.
4 A. Yes. Based on --
5 Q. Yeah.
6 A. -- literature, white papers --
7 Q. Right.
8 A. -- professional agencies and consensus.
9 Q. Okay. Well, you know that almost every one of the patients
10 who came to Dr. Szyman were referred to him by another doctor,
11 right?
12 A. Yes. I'm aware of that.
13 Q. And a referring is when one doctor recommends a patient to
14 another doctor, right?
15 A. For evaluation, correct.
16 Q. Okay. Now, you're a doctor, right?
17 A. (No response.)
18 Q. Obviously. Yeah?
19 A. You're the one that said things about my credentials so I
20 assume you know I'm a doctor.
21 Q. Right. That's right. I do. It's true. And as a doctor,
22 you would not refer one of your patients to another doctor that
23 you thought was some renegade that was doing things outside the
24 normal procedure, would you?
25 A. I would not normally do that, no.

1 Q. Okay. You, in coming up with your evaluation of
2 Dr. Szyman's treatment, you never spoke or consulted with
3 Dr. Jacoby who made multiple referrals to Dr. Szyman, did you?
4 A. I did not.
5 Q. So you never sought input from Dr. Jacoby about Dr. Szyman's
6 prescriptions or how they collaborated in terms of treatment,
7 did you?
8 A. I recognize the name Dr. Jacoby. I don't have an
9 independent recollection as to whether his past medical records
10 were in the chart I reviewed. So I can't answer that without
11 going back to look.
12 Q. No. My question is you never sought input from Jacoby. You
13 didn't.
14 A. Well, that would depend whether the past medical records
15 from Dr. Jacoby were in the chart.
16 Q. You never talked to Dr. Jacoby about this, right?
17 A. I did not talk to Dr. Jacoby, no.
18 Q. And you never tried to speak to Dr. Demetrius (phonetic) who
19 referred patients to Dr. Szyman, right?
20 A. Correct.
21 Q. You never tried to speak to Dr. Green who referred patients
22 to Dr. Szyman, right?
23 A. Correct.
24 Q. You never tried to speak to Dr. Augustine who referred
25 patients to Dr. Szyman, right?

1 A. I'll simplify it and tell you I didn't talk with any of the
2 referral doctors.
3 Q. Okay. So you didn't get input from any of those people in
4 terms of actually speaking to them about what Szyman's
5 procedures were like when dealing with patients, did you?
6 A. Well, let's parse that. I did not speak with them, but
7 there are past medical records in the chart to some degree that
8 address what their opinions are and were.
9 Q. Okay. So you're saying you didn't speak to them about their
10 experiences with them and how he handled the patients and the
11 prescriptions, right?
12 A. As I indicated, I didn't speak with any referral doctors. I
13 have not spoken with Dr. Szyman either.
14 Q. I'm going to come to that in a little bit. But, in fact,
15 there was another doctor based on -- I would think that based on
16 your review you know that there was actually another doctor that
17 was working with him at his pain clinic. Did you know that?
18 A. It was one instance where I saw intake of one of the
19 patients was seen by a doctor other than Dr. Szyman.
20 Q. And that would be Dr. Klapp (phonetic), does that sound
21 right to you?
22 A. I don't have an independent recollection of what that
23 doctor's name is. Or was.
24 Q. If there was a doctor working in the same pain clinic as
25 Dr. Szyman, that doctor would have a lot of insight into

1 Dr. Szyman's methods and the adequacy of how he was prescribing
2 things, how it was working out, wouldn't they?
3 A. I have no idea whether it would or would not. I don't know
4 who the doctor was. I don't know if he was a partner, I don't
5 know if he had been there for a while and how well he knew
6 Dr. Szyman or his treatment protocol. So I wouldn't know how to
7 answer that.
8 Q. And you didn't try to speak to anyone else that worked at
9 that pain clinic either, did you?
10 A. Well, it wasn't a question of trying. The chart -- I was
11 given the medical charts and I didn't have interviews as part of
12 the process.
13 Q. Well, you are an expert, you get to decide how you're going
14 to do your evaluation, right?
15 A. No, I'm actually -- I evaluate the information that's given
16 to me. If there's critical information missing I might ask for
17 it, request it, but I do not and never have had the ability to
18 interview the doctor or other doctors involved in the case.
19 Q. All right. So you -- your -- your information is limited
20 only to what you're given then, right?
21 A. That's right. As I say, I might request additional
22 information if it looks to be critical, but I do not have the
23 opportunity to interview the doctor.
24 Q. Okay. And so then when you're getting this information, the
25 only information that you're able to review, you're getting that

1 directly from the prosecutors who are prosecuting Dr. Szyman?
2 A. No, I'm getting the information from the medical chart and
3 the PDMP data in this case.
4 Q. And where did you get that?
5 A. That was given to me by the court, by the prosecutor.
6 Q. By the prosecutors who are prosecuting Dr. Szyman.
7 A. Yes.
8 Q. All right. So you also -- you said you didn't talk to any
9 referral doctors. There were a number of these patients that
10 had psychiatrists they were working with at the same time they
11 were working with Dr. Szyman, and I take it you didn't discuss
12 anything with those psychiatrists either about how all this was
13 going.
14 A. As I indicated, Counselor, I haven't talked with any
15 physicians on this case. That's not part of what I'm privy to.
16 Q. But you would agree -- even though you didn't talk to any of
17 the referral doctors, you have said today that the amounts of
18 prescription opiates that Dr. Szyman was giving were wildly
19 outside of professional norms, right?
20 A. That's correct, yes, for the reasons that I outlined.
21 Q. Yes. But you -- nonetheless, you have to agree that
22 multiple, multiple doctors, many doctors were referring patients
23 to this guy, right?
24 A. Well, let's put it this way. They are referring patients
25 for reasons that I don't know. In some cases they were

1 frustrated because that was indicated in the medical record that
2 no progress was being made.
3 In many cases the patient had seen multiple pain
4 doctors and failed. So this was in many ways a big
5 [Indiscernible] of failed opiate trial that goes back many
6 years.
7 So it would not make sense from Dr. Szyman or any pain
8 management doctor's standpoint to simply repeat the same
9 process. It's a little bit like the definition of insanity,
10 knocking your head against the wall and expecting different
11 results.
12 Q. I'm lost. Maybe you didn't understand the question. Here's
13 the question. The question was, you can't dispute and you don't
14 dispute the fact that there's all kinds of doctors out there
15 that made the decision to refer to him, to Dr. Szyman, right?
16 A. Well, I think we've established that most of the patients
17 were referred from other doctors.
18 Q. Okay.
19 A. I'm not sure how you want to review that once again, but
20 that's obviously the case.
21 MR. BRINDLEY: Judge, I would ask that you instruct
22 the witness to try to limit himself just to the question that's
23 being asked.
24 THE COURT: That's the way it's done in court,
25 Dr. King.

1 THE WITNESS: Yes, sir.
2 THE COURT: It's not like the classroom where you tell
3 the whole story. So if there's something that you can't
4 explain, Mr. Jacobs will have a chance to come back and ask you
5 some further questions. But to move things along, listen
6 closely to the question and just answer the question.
7 THE WITNESS: Yes, sir.
8 THE COURT: Thank you.
9 BY MR. BRINDLEY:
10 Q. All right. Now, you said that the combination of
11 medications that Dr. Szyman was prescribing were dangerous in
12 many situations, right?
13 A. That's correct.
14 Q. And pharmacists. You'd agree with me that pharmacists are
15 trained to identify what combinations of medicines are
16 inherently dangerous, right?
17 A. Correct.
18 Q. And pharmacists have a duty not to be giving out inherently
19 dangerous combinations of medicines, right? I thought I heard
20 you say that.
21 A. Essentially correct, yes.
22 Q. All right. PDMP records you said showed what the
23 combinations of medicines are, right?
24 A. Correct.
25 Q. And pharmacies have PDMP records, right?

1 A. Yes.
2 Q. And you have seen from your records, though, that for
3 decades -- well, yeah, for some of these people for decades --
4 over a decade -- Dr. Szyman's opiate prescription, combination
5 prescriptions were filled at pharmacies, right?
6 A. Yes.
7 Q. Now, as a doctor, Dr. King, you're also very familiar with
8 insurance companies, right?
9 A. Yes.
10 Q. They're not always the most easy thing to work with in your
11 field I take it. In your experience when a treatment is
12 experimental or unusual or particularly nonstandard, insurance
13 companies will often refuse coverage, true?
14 A. That would be a reasoning they would use, yes.
15 Q. Okay. And you talked about Dr. Szyman's prescriptions being
16 wildly outside of normal practice, but you would agree with me
17 that insurance companies were paying on his patients'
18 medications repeatedly, right?
19 A. In some cases no, in some cases yes.
20 Q. In many cases, in the vast majority of cases they were
21 filling the prescriptions, right?
22 A. I didn't tally it up. I did not look at who paid for the
23 prescriptions so I can't honestly say they were being paid by
24 insurance companies.
25 Q. Okay. It wouldn't surprise you to find out though that

1 insurance companies were continually approving these
2 medications, right?
3 A. That could be the case. I just simply don't know.
4 Q. All right. Now, in coming to your opinion you reviewed
5 these medical records but you did not -- you did not consult
6 with the group of other pain experts who also looked at these
7 records to see if they would adopt the same view that you had
8 about Dr. Szyman.
9 A. That's correct.
10 Q. Okay. So you can't give us the consensus viewpoint of any
11 other doctors or a group of doctors that reviewed these same
12 records, can you?
13 A. Well, not that reviewed these same records. I can give you
14 the names of other groups that reviewed similar cases, yes.
15 Q. No, no, not similar cases. Dr. Szyman and his records.
16 A. No, no one else reviewed these cases except myself.
17 Q. And you consider yourself to be an objective expert in this
18 area?
19 A. I do.
20 Q. You have served as an expert and consultant multiple times,
21 right?
22 A. Yes.
23 Q. In federal court before, right?
24 A. Federal court once before, yes.
25 Q. As a testifying witness once before?

1 A. Correct, yes.
2 Q. Okay. But you've been a consultant on criminal matters in
3 working with the federal court system on multiple occasions,
4 right?
5 A. In cases that did not go to court but had plea testimonies,
6 yes.
7 Q. And in every single one of the times that you served as an
8 expert or a consultant in a federal criminal matter you worked
9 for the prosecuting authority in the Department of Justice,
10 right?
11 A. For the federal cases, yes.
12 Q. Okay. And with respect to the state criminal cases that you
13 worked on, in each of the times that you worked on state
14 criminal cases you worked for the Office of the Attorney
15 General, right?
16 A. That's correct.
17 Q. Office of the Attorney General is a prosecuting body, isn't
18 it?
19 A. Correct.
20 Q. You have done expert and consultant work for the Federal
21 Bureau of Investigation, right?
22 A. To the extent they were parties of a federal suit, yes.
23 Q. And so you worked for them.
24 A. I worked with them in the sense that I worked for the
25 Department of Justice, but the FBI was participating in the

1 investigation and providing material.
2 Q. Okay. And you've also consulted with the Drug Enforcement
3 Administration, right?
4 A. Correct.
5 Q. Drug Enforcement Administration is the same body that's been
6 involved in the investigation of Dr. Szyman. ; is that true?
7 A. I assume so, yes. Again, I'm not privy to that information.
8 But that would sound correct.
9 Q. And obviously you don't do this for free, you have to be
10 paid for your consulting, right?
11 A. Correct.
12 Q. How much are you getting paid for this?
13 A. My hourly fee is $350 an hour. And for a day of testimony
14 it's $5,000.
15 Q. And so you have been repeatedly paid these fees by the
16 federal government and the Department of Justice, the
17 prosecuting authority, right?
18 A. I've been paid over the last several years, yes.
19 Q. You have never worked in a criminal case for a defendant or
20 defense attorney who's defending a doctor, have you?
21 A. From a federal and state standpoint, no.
22 Q. And before you came to give your testimony about your
23 opinions in this case you did not have those opinions peer
24 reviewed by someone, a medical expert who didn't have a history
25 of testifying for the prosecution repeatedly, did you?

1 A. I'm not sure what you're asking. I obviously could not
2 share these files with anyone else, so I logically would not
3 have gotten someone else's opinion on the topics since I
4 couldn't share the files.
5 Q. Who told you you couldn't share them?
6 A. I think the -- the situation is such that these charts are
7 closely guarded from a confidentiality standpoint and they're
8 not to be shared.
9 Q. So you didn't have your opinion evaluated by anyone that
10 doesn't have a history of getting paid by the federal
11 government, right?
12 A. (No audible response.)
13 Q. True?
14 A. True.
15 Q. All right. So you have given a number of -- and you have
16 been paid to provide many presentations and seminars in the
17 past, right?
18 A. Some of the seminars I'm paid for. Probably over half of
19 them I'm not.
20 Q. Okay. So some of them you're paid for, some you are not.
21 But you've done a bunch of presentations and seminars that are
22 listed here on your credentials, your curriculum vitae, right?
23 A. That's correct.
24 Q. You gave a symposium speech called "Pain Clinic Fraud," a
25 symposium put on by the International Association of

1 Investigation Units; is that right?
2 A. That's correct.
3 Q. You did a workshop entitled, "Drug Diversion" put out by the
4 Kentucky State Police, right?
5 A. I participated in that, yes.
6 Q. You participated in a presentation called "Investigation of
7 Prescription Drug Diversion" for something called the Public
8 Training Course, right?
9 A. Correct.
10 Q. You presented a presentation called "Forensic Approach to RX
11 Drug Diversion," the Annual Association of Insurance Fraud
12 Investigators, right?
13 A. Correct.
14 Q. You did a presentation on "Pharmacology of Proper Opiate
15 Use" at the Drug Investigators Annual Seminar, right?
16 A. I'm not sure which one that is, but --
17 Q. Does that sound right?
18 A. (No audible response.)
19 Q. Do you have your CV up there?
20 A. I do not, no.
21 THE COURT: We're giving it to him.
22 THE WITNESS: Thank you.
23 BY MR. BRINDLEY:
24 Q. Just take a look at the bottom of page 4.
25 THE COURT: This is exhibit what now?

1 MR. BRINDLEY: This is 104, Judge.
2 BY MR. BRINDLEY:
3 Q. Let's see. And the one I'm looking at here is the one
4 that's called "Pharmacology of Proper Opiate Use" and that was
5 the Drug Investigators Annual Seminar.
6 A. That's correct. Indiana Office of the Attorney General,
7 yes.
8 Q. You gave a presentation called "Drug Diversion For Law
9 Enforcement" at some law enforcement lecture series, right?
10 A. If you could point out where that is.
11 Q. Oh, yeah. It's right -- it's the next one underneath.
12 A. Oh, yes.
13 Q. Okay. And then if you go down toward the bottom, you did a
14 presentation called "Role of Medical Expert in Drug Diversion
15 Cases" put on by the annual -- the Attorney General's --
16 four-day Attorney General's Prescription Drug Abuse Symposium,
17 right?
18 A. That's right.
19 Q. That was the attorney general again, right?
20 A. Ah --
21 Q. Just a minute ago you had said that --
22 A. It was sponsored by them, yes.
23 Q. All right. You gave a presentation called "A
24 Physician's" -- go on to the next page -- presentation called "A
25 Physician's Perspective" at the Third Annual Attorney General's

1 Prescription Drug Abuse Symposium, right?
2 A. Correct.
3 Q. So you've done a lot of work giving presentations,
4 symposiums associated with law enforcement and the attorney
5 general, right?
6 A. Under the auspices of the attorney general. Most of those
7 were presented to larger audiences where there were social
8 services, other doctors and the lay public. The Attorney
9 General's Office in Indiana has been very active in an outreach
10 program to lecture and educate all stakeholders in the opiate
11 crisis.
12 Q. So you've done a lot of these things with the attorney
13 general and you've done a lot of them at their -- occurring at
14 functions for law enforcement it appears.
15 A. Well, under their auspices. It was presented to many
16 stakeholders.
17 Q. All right.
18 A. And then in some cases it was presented specifically to law
19 enforcement.
20 Q. Okay. Now, law enforcement and the attorney general, these
21 are people who investigate and prosecute doctors, right?
22 A. Correct.
23 Q. Now, if we wanted to -- you'd agree with me that if we
24 wanted to get an objective opinion about a drug, it would be a
25 bad idea to obtain that opinion from someone who was regularly

1 paid by the company that makes the drug, right?
2 A. I don't know that it would be a bad idea, but one would
3 always look at the circumstances.
4 Q. It would create what we might call a "fox in the henhouse"
5 problem, right?
6 A. Well, I think you're saying that too strongly. I still
7 think there can be legitimate opinions put forth, but one would
8 want to be aware of that for sure.
9 Q. Okay. Now, you've given all these -- you gave all these
10 lectures here listed in your CV that I have mentioned that have
11 connection to the attorney general or to law enforcement in some
12 way. But outside of one occasion at the Indiana University
13 School of Medicine, outside of one occasion none of the
14 presentations and seminars that you have listed here, there's
15 not any -- about opiate use or standard care for opiate use,
16 there's none of those that occur at any university or
17 institution of higher learning that are listed here at all, are
18 there?
19 A. No, that's not true. Basically I give a lot of lectures to
20 medical groups. They aren't all listed here. But as a for
21 instance, I lectured at the annual meeting of the American
22 Academy of Family Practice --
23 Q. Uh-huh.
24 A. -- in 2013, to educate them about appropriate opioid use.
25 Q. I'm talking about universities, places of higher learning.

1 Universities, medical schools. Like the one on here about you
2 telling -- giving your expert opinions about opiates. Outside
3 of your alma mater Indiana University one time.
4 A. Well, I don't do a lot of lecturing within the university
5 itself. They typically maintain those with their own on-site
6 staff.
7 Q. So then you have not done much lecturing, you haven't done
8 any lecturing at universities on these opinions about opiates.
9 Is that what you're saying?
10 A. Well, as you point out I was --
11 Q. In that one sentence.
12 A. And that was a critical instance. I came in to talk to
13 third- and fourth-year medical students about the proper use of
14 opioids at Indiana University.
15 Q. Where you graduated.
16 A. Correct.
17 Q. Yeah. And it says in the first page of your CV here, it
18 says that you are an affiliated physician at the University of
19 Chicago, right?
20 A. Of the University of Chicago Care Network, yes.
21 Q. But you've never been asked to provide any of your opinions
22 about opiates at the University of Chicago either, have you?
23 A. Not as a formal lecturer. However, I worked shoulder to
24 shoulder with the orthopedic doctors in the University of
25 Chicago in the same clinic. So there are many discussions we

1 have. Not formal lectures, but many discussions and
2 consultations that go on during the course of a normal clinical
3 day.
4 Q. Okay. Medical publications are often peer reviewed, right?
5 A. Correct.
6 Q. And what that means is you write a publication with your
7 opinions, a group of peers look at it, approve it, and then it
8 gets published, right?
9 A. Correct.
10 Q. Okay. Now, you on your CV here, you list publications,
11 medical publications that you have, right?
12 A. Actually that's a typo. Those are not medical publications.
13 That's since been changed to just publications.
14 Q. So these are all your publications.
15 A. Such as they are, yes.
16 Q. And you have two publications in something called Ocean
17 Navigator. Right?
18 A. Correct.
19 Q. One called "Sleep Cycle at Sea" and one called "Surviving an
20 Alaskan Storm," right?
21 A. Correct.
22 Q. Neither one of those are presenting opinions about opiates
23 or standards of care, are they?
24 A. No.
25 Q. And then you have two others that appear to be about -- some

1 obscure medical research points I think. Is that right?
2 A. Well, I don't know that -- I work with those, I'm not sure
3 I'd classify it as obscure. But it's part of basic science,
4 basic biophysical research that was carried on during my early
5 training.
6 Q. And none of those have anything to do with opinions on
7 opiates, though, do they?
8 A. That's correct.
9 Q. Dr. King, you would agree with me --
10 MR. BRINDLEY: Judge, I'm about to start a whole other
11 subject here. So do you want to stop now?
12 THE COURT: Well, approach.
13 (Non-recorded discussion at side bar.)
14 THE COURT: Okay. This is our breaking time. We're
15 going to stick to it. Mr. Brindley has some additional areas
16 and sometimes if you give him a night to gather his thoughts you
17 get something like yesterday over almost where it's much
18 shorter. But we certainly want to, you know, him to have a full
19 opportunity to question Dr. King.
20 So we'll be in recess. Have a safe journey, but don't
21 forget not to discuss the case with anyone. And avoid media
22 accounts as well. So keep doing that.
23 You can leave the -- well, take them to the jury room
24 because there might be some discussion of them again tomorrow.
25 So leave them in the jury room with your notes, the exhibits

1 that you have -- or the exhibit that you have. Okay?
2 Nine o'clock. Right. Have a good evening, safe drive.
3 (Jury out at 4:58 p.m.)
4 THE COURT: Dr. King, I hope you don't mind staying
5 overnight.
6 Counsel, anything to put on the record?
7 MR. BRINDLEY: I don't think so, Judge, no.
8 MR. JACOBS: Do we know how many witnesses we expect?
9 Because this is our last witness, Judge.
10 THE COURT: Okay.
11 MR. BRINDLEY: Judge, we will have actually three.
12 One long witness which will be Dr. Szyman. His nurse, Linda
13 Kramer will be here to testify tomorrow. And I may -- I'm
14 thinking I will -- one of the witnesses the government
15 originally was on their list was this man Dabian Peterson.
16 We've been in touch with Mr. Peterson. Sounded like he's
17 willing to testify for the defense and we may call him as well,
18 but that won't be a long witness.
19 THE COURT: Okay. Tomorrow if we finish early and
20 particularly I'd like to go over jury instructions. You
21 submitted a joint instruction on the substantive offense. I've
22 been looking at this area some, and do you both have access to
23 Westlaw?
24 MR. JACOBS: Yeah.
25 MR. BRINDLEY: Yes, Judge.

1 THE COURT: Okay. Take a look at *United States vs.*
2 *Werther.* It's a unpublished decision out of the Eastern
3 District of Pennsylvania. It has a jury instruction in
4 precisely this case and it's at 213 WL 5309451. And it combines
5 the substantive discussion of the elements but also with the
6 knowingly element and the good faith -- a good faith element
7 that I think may apply here.
8 But I want you to take a look at it. I've been
9 looking at it and I think it might be at least a good discussion
10 point.
11 MR. BRINDLEY: Thank you, Your Honor.
12 MR. THOMPSON: Could you read that number one more
13 time? 213 Westlaw?
14 THE COURT: 213 WL 5309451. 5309451.
15 MR. JACOBS: Thank you, Your Honor.
16 THE COURT: This is from September 23rd, 2013.
17 Werther is W-E-R-T-H-E-R. And particularly at -- note asterisk
18 8 to 9.
19 Okay. Have a good evening everyone. We'll see you
20 tomorrow.
21 (Trial adjourned for the day at 5:00 p.m.)
22 * * *
23
24
25

C E R T I F I C A T E

I, JOHN T. SCHINDHELM, RMR, CRR, Official Court Reporter and Transcriptionist for the United States District Court for the Eastern District of Wisconsin, do hereby certify that the foregoing pages are a true and accurate transcription of the audio file provided in the aforementioned matter to the best of my skill and ability.

Signed and Certified November 30, 2017.

/s/John T. Schindhelm

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91	Dr. King chronological summary of patient records for Patient B	68	68
92	Dr. King chronological summary of patient records for Patient C	68	68
93	Dr. King chronological summary of patient records for Patient D	68	68
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3 99 Dr. King chronological summary of patient 68 68
4 records for Patient J
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6 records for Patient K
7 101 Dr. King chronological summary of patient 68 68
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UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF WISCONSIN

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	Case No. CR 16-00095-WCG-1
	)	Milwaukee, Wisconsin
vs.	)	
	)	November 16, 2017
CHARLES R. SZYMAN,	)	9:00 a.m.
	)	
Defendant.	)	

TRANSCRIPT OF JURY TRIAL EXCERPT
TESTIMONY OF DR. TIMOTHY KING - PART 2 OF 2
BEFORE THE HONORABLE WILLIAM C. GRIESBACH
UNITED STATES CHIEF DISTRICT JUDGE

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Proceedings recorded by electronic recording,
transcript produced by computer aided transcription.

1 TRANSCRIPT OF JURY TRIAL EXCERPT

2 **TESTIMONY OF DR. TIMOTHY KING - PART 2**

3 Transcribed From Audio Recording

4 * * *

5 THE COURT: Okay. Good morning, everyone. The record
6 can reflect counsel are here as well as Dr. Szyman and Dr. King.
7 Anything to discuss before we bring in the jury or as
8 the jury is entering?
9 MR. BRINDLEY: No, Your Honor.
10 MR. JACOBS: Not at this time, no.
11 (Jury in at 9:04 a.m.)
12 THE COURT: Good morning, ladies and gentlemen.
13 Please be seated. And we will continue with the
14 cross-examination of Dr. King.
15 Dr. King, you're still under oath as I'm sure you're
16 aware.
17 THE WITNESS: Yes, sir.
18 THE COURT: Go ahead, Mr. Brindley.
19 MR. BRINDLEY: Thank you, Your Honor.
20 DR. TIMOTHY KING, GOVERNMENT WITNESS, PREVIOUSLY SWORN
21 CONT'D CROSS-EXAMINATION
22 BY MR. BRINDLEY:
23 Q. Dr. King, yesterday you were talking about what -- at one
24 point we were talking about what you reviewed in coming to your
25 opinions in this case, and you agreed that -- you said that you

1 had reviewed the Holy Family patient files that were provided
2 you by the prosecution, right?
3 A. That's correct, yes.
4 Q. All right. Now, you did not get copies of the files from
5 the other doctors, the referring doctors who had the patients
6 before Dr. Szyman, did you?
7 A. Except insofar as the medical records sometimes contain the
8 past medical records. I did not get any separate records.
9 Q. Unless they were in the Holy Family files themselves you
10 didn't get them, right?
11 A. That's correct.
12 Q. So it's certainly very possible that Dr. Szyman had access
13 to records about these patients that you did not when he made
14 his treatment decisions, correct?
15 A. Typically those files would be in the medical record. We
16 generally view the fact that the medical record is a complete
17 compilation of files and material reviewed. So there may have
18 been other files that existed, I'm sure there were, but one
19 would assume that those files would be part of the medical
20 record.
21 Q. And that would -- that would have to do with the Holy Family
22 Hospital and how they were handling their record system,
23 wouldn't it?
24 A. Well, it would more have to do with the doctor himself and
25 how he practiced medicine.

1 Q. Well, Holy Family is a large hospital system, isn't it,
2 Dr. King?
3 A. I presume it is. I don't know the system.
4 Q. Okay. You don't know the Holy Family system, correct?
5 A. I do not.
6 Q. All right. And do you know who makes the decision about how
7 to handle the electronic records at Holy Family or what their
8 requirements are?
9 A. I do not.
10 Q. All right. Now, you talked yesterday about various forms of
11 diagnostic treatment that you think should be done whenever you
12 have a new pain management patient, right?
13 A. Various diagnostic options, yes.
14 Q. You talked about scans and MRIs and x-rays and a lot of
15 different techniques, right?
16 A. Correct.
17 Q. Of course, you would agree with me that all of those
18 treatment options, all of those techniques cost money, right?
19 A. Well, they certainly have a cost associated with them, yes.
20 Q. Yes. And some patients don't have health insurance, right?
21 A. Correct.
22 Q. Some patients are on Medicaid, right?
23 A. Correct.
24 Q. Medicaid puts a lot of limits on what treatments you can
25 get, right?

1 A. Correct.
2 Q. And what they'll pay for, right?
3 A. Yes.
4 Q. Okay. So when a doctor is dealing with a patient who has
5 limited resources, no insurance or limitations on Medicaid,
6 there are times when the doctor cannot do all of the medical
7 procedures he would like. Isn't that fair to say, in reality?
8 A. In reality there are sometimes limitations as we examine a
9 patient and try to verify a diagnosis.
10 Q. And outside of just diagnostics, other forms of treatment,
11 there are forms of treatment that doctors might want to do on a
12 patient, a pain management patient who -- which they can't do if
13 the patient doesn't have medical insurance or can't get approval
14 for Medicaid. That's true, isn't it?
15 A. There are sometimes treatment options that we choose that
16 are not covered by insurance and that does create a challenge.
17 Q. Creating a challenge meaning if the people don't have the
18 money you can't do it, right?
19 A. We always have to do the right thing. We don't want to
20 resort to a bad choice simply on the basis of economics. Our
21 main focus, as I talked about yesterday, as a physician, is to
22 do no harm.
23 MR. BRINDLEY: Judge, I would again ask you to remind
24 Dr. King to just try to answer the question asked. We're going
25 pretty far afield here.

1 THE COURT: It's easy to get away from, but listen
2 closely to the question, answer that, and then rely on
3 Mr. Jacobs to come back and ask for follow-up.
4 THE WITNESS: Yes, sir.
5 BY MR. BRINDLEY:
6 Q. So, Dr. King, what I'm asking you is, the reality is there
7 are times where you said there was a challenge, there's times
8 when doctors have treatments they'd like to do for patients
9 without money and without coverage that they just can't do.
10 That's a reality in the system the way it is, isn't it?
11 A. That happens from time to time, yes.
12 Q. All right. And you did not review the financial situation
13 of each of the patients in the medical files, did you?
14 A. I did not.
15 Q. Now, each of the medications that Dr. Szyman had prescribed,
16 all of them had been approved by the Federal Drug
17 Administration, right?
18 A. (No audible response.)
19 Q. These were all approved medications, weren't they?
20 A. Well, the medications were approved by the FDA, yes, for
21 various purposes, yes.
22 Q. And the FDA has not put restrictions on the number of any of
23 these pills that can be prescribed to a patient, have they?
24 A. Not on the numbers, no.
25 Q. All right. Now, Dr. King, you know --

1 Well, you mentioned yesterday that you use opioid
2 treatment agreements with your patients, right?
3 A. That's correct.
4 Q. The purpose of an opioid treatment agreement is so you
5 have -- you and the patient both -- have documented evidence
6 that you have discussed the significant risks associated with
7 opioid therapy, right?
8 A. Among other things that is one of the things that is in the
9 opioid agreement, yes.
10 Q. The agreements contain references to the risk of dependency
11 and withdrawal, right?
12 A. Yes.
13 Q. And they talk about some of the other risks of side effects
14 that can come from opioid medications, right?
15 A. It can, yes.
16 Q. And you know that Dr. Szyman -- from the medical records,
17 you know that he used opioid agreements with his patients.
18 A. Yes.
19 Q. And you know that these agreements and these contracts that
20 the patients signed indicated that the patients were agreeing to
21 take the medications as prescribed, right?
22 A. Yes.
23 Q. And each of these patients, as you understand it, signed
24 these agreements and indicated that they wanted to take the risk
25 and try the opioid therapy, right?

1 A. I don't have an independent recollection of whether they
2 were all signed, but presumably they were.
3 Q. All right. Now, you would agree with me, for example, there
4 are situations where patients are facing -- or people are facing
5 potentially terminal diagnoses, like cancer patients, and
6 sometimes they have to make a choice between a high-risk surgery
7 that's got a lot of downside or perhaps chemotherapy. Those
8 circumstances arise in the treatment of patients, don't they?
9 A. That's correct.
10 Q. You would also agree with me that many of these patients
11 that came to Dr. Szyman, when they came to Dr. Szyman they had
12 already been to multiple other doctors before, right?
13 A. That is correct.
14 Q. Some of them had been to orthopedists and other pain
15 specialists and surgeons, right?
16 A. Correct.
17 Q. Okay. And in every one of those instances those other
18 doctors, after trying to help them, decided that they needed to
19 refer them to Dr. Szyman, right?
20 A. Some of them were referred. Some of the -- as I understand
21 it some of the other doctors had the patients leave them looking
22 for other options. Not all of them were referred out.
23 Q. Which one wasn't referred?
24 A. Well, there were a number of cases -- a number of physicians
25 who examined and treated the patients several times prior to

1 getting to Dr. Szyman.
2 Q. And you can't identify any of them outside of Russo and
3 Kingston. Let's put them aside. But outside of Russo and
4 Kingston, you can't identify any of these patients that didn't
5 come to Dr. Szyman as a referral from some other doctor, can
6 you?
7 A. That is correct, yes.
8 Q. All right. So at some point in each of those instances some
9 other doctor was trying to treat them, decided that they needed
10 to send them to Szyman because there was nothing more they could
11 do. Is that right?
12 A. That's correct.
13 Q. Okay. And you would agree with me that patients who were
14 suffering from significant pain that limits their functionality,
15 which we were talking about yesterday, those patients -- it
16 would be easy for those patients to view that pain as something
17 akin to a terminal or a life-altering illness, right?
18 A. I'm not sure how to answer that.
19 Q. Well, if a patient has terrible pain and it's limiting their
20 functionality significantly, they could view that as -- I mean
21 that's -- when they're viewing how that affects them they may
22 view that as a terrible and significant illness that needs
23 correction, right?
24 A. That could be true.
25 Q. Okay. And certainly in the example we were talking about

1 earlier where you have a cancer patient who has a high-risk
2 therapy option to try to save their life versus a chemotherapy
3 option, the cancer patient should be able to choose the
4 high-risk therapy, right?
5 A. Well, the cancer patient should be allowed to participate in
6 the decision.
7 Q. Are you saying that the patient shouldn't be able to make
8 the decision for themselves whether I want to take a risk for
9 the chance of a treatment working rather than suffering
10 continually? You're saying they shouldn't be able to make the
11 choice?
12 A. I think they should have a large part in it. But the
13 medical standards suggest that it should be a joint decision,
14 along with the caregivers, the specialists who are providing the
15 care, because they are the ones who understand the risks more
16 fully than the patient does.
17 Q. Sure.
18 A. So it's a joint decision.
19 Q. It's a joint decision. The patient has to talk to the
20 doctor, right?
21 A. Correct.
22 Q. The doctor has to explain the risks, right?
23 A. Correct.
24 Q. And the patient has to then give the doctor their input on
25 whether they want to take those risks to try to combat a

1 condition that's limiting their lives, right?
2 A. That's correct.
3 Q. And you said that you know that Dr. Szyman had these
4 contracts to go over the risks of opioid treatment with his
5 patients, right?
6 A. Correct.
7 Q. Now, you talked about your opinion and the standard of care,
8 the language that you were using yesterday. You don't know --
9 based on your analysis of this case, you don't know what
10 seminars or other doctors, teachers in the area of pain
11 management Dr. Szyman followed, do you?
12 A. I do not, no.
13 Q. Okay. Are you familiar with the philosophy of a pain
14 management espoused by a Dr. Steven Passik?
15 A. I'm aware of Dr. Passik, but I could not quote to you his
16 philosophy.
17 Q. All right. Do you know if Dr. Szyman along with many other
18 physicians attended seminars put on by Dr. Passik?
19 A. I'm not aware of what seminars he attended.
20 THE COURT: Can you spell that name?
21 MR. BRINDLEY: P-A-S-S-I-K, Judge, I think.
22 THE COURT: Thank you.
23 MR. BRINDLEY: I think my spelling is correct.
24 BY MR. BRINDLEY:
25 Q. You are familiar, Dr. King, with the -- are you familiar

1 with Russell Portenoy?
2 A. Yes, I am.
3 Q. And you know that in the past, years past, Dr. Portenoy
4 espoused the philosophy that high-dose opiates should be used
5 for patients, didn't he?
6 A. He was addressing primarily terminal care. And yes, the
7 answer is yes, he did espouse that for chronic pain as well.
8 Q. Okay. And you know whether in the past Dr. Szyman attended
9 lectures put on by Dr. Portenoy?
10 A. I do not.
11 Q. Now, you were talking yesterday about the need to have a
12 diagnosis when you're dealing with pain management, right?
13 A. Correct.
14 Q. Now, I want to make sure I understand what you're saying
15 when you're saying that. So you're saying you're talking about
16 you need to come up with a diagnosis for what the cause of the
17 pain is, right?
18 A. What we need to do is find an objective reason for why the
19 patient is complaining of what they are. And we call that a
20 diagnosis. So we try to be as objective as we can on that.
21 Q. You're trying to come up --
22 A. It's defining.
23 Q. You're trying to come up -- I don't mean to cut you off,
24 sir. You're trying to come up with a reason for the pain.
25 A. Correct.

1 Q. And you understand based on the records that many of these
2 patients had already had other doctors trying to come up with a
3 reason for the pain, right?
4 A. Correct.
5 Q. Let's take an example. Nancy Walt had been through all
6 kinds of treatment with an orthopedist, right? For her knees.
7 A. (No audible response.)
8 Q. Go ahead and take a look at that. I'm sorry, I don't expect
9 you to remember everybody that's --
10 A. I presume she had been thoroughly evaluated by other
11 doctors, but I don't have those records --
12 Q. Okay.
13 A. -- except for the fact that she obviously had a knee
14 replacement so she had to have seen an orthopedic doctor at some
15 point.
16 Q. Did she actually have a knee replacement surgery, Dr. King,
17 or did she have other surgeries on her knees and opt not for a
18 knee replacement? Do you know?
19 A. I do not know.
20 Q. All right. But in that situation where an orthopedist has
21 done everything they can to try to --
22 Well, let me back up a second. Orthopedists, their
23 specialty is in diagnosing and treating issues with what?
24 A. In this case with joints. Musculoskeletal problems that
25 require surgical intervention.

1 Q. And the knee would be a joint. It would be within the
2 specialty of an orthopedist, right?
3 A. Correct.
4 Q. Okay. And so if an orthopedist looks at a patient and tries
5 to treat him for a period of years and can't find a way to
6 control their pain after trying to treat their joints and sends
7 them to a pain specialist, it certainly isn't reasonable to
8 expect that the pain specialist is somehow going to be able to
9 come up with some answer that the knee expert couldn't for
10 what's wrong with the knees, right?
11 A. The pain specialist has training to look for other sources
12 of pain. We would expect the pain doctor may come up with
13 another diagnosis to explain the pain. May not be an orthopedic
14 reason, but there may be other reasons that he could come up
15 with diagnostically.
16 Q. What if there is an orthopedic reason? What if there is an
17 orthopedic problem that the orthopedist decides can't be
18 corrected with surgery, can't be corrected with any additional
19 skeletal work and this patient is still suffering from
20 debilitating pain and he sends him to a pain specialist? You
21 can't then expect the pain specialist to change the fact that
22 there's an orthopedic problem with the knees than can't be
23 corrected, can you?
24 A. Well, there may not be an orthopedic reason causing the
25 pain.

1 Q. What if the orthopedist says there is and they just can't
2 fix it?
3 A. Well, if the orthopedic doctor says there is and he can't
4 fix it, then as a pain physician we look at other ways to help
5 the patient deal with it.
6 Q. Right.
7 A. Or work with other contributing factors --
8 Q. Right.
9 A. -- that we may be able to deal with more effectively that
10 could help with the pain.
11 Q. Now, a patient -- when a patient comes in and describes that
12 they're in a debilitating kind of pain that they're having
13 chronically and unable to function like they need to in their
14 life, you have said that what you need to do is go through this
15 intense diagnostic to start with, right?
16 A. As part of the initial evaluation, yes.
17 Q. Okay. Now, if the patient's already had MRIs, already had
18 x-rays, already had other evaluation from expert surgeons or
19 orthopedists, et cetera, if they've already had that it's your
20 position that the pain specialist needs to repeat all of that;
21 is that correct?
22 A. I don't know what you mean by "repeat."
23 Q. Well, if they've already done it, if the orthopedist and the
24 surgeon have already done the x-rays and they've already done
25 the MRIs and they've already looked at all that and then they

1 send him to the pain doctor, is it your position that a pain
2 doctor then has to go through and do all of those things over
3 again?
4 A. No.
5 Q. Okay. So it's okay for the pain doctor to rely on what he
6 gets from the prior doctors that they provide.
7 A. The pain doctor should review those results specifically as
8 well as the medical records from the other doctor.
9 Q. And it's certainly true in terms of what diagnostics or --
10 well, let me put it a different way. When you work for a
11 hospital as a doctor, the hospital administration has input into
12 how that hospital wants to spend its money, right?
13 A. Yes.
14 Q. The hospital has input into whether or not they want to
15 approve expenditures that a doctor might want to make for
16 treatment, whether it be diagnostic or actual treatment of a
17 condition, right?
18 A. Well, insurance companies as we discussed certainly do. I'm
19 not sure if the hospital has as big a part in all that.
20 Q. Okay. It certainly is the case that hospitals can make it
21 clear, give directives to doctors that they don't want them
22 wasting hospital dollars on certain kinds of repetitive analyses
23 or treatments, right?
24 A. Again, I'm not aware that's a specific hospital policy.
25 Q. Well, I'm not -- you're telling me -- you can't tell me that

1 doesn't happen, hospitals do that, right? They're trying to
2 make money.
3 A. Well, of course they're trying to make money and they want
4 to avoid wastefulness.
5 Q. Yes.
6 A. But typically we don't get directives from the hospital in
7 the manner that you're proposing there.
8 Q. You don't get -- or you haven't gotten them.
9 A. Well, I've been through a lot of hospitals and that has
10 never been certainly my experience that I've observed over the
11 years.
12 Q. But you didn't work at Holy Family Hospital certainly.
13 A. I did not work at Holy Family.
14 Q. You don't know what size hospital that is, do you?
15 A. I do not.
16 Q. You did your -- you said you worked in Washington, where was
17 that?
18 A. Say that again?
19 Q. What was the hospital you worked at in Washington? You did
20 a bunch of work there?
21 A. Well, I did my training at the University of Washington in
22 Seattle.
23 Q. Right. And that's a very large hospital, right?
24 A. It's a large series of hospitals, yes.
25 Q. They have an extraordinary system there, excellent

1 resources, right?
2 A. They do.
3 Q. But not all hospitals are like that, are they?
4 A. No.
5 Q. A lot of hospitals are smaller, right?
6 A. Correct.
7 Q. A lot of hospitals have less resources, right?
8 A. Correct.
9 Q. And how much resources your hospital has, that impacts what
10 kind of treatment you might be able to provide to somebody,
11 right?
12 A. No.
13 Q. If your hospital doesn't have the available resources to do
14 a form of treatment you can't somehow do it yourself, can you?
15 A. No, but you can refer the patient out.
16 Q. Okay. So you could refer the patient to somebody else,
17 right?
18 A. Somebody else or to some other facility --
19 Q. Uh-huh.
20 A. -- that may have the equipment to do what you need to have
21 done.
22 Q. All right. So you could do that, right?
23 A. Correct.
24 Q. But depending on that, all that has to take into account
25 where the other facility's located, right?

1 A. Of course.
2 Q. And it has to take into account what the patient's ability
3 and their options are in terms of their ability to go there,
4 right?
5 A. Correct.
6 Q. And it also once again impacts their finances and whether
7 they can do that, right?
8 A. Correct.
9 Q. Okay. Now, there are various forms of treatment that people
10 can try to use in order to limit the dosage of opioids that a
11 patient might be taking, right?
12 A. Correct.
13 Q. And one of those forms of treatment is something called a
14 spinal cord stimulator. Is that true?
15 A. That is one of the treatment options, yes.
16 Q. A spinal cord stimulator is a device where there's some
17 wires that can be used --
18 You explain it. How does it work? I know there's
19 wires and a spine. What happens?
20 A. A spinal cord stimulator is a very sophisticated device
21 that's implanted in the epidural space. It basically one might
22 say is like an internal TENS unit. It's a surgical procedure.
23 It's a very expensive procedure. We use it primarily for
24 chronic nerve pain. If we've been able to objectively
25 demonstrate there's a chronic sciatica or injury to a nerve and

1 when you [Indiscernible] counter stimulate that injured nerve we
2 would consider an implantation of a spinal cord stimulator.
3 Q. All right. You said something about a TENS unit, what was
4 that?
5 A. A TENS unit, which I think most of us are familiar with, is
6 a unit -- a small box that has adjustments on it and the TENS
7 unit delivers electrical stimuli through patches that you would
8 put on your low back or your neck or your shoulder to again
9 counter stimulate the pain response there to reduce the muscle
10 contracture, the muscle spasm in what we would call a
11 transcutaneous way. It's not a surgical procedure.
12 Q. Okay. And then there's this -- there's some kind of a
13 intrathecal pump. What is that?
14 A. An intrathecal pump is the other implantation or surgical
15 tool that most pain doctors have available to them. That
16 basically is a way of infusing opiates, pure opiates and
17 high-concentration opiates. Instead of orally or intravenously
18 it puts it actually into the spinal fluid.
19 We typically use that as a way of delivering what
20 would otherwise be a very high dose of oral opiates selectively
21 to the spinal area to try to address a chronic pain problem that
22 would be responsive to that type of treatment.
23 Q. And that's something that you would try to use in order to
24 limit or prevent a real high-dose opioid ingestion in terms of
25 medication, right?

1 A. It would be a reasonable option. It clearly is not
2 something that's for everybody because it is a sophisticated
3 implantation that requires a great deal of care and tending on a
4 monthly basis with refills, and monitoring plumbing issues,
5 electrical issues, programming issues.
6 So it's a very sophisticated device that clearly is
7 not for everybody.
8 Q. Sure. But you know from the records that with many of these
9 patients Dr. Szyman attempted to try spinal cord stimulaters,
10 right?
11 A. Yes.
12 Q. With many of the patients there was either actual
13 implementation of intrathecal pumps or evaluations to see
14 whether that would work, right?
15 A. Yes.
16 Q. You know that many of the patients were subjected to
17 physical therapy, right?
18 A. Some of them had followed through with their physical
19 therapy, yes.
20 Q. Okay. And ultimately the patient has to report to you about
21 whether or not these alternative methods are addressing their
22 pain, right?
23 A. That's correct.
24 Q. Now, you said that the -- you would look at the records for
25 these patients and you said that the treatment of the

1 medication, it wasn't working is what you said. It wasn't doing
2 any good, right?
3 A. Well, it wasn't fulfilling the criteria that we would use to
4 define success.
5 Q. The criteria as I understand it, the gold standard, is --
6 does -- is the treatment bringing greater degree of
7 functionality, right?
8 A. Is it meeting the goals that were established for function.
9 Yes.
10 Q. Okay. So if it's allowing people to go to work when they
11 couldn't go to work before, that would be meeting the goals of
12 functionality, right?
13 A. It would, yes.
14 Q. If it's allowing people to have more mobility then they had
15 before, that would be meeting the goals of functionality, right?
16 A. Again, we define mobility. And, for instance, was the
17 individual, if it was a woman was she able to do her laundry or
18 go up and down stairs. But we would have to define that in an
19 objective way, but yes.
20 Q. Okay. And it certainly is the case that when you're seeing
21 a patient on a regular basis for a period of years you can
22 observe changes in their mobility, can't you?
23 A. Probably one thing we'd look for, yes.
24 Q. And you can observe -- observe changes in their demeanor,
25 can't you?

1 A. That would be one thing we would look for, yes.
2 Q. Okay. And they could report to you about what they're
3 doing, how they're doing at work, how they're doing at home, how
4 things are going, right?
5 A. Those would be subjective responses that we would want to
6 verify objectively.
7 Q. All right. But this objective verification, I mean, doctors
8 aren't supposed to be detectives, are they?
9 A. No, that's where -- as I indicated yesterday, it's very
10 difficult to be a doctor. You have to be a detective. Our
11 universal precautions dictate to some degree that we be
12 detectives.
13 Q. You're not expecting doctors to go around and check up on
14 these people and see if they're really being able to work like
15 they say, are you?
16 A. Well, we expect the doctors especially in this area to
17 verify. So to a certain extent we have to find other ways to
18 verify that what the patient says regarding their increased
19 activity is really true.
20 We may have to contact a family member, we may have to
21 contact an employer, we may have to have other types of
22 verification. But we need something objective.
23 Q. Okay. And, but the reality is, Dr. King, you know,
24 objectively -- and in a perfect world that would be great, but
25 in reality there's some circumstances when there's not very many

1 good objective indicators and you can't tell, right?
2 A. It's always difficult --
3 Q. Yeah.
4 A. -- but it has to be done.
5 Q. It has to be attempted, right?
6 A. No, it has to be done.
7 Q. Have you ever heard the phrase that we can't make the
8 perfect the enemy of the good? Have you ever heard of that?
9 A. I've heard of that.
10 Q. Yeah. And so what you're talking about in the best-case
11 scenario, of course, you would want to be able to have all kinds
12 of objective criteria that you could check, right?
13 A. Well, the standard of care requires that we have objective
14 criteria of some sort.
15 Q. Okay. And, but in reality down in the trenches where you
16 said that you're at, down in the trenches it's often the case
17 that doctors are dealing with patients where there is very
18 limited availability of these objective criteria. Right?
19 A. Down in the trenches I know I can do danger with these
20 opiates. And even though it's difficult to get those criteria,
21 they have to be achieved in some manner.
22 Q. You said you saw 20 to 25 patients a day, right?
23 A. Correct.
24 Q. How long is your work day? When do you start?
25 A. My work day starts at about 8:00 in the morning and get done

1 about 5:00.
2 Q. All right. So 8:00 to 5:00, how many hours is that, nine
3 hours?
4 A. Nine hours.
5 Q. Okay. And what, you just take some time off in the
6 afternoon to have some lunch?
7 A. I rarely get lunch.
8 Q. No lunch, okay. So nine hours. You're working straight
9 through; is that right?
10 A. Sort of evaluating on the run, if you will.
11 Q. All right. So if you're seeing 20 to 25 patients and you
12 got nine hours to do it, how much time does that give you for
13 each patient?
14 A. You have to do the math there, but I'm sure you have.
15 Q. What's that?
16 A. I said you've probably done the math on it so -- without my
17 calculator you can tell me what it turns out to be.
18 Q. If you're doing 20 to 25 patients a day you got less than a
19 half hour to spend with each patient if you're working the
20 entire day long. Does that sound right to you?
21 A. That sounds about right.
22 Q. Okay. And so in less than a half hour you're saying that
23 you're able to do all of this detective work and objectively
24 evaluate what's going on?
25 A. What I would present to you is that out of those 20 or 25

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1 patients probably the majority of them would be patients who I
2 had been taking care of for months or years more likely.
3 Q. Okay.
4 A. So their visits typically are a lot shorter, which allows me
5 then to spend longer time with the newer patients or more
6 complicated ones.
7 Q. Right. So if you had been treating patients for months or
8 years and had familiarity with them, the length of their visit
9 would decrease, you wouldn't need to talk to them as long,
10 right?
11 A. As long as they were stable on their regimens and I had
12 previously documented their improvements, yes.
13 Q. And you know that Dr. Szyman had seen these patients for
14 months and years at a time, all of them, right?
15 A. Generally true, yes.
16 Q. All right. Now, let's talk about some of these specific
17 patients a little bit if you could. You've never been able to
18 interview any of them, is that what you said?
19 A. That's correct.
20 Q. All right. So you don't have any subjective, as you might
21 call it, you don't have any input from the people actually
22 experiencing the pain telling you how these treatments impacted
23 them, do you?
24 A. No, I do not.
25 Q. All right. And when evaluating whether or not a pain

1 medication is helping someone with their pain, certainly one of
2 the most helpful analyses or one useful form of analysis is to
3 find out what they say about how it's impacting their pain,
4 right?
5 A. That's certainly one of the things we look for.
6 Q. Now, with respect to Mr. Orth, for example, do the medical
7 records tell you whether or not Mr. Orth went to Dr. Szyman
8 because he was trying to delay a surgery and needed some page
9 relief in the meantime? Or not?
10 A. Without reverting to the medical record my notes indicate
11 that he was a -- excuse me, I need to get the right chart here.
12 My notes -- my summary notes indicate that he
13 presented with a history of, quote, an incident not related to
14 work and he was complaining of neck pain.
15 Q. All right. So do you know whether or not he started out
16 because he was trying to delay surgery and then later got
17 surgery? Your records don't really tell you that, do they?
18 A. The records indicate that he had some interaction with the
19 surgeon and ultimately did get surgery.
20 Q. Okay. But in terms of the reasons why and why he wanted to
21 wait on the surgery, you can't find that in the records, can
22 you?
23 A. Well, without a complete review of them right now I don't
24 have an independent recollection of that.
25 Q. But certainly Mr. Orth would know why it was that he wanted

1 to delay the surgery, right?
2 A. Presumably.
3 Q. And you wouldn't disagree that a patient who is having
4 chronic pain and needs a surgery and has to delay it because of
5 work reasons, you wouldn't -- is it your position that that
6 patient should be prevented from having opiate treatment in the
7 meantime so his pain is controlled until he can have the
8 surgery?
9 A. Well, my position is that there has to be a risk management,
10 a review of that as a pain physician. As a specialist I have to
11 look at the risk -- compare the risk of my opiate, if that's
12 what I choose to use, versus surgery and I have to counsel the
13 patient accordingly.
14 Q. Right. And all of that happens in one-on-one interaction
15 between you and the patient, right?
16 A. Correct.
17 Q. And you don't have access to that one-on-one interaction
18 because you weren't there to hear what Mr. Orth was telling
19 Dr. Szyman, right?
20 A. I saw what was in the medical record. I obviously did not
21 get a chance to talk to Mr. Orth.
22 Q. The medical records reflect certain notes that are taken,
23 correct?
24 A. Presumably they are the high points, they are the
25 appropriate summaries for review and document things

1 accordingly.
2 Q. But when you're seeing a patient regularly for months and
3 years, I mean your interaction with that patient, you're getting
4 more out of it than some piece of paper reflects, right?
5 A. Well, I will always put down in the medical chart as the
6 standard of care requires the important parts. And again that's
7 presuming that the patient is stable. And Mr. Orth was not a
8 stable individual, he was continuing to have issues that
9 required medication of an escalating nature.
10 Q. Right. And not all of that had to do with Mr. Orth talking
11 to Dr. Szyman about what his pain was and what his situation was
12 and Dr. Szyman responding to it, right?
13 A. I'm not sure what you're saying. Everything of importance
14 should be reflected in the medical chart.
15 Q. Setting aside the medical chart, there's all these meetings
16 where Dr. Szyman would be talking with Mr. Orth and Mr. Orth
17 would be giving him input, right?
18 A. Correct.
19 Q. And Mr. Orth would have certainly a more detailed grasp on
20 what happened between he and Dr. Szyman than you do having
21 looked at the records, right? He was there and you weren't.
22 A. Well, he was there and I was not, but presumably the
23 professional, the doctor would document the important parts.
24 Q. I see. Now, following his surgery, do you know whether
25 Mr. Orth and Dr. Szyman began to work together to reduce his

1 opiate use?
2 A. Could you give me the date of the surgery?
3 Q. No. I don't know the date of the surgery as I'm sitting
4 right here, Dr. King. I'm just asking whether --
5 Well, take the surgery out of it. We don't need to
6 talk about this in terms of when the surgery happened, in terms
7 of dates. But do you know that Dr. Szyman began working with
8 Mr. Orth to step him off of the opiate medications? Do you know
9 if that happened?
10 A. Well, again -- and I'd be happy to reference that if I could
11 look at the chronology here and target when the surgery occurred
12 and I could tell you very quickly what happened afterwards.
13 Q. Is there any note in your records of Mr. Orth and Dr. Szyman
14 working together to reduce the opiates he was on, regardless of
15 the timing?
16 A. I'm reviewing the chronology here. There are 10 pages so
17 pardon me while I review it.
18 Q. Right.
19 (Brief pause.)
20 A. Yes, there is a point where the medications were discussed
21 in terms of weaning.
22 BY MR. BRINDLEY:
23 Q. Okay. Now, you noted yesterday that Mr. Orth had drug
24 screens showing marijuana use, right?
25 A. Correct.

1 Q. A lot of people use marijuana; isn't that right, Dr. King?
2 A. Well, I'm not an expert on marijuana use, but certainly it's
3 one of the common drugs, common illegal drugs we look for.
4 Q. Well, it's not illegal everywhere, is it?
5 A. Currently it's not.
6 Q. All right.
7 A. Well, on a national basis it's still illegal.
8 Q. Yeah, the feds still say it's illegal, but there's a lot of
9 states where they say marijuana is legal to use, right?
10 A. Correct.
11 Q. Okay. And Mr. Orth, he was using marijuana and had it in
12 his urine stream. And you don't know -- or you weren't present
13 for any discussion that he may have had with Dr. Szyman about
14 it, were you?
15 A. No. I wasn't there for the discussions, no.
16 Q. Okay. Now, a patient that's using marijuana and has a
17 significant pain, is it your testimony that just because they
18 had a marijuana positive that you would eliminate the opiates?
19 Or is that not what you're saying?
20 A. It's a risk factor. I would not on that factor alone
21 recommend and I don't think the standard of care recommends that
22 opiates be stopped strictly on the basis of that.
23 Q. All right. The medical records indicate anything to you
24 about Dr. Szyman taking particular steps working with the
25 pharmacy to try to package Mr. Orth's medications such that he

1 made sure that he could take them properly? Is that in there?
2 A. Do you have -- again, there were many hundreds of pages on
3 this, if you could refer me to where you're looking I could
4 answer that.
5 Q. Okay. You don't remember anything like that, though, do
6 you?
7 A. I went through thousands and thousands of pages so I don't
8 have an independent recollection of that.
9 Q. But if that did happen Mr. Orth would be a good source to
10 find out about it, right?
11 A. I don't understand the question.
12 Q. If that did happen Mr. Orth would be a good source of
13 information to determine how it took place, right?
14 A. Well, the medical chart would. And I'm sure if it were here
15 I could go through it if we had the time and I could find it if
16 it existed.
17 Q. Is it really your testimony, Dr. King, that the medical
18 chart is somehow better than the word of the person who was
19 actually there? Is that really your testimony?
20 A. The medical chart is designed so that independent
21 individuals can review it and get an idea as to the proper
22 evaluation, treatment, diagnosis of the patient.
23 Q. You can review it and get an idea, but the person who is
24 there is going to have a lot more detail and a lot more
25 knowledge than anything you're going to be able to find in

1 notations in a medical chart. That's common sense and it's just
2 true, isn't it?
3 A. No, it's not common sense and that's not true. We would
4 expect the physician --
5 Q. Okay.
6 A. -- as the professional to document things. Accordingly,
7 that would be the source that I would go to.
8 Q. Right. That's the only source -- that's the source you go
9 to because that's all you got, right?
10 A. Well, it's what was given to me because --
11 Q. Yeah.
12 A. -- standard of care dictates that's what the appropriate
13 source is.
14 Q. I'm sorry. That's all you got, right?
15 A. Well, that along with the prescription monitoring data, the
16 PDMP, yes.
17 Q. Okay. Now, Heidi Buretta -- the lady you didn't know that
18 she had died, that you found out yesterday, Ms. Buretta -- do
19 you know where she worked?
20 A. It was represented in the chart that she was a nurse.
21 Q. All right. And do you have any reason to believe that that
22 was somehow a fraud, that she wasn't really a nurse?
23 A. I don't have a reason to believe that was a fraud.
24 Q. And Dr. Szyman recorded in the medical charts -- I think you
25 indicated this somewhere in your testimony yesterday -- that

1 there were indications of improved functionality and that she
2 was able to get a job, she was able to buy a house, she was able
3 to do a lot more things in her life. That was reflected, wasn't
4 it?
5 A. Along with other issues that said that she was suffering
6 from significant side effects of concentration, agitation and
7 thinking.
8 Q. Right. I mean there may be side effects, but at the same
9 time you have to look at the patient and balance side effects
10 versus functionality, right?
11 A. One wants to look at the trend and see whether the
12 medications are overall causing problems, particularly for a
13 nurse. Particularly for a medical professional.
14 Q. Okay. Right. And the medical professional in this case was
15 Ms. Buretta and Ms. Buretta would be one of the two people
16 that's involved in the consultation and working to make
17 decisions about how to handle this treatment, right?
18 A. That's correct.
19 Q. Now, you said that Ms. Buretta, if she was taking -- I think
20 I heard this right -- you said that if Ms. Buretta was taking
21 the medication as prescribed you thought that she wouldn't be
22 able to -- she would die basically, right?
23 A. Correct.
24 Q. Okay. Do the medical records indicate anything about
25 Ms. Buretta's gallbladder surgery at Holy Family Hospital?

1 A. No.
2 Q. Okay. Do you know whether, in fact, then, when she had a
3 gallbladder surgery at Holy Family Hospital, do you know
4 whether, in fact, she was given intravenously the actual
5 prescribed dosage of the medication and did not suffer ill side
6 effects? Do you know if that happened?
7 A. No, I did not read that admission record.
8 Q. Now, Dr. King, one of the things you were talking about
9 yesterday is, you know, you tried to trust your patients or you
10 want to trust them and you do trust them but you have to look
11 for these red flags because -- and the reason you're doing that
12 is because sometimes patients lie, right?
13 A. Sometimes patients lie and sometimes patients are
14 dishonestly deceived and have expectations that I have to temper
15 and define because they're not realistic.
16 Q. But you expect your patients when they're taking medication,
17 you expect your patients to honestly advise you on what kind of
18 side effects the medication is having if it's having any, right?
19 A. We hope that they will. Again sometimes we have to prompt
20 them and ask them about certain specific things. But certainly
21 that's one of our primary sources when we -- again referring to
22 the four A's, when we ask them about adverse side effects, of
23 course, we're talking to the patient.
24 Q. All right. And if the patient is having side effects and
25 decides to hide them from you or lie to you about them for some

1 reason, that is definitely going to have a negative impact on
2 your ability to treat them, right?
3 A. Yes.
4 Q. If a patient comes in and lies to you about their degree of
5 pain or they lie to you about how much of the medication that's
6 been prescribed they're taking, that too has a negative impact
7 on your ability to assess either their tolerance for medication
8 or the proper prescription for medication, it's got a negative
9 impact on all of that, right?
10 A. Of course it does.
11 Q. And you have to call upon your patients and ask your
12 patients to tell you the truth about these things, right?
13 A. We like to think the patients are taking the truth -- or
14 telling us the truth, but again that's why so often, as we've
15 discussed, we have to verify it.
16 Q. You want to try to verify it if you can. Right?
17 A. Correct.
18 Q. Okay. But in reality there is a big part of this that
19 requires the patient to be honest and when they're not that
20 negatively impacts the doctor, right?
21 A. That's correct. Well, it doesn't negatively impact the
22 doctor, it negatively impacts the patient long term.
23 Q. Well, it negatively impacts the doctor's ability to
24 adequately and correctly treat the patient, right?
25 A. Correct.

1 Q. Okay. So if you have patients, for example -- there's
2 different mechanisms that are used to try to evaluate whether or
3 not a patient is taking their medication as prescribed, right?
4 A. Yes.
5 Q. One of them is this pill count, right?
6 A. Correct.
7 Q. But there's certain ways that patients can manipulate pill
8 counts, right?
9 A. Correct.
10 Q. Okay. And so if patients are expressly and purposely trying
11 to manipulate the pill counts and mislead the doctors, that
12 negatively impacts the doctor's ability to treat the patient,
13 right?
14 A. Of course.
15 Q. And if -- people also manipulate urine drug screens, right?
16 A. They do.
17 Q. What they'll do is, for example, patients cannot be taking
18 the medicine they're supposed to be and then when they know the
19 urine drug screen is going to come they could take it right
20 before so something will show up in their system when it
21 wouldn't otherwise, right?
22 A. Or they could adulterate the sample as we discussed
23 yesterday, yes.
24 Q. Okay. So there's also all kinds of ways for people to
25 manipulate urine drug screens, right?

1 A. Correct.
2 Q. And if people are purposely manipulating urine drug screens,
3 that negatively impacts the doctor's ability to effectively and
4 accurately treat them, doesn't it?
5 A. It does.
6 Q. All right. That's why you said being a pain doctor is --
7 it's really hard, isn't it?
8 A. It's very difficult. You have to spend the time and the
9 energy to get what you need to do an adequate job, to do a
10 standard of care job.
11 Q. And not only that, not only is it difficult in the sense
12 that -- it -- let me rephrase that question.
13 In addition to being difficult it requires a lot of
14 discretionary decision-making, right?
15 A. Yes, it does.
16 Q. You gotta make a lot of calls on whether to give people the
17 benefit of the doubt or not, right?
18 A. You have -- it's discretionary and you hopefully base your
19 decisions on a good scientific medical foundation. You can't
20 base it all on judgment. Basically you have to have some
21 objective foundation.
22 Q. You look at what the objective foundation is. And even when
23 you have a situation where there's a problem with a urine drug
24 screen or there's one of these random phone calls that you talk
25 about coming in saying there's a problem, when that happens you

1 need to sit down and address it with the patient, right?
2 A. [Indiscernible], yes.
3 Q. And if you sit down and you address it with the patient,
4 patients may have explanations, right?
5 A. One would want to know what the patient's explanation is,
6 yes.
7 Q. Okay. And do you know that -- at whether when in these
8 circumstances where calls came in, do you know whether
9 Dr. Szyman actually sat down with the patient and other hospital
10 staff in order to come up with a consensus viewpoint on the
11 reasonability of the patient's explanation? Do you know if that
12 was going on?
13 A. I don't see any documentation of that in the chart, no.
14 Q. Regardless of whether the chart reflects it or not, if the
15 chart doesn't reflect it you don't know if it happened, right?
16 A. Typically in medicine we figure if it's not documented it
17 did not happen.
18 Q. All right. Well, let me put it to you a different way.
19 Just because something wasn't noted in the medical chart it does
20 not mean in reality it did not happen, does it?
21 A. It's a standard of care in medicine that if it's not
22 documented it did not happen.
23 Q. Okay. So if Dr. Szyman has a conversation with hospital
24 staff and a patient about a phone call that came in and that
25 patient then recalls and reflects yes, we had that conversation

1 and attests to it under oath, is it your position that because
2 it's not in the medical chart that we should just assume that it
3 didn't happen?
4 A. I'm most interested in what the doctor says. So the patient
5 again may say one thing and he may be correct, but the
6 documentation that we depend on is what's put in the chart.
7 Q. Okay.
8 A. And if it's not in the chart we assume that it didn't exist
9 or we give it less credibility.
10 Q. Okay. But normally when these calls come in doctors have to
11 talk to the patients and then they have to utilize discretion in
12 evaluating the patient's explanation, right?
13 A. Correct.
14 Q. Okay. For example, you talked yesterday about Debra Ramirez
15 and you talked about there were charges that you mentioned where
16 she had been charged with something related to contributing to a
17 homicide or something, right?
18 A. The record would reflect exactly what that was.
19 Q. Yeah. Can you see it? You mentioned it yesterday.
20 A. That was on Bates page 880 where it indicated she was
21 arrested for, quote, first degree reckless homicide with
22 delivery of drugs and negligent manslaughter.
23 Q. Okay. And that was an arrest record, right?
24 A. Well, it had --
25 Q. It indicates she was arrested for that, right?

1 A. Correct.
2 Q. And you said that this would create a red flag and that
3 would impact your willingness to continue to distribute opiates,
4 right?
5 A. Well, certainly that would be something that would be a
6 major red flag.
7 Q. Yes.
8 A. And --
9 Q. But your records don't say and what you're not aware of,
10 Dr. King, is that all of that homicide stuff, all of those
11 charges with respect to a homicide, they were dismissed.
12 Doesn't show you that, though, does it?
13 A. I have what I read to you.
14 Q. You have an arrest record, right?
15 A. Well, what I have is nursing notes. This is nursing
16 notes --
17 Q. You have nursing notes of an arrest record, right?
18 A. Well, again, I'm referring to nursing notes. This is what's
19 documented in the chart by a nurse.
20 Q. But the point -- the point -- well, so you've got a nursing
21 note that says that an arrest was reported, right?
22 A. I could read the entry if you like.
23 Q. You can agree with me that basically you have a nursing note
24 that says this arrest for these particular things that you noted
25 was reported, right?

1 A. Correct.
2 Q. Okay. And then Dr. Szyman would have to follow up on that,
3 correct?
4 A. Well, he would have to use his discernment as to how to
5 follow up on that or whether to take it at value.
6 Q. Okay. And, but nothing in the medical -- you're limited to
7 what's in these charts. But the charts don't show you what
8 happened to these charges or whether they were actually
9 substantiated against Ms. Ramirez or not, do they?
10 A. They do not.
11 Q. Okay. And, but Dr. Szyman would have been able to talk to
12 Ms. Ramirez, right?
13 A. Yes.
14 Q. And Ms. Ramirez would certainly know exactly what happened
15 because she was there, right?
16 A. Well, she would know. As to whether she would report it
17 correctly and accurately is another question.
18 Q. It seems like we're coming down to, one of the things that
19 is going to go into this then is an evaluation of how skeptical
20 a doctor chooses to be with respect to things that are reported
21 to him by his patients, right?
22 A. Doctors are required to be skeptical, we're the detectives,
23 and to a certain extent as we discussed a little bit earlier.
24 Q. What did you say about with the detectives? What
25 detectives?

1 A. Well, had you brought up whether a doctor --
2 Q. Oh, you're saying doctors should be detectives. Yes.
3 A. -- should be a detective testify.
4 Q. Okay.
5 A. And I indicated, yes, universal precautions require that we
6 do our homework in that regard.
7 Q. Right. So it's certainly true that there is going to be a
8 variation in the degree of skepticism that one doctor chooses to
9 employ versus what another one does. Some people are more
10 skeptical than others, some people are more compassionate than
11 others. That's all true, isn't it?
12 A. Which is why we have the universe of precautions in the four
13 A's, to try to standardize it, yes.
14 Q. Right, right. I mean, you've talked about your opinion
15 about the universal -- the use of these four A's, universe of
16 precaution, that's all fine. But my point is, when it comes
17 down to evaluating a person who there's an allegation about, the
18 doctor has to decide what degree of skepticism he's going to
19 give or use, right?
20 A. He's going to have to decide what degree of importance to
21 lay on that particular piece of information, yes.
22 Q. And that what contributes to that is the degree to which a
23 doctor philosophically decides that he's going to give patients
24 the benefit of the doubt. That's part of it, right?
25 A. That's part of it, yes.

1 Q. Because people could get arrested on a charge and it can be
2 that they're actually totally innocent or largely innocent.
3 That's true, right?
4 A. That happens, yes.
5 Q. Okay. Or people could call a pain clinic because they're
6 mad at somebody. Somebody wouldn't help them out and give them
7 a pill, for example, and so they call and say I know somebody's
8 abusing. People can lie to hurt other people, right?
9 A. That's theoretical. I haven't actually seen that, but we
10 raise that as a concern from time to time.
11 Q. I mean all communities are different, but in some
12 communities that could happen, right?
13 A. It's theoretical. I haven't seen it happen.
14 Q. Okay. But so if there's some -- some call comes in or some
15 arrest is made and it turns out that it's -- the person didn't
16 really do it, if a doctor ceases to help that person, ceases to
17 provide that person with their medication, a doctor could be
18 harming that person unnecessarily, right?
19 A. Well, you said two things. Let me parse what you said. You
20 said the doctor would cease to help the patient and then you
21 said the doctor would cease to prescribe the narcotics.
22 Q. All right.
23 A. There's a difference between those two.
24 Q. Well, if the patient is being helped by narcotics and
25 reporting that the narcotics are helping their pain and then

1 there's some call that comes in and the doctor cuts them off
2 from the narcotics based on the call and it turns out in reality
3 that the call was not true, then the doctor could have taken
4 away medicine that somebody needed and been wrong, right?
5 A. That could be the case, but not in this case.
6 Q. What?
7 A. That could be the case --
8 Q. You just said you don't know what happened with Ms. Ramirez.
9 A. Well, we were referring and you were asking me about this
10 specific case --
11 Q. Yeah.
12 A. -- when she was booked for first degree reckless homicide
13 and you asked me the question was I aware that those charges
14 were dismissed and I said no, I don't know what the disposition
15 of that case was.
16 Q. Uh-huh.
17 A. But the concern is that she -- a red flag has nevertheless
18 been raised --
19 Q. Right.
20 A. -- because a latter part of that entry indicates that the
21 detective told the nurse that, quote, the patient's house looks
22 like a pharmacy. And that should raise a red flag regardless of
23 the legal implications as to whether the narcotics were being
24 taken as prescribed or whether they were being abused or
25 diverted.

1 So quite aside from the legal aspect, this is a major
2 red flag that needs to be carefully and objectively evaluated by
3 the doctor.
4 Q. Wait, wait, wait. I think we got lost somewhere because I
5 wasn't talking about that specific case anymore. I was talking
6 in general. If you cut somebody off from their narcotics based
7 on some call or some allegation from the police and it turns out
8 that that allegation is wrong, then you could be incorrectly
9 taking away somebody's medicine, right?
10 A. If that were the choice of treatment options that would be
11 correct, but we usually don't do that.
12 Q. Okay. And a -- a doctor who's faced with these calls that
13 you're talking about has to make a judgment on whether he's
14 willing to do that, whether to take away the narcotics or not.
15 Right?
16 A. No. You phrased it as take away the narcotics or not.
17 There are more reasonable options. We don't cut people off.
18 What we try to do is assess the situation and then do
19 what's reasonable. Cutting off usually is not an option we use.
20 We may modify our technique and in the vernacular of how we deal
21 with it we may what we call exercise an opiate exit strategy.
22 Q. Uh-huh.
23 A. And begin at that point to take them off. But we don't cut
24 people off. We don't pull the rug out from under them.
25 Q. Okay. Then so when these calls come in what the doctor

1 needs to do is talk to the patients about them and then make a
2 decision about how to proceed, right?
3 A. Correct.
4 Q. And like with the example of Ms. Ramirez, Ms. Ramirez would
5 have been there for that process and could tell us what happened
6 when she talked to Dr. Szyman, right?
7 A. She would give us her side.
8 Q. Yes. And going back to -- about Mr. Conway. Mr. Conway and
9 Ms. Buretta, isn't it true that their records indicate that
10 Dr. Szyman attempted multiple other forms of treatment besides
11 prescribe those opiates?
12 A. Well, again, I don't have an independent recollection. I
13 would have to go through them. But it is likely that other
14 things were suggested. As to whether they were trialed I'd have
15 to go back and look at it specifically.
16 Q. Like and some of those things would have been like the
17 spinal cord stimulator or the intrathecal pump, things like
18 that. You know that those things are in the record in different
19 patients, those things are tried, right?
20 A. That's correct.
21 Q. And the reason for a doctor or a physician to try these
22 alternatives is because they are attempting to find the best
23 possible method and limit the dosage of opiates. That's the
24 purpose of these things, right?
25 A. Well, that would be one of the purposes, yes.

1 Q. There were -- you talked about Russo yesterday and you were
2 talking about you didn't know that Russo was an undercover
3 agent, right?
4 A. That's correct.
5 Q. And you didn't know that Kingston was an undercover agent,
6 right?
7 A. I did not.
8 Q. So the government didn't give you access to transcripts or
9 recordings of what their actual interactions with Dr. Szyman
10 were like at all, did they?
11 A. No, they did not.
12 Q. Now, if you were able to see a transcript of the interaction
13 with Dr. Szyman and these individuals you'd be able to evaluate
14 it, right?
15 A. That would be helpful to compare to the medical record, yes.
16 Q. But you didn't even know the transcript existed, right?
17 A. I did not know they were undercover agents, no.
18 Q. And the reason you didn't know the transcript existed is
19 because the prosecutors didn't tell you, right?
20 A. They did not present me with that information. As I
21 indicated, I was not aware they were undercover patients.
22 Q. And do you know whether what -- the degree to which they
23 intentionally -- these people, Russo and Kingston -- do you know
24 the degree to which they intentionally misled Dr. Szyman?
25 A. Well, I read the medical record. And as we discussed, that

1 should document the critical parts of the examination
2 [Indiscernible] presentation. So I assume that was correct.
3 Q. But you don't know how many different -- what efforts they
4 went to to try to lie to him and mislead him on purpose because
5 you didn't have access to what they said, right?
6 A. I don't have access to the undercover tapes, that's correct.
7 Q. And in addition when you're trying to verify somebody's
8 medical history, one of the things that you want to do is reach
9 out to their prior doctor, right?
10 A. Correct.
11 Q. Okay. And so are you aware that when Dr. Szyman's office
12 tried to do that that the DEA had someone pretend to be a
13 doctor's office and suggest that a person really was a patient
14 there when it was all a lie? Do you know whether they did that?
15 A. I was not aware that there were any attempts made because
16 there was no documentation in the medical record --
17 Q. All right.
18 A. -- of that effort.
19 Q. When people walk into a doctor's office with the
20 objective -- I'm sorry, with the subjective intent to deceive
21 them and give them a bunch of false information and mislead
22 them, that's obviously going to have a negative impact on that
23 doctor's ability to properly treat that patient. Agreed?
24 A. That occurs in about a third of my patients across the
25 board, and the answer is yes.

1 Q. Yes. It makes it difficult for you, it would make it
2 difficult for Dr. Szyman, right?
3 A. Which is why it's difficult being a pain doctor, yes.
4 Q. Yes. Let's talk for a minute about Mr. Peterson. You said
5 that there were red flags about Mr. Peterson?
6 A. Correct.
7 Q. And in terms of Mr. Peterson, one of these -- well, what
8 were the red flags you noted about Mr. Peterson? You tell me
9 and then we'll talk about it.
10 A. Well, that would entail going over the bullet points from
11 yesterday, but I would be happy to do so. The bullet points
12 include this:
13 He was treated for over seven years with -- excuse me,
14 over --
15 Well, I'm sorry. Let me get the right chart here. My
16 concern with Mr. Peterson was that he had been treated for seven
17 years with no objective significant improvement.
18 Q. Let's stop right there.
19 A. That's a red flag.
20 Q. Let's stop right there with that first one, Doctor. No
21 subjective improvement. That's what you're saying, right?
22 A. No. Objective improvement.
23 Q. Oh, no objective improvement. Okay. So if it is true that
24 Mr. Peterson originally came in in a wheelchair and then after
25 he started taking the medication he was able to walk and move

1 around and he was able to mow his lawn and he was able to do a
2 bunch of things he couldn't do before, that would be evidence
3 suggesting the medication was working, right?
4 A. If that were documented, yes.
5 Q. It just wouldn't be objective, right?
6 A. I'm sorry?
7 Q. It wouldn't be objective, but it would still be evidence,
8 right?
9 A. I would assume that would be fairly objective, but I don't
10 see that documented.
11 Q. All right. And your position is if it's not documented it's
12 not true, right?
13 A. That's the general standard of care, yes.
14 Q. Okay.
15 A. Would you like me to go back and finish the other points?
16 Q. That was the first one you had mentioned. Yeah, go ahead.
17 Let's talk about -- what's the second one?
18 A. Okay. The other is he had a history of going to prison for
19 DWIs for alcohol-related offenses. That's establishing that he
20 had a significant addiction to a substance. And the addition of
21 high-dose narcotics on top of that would be inappropriate
22 because it would be activating that addiction again.
23 Q. Okay.
24 A. Or playing into it.
25 Q. All right. And let's talk about that for a minute. People

1 that haven't had an alcohol problem in the past, they can have a
2 significant pain problem too, right?
3 A. They can have.
4 Q. Okay. And Mr. Peterson, I don't even think you would
5 disagree that Mr. Peterson had a significant reason to have
6 pain, right?
7 A. He had a significant reason to have pain, but that was not
8 well established in terms of what was the reason.
9 Q. Well, he had -- what do you mean? The man had neuropathic
10 pain. You don't deny that, do you?
11 A. Uh-uh. Mr. Peterson had been involved in a significant
12 motor vehicle accident and he had multiple -- he had neurologic
13 deficits. He was still able to walk with cane, but he still had
14 deficits.
15 The concern is that just because we see a patient with
16 neurologic deficits does not necessarily translate into what you
17 referred to as nerve pain.
18 Q. Okay.
19 A. We would -- if that were the case -- if you'd like me -- do
20 you want me to expound on that?
21 Q. No, not necessarily. What -- my point is, he had been in an
22 accident and he was reporting significant pain, right?
23 A. He was reporting significant pain, but we're not sure where
24 that pain was coming from.
25 Q. Well, somebody who had a significant accident and then after

1 the accident they start reporting significant pain, seems like
2 it might be a good place to start by thinking maybe the
3 accident's the source of the pain, right?
4 A. That's a good place to start, but it's not a good place to
5 end.
6 Q. Okay. Well, regardless, if somebody has an alcohol problem
7 and then they come in and they do have pain that would respond
8 well to narcotics or opiates, the fact that they had alcohol,
9 you wouldn't want to just eliminate somebody's ability to have
10 their pain treated because they had an alcohol problem in the
11 past, would you?
12 A. I would consider whether or not I really wanted to do harm
13 by adding to a problem that was already established as an
14 alcohol abuse issue.
15 Q. But what if it [Indiscernible], Doctor?
16 A. Well --
17 Q. What if the patient was able to monitor it and work with his
18 doctor knowing that there was an alcohol problem and it made his
19 pain better? That would be a good thing, wouldn't it?
20 A. If we were using small doses of opiates we might consider
21 that with a very carefully and heavily monitored situation.
22 Q. You might consider that.
23 A. No, I'm talking about standard of care.
24 Q. I know. Everything you're talking about is standard of
25 care. Everybody always agrees with you, that's what you said,

1 right?
2 A. Well, I was asked to -- to put my opinion forth --
3 Q. Right.
4 A. -- as standard of care, not what I would do.
5 Q. Right.
6 A. So the standard of care would dictate that we would not use
7 certainly high-dose opiates and he was on very high-dose
8 opiates, 2,900 morphine equivalents as we discussed the other
9 day.
10 But the additional part of this that adds into the
11 concern about addiction is that he had been taking multiple
12 substances for many years.
13 Q. Uh-huh.
14 A. He was 45 years old, but he also had a history of IV cocaine
15 use.
16 Q. Yup.
17 A. He also had a history of current use of marijuana.
18 Q. Uh-huh.
19 A. So there are multiple substances here that we know he has
20 abused over time.
21 Q. Yup.
22 A. The red flag with regard to the fact that he went to prison
23 for alcohol related issues and, therefore, addiction is made
24 even more concerning from an addiction standpoint because of the
25 history of IV cocaine and marijuana. This is not a patient in

1 all likelihood to be using narcotics at all, let alone the
2 extremely high doses that he was put on.
3 Q. But isn't it true, Dr. King, that someone else, somebody who
4 wasn't you and had your view of the standard of care, another
5 doctor could take the viewpoint that they wanted to -- even an
6 addict, even a person who's been in prison, a doctor could take
7 the viewpoint that they wanted to try to help that person with
8 narcotics to see if it works and monitor that person?
9 A doctor could take that view if they wanted to
10 compassionately approach this man. A doctor could do that,
11 right?
12 A. A doctor could do that at lower dose and on a trial basis,
13 on a very scripted trial basis.
14 Q. All right.
15 A. And not for several years at high dose.
16 Q. Okay. And the truth of the matter is, the dosage for
17 Mr. Peterson, it increased over time. It didn't start out at
18 the level that you read off at the end, it started at one level
19 and then it increased over time, right?
20 A. Dr. Szyman escalated it significantly over time.
21 Q. Yes.
22 A. Essentially indicating that the patient had failed his trial
23 but still got the medication --
24 Q. You're saying because he increased it that means the patient
25 failed the trial?

1 A. The patient failed the trial because he was not making,
2 based on what we see in the chart, any significant objective
3 improvement and function or quality of life.
4 Q. Because of what the chart says.
5 A. Because of what's documented in the chart, yes.
6 Q. So if the patient came in now and years later after having
7 no further contact with Dr. Szyman and explained -- and no
8 ability to get drugs from Dr. Szyman -- if that patient came in
9 and explained how this narcotic medication made him able to move
10 around, made him able to function in life, made him able to mow
11 his lawn and do regular things, would you take the view, well,
12 that patient's lying, the chart is right and he's a liar. Is
13 that what you'd really say?
14 A. No. I would parse what you said. I would say that the
15 patient is not lying. He may actually believe that. But what
16 the chart says is correct.
17 In 2008 Dr. Szyman puts down here in the record on
18 that date, a visit, 7/2/08: Nothing to date has made the pain
19 much better. And that was after trials of fairly-high-dose
20 OxyContin of multiple strengths.
21 So the record reflects what really happened
22 historically. Patients, especially patients who are addicted
23 and have substance abuse problems, have a distorted sense of
24 reality.
25 I would never say the patient lied, Counselor. It's

1 just that their perception of things is not correct and as a
2 physician I have to be aware of that.
3 Q. Wait a minute. Let's say I'm your patient, all right?
4 And -- or I'm a patient, right? And I've got a -- I was in a
5 bad accident and I lost a leg or something. Or not a leg.
6 Let's say I lost an arm and I got a real problem. Right? And
7 then --
8 Actually I want to rephrase that hypothetical. Let's
9 try a different one. Let's try this hypothetical. Let's say
10 I'm the patient and I suffer an accident. I've got some severe
11 back pain and I'm not ambulatory. I'm in a wheelchair. I can't
12 move around very well. Right? And then I go and I get treated
13 with narcotic medications. And after that I am able to move
14 around, I am able to take care of my kids, I am able to mow the
15 lawn when I couldn't do that before.
16 Would you then turn around to me and say, well,
17 according to this medical chart the narcotics didn't make you
18 better? Would you really say that?
19 A. I really don't understand what you're asking me because
20 according to the medical chart it says the narcotics did not
21 make him better.
22 Q. Right. But what if Mr. Peterson comes in here and says that
23 they did?
24 A. Well, again, that's --
25 Q. That his functionality did increase and he was able to do

1 all these things. What if Mr. Peterson says that? Are you
2 gonna say, oh, it wasn't because of the narcotics, Mr. Peterson,
3 you just -- you don't know what you're talking about because you
4 used drugs in the past?
5 A. As I indicated to you, the patient's perception is often
6 distorted especially over time and especially if we're dealing
7 with somebody who is on high-dose narcotics and who suffers from
8 addiction.
9 By definition -- by definition of addiction we know
10 that those patients have control issues, cognitive issues and
11 recurrent problems related to acuteness and what we call
12 executive functions. Their memories aren't good. Their
13 recollection is not accurate. Their perception of what happened
14 in the past is just simply not something we can depend on. What
15 we do depend on is the narrative and the objectiveness of the
16 medical chart. The medical chart says he wasn't responding very
17 well to the narcotics.
18 Q. There's one note of some -- of a lack of improvement on one
19 chart there, yes. You're talking about one note.
20 A. Well, no, there are multiple notes.
21 Q. But you're referring to one.
22 A. Sure. Well, I'll go up to another one. 3/6/08 where it
23 says the morphine doesn't help with the pain, makes him off
24 balance, muscles tight and having trouble voiding.
25 Q. And so --

1 A. There are multiple entries here where --
2 Q. Right.
3 A. -- where that is indicating.
4 Q. And what that's indicating is that Dr. Szyman is repeatedly
5 talking to this patient and trying to figure out something
6 that's going to work, right?
7 A. And documenting the things that aren't working from an
8 opiate standpoint.
9 Q. Documenting the things that don't work and trying to come up
10 with something else that does work, right?
11 A. Well, he just simply escalates the opiate dose when he's
12 already indicated that that trial failed.
13 Q. Right. And, well, he indicates that something failed and
14 then he tries a different dosage, right?
15 A. He escalates the dose.
16 Q. Right. And you don't think or you say that your opinion is
17 standard of care is that you shouldn't do that, right?
18 A. Standard of care indicates that a trial on the basis of
19 weeks or maybe a month or maybe six weeks is not inappropriate.
20 And I will certainly not indicate that a doctor was out of the
21 standard of care even though I might not want to do it if he did
22 it for that timeframe. But that's not what happened here.
23 Q. But that's --
24 A. These were escalated over the course of years.
25 Q. Yes. And you haven't talked to -- you certainly haven't

1 recently talked to Mr. Peterson about his recollections and
2 about how the impact on him since Dr. Szyman's been no longer
3 able to treat him, you haven't talked to him about that either,
4 have you?
5 A. I have not talked to Mr. Peterson, of course.
6 Q. Right. You haven't talked to Mr. Peterson, you don't know
7 what his input on this would be.
8 A. Again, I've given you my thoughts with regard to the input
9 from somebody who is addicted.
10 Q. Right. And people that have addiction problems, you
11 basically don't think they have any reliability. That's what
12 you're saying. You have a prejudice against addicted people.
13 That's what you're saying.
14 A. No, sir, I'm not prejudice against them.
15 Q. I see.
16 A. But as a physician, as a specialist in the area of addiction
17 medicine and pain medicine and anesthesiology, I know for a fact
18 that there's a rewiring of the brain and the individual cannot
19 change that. That's something that occurs that is with them for
20 the long term.
21 And, therefore, as a physician I have to be aware of
22 the fact that when I talk to those patients I may not be getting
23 the full situation, I may not be getting the full truth.
24 So with compassion for them, I nevertheless have to
25 verify things, in this case go back to the medical record and

1 see what Dr. Szyman and the nursing notes and the urine drug
2 screens actually documented.
3 Q. All right. I don't even know what the question was after
4 all that.
5 Let's see. Let's try a question. So Dr. King, you
6 reviewed these medical records in all of these instances. Every
7 instance where you're a consultant you review medical records,
8 right?
9 A. That's correct.
10 Q. And when you review the medical records in criminal cases
11 you're reviewing them for the purpose of evaluating whether a
12 doctor has met your -- what you call the standard of care,
13 right?
14 A. That's correct.
15 Q. Okay. And you've done this in multiple instances for the
16 prosecutors at DOJ, right?
17 A. That's correct.
18 Q. You said that yesterday. All right. And when you come in
19 and review the records for these doctors, on how many of these
20 instances, Dr. King, did you find that the -- that the doctors
21 were acting outside the standard of care?
22 A. In the majority of cases but not all.
23 Q. How many times did you find that it wasn't the case?
24 A. There are two cases right now that I'm -- well, let me
25 clarify. When these cases are brought to me they're often

1 brought in the early stages.
2 Q. Uh-huh.
3 A. In the early stages of the development of the case they are
4 presented to me and the question is asked to me: Is this
5 physician operating outside the usual standard of care? Is this
6 physician prescribing without legitimate medical practice? And
7 they're asking me whether I think that exists.
8 And in some cases, again, there's a spectrum.
9 Sometimes we may find -- I may find that the patient is outside
10 the standard of care but it's not egregious and it doesn't look
11 like it's repetitive.
12 In other cases I may find, like in this, every case I
13 looked at had multiple red flags that were ignored and I came to
14 the conclusion that these were outside the standard of care in
15 every case.
16 But in some cases I make the recommendation that I
17 don't think it's that bad, I don't see it as extremely outside
18 the standard of care.
19 And in some cases where perhaps the records have been
20 given to me just partially, when I work with the attorney
21 general's office, I may review informally some cases where one
22 of the AGs may come to me and say look at this PDMP, what do you
23 think, do you see a pattern, do you see a concern. So
24 oftentimes on an informal basis I will say I don't think that
25 looks too bad, I think that looks within the standard of care.

1 So whereas in cases like this in federal court --
2 Q. Yes.
3 A. -- obviously things have been pre -- triaged up to a very
4 high level, with a lot of the people including me looking at
5 this in putting forth my opinion --
6 Q. When the cases go to court, the vast majority of the time
7 you always say the doctor is outside the standard of care,
8 right?
9 A. Right, because some don't come to court based on what I say.
10 Q. Right. Some of them plead guilty based on what you're
11 saying, right?
12 A. No. Sometimes they just don't come to court because my
13 opinion is such that I don't think it's that egregious, I don't
14 think it's outside the standard of care.
15 Q. Okay. But in the cases where the case is actually going to
16 go to court and you've got a doctor in court, you've always
17 testified that the doctor was outside the standard of care.
18 That is the only opinion --
19 A. Well, they come to court because -- partially -- because I
20 have opined that they are outside the standard of care.
21 Q. Right. Your opinion of the standard of care or your opinion
22 about the standard of care leads to people being prosecuted.
23 That's what you're saying.
24 A. It is one of the factors, yes.
25 Q. And when people get prosecuted you get to testify and make

1 your $5,000 a day, right?
2 A. Well, I do get paid for my time, yes. I am primarily a
3 physician. That's where I make the majority of my -- invest the
4 majority of my time and my income.
5 Q. Dr. King, big picture ultimately. In terms of patients
6 coming in and lying to their doctor, if patients are coming in
7 with an agenda to lie to their doctor about degrees of pain,
8 about the side effects of medications, about how many
9 medications they're taking, those are decisions the patient
10 makes, right?
11 A. Correct.
12 Q. Okay. And those decisions may lead the doctor to incorrect
13 impressions of what's going on, correct?
14 A. It tends in that direction, yes.
15 Q. And a doctor can be acting in good faith trying to treat
16 patients and get misled by a series of the patient lying to
17 them, right?
18 A. As a physician we assume that's going to happen and try to
19 do everything we can to prevent from being misled.
20 Q. Okay, you try to. But when people are methodically lying to
21 you, that can negatively impact what you're trying to do. You
22 can be acting in good faith and at the same time you can be
23 being misled, right?
24 A. It's difficult to be a physician, yes.
25 Q. Okay. And you would agree with me also, Dr. King, that if

1 the result is if patients are lying to you and you give them
2 opiate medications because you're trying to treat them and
3 they're lying to you and it turns out that you were wrong and
4 then you're getting prosecuted over that, that gives a
5 disincentive I think overall for people to use opiate
6 medications for treatment, period, doesn't it?
7 A. We talked --
8 Q. It's a chilling effect on doctors, isn't it?
9 A. Well, we talked about that a lot and it's in the literature
10 from an opinion standpoint, but I've not actually seen that to
11 be the case.
12 Q. No? Do you know -- do you know -- after Dr. Szyman was
13 charged do you know what the impact was on opiate prescriptions
14 here for patients in pain in Manitowoc? Do you know how much it
15 went down after Dr. Szyman was -- opiate use at all for anybody?
16 A. I do not.
17 Q. Do you know how much his prosecution might have put fear
18 into other doctors and caused them to stop treating people with
19 pain medications that people might need?
20 A. Fear or common sense, we don't know which.
21 Q. I was asking about fear.
22 A. How can I quantitate that? Maybe the response was they
23 looked at the regulations, the Wisconsin regulations and the
24 federal regulations and said maybe I have been overprescribing
25 and it's medically inappropriate. So it may have had a very

1 beneficial effect in that regard.
2 Q. Well, the reality of the situation is there's some patients
3 that really need opiate medications, aren't there?
4 A. There are some patients who do better with the opiates, but
5 we should be able to objectively address that. It turns out
6 that's a much, much lower number than we might have otherwise
7 thought.
8 Q. So the reality is your opinion of the use of opiate
9 medications is that they should be used in a limited fashion,
10 right?
11 A. My opinion is they should be used as a specific tool when
12 they objectively can be shown to improve and when the side
13 effects are minimized. It's a risk management issue like
14 everything in medicine.
15 Q. Right.
16 A. There is a place for that tool but not for everybody.
17 Q. But you just said something that I think is important. What
18 you just said is that opiates are much less useful or we need
19 much less of them than what we once might have thought? What
20 was it you said?
21 A. Well, I responded to your statement indicating that the,
22 quote, chilling effect as a result of Dr. Szyman's
23 prosecution --
24 Q. Uh-huh.
25 A. -- was that the opiates in Manitowoc were dramatically

1 decreased. And my response to that was, were they decreased
2 because of the chilling effect? Which I don't think was the
3 issue. We haven't seen that. As much as it was doctors took a
4 second look at what they were doing and by example thought maybe
5 I am overprescribing and began to lower the doses into more
6 appropriate doses. That's where we were on that.
7 Q. And in general what's happened is, trends had changed in
8 terms of thought about how much opiates and how often opiates
9 should be prescribed and now doctors are, generally speaking,
10 prescribing less. That's the trend now, right?
11 A. Doctors are doing what they're supposed to do. The standard
12 of care hasn't changed that much. What has changed is that
13 doctors are doing what they do as we talked about yesterday.
14 Q. All right. Yeah, I know you said the standard of care
15 doesn't change. Let's set that aside.
16 What I'm saying is, generally speaking, there's a
17 trend now for doctors to start prescribing less opiates than
18 they did before, right?
19 A. I think there's a trend now for doctors to do what they're
20 supposed to do in terms of diagnosis and treatment plan
21 formulation.
22 Q. That's not my question. Okay? I want you to listen to what
23 I'm saying. I'm talking about the prescription of opiates.
24 There's a trend presently for doctors to prescribe less than
25 they used to, right?

1 A. That's correct.
2 Q. And in the past there was a trend for doctors to be
3 prescribing more, right?
4 A. The opiates were being prescribed more, that's correct.
5 Q. Okay. And they were being prescribed more by many doctors,
6 right?
7 A. Correct.
8 Q. Okay. And Dr. Szyman, he started seeing these patients back
9 as far as 2004, right?
10 A. That's correct.
11 Q. And back at that time doctors were prescribing a lot more
12 opiates, right?
13 A. Statistics reflect that, yes.
14 Q. Okay. And you say the standard of care says they shouldn't
15 have been doing that, right?
16 A. The standard of care for a physician has always been in this
17 regard the same.
18 Q. Okay.
19 A. In the sense that we examine the patient, we make a
20 diagnosis, we formulate a treatment plan, and then we do no
21 harm. We monitor the patient.
22 Q. Right.
23 A. That hasn't changed.
24 Q. I understand that. I've heard --
25 A. And new medicines come out all the time.

1 Q. Right.
2 A. New opiates come out all the time. But we still as
3 physicians are constrained to those four elements.
4 Q. Right, of course. But when doctors are prescribing
5 medications doctors are aware of trends of what other doctors
6 are doing. Generally speaking, that's something that you guys
7 know, right?
8 A. We may be aware of them, but that's not what drives our
9 practice.
10 Q. Listen to my question, sir. You're aware of what other
11 doctors are doing, generally speaking, right?
12 A. More or less.
13 Q. Okay.
14 A. It's not something I emphasize. It's --
15 Q. And you -- I'm not asking what you want to emphasize, I'm
16 ask you whether you're aware of. And you are, aren't you?
17 A. Partially.
18 Q. Okay. And in the past you have now said that people used to
19 be prescribing higher dosages of opiates, right?
20 A. Well, the dosage of opiates prescribed have increased as the
21 years have gone on.
22 Q. The other prescription dosages have increased?
23 A. Yes.
24 Q. But the number of doctor -- how many opiates doctors are
25 prescribing? You're saying that's trending down now, right?

1 A. Well, you had indicated that it was [Indiscernible] for the
2 local area here and I don't have specific knowledge of that.
3 But I wouldn't disagree if you represented it to me
4 [Indiscernible].
5 Q. No, no, no, no. In general. In general. Presently isn't
6 there a trend overall -- not just here, but in general isn't
7 there a trend for doctors to be prescribing less opiates than
8 they used to? You just said there was.
9 A. Yes. Certainly within the last year we're seeing that, yes.
10 Q. Okay. And so before the last year, around the country
11 doctors are prescribing more, right?
12 A. Correct.
13 Q. Okay. And Dr. Szyman was one of those doctors, correct?
14 A. Yes.
15 Q. And it's certainly the case that doctors may be influenced
16 by what other doctors are doing, right?
17 A. They may be influenced.
18 Q. And Dr. Szyman -- you said you didn't know what seminars,
19 symposiums Dr. Szyman was going to back over the years, do you?
20 A. I do not.
21 Q. But you do know that over those years when Dr. Szyman was
22 training these patients there were doctors out there giving
23 seminars advocating high-dosage opiate prescription. That was
24 going on and you know it, right?
25 A. There were one or two doctors who were proposing that, yes.

1 Q. And they were proposing that as experts in their field to
2 hundreds of other doctors who were willing to listen to them,
3 right?
4 A. They were.
5 Q. Okay. And those hundreds of other doctors could have easily
6 been influenced by that and followed that protocol, right?
7 A. They could.
8 Q. Okay. And those doctors could be following that protocol
9 trying to act in good faith even though they don't meet the
10 standard of care that you're describing.
11 A. They didn't meet the overall standard of care and they could
12 have acted accordingly, yes.
13 Q. Okay. So they could have been trying to act in good faith
14 that whole time doing that, using high-dose opiates, right?
15 A. If they depended on that as their sole input that would not
16 be appropriate, but if they reasoned that as their sole reason
17 for prescribing higher-dose opiates then they would be acting in
18 good faith based on that one point, yes.
19 Q. Okay. On the one point about high-dose opiate use.
20 A. Correct.
21 Q. Okay. And, Dr. King, with respect to -- just one moment.
22 (Brief pause.)
23 BY MR. BRINDLEY:
24 Q. So you did not review any of -- well, let me put it to you a
25 different way.

1 You talked about the patients that you did review who
2 all were taking high-dose opiates from Dr. Szyman. Do you know
3 the number of overall patients that Dr. Szyman had?
4 A. I do not.
5 Q. Do you know whether, in fact, high-dose opiates patients
6 were a very small percentage of his practice?
7 A. I don't know one way or the other.
8 Q. Do you know whether he only used the high-dose opiates on
9 certain patients that he viewed as having exhausted all other
10 opportunities with other doctors? Do you know that?
11 A. I don't know one way or the other.
12 Q. Okay.
13 THE COURT: Mr. Brindley, are you close to the end?
14 It's a break time.
15 MR. BRINDLEY: Let's take the break, Judge. I might
16 come back and be short, but I want to be sure.
17 THE COURT: All right. Let's take our morning break.
18 (Jury out at 10:34 a.m.)
19 THE COURT: Anything to put on the record?
20 MR. BRINDLEY: No, Your Honor.
21 THE COURT: Okay. We're in recess.
22 (Recess taken at 10:35 a.m., until 10:52 a.m.)
23 (Jury in at 10:54 a.m.)
24 THE COURT: Okay. Please be seated, ladies and
25 gentlemen. And you may continue, Mr. Brindley.

1 BY MR. BRINDLEY:
2 Q. Dr. King, you have said repeatedly that it's difficult to be
3 a pain doctor, right?
4 A. Correct.
5 Q. And you -- as a pain doctor you are confronted with very
6 difficult situations, right?
7 A. Yes.
8 Q. And as a pain doctor you are put in the position where you
9 have to do your best to make very difficult judgments, right?
10 A. That would be correct.
11 Q. All right.
12 MR. BRINDLEY: Judge, I have nothing else for
13 Dr. King.
14 THE COURT: Okay. Mr. Jacobs?
15 MR. JACOBS: Thank you, Your Honor.
16 THE COURT: Redirect? Uh-huh.
17 REDIRECT EXAMINATION
18 BY MR. JACOBS:
19 Q. Dr. King, defense counsel asked you about I guess doctors
20 who had advocated high-dose opioids?
21 A. Yes.
22 Q. I think you said there were one or two; is that right?
23 A. Correct.
24 Q. First of all, what are we talking about by those advocates
25 of high-dose opioids? What doses are we talking about that

1 those doctors were advocating?
2 A. They were advocating no upper dose. They were indicating
3 that doses up to --
4 Well, I shouldn't say that. Let me rephrase that.
5 What they were indicating was doses up to perhaps a couple
6 hundred. One of those two individuals -- one of the two
7 "thought leaders," if you will, was at the time advocating I
8 believe it was up to about 200 or 240 milligrams. I'm not
9 exactly sure of that, but somewhere close to that as sort of a
10 reasonable upper dose.
11 Q. So that's -- are we talking 250 morphine equivalency units
12 or doses?
13 A. Yes. Yes, correct. 240 morphine equivalencies.
14 Q. That's on a daily basis?
15 A. Yes.
16 Q. That's what they're advocating for high-dose opioid use?
17 A. Yes.
18 Q. Did anybody advocate 3,000 morphine equivalency doses on a
19 daily basis?
20 A. No, they did not. They never went up that high. And as a
21 matter of fact, the one physician, Dr. Portenoy, which defense
22 brought up, Dr. Portenoy recanted all that in 2012 in the letter
23 to the Wall Street Journal entitled, "Pain Doctor Has Second
24 Thoughts." At which time he quoted -- was quoted as saying, if
25 I had known then what I know now I never would have said that or

1 advocated that.
2 So even that -- so no one -- no one advocated those
3 high doses that we're seeing here and certainly at that
4 Dr. Portenoy recanted all of that.
5 Q. And so -- but even before that, the high dose that they were
6 talking about was 200, 240 MEQ a day?
7 A. Correct.
8 Q. Is it fair to say that's a tenth to one-fiftieth of what
9 Dr. Szyman was prescribing to some of the patients you reviewed?
10 A. That's correct.
11 Q. Now, defense counsel asked you about your compensation for
12 testifying and for reviewing the files, the patient files here.
13 Did anyone direct you what to conclude?
14 A. No. My opinion was asked, without prejudice, saying, what
15 do you think? And there was no pressure to come to a conclusion
16 one way or the other.
17 Q. And I think you indicated that your conclusion may have been
18 one of the factors that influenced whether charges were brought.
19 It was not the only factor is your understanding; is that right?
20 A. Clearly not the only factor, correct.
21 Q. Defense counsel asked you about Mr. Peterson, Dabian
22 Peterson. Do you have his chronology there?
23 A. I do.
24 Q. And I'm going to refer to some of the pages from his patient
25 file which is Exhibit 5 I believe. And was Mr. Peterson being

1 seen by another physician prior to Dr. Szyman?
2 A. He was seen by multiple physicians prior to Dr. Szyman.
3 Q. And in particular was he seen by a neurologist?
4 A. Yes, he was.
5 Q. And I want to turn your attention to an entry in his patient
6 file on August 31st of 2007. Do you see that?
7 A. I do, yes.
8 Q. And is that an entry being made by a physician other than
9 Dr. Szyman?
10 A. It is.
11 Q. And who is that?
12 A. That physician -- and I'm not sure I can pronounce his name
13 correctly -- Dr. Shewmake perhaps -- he's a neurology
14 specialist.
15 Q. And for the record it's S-H-E-W-M-A-K-E; is that right?
16 A. That's correct, yes.
17 Q. Okay. And does -- he's a neurologist?
18 A. Yes.
19 Q. And can you explain to the jury, what's a neurologist do?
20 A. A neurologist specializes in disorders of the nerves in the
21 brain. So it would be a colleague that we would look to for
22 nerve-type pain issues or in other areas neurologists would
23 address epilepsy, seizure disorders, multiple sclerosis, that
24 sort of thing.
25 Q. And does that neurologist provide information about

1 Mr. Peterson and his pain and how it should be treated?
2 A. He does. He's very specific.
3 Q. What does he say?
4 A. He acknowledges that the individual has a history of spinal
5 cord injury with hand pain and further acknowledges that
6 Mr. Peterson describes a, quote, lot of stresses and having to
7 leave town.
8 He goes on specifically to indicate that the mother
9 and the brother of the patient are alcoholics and that he would
10 suggest a nonnarcotic approach to Mr. Peterson's particular
11 situation.
12 Q. And based on your medical expertise do you know why he would
13 be suggesting a nonnarcotic approach for Mr. Peterson?
14 A. The documentation that's here appropriately acknowledges
15 that both the mother and the brother are alcoholics. We know
16 that Mr. Peterson is also an alcoholic.
17 When we do our scores to try to understand if a
18 patient has a tendency towards substance abuse, whether it be
19 opiates or other substances but specifically opiates, we look at
20 the alcoholic history among other things. If there is a close
21 family member, let alone if there are two close family members,
22 that gets a fairly high score in looking at the risk factors.
23 So I'm presuming that part of the suggestion is on the
24 basis of the fact that there are significant risk factors,
25 mother, brother, and the patient himself.

1 And then, secondly, the individual -- he has already
2 at that point not done well with the usual medications that we
3 would choose to treat nerve problems. And, therefore, I think
4 the reality from Dr. Shewmake -- and I apologize if I
5 mispronounce that -- are that we don't want to cause further
6 harm thus recommending no opiates for that particular
7 nerve-related problem.
8 Q. And can you tell from your chronology when Dr. Szyman --
9 when Mr. Peterson saw Dr. Szyman for his first visit?
10 A. Dr. Szyman's first visit with Mr. Peterson was on February
11 13, 2008, which would have been four months later.
12 Q. And with all of that information from the neurologist, the
13 recommended nonopioid treatment for his pain, was that in
14 Dr. Szyman's -- the patient file that Dr. Szyman had?
15 A. Yes.
16 Q. Okay. Now, the first visit -- Mr. Peterson goes to see
17 Mr. Szyman on his first visit -- Dr. Szyman, I'm sorry -- what
18 was his pain level on his first visit to see Dr. Szyman?
19 A. Pain level on the first visit is quoted to be at four to
20 five out of ten.
21 Q. Okay. And at that time did Dr. Szyman make an initial
22 prescription or can you tell from your chronology at the start
23 what Dr. Szyman was prescribing for Mr. Peterson?
24 A. Yes. On the initial visit based on the medical record he
25 prescribed morphine, 60 milligrams twice a day for a total of

1 120 milligrams.
2 Q. So an MEQ of 120?
3 A. Correct.
4 Q. Okay. And at some point did Dr. Szyman change the
5 prescription that he gave Mr. Peterson to hydrocodone or
6 oxycodone?
7 A. Yes. It's not clear but what maybe the hydrocodone was part
8 of that initial visit prescription. I just don't reflect it
9 here. But in the visits that followed hydrocodone was part of
10 the regimen.
11 Q. And how much hydrocodone, what quantity and what dosage did
12 Dr. Szyman initially prescribe to Mr. Peterson?
13 A. Initially prescribed hydrocodone 10 milligrams every four
14 hours. Or excuse me, four times a day. 10 milligrams four
15 times a day.
16 Q. And so -- 40 total milligrams a day of, is it hydrocodone or
17 oxycodone?
18 A. Hydrocodone.
19 Q. And what's the difference between hydrocodone and oxycodone?
20 A. Oxycodone would be Percocet or oxycodone or OxyContin.
21 Hydrocodone would be like Norco or Vicodin. He was prescribed
22 the Norco-Vicodin-Hydrocodone preparation.
23 Q. Are they similar controlled substances?
24 A. They are. Hydrocodone on a milligram-for-milligram basis is
25 the same potency as morphine.

1 Q. So when did Dr. Szyman initially prescribe that for
2 Mr. Peterson?
3 A. Well, based on the medical record I have it looked like on
4 March 3rd, 2008, which would have been a couple weeks after the
5 first visit the hydrocodone was initiated.
6 Q. So the MEQ at that time within the first month of Dr. Szyman
7 seeing Mr. Peterson was 40 MEQ?
8 A. Yes. At that point, yes.
9 Q. And Mr. Peterson had a pain level of 4-5.
10 A. Correct.
11 Q. And are there indications in Mr. Peterson's file that he
12 provided I'll call inconsistent urine drug samples?
13 A. Yes.
14 Q. And I turn your attention to October 26th of 2009. Do you
15 see that?
16 A. I do.
17 Q. And what was the result -- did Mr. Peterson provide a urine
18 drug sample on that date?
19 A. He did provide a urine drug sample on that date.
20 Q. And was there anything inconsistent about the sample
21 Mr. Peterson provided?
22 A. Prior to that date he had been prescribed oxycodone, but the
23 oxycodone did not show up in his urine at which point the
24 notation was made on that urine drug screen which was
25 inconsistent, quote: This is bad. One more patient warning

1 given.
2 Q. So again, that's in 2009.
3 A. Correct.
4 Q. Okay. And is there a visit in approximately that same
5 period of time with Dr. Szyman?
6 A. I'm sorry, say that again?
7 Q. I'll skip it. I may have the wrong date.
8 And other than subsequent --
9 Let me turn back to March of 2009, about a year later
10 after his initial visit, do you see a visit there of
11 Mr. Peterson to see Dr. Szyman?
12 A. Yes.
13 Q. And what is -- approximately a year after seeing Dr. Szyman
14 how does Mr. Peterson rate his pain?
15 A. Approximately a year after, on March 18, 2009, the chart
16 indicates he's rating his pain at 4, quote:
17 "The best it's been lately. To date nothing makes his
18 pain a whole lot better. Will continue his meds as currently
19 prescribed with follow-up in four months."
20 Q. And can you tell at that point what quantity of controlled
21 substances or narcotics is Mr. Peterson getting from Dr. Szyman?
22 A. I'm referencing a nursing note just a couple weeks prior to
23 that which indicates a requested authorization for OxyContin, 60
24 milligrams, eight per day. So 480 milligrams of OxyContin. We
25 multiply that by 1.2. Can't do the math exactly in my head, but

1 480 plus 240 is -- you know, that would be the number of
2 milliequivalents, morphine -- not milliequivalents -- number of
3 morphine equivalents that he would likely have been on relative
4 to that date we just talked about.
5 Q. So from his first month of his visit when his pain when it
6 started was 4 to 5 and he was getting an MEQ of somewhere around
7 40, about a year later his pain's at four and with an MEQ
8 somewhere around 500; is that right?
9 A. That would be correct.
10 Q. And then I gather Mr. Peterson continued to see Dr. Szyman
11 for several years?
12 A. Correct.
13 Q. And if we could turn to at least the last visit reflected on
14 your chronology, January of 2015. So six years after the visit
15 we were just discussing, approximately seven years after he's
16 seeing Dr. Szyman, how does Mr. Peterson say his pain level is
17 there?
18 A. That's an office follow-up dated January 21, 2015. States,
19 "Pain level at 5."
20 Q. So his pain bumped up a little I guess seeing Dr. Szyman.
21 A. It certainly did not improve at all. It's -- he indicated 4
22 to 5 initially and he's indicating 5 at seven years down the
23 line.
24 Q. Okay. So we're six years later and how much morphine
25 equivalents or how many narcotics is Dr. Szyman giving to

1 Mr. Peterson at this point?
2 A. He's on three different preparations of oxycodone and
3 OxyContin. Three different preparations for a total of 2,910
4 morphine equivalents, which is -- equals about 30 pain tablets
5 per day.
6 Q. And that is, he's getting 20 80-milligram OxyContin tablets
7 a day, six 30-milligram Oxycodone-Immediate Release a day, four
8 40-milligram OxyContin a day, and then some Xanax on top of
9 that, two a day.
10 A. Correct.
11 Q. Now, defense counsel asked you about cases you've reviewed
12 and suggested that you only conclude that doctors are acting
13 outside the scope of professional practice. Is that the case?
14 A. In this case?
15 Q. In all your cases you've reviewed.
16 A. No, there are sometimes when I opine that the doctor is not
17 outside the usual course of medical practice.
18 Q. And have you, in fact, recommended against pursuing criminal
19 charges against some physicians?
20 A. I have, yes.
21 Q. And is part of the standard of care to recommend the
22 cheapest option to the patient?
23 A. That would not be the practice of medicine. So that would
24 be outside the standard of care. We deal with those realities,
25 but we do have to deal with them in an appropriate and safe

1 manner.
2 Q. Now --
3 A. I'm sorry, we can't let costs totally dictate our medical
4 care.
5 Q. Now, there was some discussion about the goal is to improve
6 a patient's functionality, right?
7 A. Correct.
8 Q. Like Ms. Buretta was able to continue to work; is that
9 right?
10 A. Yes.
11 Q. Do you have to consider possible side effects when trying to
12 achieve that goal?
13 A. Again, as I've so often said, that's certainly one of the
14 four A's that we have to look at very carefully in order to be
15 safe and deliver optimal patient care. So, yes.
16 Q. So you can't just keep giving people narcotics because maybe
17 they can continue to work; is that right?
18 A. Well, I think we have to look at the side effects to find
19 out if we're giving with one hand and taking away with the
20 other. So people may be able to work, but we don't want them
21 zombies when they work, especially if they're a nurse in the
22 medical profession.
23 Q. Is death a potential side effect of excess opioids?
24 A. Yes, it is.
25 Q. Do you have to consider that?

1 A. You have to consider that, absolutely.
2 MR. JACOBS: That's all I have, Judge.
3 MR. BRINDLEY: Judge, can I ask a couple of
4 follow-ups, please? Not too many. Thank you.
5 THE COURT: Go ahead.
6 RECROSS-EXAMINATION
7 BY MR. BRINDLEY:
8 Q. You were speaking a minute ago about the functionality in
9 side effects. You have to compare the two, the degree of
10 functionality and the side effects. You have to compare both
11 and take both into account when talking with the patient, right?
12 A. That would be correct, yes.
13 Q. Okay. And patients at the same time have to consider their
14 degree of pain and the risks and side effects that have been
15 described to them by the doctor when advising the doctor on how
16 they'd like to proceed. Right?
17 A. They're participants in this as you and I have discussed,
18 yes.
19 Q. Yes. And so they have to weigh the risks against the pain.
20 A. Absolutely. Yes.
21 THE COURT: Get to something new quick.
22 MR. BRINDLEY: Yes, all right.
23 BY MR. BRINDLEY:
24 Q. You talked about Dr. Portenoy and said that he had changed
25 his mind or his opinion about high-dose opiates, right?

1 A. That's correct.
2 Q. And so then it's correct to say that opinions about these
3 medications and the use of these medications, those opinions can
4 change over time, right?
5 A. Well, Dr. Portenoy certainly did.
6 Q. Yes. And so a doctor can be acting in good faith and be
7 wrong about the best way to use a medicine as possible, isn't
8 it?
9 A. That can happen.
10 THE COURT: We've been over all this, Mr. Brindley.
11 MR. BRINDLEY: All right, one more further --
12 THE COURT: You know, we went direct, cross and
13 redirect and I'll let you go one more, but we're not going to
14 keep going back and forth forever.
15 BY MR. BRINDLEY:
16 Q. Dr. King, you mentioned Dr. Portenoy having changed his
17 opinion. That was something you said to Mr. Jacobs. You have
18 never -- you don't know whether Dr. Passik ever altered his
19 position, do you?
20 A. I'm not familiar with Dr. Passik. He wasn't considered one
21 of what we called the thought leaders.
22 Q. Okay. And you don't know whether Dr. Passik advocated
23 prescribing whatever dose of opioids it took to receive --
24 achieve functionality without significant adverse side effects.
25 You don't know whether he advocated that or not, do you?

1 A. Again, I'm not familiar with his treatment philosophy.
2 MR. BRINDLEY: That's it. Thank you.
3 THE COURT: All right. Thank you, Dr. King, you can
4 step down.
5 (Witness excused at 11:16 a.m.)
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C E R T I F I C A T E

I, JOHN T. SCHINDHELM, RMR, CRR, Official Court Reporter and Transcriptionist for the United States District Court for the Eastern District of Wisconsin, do hereby certify that the foregoing pages are a true and accurate transcription of the audio file provided in the aforementioned matter to the best of my skill and ability.

Signed and Certified December 1, 2017.

/s/John T. Schindhelm

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EXHIBITS

NUMBER	DESCRIPTION	OFFERED	ADMITTED
	None		