IN THE MISSOURI COURT OF APPEALS
EASTERN DISTRICT

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| **HENRY D. WALDEN, M.D., ET AL.,** **Appellant**, | ) | |
| **vs**. | ) | **Appeal No. ED104987** |
| **BRIAN KOON, ET AL.,** **Respondent**. | ) | |

IN THE CIRCUIT COURT OF THE CITY OF ST. LOUIS
STATE OF MISSOURI
Honorable Michael W. Noble, Judge

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| **BRIAN KOON, ET AL.,** **Plaintiff**, | ) | |
| **vs**. | ) | **Cause No. 1422-CC01258** |
| **HENRY D. WALDEN, M.D., ET AL.,** **Defendant.** | ) | |

TRANSCRIPT ON APPEAL
JUNE 20 - 28, 2016

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TWENTY-SECOND JUDICIAL CIRCUIT

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Monday, June 20th, 2016

THE COURT: Good afternoon.

(Whereupon, good afternoon was heard.)

THE COURT: Take care of some housekeeping measures, and then we will dive into it due to the time of the day. First I want to commend you all for reporting for jury service. And you can take pride in performing your service, because it is an important service to our judicial system, and we definitely appreciate the sacrifices you made coming here today.

My name is Judge Noble, as Ali said, I want to welcome you to Division 21. Let me introduce you to some of my staff. This is Maureen, she's my clerk. You met Ali, my sheriff. And in front of me is Renee, my court reporter. Renee has a very challenging job. She has to take down everything that is said during the trial. This is not the largest courtroom, but it is a little deep. And, so, there's one inconvenience about being in here, and I'm going to ask those of you that are in the bleachers -- I'm a big baseball fan, so I consider this the box, left bleachers, right bleachers. So if you are in the bleachers, I'm going to ask that if you have a response to one of the attorneys' questions or one of my questions, to please stand. One, it allows Renee to hear you better, which means that we don't have to ask you to repeat, which means we can do the process

faster. So I always hear jurors like it when we can move the jury selection as fast as possible. So if you stand when you're in the bleachers, we can hear you one time and keep on rolling. Those of you that are in the box, you do not have to stand. Okay?

All right. The other thing is when -- since Renee has to take down everything, if you have an answer, please verbalize and don't do uh-huh or nod your head. She cannot take down nods or -- or sounds, she can only take down when you verbalize your answer. So please keep in mind when you're answering that Renee is taking down everything that is said. At any time if you cannot hear the lawyers or myself, just raise your hand and ask us to repeat it and we will repeat any questions that we have.

Just so you know, a lot of -- you'll see the attorneys and myself looking at something. We have a copy of the jury panel list. When you filled out your jury questionnaire, it goes into a computer, spits out random names, and then we get the information. The information in here is not always accurate. So if one of the attorneys asks you how you enjoy being a professor, and you're actually a plummer, that's because it says professor not plummer in here. So that's part of the reason why we're doing this, to make sure that they have accurate information. And a lot of times there's blanks,

and so they need you to fill in the blanks. Once the jury is picked we collect all of these and they are destroyed. They do not have access to your addresses, zip codes, none of your pertinent personal information is accessible. But when we are done we shred everything and it never leaves the courtroom.

All right. So, in terms of timing, I anticipate that this -- and while I'm trying to predict it, I am not always accurate. I anticipate that this case will be given to the jury on Friday to deliberate. And so that is the -- that's the time frame we're operating on. I am not a hundred percent sure on how we end up, but I want to keep that -- everybody keep that in mind. Because on your jury form I believe it says it will last for several days.

So later on I'll be asking you if anybody has any hardship issues, and we'll deal with that. But keep in mind that this case will probably -- we will hear evidence and argument probably up until Friday morning. If not -- if it goes past the weekend, I'll let everybody know. You will not be sequestered in the sense that -- in other words, you will be able to go home every night in this type of case. But I'm not sure -- our goal is to have it wrapped up by Friday. But if it goes long because we've gotten the jury late in the day, it might roll over into the following week. So I'll deal with any hardship

question issues later.

All right. I think we're ready to dive in. All right. The case that you have been sent to this division is a civil case where Brian and Michelle Koon have filed a medical malpractice suit against Dr. Henry Walden and St. Louis University.

The first order of business is going to be jury selection, and the Court as well as the attorneys are given the opportunity to ask you various questions as a group and individually for the purpose of making the selection of a fair and impartial jury panel.

The questions are intended to find out whether any of you -- any of your lifetime experiences or beliefs that you might have might affect your ability to be fair and impartial in this particular case and to reach a verdict based upon the law and the evidence presented. Your answers to these questions may reveal that some of you may be better suited for a different case.

Since this is an important part of the trial, you're required to be sworn before questions are asked. Please rise now and be sworn to answer questions.

(Jury panel is sworn.)

THE COURT: Please be seated. Please listen very carefully to all the questions. Take your time in answering. Please search your memory before answering

questions. Some of the questions may require you to recall experiences during your entire lifetime. Your answers must not only be truthful, but they must be full and complete. During the questioning process if you remember something that would modify an answer that you gave previously, or you remember something that would provide information you didn't give earlier, please raise your hand and you'll be given an opportunity to provide that information. If you're not sure whether or not a question applies to you, please resolve any doubt in favor of giving us an answer and letting the attorneys and I decide whether or not it's relevant to the question that was asked. There are cases that have been tried all over again because it's at this very stage of the proceedings someone on the panel did not answer a question that applied to them or that was put to them or because they failed to reveal the information requested of them.

Ladies and gentlemen, please understand that none of these questions are meant to cause you any embarrassment or any discomfort. If any of your answers involve issues that are personal or private, we have -- and you don't want to share in front of open court in front of fellow jurors, we can address those issues during a break. Just raise your hand and say that's a personal matter, we'd like to talk about it at the break, we'll

make a note of it and we'll bring you in individually and talk about that issue. So please do not feel that -- do not fail to answer because of concern about your information. We can make that situation available for you to be able to do that.

If you are selected as a juror, it's going to be your job to decide what the facts are based on the evidence you will see and hear. And it's my job to instruct you on the law which you are to apply to those facts. Is there anyone here who would not for any reason follow that instruction that I will give you during this trial? If so, raise your hand. All right. I see no hands. You'll hear myself and maybe the attorneys say that phrase, that's just so Renee knows that nobody raised their hand.

All right. We're going to proceed in the following manner. I'm going to ask a couple general questions, and then the plaintiff gets an opportunity to ask questions, and then, based on time, we'll have the defense ask their questions.

So my first question is, is there any of you on the panel, based on the possible length of the trial, would create an extreme hardship or believe it to be impossible for them to serve on this jury? If so, raise your hand.

All right. Let's start with Miss Hercules.

VENIREMAN HERCULES: Yes, sir.

THE COURT: All right. I'm going to make a note. Those of you that have hardship issues, I'm going to take them up at the break. I have you down, Miss Hercules, that you have a hardship?

VENIREMAN HERCULES: Yes, sir.

THE COURT: All right. Anybody else in the box?

VENIREMAN ROSEN: (Raises hand.)

THE COURT: That would be juror number 402, Miss Rosen?

VENIREMAN ROSEN: Yes.

THE COURT: All right, Miss Rosen has a hardship. All right. Left bleachers?

Is that Mr. Shelby?

VENIREMAN SELBY: Selby, yes, sir.

THE COURT: Selby. Can you stand for me, Mr. Selby? All right. Mr. Selby, you have a hardship?

VENIREMAN SELBY: I believe so, sir.

THE COURT: All right. We'll take it up at the break. Anybody else in the left bleachers? Right bleachers?

Is that Miss Lanier?

VENIREMAN LANIER: Yes.

THE COURT: All right. Juror 1043. All right.

We'll take it up at the break. Hardship?

VENIREMAN LANIER: Yes.

THE COURT: All right. Anybody else? All right.

We'll keep those in consideration, but during this panel please still respond to the attorneys' questions and then at the break we'll discuss what the hardships are.

All right. Next question, is there anyone here who is not a citizen of St. Louis? A city resident? Anyone not a city resident? All right. I see no hands.

Anyone here where English is their second language? English is their second language? Please raise your hand. All right.

VENIREMAN CALDERON NUNES: (Raises hand.)

THE COURT: All right. That is Miss Calderon?

VENIREMAN CALDERON NUNES: Yes.

THE COURT: Is it Calderon Nunes?

VENIREMAN CALDERON NUNES: Calderon Nunes.

THE COURT: All right. Miss Calderon Nunes, what is your first language?

VENIREMAN CALDERON NUNES: Spanish.

THE COURT: All right. Ma'am, how long have you lived in the United States?

VENIREMAN CALDERON NUNES: Since I was six years

old.

THE COURT: Okay. Have you had any difficulty understanding anything I've said?

VENIREMAN CALDERON NUNES: No.

THE COURT: All right. Anyone else in the box? Left bleachers? Right bleachers? English is their second language. All right.

The next question I'm going to ask, I want to know whether you have served on a jury before. And so I'm going to ask you if you have ever served on a jury, and I want to know whether it was civil or criminal, whether you were the foreperson, and whether your jury arrived at a verdict. I do not want to know what the verdict was, so please don't tell me we found so and so guilty or not guilty. I just want to know that you arrived at a verdict.

So it will be civil, criminal, foreperson, and did you arrive at a verdict. And we'll go row by row. Starting with the first row. Anybody in the first row ever been on a jury before?

All right. Miss Presberry?

VENIREMAN PRESBERRY: Yes.

THE COURT: All right. Was it civil or criminal?

VENIREMAN PRESBERRY: Civil.

THE COURT: All right. And were you the

foreperson?

VENIREMAN PRESBERRY: No.

THE COURT: And did you arrive at a verdict?

VENIREMAN PRESBERRY: Yes.

THE COURT: All right. Thank you, ma'am.

Anybody else in the back row? All right. Miss Wallace?

VENIREMAN WALLACE: Yes.

THE COURT: Civil or criminal?

VENIREMAN WALLACE: Both.

THE COURT: All right. Let's start with civil. Were you the foreperson?

VENIREMAN WALLACE: No.

THE COURT: Did you arrive at a verdict?

VENIREMAN WALLACE: Yes.

THE COURT: All right. The criminal case, were you the foreperson?

VENIREMAN WALLACE: No.

THE COURT: Did you arrive at a verdict?

VENIREMAN WALLACE: No.

THE COURT: All right. And then Mr. -- Miss Brennan? How are you?

VENIREMAN BRENNAN: Yes. Both civil and criminal. No, I was not a foreperson. And yes, we did arrive at a verdict on both of them.

THE COURT: All right. Miss Brennan, you'll have an answer to my question when I ask you who do you know.

VENIREMAN BRENNAN: Yeah.

THE COURT: All right. Anybody else in that back row been on a jury before? All right. Second row, anybody been on a jury?

All right. Miss Heisler?

VENIREMAN HEISLER: Heisler.

THE COURT: Heisler. Miss Heisler, was it civil or criminal?

VENIREMAN HEISLER: Both.

THE COURT: Start with civil. Were you the foreperson?

VENIREMAN HEISLER: No.

THE COURT: Did you arrive at a verdict?

VENIREMAN HEISLER: Yes.

THE COURT: Criminal, were you the foreperson?

VENIREMAN HEISLER: No. But I'm trying to remember if I was an alternate, and then I left before the verdict was given.

THE COURT: All right. So you were an alternate. Thank you, ma'am.

Who else? That would be Miss Frerichs?

VENIREMAN FRERICHS: Frerichs.

THE COURT: Frerichs?

VENIREMAN FRERICHS: Frerichs.

THE COURT: Frerichs. Ma'am, was it civil or criminal?

VENIREMAN FRERICHS: Both.

THE COURT: Let's start with civil. Were you the foreperson?

VENIREMAN FRERICHS: No.

THE COURT: Did you arrive at a verdict?

VENIREMAN FRERICHS: Yes.

THE COURT: On the criminal case, were you the foreperson?

VENIREMAN FRERICHS: No.

THE COURT: Did you arrive at a verdict?

VENIREMAN FRERICHS: Yes.

THE COURT: All right. Who else do I got in that row? Miss Kinsella?

VENIREMAN KINSELLA: Uh-huh.

THE COURT: Miss Kinsella, was it civil or criminal?

VENIREMAN KINSELLA: Criminal.

THE COURT: On the criminal case, were you the foreperson?

VENIREMAN KINSELLA: No. And we reached a verdict.

THE COURT: You did? All right. Thank you, ma'am.

All right, in the chairs, anybody been on a jury before? All right. Mr. Boyd?

VENIREMAN BOYD: Yes.

THE COURT: Civil or criminal?

VENIREMAN BOYD: Criminal.

THE COURT: Were you the foreperson?

VENIREMAN BOYD: No.

THE COURT: Did you arrive at a verdict?

VENIREMAN BOYD: Yes.

THE COURT: All right. Anybody else? That would be Miss Huskey? Civil or criminal?

VENIREMAN HUSKEY: Civil.

THE COURT: All right. Were you the foreperson?

VENIREMAN HUSKEY: No.

THE COURT: Did you arrive at a verdict?

VENIREMAN HUSKEY: I was an alternate.

THE COURT: Alternate. All right. Then there was another hand I thought I saw. All right. Miss Abercrombie? Ma'am, was it civil or criminal?

VENIREMAN ABERCROMBIE: Both.

THE COURT: Let's start with the civil. Were you the foreperson?

VENIREMAN ABERCROMBIE: No.

THE COURT: Did you arrive at a verdict?

VENIREMAN ABERCROMBIE: Yes.

THE COURT: For the criminal case, were you the foreperson?

VENIREMAN ABERCROMBIE: No.

THE COURT: Did you arrive at a verdict?

VENIREMAN ABERCROMBIE: Yes.

THE COURT: All right. Thank you, ma'am. Front row, left bleachers, anybody been on a jury? All right. I believe that's the entire row.

All right. Let's start with Miss Thomas. All right, Miss Thomas, civil or criminal?

VENIREMAN THOMAS: Criminal.

THE COURT: Were you the foreperson?

VENIREMAN THOMAS: No.

THE COURT: And did you arrive at a verdict?

VENIREMAN THOMAS: Yes.

THE COURT: Thank you, ma'am.

Miss Houston, civil or criminal?

VENIREMAN HOUSTON: Civil.

THE COURT: Were you the foreperson?

VENIREMAN HOUSTON: No.

THE COURT: Did you arrive at a verdict?

VENIREMAN HOUSTON: Yes.

THE COURT: Thank you, ma'am.

Miss Taylor, civil or criminal?

VENIREMAN TAYLOR: Civil and criminal.

THE COURT: Let's start with civil. Were you the foreperson?

VENIREMAN TAYLOR: No.

THE COURT: Did you arrive at a verdict?

VENIREMAN TAYLOR: Yes.

THE COURT: All right. Criminal, were you the foreperson?

VENIREMAN TAYLOR: No.

THE COURT: Did you arrive at a verdict?

VENIREMAN TAYLOR: Yes.

THE COURT: Thank you, ma'am.

Miss Suggs, civil or criminal?

VENIREMAN SUGGS: Civil, I was not the foreperson, and we did arrive at a verdict.

THE COURT: Thank you, ma'am.

Miss Griggs?

VENIREMAN GRIGGS: Both.

THE COURT: Civil, were you the foreperson?

VENIREMAN GRIGGS: No.

THE COURT: Did you arrive at a verdict?

VENIREMAN GRIGGS: Yes.

THE COURT: Criminal, were you the foreperson?

VENIREMAN GRIGGS: Yes.

THE COURT: Did you arrive at a verdict?

VENIREMAN GRIGGS: Yes.

THE COURT: Thank you, ma'am. And then Miss Jacox, civil --

VENIREMAN JACOX: Civil and criminal, and I wasn't the foreperson, and we got a verdict on both.

THE COURT: Thank you, ma'am.

All right. Second row, left bleachers, anybody been on a jury? Looks like I have the two at the end.

Miss Kain? Miss Kain, was it civil or criminal?

VENIREMAN KAIN: Both.

THE COURT: Let's start with civil. Were you the foreperson?

VENIREMAN KAIN: No.

THE COURT: Verdict?

VENIREMAN KAIN: Yes.

THE COURT: On the criminal, were you the foreperson?

VENIREMAN KAIN: No.

THE COURT: Verdict?

VENIREMAN KAIN: Yes.

THE COURT: Thank you, ma'am. And then Miss Kuenzel?

VENIREMAN KUENZEL: Two criminal, not a foreperson on either, and verdicts in both.

THE COURT: Thank you, ma'am.

Did I miss anybody else? All right. Is that Miss Currans?

VENIREMAN CURRANS: Currans.

THE COURT: All right. Miss Currans, can you stand for me? All right. Thank you, ma'am. Civil or criminal?

VENIREMAN CURRANS: It was civil.

THE COURT: All right. And did you --

VENIREMAN CURRANS: I was the foreman.

THE COURT: You were not?

VENIREMAN CURRANS: I was.

THE COURT: You were? Okay. Did you arrive at a verdict?

VENIREMAN CURRANS: No, the last day the lawyers decided to get together put their heads together and they said we don't need you anymore.

THE COURT: They settled, huh? All right. Thank you, ma'am.

Anybody else in that second row? All right. Third row, left bleachers, anybody been on a jury? All right. I see three hands. Let's start with Mr. Nasser?

VENIREMAN NASSER: Yes.

THE COURT: Mr. Nasser, civil or criminal?

VENIREMAN NASSER: Both. I was not foreperson

in either one, reached a verdict in civil and not in criminal.

THE COURT: Thank you, sir.

All right. Then I think -- was it Miss Scott?

VENIREMAN SCOTT: Yes.

THE COURT: All right. Miss Scott, civil or criminal?

VENIREMAN SCOTT: Civil.

THE COURT: All right. Were you the foreperson?

VENIREMAN SCOTT: No.

THE COURT: Did you arrive at a verdict?

VENIREMAN SCOTT: Yes.

THE COURT: Thank you, ma'am. Then did I see Mr. Lehmuth?

VENIREMAN LEHMUTH: Yes.

THE COURT: Civil or criminal?

VENIREMAN LEHMUTH: Both.

THE COURT: All right. Were you the foreperson on either one?

VENIREMAN LEHMUTH: Yes.

THE COURT: Let's start with the civil. Were you the foreperson on the civil?

VENIREMAN LEHMUTH: No.

THE COURT: Did you arrive at a verdict?

VENIREMAN LEHMUTH: Yes.

THE COURT: On the criminal case, were you the foreperson?

VENIREMAN LEHMUTH: Yes.

THE COURT: Did you arrive at a verdict?

VENIREMAN LEHMUTH: Yes.

THE COURT: Thank you, sir.

Did I get everybody on the left bleachers? All right. The right bleachers, first row, anybody been on a jury? All right. That would be Miss Love?

VENIREMAN LOVE: Yes.

THE COURT: All right. Miss Love, civil or criminal?

VENIREMAN LOVE: Criminal.

THE COURT: All right. Were you the foreperson?

VENIREMAN LOVE: No.

THE COURT: Did you arrive at a verdict?

VENIREMAN LOVE: Yes.

THE COURT: All right. Second row, right bleachers, anybody been on a jury? All right. We've got Mr. Edinger?

VENIREMAN EDINGER: Yes.

THE COURT: All right, sir, civil or criminal?

VENIREMAN EDINGER: Two civils.

THE COURT: All right. On either civil were you the foreperson?

VENIREMAN EDINGER: No.

THE COURT: Did you arrive at verdicts on both of those?

VENIREMAN EDINGER: One yes, the other was adjudicated by the judge after three days.

THE COURT: All right. Thank you, sir.

All right. There was another hand in that row. Was that Mr. -- is that Mr. Nolan? I'm sorry. Miss White?

VENIREMAN WHITE: Yes.

THE COURT: All right. Miss White, civil or criminal?

VENIREMAN WHITE: Criminal.

THE COURT: All right. Were you the foreperson?

VENIREMAN WHITE: No.

THE COURT: Did you arrive at a verdict?

VENIREMAN WHITE: Yes.

THE COURT: Thank you, ma'am.

Mr. Nolan, was it civil or criminal?

VENIREMAN NOLAN: Civil.

THE COURT: All right. Were you the foreperson?

VENIREMAN NOLAN: No, sir.

THE COURT: Did you arrive at a verdict?

VENIREMAN NOLAN: No.

THE COURT: Okay. All right. Last row, anybody

been on a jury before? I see three hands. Let's start with Miss Young. Civil or criminal?

VENIREMAN YOUNG: Civil.

THE COURT: Were you the foreperson?

VENIREMAN YOUNG: No.

THE COURT: And did you arrive at a verdict?

VENIREMAN YOUNG: Yes.

THE COURT: Thank you, ma'am.

There was another hand in the middle. That would be -- is that Miss --

VENIREMAN SITZES: Sitzes.

THE COURT: Sitzes? Miss Sitzes, civil or criminal?

VENIREMAN SITZES: Both civil.

THE COURT: On the civil case -- go ahead.

VENIREMAN SITZES: No foreman.

THE COURT: All right.

VENIREMAN SITZES: And both got a verdict.

THE COURT: Thank you, ma'am.

Then I think there was one more hand, and that would be Miss Lacey? All right, Miss Lacey, civil or criminal?

VENIREMAN LACEY: Both.

THE COURT: With the civil case, were you the foreperson.

VENIREMAN LACEY: No.

THE COURT: Did you arrive at a verdict?

VENIREMAN LACEY: Yes.

THE COURT: All right. And for the criminal case, were you the foreperson?

VENIREMAN LACEY: No.

THE COURT: Did you arrive at a verdict?

VENIREMAN LACEY: I was an alternate.

THE COURT: Alternate. Thank you, ma'am.

Did I miss anybody? Okay. I did miss somebody.

VENIREMAN HEISLER: Heisler.

THE COURT: Heisler?

VENIREMAN HEISLER: I forgot I was on another criminal case, I was not the foreman, and we had a verdict.

THE COURT: Okay. All right. Anybody else that I missed? All right, my next question, I want to know if anybody recognizes myself or my staff.

I know, Miss Brennan, we know each other from my days down at the --

VENIREMAN BRENNAN: Family court.

THE COURT: -- family court. That means you know Maureen, because she was my clerk then.

VENIREMAN BRENNAN: Yes, I know Maureen.

THE COURT: Anything about knowing myself,

Maureen, or anybody on my team that's going to affect your ability to be fair and impartial to the individuals in this case?

VENIREMAN BRENNAN: Nope.

THE COURT: All right. Let me see. And I believe I saw another hand. All right. Miss Bonner?

VENIREMAN BONNER: Yes.

THE COURT: All right. Miss Bonner, who do you know?

VENIREMAN BONNER: I know you, Judge.

THE COURT: Remind me how we know -- is it good, bad or something we need to talk about at a break?

VENIREMAN BONNER: Well, it's good. It's through the Mound City Bar Association, and my reputation in the community.

THE COURT: All right. Anything about that that will affect your ability to be fair and impartial to the plaintiffs and the defendants in this case?

VENIREMAN BONNER: No.

THE COURT: Okay. All right. Anybody else know my staff or myself? All right.

The next fun question is, does anybody, now that you've been here a little while, recognize a fellow juror? We've been hanging out -- oh, yeah. Usually -- it's always an even number -- I was going to say, it's always an even

number. There we go. Let's see who we know.

All right. Miss Presberry, who do you know?

VENIREMAN PRESBERRY: Miss Houston.

THE COURT: All right. Miss Presberry, juror 83, and she knows Miss Houston, who is juror --

VENIREMAN HOUSTON: 30.

THE COURT: 30. So Presberry and Houston. All right. How do you know each other?

VENIREMAN PRESBERRY: She's my caseworker.

THE COURT: Okay. So, we need to talk about the details later, but anything about the fact that Miss Houston used to be your caseworker that if you were selected on the same jury that you would be able to deliberate without regard to the fact that she used to be your caseworker? In other words, can you arrive at your decision independently on your own?

VENIREMAN PRESBERRY: Yes, sir.

THE COURT: All right. Miss Houston, anything about the fact that you used to be her caseworker that would make you feel like you have to change your mind because you wouldn't be able to deliberate independently because you guys used to have a relationship?

VENIREMAN HOUSTON: I'm still her caseworker.

THE COURT: You're still her caseworker?

VENIREMAN HOUSTON: Yes.

THE COURT: All right. We'll talk about that one at the break.

VENIREMAN HOUSTON: But it won't change no mind.

THE COURT: All right. Anybody else know each other? All right. Mr. Becherer? Becherer?

VENIREMAN BECHERER: Becherer.

THE COURT: Wow, look at that one. Mr. Becherer, who do you know?

VENIREMAN BECHERER: Nate Master.

THE COURT: So 32 knows 244. How do you guys know each other?

VENIREMAN BECHERER: He's my brother-in-law's good friend.

THE COURT: He's my brother-in-law's good friend. Anything about the fact you know each other through a brother-in-law, if you were picked to be on the same panel, would you be able to deliberate independently of each other? First Mr. Becherer.

VENIREMAN BECHERER: Yeah.

THE COURT: Sir?

VENIREMAN MASTER: Yes.

THE COURT: Okay. How often do you guys see each other?

VENIREMAN BECHERER: Weekly?

VENIREMAN MASTER: Yeah. Pretty frequently.

THE COURT: Weekly? Do you break bread together over the holidays?

VENIREMAN BECHERER: Yeah.

THE COURT: All right. Will this be a situation that on the holidays that you're sitting across the table and you would feel some type of pressure during the holiday that -- to, wow, I want to make sure that the family continues to roll smoothly and I better surrender my views to make the family dinner go better? Would that be a situation where either one of you felt that pressure?

VENIREMAN MASTER: It might be a little awkward.

THE COURT: All right. Tell me about the awkwardness.

VENIREMAN MASTER: More like I see the guy pretty regularly, and if we disagreed, or something like that.

THE COURT: All right. So that's my concern. Since you see each other regularly, would you feel pressure to have to change your thought process to be in line with his because you don't want to be awkward at those dinners?

VENIREMAN MASTER: I would hope not.

THE COURT: All right. One of the things you're going to learn, we are going to need to press you. Gray areas don't really work during jury selection. All right?

I'll give you an example. When you get on the plane and the pilot -- you say, hey, are you going to land this plane, you don't want him to say I hope not or I hope so. You want him to be completely convinced of either landing the plane or don't fly. Right?

VENIREMAN MASTER: Yeah.

THE COURT: So I've got to pressure you. Are you going to be able to deliberate independently, or are you going to succumb to the pressure?

VENIREMAN MASTER: I can be fine.

THE COURT: Fine?

VENIREMAN MASTER: I can be good, perfect.

THE COURT: Okay. What about you, Mr. Becherer?

VENIREMAN BECHERER: Yeah, I can handle the pressure.

THE COURT: Anybody else know each other, now that you know the drill? All right. Miss Brennan?

VENIREMAN BRENNAN: Yes, Miss Jacox, 212.

THE COURT: How do you know each other?

VENIREMAN BRENNAN: Friends. Well, acquaintances. We see each other out.

VENIREMAN JACOX: Been a while since we seen each other.

THE COURT: Break bread on a regular occasion?

VENIREMAN BRENNAN: No.

THE COURT: And can you deliberate independently from Miss Jacox?

VENIREMAN BRENNAN: Yes.

THE COURT: And, Miss Jacox, can you deliberate independently from Miss Brennan?

VENIREMAN JACOX: Yes.

THE COURT: All right. Anybody else know each other? All right. That would be Mr. Traubitz? Mr. Traubitz, who do you know?

VENIREMAN TRAUBITZ: Mr. Edinger.

THE COURT: How do you guys know each other? Or you gentlemen know each other?

VENIREMAN TRAUBITZ: A setting such as this three or four years ago.

THE COURT: I'm sorry?

VENIREMAN TRAUBITZ: In a setting such as this three or four years ago.

THE COURT: Were you on the same jury before?

VENIREMAN TRAUBITZ: No, we were just in a panel like this, and loafing around out in the hall waiting to go someplace.

THE COURT: Okay. So -- but prior to your --

VENIREMAN TRAUBITZ: I haven't seen him since.

THE COURT: All right. What about you, sir?

VENIREMAN EDINGER: We frequent the same

drinking establishment, and we would see each other at the YMCA and shoot the breeze.

THE COURT: Okay. So, similar to the relation, are you going to feel -- if you end up at the same watering hole again at the same time, are you going to feel any type of pressure to continue the friendship and not be able to deliberate independently if you are on the same panel?

VENIREMAN EDINGER: No pressure.

VENIREMAN TRAUBITZ: That wouldn't be a problem.

THE COURT: This wouldn't be something that you would feel that you would be swayed one way or another and not be able to make up your own decision based on the facts and the evidence that you've seen?

VENIREMAN TRAUBITZ: That would not be a problem for me, no.

THE COURT: Same thing for you, sir?

VENIREMAN EDINGER: Would not be a problem, no.

THE COURT: All right. Anybody else know each other? All right.

If later on somehow you do think you know somebody, make sure you bring it to one of the attorneys' attention, because every once in a while it dawns on someone.

I'm going to let the attorneys introduce

themselves when it's their turn to go through the program, so that way if you recognize one of them you can bring that to their attention as well.

So, you've heard enough from me, at this time I'm going to turn it over to the plaintiffs in this case and let them proceed with jury selection.

MR. SIMON: Thank you, Your Honor.

VOIR DIRE ON BEHALF OF THE PLAINTIFFS

MR. SIMON: Good afternoon, everybody.

(Whereupon, good afternoon was heard.)

MR. SIMON: I'm John Simon, and Tim Cronin and Erica Slater and I represent the plaintiffs in this case. And, you know, it's a very experienced panel here. I mean, a lot of you have served on other juries. You know, you just walked into the room, I don't know much about any of you other than what's on this sheet of paper, and I got it five minutes before you walked in the room. My job is to try to get to know you. There's fifty-four of you. That's a -- that's a tough call. And I want to try to get information from you. And the only way that's going to work is if -- if you talk.

And I know a lot of times, you know, maybe people don't want to raise their hand -- although everybody has been sort of active so far, it's so important, it's just so important to listen to the questions and tell us -- both

sides, tell us what's on your mind. Nobody is going to argue with you, nobody is going to try to change what you're thinking, we just want to know what you're thinking. Does everybody understand that? Okay.

And what I'm going to do is, you know -- I get to ask questions about who you are, what you're thinking, you know, what you do for a living, and I want to start out telling you just a little bit about me so it kind of will be fair a little bit. Is that okay? All right?

I was born in St. Louis, I grew up in St. Louis, I grew up not too far from here, about two miles away, California and Arsenal, I went to high school, undergrad and law school in St. Louis, and I have been a practicing lawyer here for thirty years this year, about two blocks from this very courthouse. So, been in St. Louis my whole life. That's a little bit about me. Okay?

Let's -- let me start out with -- I want to ask permission. Is it okay for me to talk to you? Everybody okay with that? Okay. That's a big deal. Okay? And let me tell you about this. Everybody took an oath. Everybody understands how important an oath is, correct? Right? And can everybody here -- I want to say the only answer -- the only truthful answer is a truthful answer. Does everybody understand that? Okay. If -- you know, if you -- I mean, you're not going to hurt my feelings,

you're not going to hurt the other lawyers' feelings, we really want to know what you're thinking. Okay?

Now, why do I say that? Well, you know, everybody has got strong feelings about one thing or another. Right? I mean, we all, you know, have a life outside of the room, we've had a lifetime of experiences, and that's really what we're getting at. We want to know, you know, do you have strong feelings about -- you might have strong feelings about a certain issue in the case. And I can't get into the facts of the case other than, you know, very little. You know, for instance, let me give an example. The Rams. The St. Louis Rams. If this case was about the St. Louis Rams, if the St. Louis Rams were a party, some of us might have strong feelings one way another. That's kind of what I'm getting at. Does that mean you're not a fair person? Of course not, right? But that's really what I'm looking for. The sort of things -- and I can touch on a few of the issues in the case, and I want to talk to you about how you feel about them, what you think about them. Is everybody okay with that?

This is a medical malpractice lawsuit. We represent the plaintiffs. It's Brian and Michelle Koon. And Brian, Michelle, why don't you stand up. Let me introduce you to Brian and Michelle. Okay? This is Brian and Michelle, they are the plaintiffs in this case. You

can sit down. Thank you.

In this case, Brian and Michelle Koon have a claim against Dr. Walden, who is seated here. And Dr. Walden is an employee of St. Louis University. He's a physician, an internal medicine doctor. And the claim is that Dr. Walden overprescribed and misprescribed opioid narcotics to Brian Koon over a four year period of time. That's what the case is about. To put the questions in context a little bit, so when I'm asking you something, you kind of get an idea why I might be asking you. Okay?

Does anybody here know Brian or Michelle Koon? And I'll give you -- you don't recognize them from looking at them, right? Well, let me just tell you, Brian is a -- works for the City of St. Louis Parks Department, he's been there eighteen, twenty years, he's working there now. Nobody thinks -- anybody think that they recognize Brian or Michelle either by name or sight? Okay. I don't see any hands.

Does anybody know Dr. Walden? Dr. Henry Walden? He's an internal medicine doctor at SLUCare. Anybody think they recognize Dr. Walden? Okay. And later on, as we go through this, if something rings a bell or something comes up, please stop me and raise your hand, if you would, okay? All right?

St. Louis University is one of the defendants in

this case. Now, everybody here -- who doesn't -- everybody has heard of St. Louis University, right? Okay. Does anybody here -- I don't think so, does anybody here work for St. Louis University?

VENIREMAN SUGGS: I used to.

MR. SIMON: Does anybody here now work for St. Louis University, or have you in the past worked for St. Louis University? Okay? We'll start over here in the jury box, in the front row. Anybody here, either now or have you ever worked for St. Louis University? Okay. Nobody in the first row. Into the second row?

Okay. And it's Miss Bonner?

VENIREMAN BONNER: Yes.

MR. SIMON: Okay. Can you tell us about that, please?

VENIREMAN BONNER: Several years ago I was an administrative assistant to a special program for law students at St. Louis University under attorney Michael Gore.

MR. SIMON: Okay. How long did you do that?

VENIREMAN BONNER: About a year before -- about a year.

MR. SIMON: Okay. And let me -- you know, is there anything about that that's going to affect your judgment, you think, in this case even a little bit?

VENIREMAN BONNER: No.

MR. SIMON: Okay. Very good.

Then, in the second row, was there any other hands? And it's Miss Kinsella?

VENIREMAN KINSELLA: Yeah. I didn't work there, but my father did all his professional life. First as professor of medicine, and then chief of staff. So I am somewhat biased.

MR. SIMON: Okay. All right. Thank you very much. Thank you for your honesty and your truthfulness. So, in other words, Brian and Michelle might be starting out a little bit behind?

VENIREMAN KINSELLA: Right.

MR. SIMON: Okay. All right. Anybody else in that second row? Okay. And let's go up to the third row. And it's Miss Wallace?

VENIREMAN WALLACE: Yes.

MR. SIMON: Tell us about it, please.

VENIREMAN WALLACE: I worked for -- actually, St. Louis University Hospital that was ran by the university. And otolaryngology department.

MR. SIMON: Miss Wallace, how long did you do that?

VENIREMAN WALLACE: About a year.

MR. SIMON: Okay. And did you leave or did the

-- did you quit working because somebody else bought the hospital?

VENIREMAN WALLACE: No, because Tenet was already in there at the time.

MR. SIMON: Okay. All right.

VENIREMAN WALLACE: It's just certain sections were still ran by the university.

MR. SIMON: Okay. What did you do there?

VENIREMAN WALLACE: I was billing coordinator.

MR. SIMON: Okay. And the same thing, the same kind of issue, you know, you've worked there, you might know people there, St. Louis University is a party in this case. On a close call, would -- might that affect your decision on some issue in this case?

VENIREMAN WALLACE: No.

MR. SIMON: Okay. Thank you, Miss Wallace.

Anybody else in the third row? Okay. Anybody else in the jury box here? Okay. Either now -- worked now -- even broader a little bit. Anybody got a family member, close family member that works at St. Louis University? Okay. All right?

VENIREMAN HERCULES: Sorry. He's affiliated with the university.

MR. SIMON: Okay. It's Miss --

VENIREMAN HERCULES: Hercules.

MR. SIMON: Hercules? And tell me about that.

VENIREMAN HERCULES: It's a -- it's called Into St. Louis, or Into SLU, he's their executive director now. It's a new, basically, program that SLU has lanched to get international students to the university.

MR. SIMON: Okay. And who is this? Is it a family member or friend?

VENIREMAN HERCULES: It's my brother.

MR. SIMON: Oh, your brother. Okay. And is he still there?

VENIREMAN HERCULES: Yes, sir.

MR. SIMON: Miss Hercules, the same thing, might we be starting off a little bit behind?

VENIREMAN HERCULES: No.

MR. SIMON: Okay. Very good.

So anybody else in this group here either work for or has worked for SLU? Or a close family member? Okay. Don't see any hands. Now we'll go over to the left side bleachers, as Judge Noble would call it. Anybody in the -- let's go with the first row. Anybody in the first row?

Okay. And it's Miss Suggs?

VENIREMAN SUGGS: Suggs.

MR. SIMON: Okay. Can you tell us about that, please?

VENIREMAN SUGGS: I was a --

THE COURT: Can you stand for me, Miss Suggs, please, ma'am?

VENIREMAN SUGGS: Sure. I was a development director for the College of Arts and Sciences for three years, and I managed an outreach program for the School of Medicine for five years; however, I don't believe I ever interacted with Dr. Walden specifically.

MR. SIMON: Okay. So you were there for five years?

VENIREMAN SUGGS: I was there a total of eight years.

MR. SIMON: Okay. What did you do -- you said for medical school you did something?

VENIREMAN SUGGS: I managed an outreach program for high school students.

MR. SIMON: Okay. What was that?

VENIREMAN SUGGS: AIMS program, Adventures In Medicine and Science.

MR. SIMON: Okay. And, Miss Suggs, is -- do you think the fact you worked there eight years might have --

VENIREMAN SUGGS: No.

MR. SIMON: And, again, I'm not asking if -- you are a fair person, I'm sure, but if there's a close call in this case on some issue, might it --

VENIREMAN SUGGS: The only thing I would say is

that I had a lot of interaction with a lot of doctors there and a lot of faculty members at the School of Medicine by virtue of the work that I did. We did several workshops, we had a lot of doctors that came in. But, I mean, this particular doctor I'm not familiar with. And I don't believe as a result that would cause any prejudice on my part.

MR. SIMON: Thank you very much.

Anybody else in the first row over here to my left? Okay. And in the second row? Anybody in the second row? Okay. And it's Miss Currans? I'm sorry.

VENIREMAN BLANKMEYER VOTAW: Votaw.

MR. SIMON: Votaw. Okay.

VENIREMAN BLANKMEYER VOTAW: I'm currently a director of students in the Psychology Department at SLU, and I have taught classes in the Psychology Department. I don't think that would affect my judgment. The only other possible thing is that I see the SLUCare professionals as my general doctors, but I don't recognize this specific gentleman.

MR. SIMON: Okay. Well, let me ask you this. Are you an employee of the university right now?

VENIREMAN BLANKMEYER VOTAW: Not currently. I have adjunct taught classes.

MR. SIMON: As an adjunct? You still teach as

an adjunct?

VENIREMAN BLANKMEYER VOTAW: Not anymore. My last classes were last fall. I now currently work at University of Missouri-St. Louis.

MR. SIMON: Okay. Anything about that relationship that you think would cause concern for the plaintiffs in this case?

VENIREMAN BLANKMEYER VOTAW: No, I don't think so.

MR. SIMON: Okay. Thank you very much.

Okay. Anybody else in the second row on the left? Okay. What about the last row? I know there's somebody in the last row. And is that --

VENIREMAN LAPIERRE: Lapierre.

MR. SIMON: Miss Lapierre?

VENIREMAN LAPIERRE: My husband works for the hospital. He's worked there for five years. I don't know Dr. Walden. It wouldn't make a difference in the case.

MR. SIMON: Okay. What does your husband do?

VENIREMAN LAPIERRE: He works in the pulmonary function lab.

MR. SIMON: Okay. And, again, you don't think that that would have any effect in terms of any issues in this case of --

VENIREMAN LAPIERRE: No, sir.

MR. SIMON: To render a judgment against St. Louis University if you think that's appropriate?

VENIREMAN LAPIERRE: No.

MR. SIMON: Okay. Thank you very much.

All right. Anybody else on the left? Okay. And we'll move over to the right bleachers. Okay. Anybody in the right bleachers, either you have worked for in the past or now work for SLU, or a close family member? Okay. And we have nobody in the first row.

The second row, it's -- is it Miss Carosello?

VENIREMAN CAROSELLO: Yes.

MR. SIMON: Okay. Tell us about that, please.

VENIREMAN CAROSELLO: My husband works for St. Louis University. He's been with them for eight years.

MR. SIMON: For eight years?

VENIREMAN CAROSELLO: Yeah. He's in distribution, and now he delivers mail. That would not have an effect.

MR. SIMON: Okay. All right. Thank you very much. Okay. And, finally, the last row? And is it Miss Lacey?

VENIREMAN LACEY: Yes, sir.

MR. SIMON: Okay.

VENIREMAN LACEY: My best friend works for St. Louis U.

MR. SIMON: Okay. And what -- what does he or she do?

VENIREMAN LACEY: She's an MRI tech.

MR. SIMON: Okay. And is there anything about that that you think would affect you even slightly in this case?

VENIREMAN LACEY: No, sir.

MR. SIMON: Okay. Thank you very much.

Any other hands? Before we leave that topic, let me just ask in a general way, just St. Louis University generally, whether you've worked there or not --

Yes, and it is Mr. Nolan?

VENIREMAN NOLAN: Mr. Nolan. Yes.

MR. SIMON: Mr. Nolan, yes, sir?

VENIREMAN NOLAN: I went to school there.

MR. SIMON: Okay. How many people attended St. Louis University at one time or another? Okay. All right. Let me just ask this more broadly. Is there anything about the fact that St. Louis University is the defendant in this case, apart from the evidence, apart from what the law is -- in other words, before you hear one word of evidence in this case does anybody feel that because St. Louis University is a defendant, that maybe they're starting out a little bit ahead?

VENIREMAN HOUSTON: Sir.

MR. SIMON: Yes?

VENIREMAN HOUSTON: I'm a patient at St. Louis U. I've been a patient ever since I've been on my job for thirty-four years.

MR. SIMON: Okay. And it's Miss Houston?

VENIREMAN HOUSTON: Juror 30.

MR. SIMON: It's Miss Houston, right?

VENIREMAN HOUSTON: Yes. I'm a patient. I've been there as a patient.

MR. SIMON: Okay. The fact that you're a patient there, do you think maybe the plaintiffs in this case might be starting out a little bit behind?

VENIREMAN HOUSTON: I never met that doctor. I don't know nothing about that doctor.

MR. SIMON: All right. I saw some other hands. I don't want to miss anybody. So on the right side here, nobody in the first row. Second row?

And it's Miss Frerichs?

VENIREMAN FRERICHS: Yes.

MR. SIMON: Okay.

VENIREMAN FRERICHS: I have a problem with St. Louis University Hospital. It's personal.

MR. SIMON: Okay. Meaning --

THE COURT: We'll talk about it at the break.

VENIREMAN FRERICHS: Yeah.

MR. SIMON: Okay. Anybody else in the second row? Okay. And it's Miss Bonner?

VENIREMAN BONNER: Yes. I attended St. Louis University School of Law.

MR. SIMON: Okay. And you are practicing now?

VENIREMAN BONNER: Kind of, sort of.

MR. SIMON: Okay.

VENIREMAN BONNER: I'm on the down spiral.

MR. SIMON: What kind of work did you do?

VENIREMAN BONNER: I was an attorney, I worked in various governmental positions, private practice.

MR. SIMON: Okay. What year did you graduate? I'm sorry.

VENIREMAN BONNER: 1970 -- 1978.

MR. SIMON: Withdraw the question.

VENIREMAN BONNER: 1978. No, I'm okay with it. I'm very proud of it.

MR. SIMON: Let me tell everybody, you're looking at somebody that went to St. Louis University undergrad and St. Louis University Law School. You hear that? St. Louis University undergrad, St. Louis University Law School. I am an adjunct professor at St. Louis University Law School. Okay? That's why I'm asking these questions. All right?

This is -- this is a particular case, involving a

particular set of circumstances with St. Louis University and a particular physician. Does everybody understand that?

VENIREMAN BONNER: Yes.

MR. SIMON: Okay. All right. And, so, again, I don't want to miss anybody. Anybody just generally their feelings about St. Louis University would prevent them -- I don't want to say prevent, but it might cause you to lean a little bit one way or another on some issue?

MR. VENKER: Your Honor, may we approach?

THE COURT: You may.

(The following proceedings were held at the bench.)

MR. VENKER: My concern about the way John's phrasing these questions is I think we're supposed to be trying to find out whether these people think they can be fair and impartial. When he uses phrases like might somebody be a little ahead or somebody leaning a certain way, I just feel like that's a really soft phrasing of this. And I think we're supposed to be finding out whether they think they can be fair and impartial. I mean, whether they start out leaning one way or the other isn't really the question. The question is can they be fair and impartial.

MR. SIMON: Two things, Your Honor. Statute does not use those words fair and impartial. The statute

-- I've got a copy of it in my outline -- talks about whether they've expressed some opinion that may affect one of the issues in the case. It's not as clear-cut.

Secondly, I don't -- in having done this for a while, I don't think somebody is going to immediately raise their hand and say that they're not a fair person, and that's the reason that you need to lead the way to get into the question and address it a little bit more in depth.

THE COURT: I consider it a style issue. If we get down the road and there's an issue whether someone has made a comment that rises to the level of cause, then we'll bring that person in and introduce them further to the issue. But, as of now, I'm not -- I think it's a style issue and I'm going to allow him to do it. And your argument would be if it comes time to -- something the person said is enough, then I'll take that into consideration.

MR. VENKER: And one more thing, Your Honor. I know Mr. Simon is proud of being a SLU Law grad and adjunct professor there. I think he's injected a little personal information now that could cause some jurors to view his role in this case a little differently since he's suing an institution with which he's affiliated. I think that is really sharing his personal information. I think the lawyer, as an officer of the Court, is supposed to be

neutral and not injecting their own personal information. So I would just object to future references. I don't know what can be done about it now.

MR. SIMON: I just brought it up in response to Miss Bonner's comment she's a SLU grad just like I am.

THE COURT: I'm not putting any negative intent, but we're good on your personal information.

MR. SIMON: Okay. All right.

(Proceedings returned to open court.)

THE COURT: You may continue.

MR. SIMON: Thank you, Your Honor.

So, Miss Bonner, anything about that you think would cause you to have issues or problems in this case?

VENIREMAN BONNER: I don't -- no, absolutely not. I'm trained otherwise.

MR. SIMON: I understand. Okay.

Anybody else in the first group here? Okay. In the box? All right. Any other -- okay. And -- it's Miss Nunes?

VENIREMAN CALDERON NUNES: Yes. Calderon Nunes. My husband is a medical doctor at Washington University, so I feel like I might have some kind of bias there, just a little close to home.

MR. SIMON: Okay. Thank you. Tell us about that. Why do you think you might be somewhat bias?

VENIREMAN CALDERON NUNES: Because I -- I'm more inclined to side with the medical provider side point of view just because I'm so close to them.

MR. SIMON: You see it from your husband's side, obviously?

VENIREMAN CALDERON NUNES: Correct. I look at it from his point of view.

MR. SIMON: Thank you very much. Anybody else? Back to -- I don't want to -- back to St. Louis University being a defendant. Okay.

Anybody else -- yes. And you are Miss Griggs?

VENIREMAN GRIGGS: Yes.

MR. SIMON: What can you tell us about that, Miss Griggs?

VENIREMAN GRIGGS: When my mother was dying she was at St. Louis University Hospital, and she was on a do not resuscitate, they said that -- they claimed that they --

THE COURT: All right. Miss Suggs (sic), that sounds like a pretty personal thing. We'll take that up at the break, okay, ma'am?

VENIREMAN GRIGGS: But I don't think I could be fair towards them, is what I'm saying.

THE COURT: All right. We'll go over that on the break. It sounds pretty personal.

MR. SIMON: All right. Thank you, Miss Suggs (sic).

Okay. Anybody else?

THE COURT: Miss Griggs, right?

MR. SIMON: Miss Griggs? Okay. One way or another, is -- whether to either side? In other words, the fact that St. Louis University is a defendant in this case, would -- might that affect somebody's judgment in this case one way or another for either side? Okay. I don't see any hands. Thank you.

Does anybody know me?

VENIREMAN CAROSELLO: (Raises hand.)

MR. SIMON: And you're a teacher at St. Mary's High School; is that correct?

VENIREMAN CAROSELLO: Yes.

MR. SIMON: How long have you been there?

VENIREMAN CAROSELLO: Twenty-one years. So I don't know you personally, but I know of you. You just gave our commencement address, right?

MR. SIMON: Yes. I'm a '79 graduate of St. Mary's High School. Should the other side be worried about that?

VENIREMAN CAROSELLO: No, not at all.

MR. SIMON: Thank you. Okay. Anybody else know -- yes, it's Mr. -- hang on a second. Let me grab my

notes here. It's Mr. Becherer?

VENIREMAN BECHERER: Yeah, I think my sister is actually friends with your daughter. They go to Cor Jesu together.

MR. SIMON: Oh, okay. My daughter Mary?

VENIREMAN BECHERER: Yes. My sister is Carolyn Becherer.

MR. SIMON: Oh, okay. I do know Carolyn.

VENIREMAN BECHERER: Yeah.

MR. SIMON: Should the other side be worried about that?

VENIREMAN BECHERER: Possibly.

MR. SIMON: Okay. All right. Fair enough. Okay. All right. You know, for their sake, you think you would probably be a better fit on some other case; is that fair, Mr. Becherer?

VENIREMAN BECHERER: Yes.

MR. SIMON: Okay. Very good. Thank you. Okay.

Anybody else think they know me? All right. And my firm is the Simon Law Firm. Anybody ever had any dealings with the Simon Law Firm?

Okay. Miss Bonner?

VENIREMAN BONNER: Is that Loretta Simon?

MR. SIMON: That's my sister. Different Simon Law Firm. That's my sister.

VENIREMAN BONNER: I know Loretta.

MR. SIMON: Okay. Miss Bonner, same thing -- getting all my friends off.

VENIREMAN BONNER: No. As I've indicated before, I am a professional.

MR. SIMON: Okay. Very good. All right. Okay.

And Dr. Walden and St. Louis University are being represented by Mr. Paul Venker, John Mahon, and Mike Barth, who are seated at the table here with Dr. Walden.

Does anybody think they know any of the attorneys or the firm? Williams, Venker & Sanders is the law firm. Okay.

VENIREMAN HEISLER: That man there looks familiar to me, but I don't know why.

MR. SIMON: Okay. And it's Miss -- need to think on it a little bit. All right. And it's Miss Heisler?

VENIREMAN HEISLER: Heisler.

MR. SIMON: Heisler. Okay. All right. And you're talking about the gentleman on the end?

VENIREMAN HEISLER: No.

MR. SIMON: Paul?

VENIREMAN HEISLER: That one. I don't know what his name is.

MR. VENKER: I'm Paul Venker. Sorry.

VENIREMAN HEISLER: Venker? Have you ever been on a TV ad for your firm or something?

MR. VENKER: No.

VENIREMAN BONNER: I think I may have had some interactions with Mr. Venker.

MR. SIMON: Okay. And, Miss Bonner, anything about that that you're --

VENIREMAN BONNER: Same answer. You've been told.

MR. SIMON: Okay. Very good. So nobody thinks they know -- and if something kind of rings a bell later, we get a little bit further down the road, would you please raise your hand and stop me? Okay.

So, does anyone here -- and we -- you know, we heard from -- it's Miss Nunes? Calderon Nunes?

VENIREMAN CALDERON NUNES: Calderon Nunes.

MR. SIMON: Did I pronounce that right?

VENIREMAN CALDERON NUNES: Yes.

MR. SIMON: Thank you. And her doctor is a doctor at Washington University. Does anybody else either here or immediate family member ever work in the medical field? Okay. I feel like we're going to get a lot of hands. So we don't miss anybody, I'm going to start over here. Anybody in the first row, either you or family member ever work in the medical field?

Okay. And it's Miss Abercrombie? Okay. Can you tell us about that, please?

VENIREMAN ABERCROMBIE: I've been a medical assistant since 1999.

MR. SIMON: Where at?

VENIREMAN ABERCROMBIE: Oh, wow. Washington University, spent ten years there. Avada Healthcare. Mostly private doctors' offices.

MR. SIMON: Was it seeing patients, like day-to-day seeing patient?

VENIREMAN ABERCROMBIE: Uh-huh.

MR. SIMON: Any particular types of patients?

VENIREMAN ABERCROMBIE: Internal medicine.

MR. SIMON: Okay. And were you ever involved in helping administer medications, pain medications?

VENIREMAN ABERCROMBIE: Uh-huh.

MR. SIMON: This case involves opioid narcotic analgesics. You're familiar with those?

VENIREMAN ABERCROMBIE: Uh-huh.

MR. SIMON: Okay. And have you been involved with helping get prescriptions filled or -- you know, for the patients?

VENIREMAN ABERCROMBIE: Uh-huh. Uh-huh.

MR. SIMON: Okay. You need to say yes or no.

VENIREMAN ABERCROMBIE: Yes. I'm sorry.

MR. SIMON: She can't get it down when you're just nodding. Okay? All right.

Anybody else in the -- okay. We'll go to the second row. And it's Miss Heisler?

VENIREMAN HEISLER: Uh-huh. My daughter has worked for urologists in the past, and right now she works for two chiropractors.

MR. SIMON: Okay. And how long has she been in the medical field? Since she got out of school?

VENIREMAN HEISLER: No. She did retail first, but she's been working for this chiropractor office a long time.

MR. SIMON: Okay. Thank you very much.

And, Miss Hercules, right?

VENIREMAN HERCULES: Right. I don't have anyone.

MR. SIMON: Okay. I'm sorry. And it's Mr. -- is it Hostuttler?

VENIREMAN HOSTUTTLER: Hostuttler.

MR. SIMON: Hostuttler?

VENIREMAN HOSTUTTLER: Yeah. Grandmother is a registered nurse since 1942. Retired, obviously. Uncle is a lab technician in the state of New York.

MR. SIMON: Okay. Thank you very much.

And it's Miss Kinsella?

VENIREMAN KINSELLA: Yes. My parents are both physicians, both internists, and I have a brother and a sister who are physicians, and I come from a family of physicians.

MR. SIMON: Okay. Thank you.

And back row, it's Mr. Lambert?

VENIREMAN LAMBERT: Yes. My father was a hospital administrator. My mother was a surgical nurse. And I have a niece that's a nurse.

MR. SIMON: Okay. Thank you.

Okay. And it's Miss Brennan?

VENIREMAN BRENNAN: I had a part-time job as a pharmacy technician for Walgreens in the '90s, and I worked in human resources at St. Louis Connect Care.

MR. SIMON: Was it also in pharmacy-related stuff?

VENIREMAN BRENNAN: No.

MR. SIMON: Connect Care?

VENIREMAN BRENNAN: No. I mean, I was in human resources then. But I had a part-time job in the '90s as a pharmacy tech filling prescriptions.

MR. SIMON: Okay. Thank you.

And it's Miss Rosen?

VENIREMAN ROSEN: My husband works for SSM, but he's -- he's not a doctor, he works in medical records,

front desk, does some physician's assistant.

MR. SIMON: Okay. Thank you very much.

Anybody else in the back row? Okay. All right. We'll go over to the left here. Either -- anybody in the first row, either you or a member of your family in medical --

MR. SIMON: Is it Miss Boyd? I'm sorry. Miss Houston?

VENIREMAN HOUSTON: Yes. I'm a proud mother, my daughter is a nurse, my son is a CNA, my granddaughter is a CNA.

MR. SIMON: Okay. All right.

And, Miss Thomas, you had your hand up?

VENIREMAN THOMAS: I'm a social worker for a skilled nursing center, and before that I passed pills, I was a med tech.

MR. SIMON: Okay. Thank you.

And it's Miss Suggs?

VENIREMAN SUGGS: Suggs. My brother-in-law is a gastroenterologist, and I have a cousin who's a maxillofacial surgeon.

MR. SIMON: Okay. And, Miss Suggs, is there anything about those relationships that you think would affect your judgment in this case?

VENIREMAN SUGGS: No.

MR. SIMON: Very good. Thank you.

Okay. Anybody else in the first row on the left? I don't see any hands. And let's go to the second row. We'll start with Mr. Vancil?

VENIREMAN VANCIL: Fire/EMT in the city.

MR. SIMON: Okay. So you have EMT training?

VENIREMAN VANCIL: Yes.

MR. SIMON: How long have you been doing that?

VENIREMAN VANCIL: Eleven years.

MR. SIMON: Thank you, sir.

Okay. And second row, we had another hand all the way to the right, and it's Miss Kuenzel?

VENIREMAN KUENZEL: Yeah. I worked at Mercy for three years in the emergency room as a support associate. My sister-in-law works for Mercy as well, she is a surgical tech of some sort. And my other sister-in-law is a nursing student.

MR. SIMON: Okay. Thank you, Miss Kuenzel.

Okay. And then, finally, the last row on the left side? Any hands? Okay. And it's -- is it Miss Vikesland?

VENIREMAN VIKESLAND: I was a faculty member at Wash U within the Department of Medicine because I was a BMC. And my grandfather was a doctor. And, actually, I worked at a pharmacy when I was eighteen.

MR. SIMON: How long did you work at a pharmacy?

VENIREMAN VIKESLAND: A year.

MR. SIMON: Okay. What did you do there?

VENIREMAN VIKESLAND: I don't know. I was, like, eighteen, so --

MR. SIMON: Okay.

VENIREMAN VIKESLAND: Refill things, did packages.

MR. SIMON: Whatever they told you to do, right?

VENIREMAN VIKESLAND: Yes, actually.

MR. SIMON: Anybody else in the last row, third row on the left side? I don't see any hands. We'll move over to the right side. Okay. First row?

Let's start with Miss Klumb.

VENIREMAN KLUMB: My son is a dentist for about six years, and my sister-in-law is a pharmacist for about twenty-five years.

MR. SIMON: Okay. Thank you.

All right. And it's Miss -- Mr. Leible?

VENIREMAN LEIBLE: Yes. My brother is a pharmacist, and my sister is a nurse.

MR. SIMON: Thank you, Mr. Leible.

Okay. Anybody else in the front row? It's Miss Love?

VENIREMAN LOVE: Yes. My sister is an RN.

MR. SIMON: Thank you.

And Miss Lanier?

VENIREMAN LANIER: Yeah. I start work at Barnes on Monday as a palliative care social worker.

MR. SIMON: Okay. I'm sorry, as a --

VENIREMAN LANIER: In palliative care.

MR. SIMON: All right. Is that end of -- what kind of care is this?

VENIREMAN LANIER: Yeah, end of life and life limiting illnesses. So we do a lot of quality of life and management. So, pain management.

MR. SIMON: Okay. Thank you very much.

And then the second row on the right side? Okay. All right. And Miss Carosello?

VENIREMAN CAROSELLO: My daughter is in OR, and my son-in-law is a PA, physician's assistant.

MR. SIMON: Okay. Thank you.

All right. And Miss Wampler?

VENIREMAN WAMPLER: Retired pediatric nurse, graduated from SLU in '83, I'm a doula/midwife currently.

MR. SIMON: How long were you a pediatric nurse at SLU?

VENIREMAN WAMPLER: I graduated from SLU, I worked at Deaconess and Visiting Nurse for fifteen years.

MR. SIMON: Okay. Thank you. And it's Mr.

Nolan?

VENIREMAN NOLAN: I work in a federally-qualified health center.

MR. SIMON: Okay. And what is that and what do you do there?

VENIREMAN NOLAN: I do business development, so I work with the doctors, I also do marketing. Serve, like, thirty thousand people a year. Most below the poverty line. So I do a lot of pain prescription medication.

MR. SIMON: How are you involved? What involvement do you have with pain medication?

VENIREMAN NOLAN: I don't prescribe, but if I need data, I'm exposed to it. Meetings, whatnot. That sort of thing.

MR. SIMON: And can you tell me a little bit more about that? In what way?

VENIREMAN NOLAN: Well, I work -- I do marketing, so, any -- excuse me. I'm kind of nervous.

MR. SIMON: That's all right. Take your time.

VENIREMAN NOLAN: So nervous. I put together the annual report every year, work with any data collection that we do to help facilitate meetings, say, for instance, with SLU. We have mental health providers from SLU working with us, so --

MR. SIMON: So are you sort of on the business end of it versus the medical end?

VENIREMAN NOLAN: Yeah, business development.

MR. SIMON: Okay. And you put together information from the business side, but sometimes you work with the doctors or physicians to do it?

VENIREMAN NOLAN: Yeah. Exactly.

MR. SIMON: Okay. All right. Mr. Nolan, thank you very much.

Okay. And any other hands on the right side? Okay. And it's Miss White?

VENIREMAN WHITE: Yes. I work for the Department of Mental Health as a psych tech. I've been there for nineteen years.

MR. SIMON: And what do you do there?

VENIREMAN WHITE: I'm a psych tech. I mainly oversee mentally ill clients.

MR. SIMON: You say you've been doing that for nineteen years?

VENIREMAN WHITE: Uh-huh.

MR. SIMON: Okay. Thank you very much.

And the back row? We've got Mr. Master?

VENIREMAN MASTER: Yes. My sister is a PA out in Pennsylvania.

MR. SIMON: I'm sorry?

VENIREMAN MASTER: My sister is a PA at U Penn Hospital in Pennsylvania.

MR. SIMON: Okay. Thank you, Mr. Master.

Okay. Any other hands? All right. And it's Miss Love?

VENIREMAN COLEMAN NICHOLS: Nichols.

MR. SIMON: Nichols? I'm sorry. I've got the pages wrong.

VENIREMAN COLEMAN NICHOLS: My brother-in-law is a pharmacist.

MR. SIMON: Okay. And is he here in St. Louis?

VENIREMAN COLEMAN NICHOLS: No, he's in Michigan now. He was in Missouri, Florida, now Michigan.

THE COURT: And, Miss Nichols, you're an attorney?

VENIREMAN COLEMAN NICHOLS: Yes.

THE COURT: And you work for Panera?

VENIREMAN COLEMAN NICHOLS: Yes.

THE COURT: What kind of law do you practice there?

VENIREMAN COLEMAN NICHOLS: Tax.

THE COURT: You do tax stuff?

VENIREMAN COLEMAN NICHOLS: Yes.

THE COURT: How long have you been there?

VENIREMAN COLEMAN NICHOLS: Almost six years.

MR. SIMON: Okay. All right. Any other -- any other hands? Yes, we've got one in the back on the left. And that would be Mr. Lehmuth?

VENIREMAN LEHMUTH: Yes. My son is a dentist, he has his own practice.

MR. SIMON: Okay. Thank you very much, Mr. Lehmuth.

Does anybody here think that medical malpractice doesn't happen? Let me say that again. Does anybody here think that medical malpractice does not happen? Raise your hand. Okay. I don't see any hands.

Let me change subjects and get a little more specific with everybody. In this case, you're going to hear -- if you're on the jury, you're going to hear a lot of information about certain opioid narcotics. Vicodin, oxycodone, OxyContin, Percocet.

Has anybody here -- just a show of hands, has anybody ever taken a pain prescription opioid?

(Whereupon, hands were raised.)

MR. SIMON: Okay. Most of you, right? Okay. All right. Okay.

Let me -- let me narrow it down a little bit. Has anybody here ever taken an opioid pain narcotic analgesic, pain medicine, for an extended period of time?

Okay. All right. And let me talk to you about

what I mean by extended. You might have a surgery, or have a medical procedure, and you're given some -- an injury, you're given a narcotic opioid for a week or two weeks, and I'm talking about where you've been on it for months, six months, eight months, twelve months. Okay? All right?

So we've got -- let's start over here on the right. It's Miss Wallace?

VENIREMAN WALLACE: Yes.

MR. SIMON: Okay. Could you tell us about that, please?

VENIREMAN WALLACE: I'm currently on pain medication. Because I'm on another medication that causes joint and muscle pain. So, I need the pain medication just to be able to walk.

MR. SIMON: Okay.

VENIREMAN WALLACE: And I've been on that about three months now.

MR. SIMON: Okay. So you've been on it three months?

VENIREMAN WALLACE: Yes.

MR. SIMON: And I -- Miss Wallace, if you want to, you know, answer this during a break, or whatever, I'm not trying to pry but do you know what kind of medicine it is?

VENIREMAN WALLACE: The medication I'm on now is -- it's controlled, but I don't think it's an opioid. I'm on Meloxicam and Tramadol.

MR. SIMON: Okay. And you say you've been on it for three months?

VENIREMAN WALLACE: Yeah, around three months.

MR. SIMON: Is there some end in sight, or they just don't know, or --

VENIREMAN WALLACE: We won't know until I finish the other medication I'm on, and I finish that the end of this month, so we have to see how my body responds to the other medication.

MR. SIMON: Okay. Just so -- I'm trying to be consistent. Let's say -- let me make the question a little more specific for everybody so I'm not all over the place.

I'm interested in if anyone has been on an opioid narcotic for an extended period of time, meaning more than three months. Okay? And do I see any hands here in the box here on the right? Other than Miss Wallace? Okay, I see no hands. Is that right? Okay.

Let's go over to the group on the left, the left bleachers. Okay. And, again, anybody been on an opioid narcotic for over three months consecutively?

And it's Miss Houston, right?

VENIREMAN HOUSTON: Yeah. I have bad back problems and leg problems, so I have -- they give me Percocet or another medicine. They can give it to you so long that you got to take your own self off of it. I take Tramadol and I take Naproxen, and Ibuprofen eight hundreds.

MR. SIMON: Okay. So you're on Ibuprofen, right?

VENIREMAN HOUSTON: Yeah. I took myself off the Percocets and the OxyContin because I wasn't ready to retire, so -- because, you know, the doctor will give it to you --

THE COURT: All right, Miss Houston, we're good. We'll talk a little bit more on the break.

VENIREMAN HOUSTON: Okay. All right. I'm on all of that for my back and leg so I can continue working, because I'm not ready to retire.

MR. SIMON: Okay. All right. Anybody else -- thank you, Miss Houston.

Anybody else on the left-hand -- I'll call them the left bleachers -- been on opioid narcotics long term for -- meaning more than three months? I don't see any hands.

And then the same question on the right bleachers, okay? And it's -- it is Miss Fortenberry?

VENIREMAN ALEXANDER FORTENBERRY: Yes.

MR. SIMON: Okay. If you could tell us, please.

VENIREMAN ALEXANDER FORTENBERRY: I have migraine headaches, and I have three herniated disc in my back, and arthritis. I've been on -- on medication for six years. And there's no end in sight they say, there's no cure.

MR. SIMON: Okay.

VENIREMAN ALEXANDER FORTENBERRY: So, if -- and it's Percocet, it's Dilaudid. So, I don't know what all -- what all you need to know about that.

MR. SIMON: Okay. Well, let me ask you this. Have you been on OxyContin?

VENIREMAN ALEXANDER FORTENBERRY: (Shakes head.)

MR. SIMON: Have you been on that for extended periods of time?

VENIREMAN ALEXANDER FORTENBERRY: Uh-huh.

MR. SIMON: Meaning more than three months?

VENIREMAN ALEXANDER FORTENBERRY: Uh-huh.

MR. SIMON: Okay. All right. And Vicodin?

VENIREMAN ALEXANDER FORTENBERRY: Uh-huh.

MR. SIMON: Okay. And do you go to the same doctor for the medication?

VENIREMAN ALEXANDER FORTENBERRY: Uh-huh.

MR. SIMON: Is it a pain doctor or internal --

VENIREMAN ALEXANDER FORTENBERRY: I go to pain

management, yes.

MR. SIMON: You are going to a pain management doctor, it's not your regular --

VENIREMAN ALEXANDER FORTENBERRY: Right. I go to pain management.

MR. SIMON: It's not your regular primary care doctor, correct?

VENIREMAN ALEXANDER FORTENBERRY: No. Yes.

MR. SIMON: Are you currently on those medications?

VENIREMAN ALEXANDER FORTENBERRY: Yes.

MR. SIMON: Your pain management doctor is coordinating that and taking care of that for you?

VENIREMAN ALEXANDER FORTENBERRY: Yes.

MR. SIMON: Thank you, Miss Fortenberry.

Anybody else on the right in the back? Okay. All right. Thank you. Thank you.

Switching gears a little bit. The law requires that cases be tried by a jury in the community where the act happened.

MR. VENKER: Your Honor, may we approach?

THE COURT: Yes.

(The following proceedings were held at the bench.)

MR. VENKER: Your Honor, my objection to this

question is going to be -- or this line of questioning is that he's asking these people about a venue statute. It's really about social policy. He's going to ask them about why they think that there's a venue statute, what's the point, what's the rationale. I don't think that has anything to do with finding out whether these are fair and impartial juror or potentially fair and impartial jurors, I think it's confusing, and I think it's not part of the mission we're on now. I object to that line of questions.

MR. SIMON: Judge, there's punitive damages in this case. One of the issues is going to be whether or not jurors are objectionable to making a decision in a case that is going to have an effect on their community, okay? That's what I'm getting into. I'm not going to a particular venue statute, I'm just asking them about their thoughts about a -- you know, a verdict having an effect on conduct going forward. Which is exactly what punitive damages are. It's to punish and deter future conduct. Some people have an issue with that, some people have -- I have spoken to jurors who, you know, don't agree with that general concept. That what I'm leading in to.

MR. VENKER: If he wants to ask them about whether or not -- St. Louis University is already out in the case. We all know it's part of the St. Louis community. I don't think there's any question it's fair

to ask that question, is there anybody who can -- that has a problem with awarding damages against St. Louis University, but I don't see what a venue statute has to do with it. I just don't.

THE COURT: I don't have a problem with the topic, I just think he needs to drill down to it.

MR. SIMON: Sure.

(There was a discussion held off the record.)

THE SHERIFF: Judge, Miss Houston is wondering if she can move to a chair?

(Whereupon, the following was held at the bench.)

THE COURT: All right. Does anybody object to us excusing Miss Houston?

MR. VENKER: No objection from the defendant.

MR. SIMON: No, sir.

(Whereupon, proceedings returned to open court.

THE COURT: All right. Miss Houston, my benches are way too brutal on you, so here's what I'm going to do. Instead of making -- this is a physical hardship for you. We're going to go ahead and discharge you for the day. Is that okay?

VENIREMAN HOUSTON: Thank you.

THE COURT: And, Miss Houston, this works as your jury service.

(Whereupon, a short recess was taken.)

THE COURT: You may proceed.

MR. SIMON: Thank you, Your Honor.

Ladies and gentlemen, sometimes a person sues not only to get justice for a wrong, but to make sure it doesn't happen again. Some people don't think that's a proper use of the court system, others are okay with it. Which side do you come down on?

Miss Hercules?

VENIREMAN HERCULES: Can you repeat that question?

MR. SIMON: You bet. Sometimes a person sues not only to get justice for a wrong, but to make sure what happened doesn't happen again to somebody else. Some people think that's an appropriate use of the civil justice system, others don't. How do you feel about that?

VENIREMAN HERCULES: I agree.

MR. SIMON: Okay. Which one do you agree with?

VENIREMAN HERCULES: The first. Hoping that it will prevent something to happen again.

MR. SIMON: Okay. And why do you agree with that?

VENIREMAN HERCULES: I agree with that because I think it's something that hopefully people will learn from it and then be able to do better from moving forward.

MR. SIMON: Okay. All right. And Miss Heisler?

VENIREMAN HEISLER: Yes.

MR. SIMON: What do you think about that?

VENIREMAN HEISLER: I'm not really sure. I think if it's something that really is bad that happened, they need to have people notice that. I mean, I don't know if this kind of stuff goes in the newspaper that people can read it. But there was this one doctor I went to, he wanted to operate on my back, and somebody told me some things that he did, and I decided not to. I mean, if they want to ask me who it was in private, that's -- but I don't want to say the name.

MR. SIMON: Thank you. I appreciate that. Thank you very much.

Mr. Traubitz? What do you think about that?

VENIREMAN TRAUBITZ: I haven't given it very much thought, to tell you the truth. I think it's probably -- I don't know, I guess it depends on the case. If it's something very egregious, I think, yes, it could serve that purpose.

MR. SIMON: Okay. All right. And so you would generally agree with Miss Hercules' position on it?

VENIREMAN TRAUBITZ: More or less, yes.

MR. SIMON: Okay. All right. And, Mr. Boyd, what do you think about that?

VENIREMAN BOYD: Well, I kind of agree with the juror behind me. If there's negligence, then I think it should be exposed to prevent it from happening to someone else. And if it means an individual sacrificing him or herself that it doesn't happen to anyone else, then, yeah, I agree that should happen.

MR. SIMON: Okay. All right. And, Miss Huskey, what do you think?

VENIREMAN HUSKEY: Pretty much agree. I just would hope that something good would come out of anything that is presented, whether it's win or lose, that still there's a hope there for somebody.

MR. SIMON: Okay. All right. And, Miss Nichols, what do you think?

VENIREMAN COLEMAN NICHOLS: That's a tricky one. I think in most situations, to prevent it from happening again.

MR. SIMON: Okay. And why do you feel that way?

VENIREMAN COLEMAN NICHOLS: Because I think sometimes things would be allowed to continue if it was overlooked in situations, this would be to the public's attention, that they need to be aware of this.

MR. SIMON: Okay. By bringing it to the public's attention you would hope to prevent it or keep it from happening to somebody else?

VENIREMAN COLEMAN NICHOLS: Yes.

MR. SIMON: Okay. Does anybody disagree with that concept? Yes, sir, Mr. Lambert?

VENIREMAN LAMBERT: I probably should bring this up. I was involved in a lawsuit with my son, he was -- it was against a pharmacy, he was prescribed ten times the dosage of medication --

THE COURT: All right. We'll take that up at the break.

VENIREMAN LAMBERT: Okay. Probably relevant.

MR. SIMON: Okay. And without getting into the details of the case with your son, just the general concept of bringing a case to prevent what happened from happening again to somebody else, how do you feel about that?

VENIREMAN LAMBERT: Not sure we were successful, but we had to try.

MR. SIMON: Okay. You're generally in favor of the concept? Okay. You need to say yes or no.

VENIREMAN LAMBERT: Yes. Sorry.

MR. SIMON: Thank you.

Does anybody disagree with that concept? Okay. And I -- Mr. Master?

VENIREMAN MASTER: Yes. I think medication like that can be counterproductive sometimes, it can often set

precedence that makes it harder, especially in a case like medicine, where it could be harder to save somebody's life just because of one ruling. So sometimes setting precedence creates obstacles for doctors.

MR. SIMON: Okay. All right. That's a very good point. And who -- who has some thoughts along those lines? Who agrees with -- somewhat with what Mr. Master said?

Okay. And Miss Bonner?

VENIREMAN BONNER: I was going to say I'm probably more in agreement with the gentleman in front of me. I think that it needs to be a case-by-case basis. Because otherwise, if it's not, I would say in the interest of the public -- if it's not widespread enough to be in the interest of the public, you will probably wind up clogging up the system with the individual kind of broader cases.

So, I -- I do think -- I think that there are places for that, for -- for having the public interest involved in an individual wrong case. But I think it has to be on a case-by-case basis.

MR. SIMON: Okay. All right. Thank you, Miss Bonner.

Any other views on that? We haven't heard -- anybody over here on the left? Okay. And it's Mr.

Vancil?

VENIREMAN VANCIL: I agree with the juror over here.

THE COURT: Mr. Master?

VENIREMAN VANCIL: It can handcuff the provider sometimes.

MR. SIMON: And tell me more about that. Why do you --

VENIREMAN VANCIL: And limit their power to, you know, provide care.

MR. SIMON: Okay. And why do you think that?

VENIREMAN VANCIL: I mean, personally, like some of our SOP's right now go against American Heart Association, so they're asking us to do something that's against a national standard. You know, there's a lot of gray areas.

MR. SIMON: Okay. All right. And you see that in what you do as an EMT, right?

VENIREMAN VANCIL: Yes.

MR. SIMON: Okay. All right. Thank you, Mr. Vancil.

Okay. And Miss Vikesland?

VENIREMAN VIKESLAND: I kind of respectfully disagree with this guy. I mean --

MR. SIMON: Could you stand up, please? Thank

you.

VENIREMAN VIKESLAND: I think nothing is perfect, but there has to be some sort of system of checks and balances for anyone in power, and anyone who has a power has to have a checks and balance or they have the opportunity to abuse it. So --

MR. SIMON: Okay. Thank you very much.

Anybody else over here on the left have any thoughts about that? I mean, you probably weren't thinking about it earlier today before we brought it up.

Is it Miss -- I'm sorry -- yes, Miss Votaw.

VENIREMAN BLANKMEYER VOTAW: Votaw. No, I was not thinking about it until you said it. But I think it's implicit how we used to think about criminals, the idea, so they won't do whatever crime again. But it's kind of, like, punishing someone who maybe -- something that wouldn't happen in the future. So -- just kind of another perspective that -- because you made that distinction between justice from what's been done in the past versus so they wouldn't do it again.

MR. SIMON: And what do you think about -- how do you feel about that personally? What side do you come down on? That's a good point, but how do you feel about that?

VENIREMAN BLANKMEYER VOTAW: Oh, I don't know.

I feel like until this point I've always thought about it as yes, so the people don't do that in the future also. But, just since you asked and everybody is kind of talking about it, there is potentially another argument to be made. I guess on my own stance I probably would still be more rooted in kind of the way I've been thinking the past thirty years.

MR. SIMON: Okay.

VENIREMAN BLANKMEYER VOTAW: So it doesn't happen again.

MR. SIMON: Sort of -- I think what you're saying is you've always thought that as a part of the process?

VENIREMAN BLANKMEYER VOTAW: Uh-huh. Yes.

MR. SIMON: Okay. Thank you very much.

Okay. Anybody else here over on the left? And is it -- in the back row, is it Miss -- is it Lapierre? I'm sorry. Is it --

VENIREMAN LAPIERRE: Lapierre. Yes. Are you just asking me?

MR. SIMON: I thought you were -- yeah. Yes, what do you think? You looked like you were shaking your head, having some problems with it one way or another.

VENIREMAN LAPIERRE: No, I mean, I think that -- I think that people respond well to -- I think that

consequences are catalytic of change. But I -- you know, I do agree that there is -- there's kind of a moral conundrum in punishing someone for something they haven't done yet under the assumption that because they made an egregious error once, that they would continue to do that again. I don't actually know if that's what you are asking, but that's kind of what I was thinking in my head.

MR. SIMON: Yeah, sort of. And let me kind of bring it back to, I think, where we started, was, you know, one purpose of bringing a case, a claim, is to get compensated for how you've been injured. And another purpose may be to shine a light on what happened so that people in the community hear about it and know about it, and that maybe because of that it won't happen again. That's sort of what I'm getting at. That concept.

Are you okay with that concept?

VENIREMAN LAPIERRE: Without knowing the details of the case, I -- I don't think that I can -- I, just in good conscience, can't answer that because there are so many shades of gray. And I think that everybody has made really valid points about not being able to, you know, draw these lines in the sand. Because doctors and medical care professionals do have to make decisions often, you know, kind of based on their own discretion, but that there also does need to be a system of checks and

balances. I feel like I'm just talking in circles. I don't actually have an answer. I'm sorry.

MR. SIMON: No, no, no, you're not. You're not. You're not. And let me tell you why I'm bringing this up. Okay? At the end of this case, if you're chosen to be on the jury, His Honor, Judge Noble, may decide to allow you to consider what's known as punitive damages. Okay?

Anybody here not heard -- everybody heard of punitive damages? Miss Hercules, do you know what punitive damages are?

VENIREMAN HERCULES: Yes. You're going to make me explain them, too, aren't you?

MR. SIMON: Yes, please. What's your general understanding of punitives?

VENIREMAN HERCULES: Basically to get some sort of monetary support for what has happened.

MR. SIMON: Okay. Well, that's --

VENIREMAN HERCULES: See, I told you it was wrong.

MR. SIMON: Well, that's close. It's pretty close. Punitive damages are damages not to compensate the party for the harms and losses, but where the law says because the conduct is such that you will be instructed to award an amount sufficient to punish the defendant and to deter the defendant and others from like conduct in the

future.

Everybody generally understand that? In other words, there's compensatory damages to compensate the party for harms and losses. Then in certain circumstances there are punitive damages. And if you're on the jury, and you're allowed to consider punitive damages, you will be asked -- I believe His Honor will instruct you that you are to award an amount sufficient to punish the defendant and deter the defendant and others from like conduct.

Yes. And it's Miss --

VENIREMAN ROSEN: Rosen.

MR. SIMON: Rosen?

VENIREMAN ROSEN: I have a question. Do those punitive damages go to the defendants, or -- where does that money go?

MR. SIMON: All I can tell you is they're not to compensate the plaintiff. I don't believe I can tell you where they go.

VENIREMAN ROSEN: Okay.

THE COURT: No.

MR. SIMON: Okay -- so --

MR. VENKER: May we approach, Your Honor?

THE COURT: You may.

(The following proceedings were held at the bench.)

MR. VENKER: I'm going to object because I think it's at least confusing. I'm not suggesting that John was trying to be confusing, but now the jury is getting the impression that none of the punitive damages, if awarded, are going to the plaintiffs. And that's not true.

MR. SIMON: Your Honor, they don't all go to the plaintiffs. Half goes to the State.

MR. VENKER: Well, the way --

MR. SIMON: I mean, we're not allowed to tell them one way or another. I didn't inject it. She asked the question. I said I couldn't tell her.

MR. VENKER: Well, you did tell her, though, it wouldn't go to the plaintiffs.

MR. CRONIN: No, he didn't. He said it's not to compensate the plaintiffs.

MR. VENKER: I didn't want to interrupt. It also sounds like now Judge Noble is going to submit these -- the last statement about -- the first time you said he might, so I didn't say anything. This last time he made it sound like he, you know -- I think he's going to. This is what you said. And I object to that.

THE COURT: Okay. I listened, and I didn't -- I -- I agree with you first that he didn't say that I was going to do it. The second time I thought he still kept it as a -- an option. I think, in answering the question,

it seemed like it was more directive, but it wasn't. I think it's more response.

MR. SIMON: I can pull back from that.

THE COURT: But -- if you feel that way, what do you think a recommended cure would be for the where does the money go? I was trying not to get into it.

MR. SIMON: Judge, I would be okay telling them the truth of the matter, half goes to the State Education Fund.

MR. VENKER: I'm not --

THE COURT: Okay. That's a little bit --

MR. VENKER: Why don't we think on this, then deal with it later during voir dire. I don't think we can sort it out just standing here.

THE COURT: Yeah. I think right now -- if it becomes an issue, we'll address it. Right now I think we've nipped it in the bud, so I think we can move on.

MR. SIMON: Okay. All right.

MR. VENKER: Could I ask for one thing, Your Honor, and that is -- would it be acceptable if John were to say, when he goes back to the podium, the first thing or the next thing, just to be clear the Judge has not decided whether those punitive damages will be submitted, that's to be determined by the evidence and the law.

THE COURT: I think he did, but okay. Because

of that last question. I think if you wrap it up and move on, I think we'll be okay. Segue.

MR. VENKER: Segue.

THE COURT: Yeah, segue.

(Proceedings returned to open court.)

MR. SIMON: Okay. Ladies and gentlemen, if Judge Noble decides to submit punitive damages to you and you're on the jury, does anybody here have any strong feelings one or another about that?

Okay. And it's Mr. Hostuttler?

VENIREMAN HOSTUTTLER: Hostuttler. So, I think -- when it comes to over prescription of pain killers specifically, I think that's a much larger problem than just a civil court case in St. Louis. Personal experience, I've been deployed to Afghanistan, I've had friends that were put on pain medicine, graduate to heroin, kill themselves, things like that. I think it's a much larger problem than just one instance. I think this case is one of many cases throughout the United States where something like this happens.

So, I am completely one-sided on that, where there isn't a monetary amount that you could put on this. This is something that's on a case-by-case basis on its case that there needs to be some sort of regulation or something just related to prescription pain pills.

MR. SIMON: Okay. Anybody agree with that?

(Whereupon, hands raised.)

MR. SIMON: Okay. And it's Miss Wallace?

VENIREMAN WALLACE: Yes.

MR. SIMON: Okay. What do you think about that?

VENIREMAN WALLACE: I just feel the same way, that, you know, prescription medication -- these narcotics have been over prescribed, and people are graduating to harder drugs, and it's turning into people selling pills and being addicted, and things like that. Because the original -- original person had so many that they can take care of their problem and sell them all. It's just a bigger problem with the over prescription of narcotics.

MR. SIMON: Okay. Anybody else have any thoughts on that in the box, here in the jury box? Okay.

Anybody else, any thoughts about that issue? Okay. And we'll go over -- and let me -- it's Miss Currans?

VENIREMAN CURRANS: I wasn't thinking about this, but this is not a doctor did this. Okay? It's a two-party system. A doctor can give -- prescribe medication, but -- and I'm not saying I -- that is a major problem with today. But it is also the responsibility of the person taking the medication to take it properly. And if there's a problem, you need to disclose that. It's

just -- it doesn't make sense otherwise. And I do agree it's case by case.

MR. SIMON: Okay. Miss Currans brought up -- actually, you're on to my next page of questions. That's an issue that I -- well, let's jump in it and talk about it. Okay?

And what degree of responsibility do you believe patients have for their own healthcare as compared to their doctor? Everybody hear that? What degree of responsibility do you believe a patient has for their own healthcare as compared to their doctor?

And -- and let me just -- let me even narrow it further. Who here thinks the patient has no responsibility? Okay. Who here thinks that the doctor -- who thinks the patient is totally responsible? Totally responsible, it's on the patient, not the doctor? Anybody feel that way?

VENIREMAN CURRANS: (Raises hand.)

MR. SIMON: Okay. Let's start over here in the box on the right. And it's --

VENIREMAN KINSELLA: Kinsella.

MR. SIMON: Miss Kinsella?

VENIREMAN KINSELLA: Yeah.

MR. SIMON: And tell us about that, please.

VENIREMAN KINSELLA: Well, I'm just of the opinion that you have to monitor your own care. You have

to be your own advocate. And I think -- I just think with things changing more, where more results are more available with the patient these days, they -- they know exactly, you know, what their records are, they have them in their hand. So, I think people need to take charge of their life, take charge of their care.

MR. SIMON: So you would be more in the category of you believe the patient is totally responsible for their own healthcare?

VENIREMAN KINSELLA: Yes.

MR. SIMON: Okay. All right. Okay. Anybody else share that view, or something close? Okay.

Anybody else in the jury box over here? Anybody in the first row? Yes, it's Miss Nichols?

VENIREMAN COLEMAN NICHOLS: Yes, I tend to believe that it's up to you to give the information, all the facts to your doctor, and to monitor that, and you can't just take what they say for granted. I think you have to do your research, you have to follow the records.

So I would say a lot of the responsibility is on the patient and not the doctor.

MR. SIMON: Okay. And let me rephrase it, get people's thoughts on this. Maybe not total or complete, but who would share the view with Miss Nichols that, you know, most -- primarily most the bulk of the

responsibility for the healthcare is on the patient? Who feels that way?

And let's even make it more specific. In terms of prescribing pain medication. So we're not talking in a vacuum, okay? Who -- who agrees with what Miss Nichols said, that it's primarily the patient's responsibility? Okay.

And we -- Miss Kinsella, Miss Nichols, right? Okay. Anybody over here feel that way?

Okay. Miss Rosen, you look like you want to say something.

VENIREMAN ROSEN: I completely disagree.

MR. SIMON: Why?

VENIREMAN ROSEN: Why? Because medical professionals go to school for a long time, and I have a lot of respect for their expertise, and the idea that someone that doesn't have any medical expertise is somehow an expert on -- whether it's pain prescriptions or other things. I'm not saying that the patient doesn't have some responsibility. Of course. Getting second opinions. I think different opinions at times completely makes sense. It's not that you put everything in the hands of a physician. But to say that it's our responsibility to do research, to doublecheck everything that our doctors are saying, as if we have the abilities to do that -- people

in the medical field might, but most of us that are not doing -- don't have medical degrees, I can't agree with that.

MR. SIMON: Okay. All right. And let's -- Miss Abercrombie?

VENIREMAN ABERCROMBIE: Well, being a medical assistant and working in the medical field where I work now, we have patients who get narcotic prescriptions, they come in, they have to leave a urine sample, they drug test them. I have one patient who does get three hundred quantity a month, and, personally, I kind of feel like that's a lot.

But, you know, the patient, they should know their bodies, and the doctor -- you know, the patient's going by what the doctor's order says, you know, take this many, you know, in this many hours. So, they're going by what the doctor said. But also, you know, like I say, it's a two-party thing, the patients should know their bodies to say I'm okay, you know.

MR. SIMON: Okay. So I'm not trying to pigeon hole you into one slot or another, but are you sort of in the camp that you think it's primarily the responsibility of the patient?

VENIREMAN ABERCROMBIE: Yeah. Because, like I say, you should know your body.

MR. SIMON: Okay. All right. And --

VENIREMAN ABERCROMBIE: And when enough is enough and too much is too much.

MR. SIMON: Miss Huskey, you're shaking your head. What do you want to tell us about this?

VENIREMAN HUSKEY: No, I'm just -- you know, I'm not a physician, I didn't go to school for that, I go to the doctor and I tell him my symptoms, I tell him what's wrong, we do testing, or whatever, I get prescription A, B and C. I don't know if A, B and C need to be taken together. I'm not a doctor. Yeah, I'm responsible to relay what I'm feeling and how I'm feeling, and then maybe relay how the medicine's working. But I'm not responsible to know that these three prescriptions I take is okay to take together or for a long period of time.

MR. SIMON: Okay. So we've kind of defined this a little bit. Who here thinks -- let's put it in the category of the doctor's primarily responsible, or the patient's primarily responsible. Who here would put themselves in the category that they think the patient is primarily responsible for their own healthcare?

Raise your hand. Who thinks the patient should be primarily responsible?

(Whereupon, hands were raised.)

MR. SIMON: Okay. And we've got Miss Frerichs,

right?

VENIREMAN FRERICHS: Yes.

MR. SIMON: And tell us what you are thinking, please.

VENIREMAN FRERICHS: I believe the patient has to be able to have an open line of communication with the doctor and to tell all of their symptoms so that the doctor knows how to treat them. But as far as being totally liable for your own medical, I can't even make out sometimes sense of my doctor's bill when I get it.

MR. SIMON: Sure.

VENIREMAN FRERICHS: You know, so I don't think it should be totally patient.

MR. SIMON: I hear you. And Miss Hercules?

VENIREMAN HERCULES: I don't think it's one or the other, I think it's a partnership. It's kind of like I work at a school. It's like telling a kid that they're responsible for their own education, that a teacher has nothing to do with their education. It's a partnership. Everyone should be their advocate. They should know, you know, what their body can hold and be able to ask that question to the doctor. But it shouldn't be one or the other.

MR. SIMON: Okay. Who agrees with that?

(Whereupon, hands were raised.)

MR. SIMON: Wow. All right. Okay. And I'm sorry. It's miss --

VENIREMAN CURRANS: Currans.

MR. SIMON: I'm sorry. It's. Miss Currans, right?

VENIREMAN CURRANS: Yes.

MR. SIMON: What do you think?

VENIREMAN CURRANS: I still believe that your doctor is not there for six hours, for twelve hours after you get the medicine. For example, and this is personal, I had a back injury in January. My doctor prescribed -- I was in severe pain. He gave me a medication I was supposed to be able to take at work. Well, I took the pill at work as directed. And it just knocked me for a loop. Now I'm not one to say because that doctor -- I won't mention the name, he's a good doctor -- gave me that medication that it is his fault. Our bodies react to different medications different ways. And I knew that day on that I could not take that medication again. And I contacted him, and the situation was corrected.

But, I mean, it's a joint responsibility. I mean, they cannot know everything that's going on in your body if you don't take the responsibility to fight back and say, hey, look, this isn't working with me, let's try something else. I mean, he's not God.

MR. SIMON: Okay. Anybody else? Yes, and it's -- I'm sorry.

VENIREMAN HEISLER: Heisler.

MR. SIMON: Heisler?

VENIREMAN HEISLER: My doctors a lot of times wanted me to take medicine. Well, I always check side effects, how can it affect you, and if I don't think I want to take the chance, I don't get it. I think it's -- you have to -- I go on the Internet and see what the medicine is supposed to do, and my pharmacy lets me know if any of the other medicine I'm taking would be not going together well.

MR. SIMON: So, Miss Heisler, let me ask you this. Are you telling us that you don't think a patient should be able to trust their doctor?

VENIREMAN HEISLER: Well, I think you can -- to a point. But it doesn't hurt for you to look into it, too.

MR. SIMON: Okay. All right.

VENIREMAN HEISLER: I mean, I think it's both the doctor and the patient together --

MR. SIMON: Share some responsibility?

VENIREMAN HEISLER: -- talk about it and ask -- tell him I don't want to take this because of this, and he can explain it to you better.

MR. SIMON: Okay. So you're suggesting doing your own research, and then based on what you find talking to your doctor about it?

VENIREMAN HEISLER: Yeah.

MR. SIMON: Okay. All right. Who here thinks it's the doctor's primary responsibility?

(Whereupon, hands were raised.)

MR. SIMON: Okay. All right. Now, let me -- this is kind of the same issue a little bit -- another side of it. This is a case where Brian Koon is bringing a lawsuit, a medical malpractice lawsuit against his doctor for prescribing pain medication that he took. In other words, he voluntarily took the medication that was prescribed to him by his doctor and now he's filing a lawsuit over it.

Anybody have any difficulty with that?

VENIREMAN KINSELLA: What do you mean?

MR. SIMON: That you voluntarily take medication that your doctor prescribes, and then you sue the doctor if there's some harm to you from it.

VENIREMAN BOYD: Well, I feel if there were some sort of side effects from the pain medication, and he never mentioned it to his doctor, then how could the doctor know? Now, had he brought it to the doctor's attention, and the doctor continued to say, well, that's

okay and told him to continue to take it, then, you know, there's -- some onus has to fall on that individual as well. You know, this -- my body is rejecting this, I'm not feeling right.

So me personally, no, I'm going to stop, and maybe I'll seek a second opinion if my doctor continues to insist that I take this medication and it's not -- it's not helping. But if he continues to take it, then some onus or responsibility has to fall on the patient. That's what -- I -- I -- now, if he never told his doctor, you know, that he was having complications behind this medication, or there were side effects, then the doctor -- he wouldn't know, he's thinking that everything is working fine.

MR. SIMON: Well, Mr. Boyd, let me ask you this. If -- just the fact that you've got someone suing a doctor for medication that the doctor prescribed, that they took voluntarily, for an extended period of time, four years -- just that fact, would that cause you some hesitation or concern? In other words, is the plaintiff starting a little bit behind because of that, because of that fact?

VENIREMAN BOYD: Yeah.

MR. SIMON: Okay. Anybody else feel like that?

VENIREMAN KINSELLA: (Raises hand.)

MR. SIMON: Okay. It's Miss Kinsella?

VENIREMAN KINSELLA: Kinsella.

MR. SIMON: Miss Kinsella, you feel like the plaintiff is starting a little bit behind because of that? Okay.

Miss Hercules, you feel that way?

VENIREMAN HERCULES: Uh-huh. With what you just presented, yes.

MR. SIMON: Okay. In other words -- all right. And -- let's see -- anybody else feel that way? I thought I saw a hand. Was there a hand?

VENIREMAN CALDERON NUNES: Yes.

MR. SIMON: Okay. Yes. And it's --

VENIREMAN CALDERON NUNES: Calderon Nunes.

MR. SIMON: And you feel that way also?

VENIREMAN CALDERON NUNES: Yes.

MR. SIMON: Okay. Anybody else?

VENIREMAN LAMBERT: I would have to know a lot more.

MR. SIMON: And that's the problem. Because, you know, we can't tell you what all the facts of the case are, we have to explore these ideas. You're probably thinking what is this -- you know, put it in context. We can't do that. But when the case is over, it's like His Honor said, you know, can you fly the airplane. And once we're in the air, you know, it's too late, okay? And that's really why I'm --

Ladies and gentlemen, if you have even a little bit of problem or issue with this, now is the time to talk about it. Because we can't undo it when it's done, okay? And I really appreciate everybody's -- everybody has been so engaging and open about their thoughts and feelings. I mean, you guys have been great.

And, again, the whole concept of -- let me put it this way. In other words, you get back in the jury room and you say, look, you know, he decided to take it, you know, I'm done, I'm not -- you know, I'm not going to listen to the evidence, he voluntarily took this medication for four years.

Yes. And it's Miss --

VENIREMAN LANIER: Lanier.

THE COURT: Lanier?

VENIREMAN LANIER: Should I stand?

MR. SIMON: Yes.

THE COURT: Yes, please.

VENIREMAN LANIER: I respectfully, Mr. Boyd, have a problem with what you were saying. I think we need to differentiate between side effects and, like, addiction and the addictive properties of these kinds of medicines. It's one thing to be upset about, you know, my doctor didn't tell me that my anti-depressant was going to have a nausea or a weight gaining side effect. But, like,

there's something about prescribing these highly addictive medications. And, as the patient, you know, we are in a position that we're trusting that person -- there's a power dynamic between a physician and a patient, and you enter into that, and you put your trust into that physician, and -- I mean, so I think we need to make that differentiation, and it hasn't been made, so --

MR. SIMON: Well, Miss Lanier, addiction is the issue you're going to be asked to decide in the case. It's the fact he became addicted over the course of time and, you know, couldn't get off of it.

Yes. And over to the -- and it's --

VENIREMAN CURRANS: The whole point --

MR. SIMON: It's Miss Currans?

VENIREMAN CURRANS: Currans.

MR. SIMON: Currans. I'm sorry.

VENIREMAN CURRANS: The whole point is for us to listen to all the evidence you present, the other side presents, and decide who was at fault. Is there -- was it a little bit of both, was it -- was it the doctor, was it the patient. We don't know. And don't -- go in there with an open mind. It's, like, I'm a teacher --

MR. SIMON: Absolutely.

VENIREMAN CURRANS: -- a lot of people judge children's ability to read, and I can only put it in my

own terms. I go beyond what I have to do to teach this child. But send that kid home, nothing goes on. So then if they don't progress, you know, it's a judgment call. You have to listen to both sides, and then you have to weigh who is at fault, how much at fault. It's not a hundred percent of anything anyway.

MR. SIMON: Okay. Thank you.

There was another hand up. It was Miss Thomas? Was your hand up? I'm sorry. Miss Vikesland?

VENIREMAN VIKESLAND: I was just going to agree with what she said. You can -- I mean, you keep emphasizing that someone took the pills for four years. But an expert was prescribing that pill for four years. Which I guess we'll hear more about. But there's still a power dynamic, someone is in pain, someone is trusting an expert, and an expert has made this decision for four years.

MR. SIMON: Thank you very much.

Any other hands? Okay. Yes. And you're Miss --

VENIREMAN BLANKMEYER VOTAW: Votaw. Just, if it helps, I think as I'm hearing this I'm thinking for myself more on -- responsibility on the doctor, and for all the reasons we've said, it is both. But just right the point of expertise, the point of power, it's not like you can just go to WebMD and get really good information. There's

misinformation or lack of information or lack of resources. So that's where I'm personally falling.

MR. SIMON: Okay. Anybody -- Miss Bonner?

VENIREMAN BONNER: I want to add a bit of a qualifier to my belief that the physician is primarily responsible for the healthcare of those of us who don't have their training and expertise and knowledge. But having said that -- and I'm aware of the Hippocratic Oath.

MR. SIMON: Sure, yeah.

VENIREMAN BONNER: First do no harm.

MR. SIMON: Do no harm. Do no harm.

VENIREMAN BONNER: And, so, you do have to listen to the facts, though, even with -- starting with that premise, you have to know what the facts of this individual case was. Because most of us are now aware that opiates have an addictive association with it. However, and I did hear it said, the doctor's not going to be with that patient 24 hours a day. We don't have facts as to whether or not the medication was in any way abused.

So, it's not black and white. Even saying that the physician has a greater responsibility than the patient. You still have to know the individual facts of this case, because it's not black -- its not all black, it's not all white.

MR. SIMON: Okay. And that's -- that's very

well put. And, so -- in other words, everybody here can go -- or you are saying you need to go in and listen to the facts and the evidence?

VENIREMAN BONNER: Absolutely.

MR. SIMON: And you think it's primarily the doctor's responsibility, but there's some responsibility on the patient also?

VENIREMAN BONNER: Absolutely.

MR. SIMON: Okay. Any other comments, thoughts, ideas, you know, on this topic from anybody?

Okay. Yes. And it is --

VENIREMAN ALEXANDER FORTENBERRY: Miss Fortenberry.

MR. SIMON: Miss Fortenberry?

VENIREMAN ALEXANDER FORTENBERRY: My only other thought is that there are hereditary things, and some people are just -- are more prone to be addicts, and somebody -- some people can, like, drink a beer every day and not be alcoholics. And somebody else is an alcoholic and can drink a beer just on weekends. And some people can touch a drug and immediately become addicts. And some people can control it. So -- and the doctor can't necessarily know if this person is going to be that -- that person who's going to become the addict or not. And that runs in families. They've proven now that's

hereditary. So that's something else to think about, too.

MR. SIMON: Well, thank you, Miss Fortenberry.

VENIREMAN ALEXANDER FORTENBERRY: That's just a thought that's in my mind.

MR. SIMON: Let's talk about it. Let's talk about it. Let's talk about addiction. Ladies and gentlemen, some people feel like addiction is a series of bad choices. Others feel that it's a disease. Which side do you fall on?

Yes, sir?

VENIREMAN HOSTUTTLER: I think she makes a really good point, because I do believe that there are addictive personality traits amongst everyone. But I think what you're discriminating here with an opioid is the fact that there's a chemical addiction versus a mental addiction, and I believe that opiates is a legitimate physical addiction, that when that is being consumed by your body you want more of it. You need more of it. You'll get sick, you get the shakes. You know, whatever it is. It's a chemical imbalance in your body because it now functions normally under that. Where a mental addiction is a completely different type of anxiety. Right? I need a behavior, I have OCD, I need to scratch my leg every time I do this or something. Just my opinion on that.

MR. SIMON: Okay. Anybody else share those -- share those thoughts or ideas? Okay.

What about the question about, you know, is -- is an addiction a medical condition? Do you consider addiction a medical condition, or do you consider it to be a moral issue, bad choices by the person who has become addicted?

VENIREMAN HOSTUTTLER: Well, I think it's a medical -- actual addiction is a medical thing. I think it's a moral choice whether or not doing something that you know is addictive is completely different, right? So if you knew this was a highly addictive opioid, I'm going to prescribe this to you, I think at that point if I'm -- if I'm a patient going to a doctor, I'm relinquishing my right to make a decision because I'm looking to you for your medical advice, because you're an expert, I'm not. So at that point, as a doctor, I'm taking your care into my hands, right? And I'm going to say, okay, so, I know I'm going to prescribe him this high risk addictive drug, what is the plan to cycle him off this. Was one existing, did one exist? I don't know. We don't know that information.

But that's my point of view on that. It's a moral decision, you as a user make that choice, right? I'm going to do this or I'm not. And then at that point you're doing that with the assistance of your doctor, like this guy

describing it as a partnership, right? I'm relinquishing my decision making to my doctor because my doctor is saying you should really do this. This is going to help you get better in the future.

MR. SIMON: Okay. Thank you.

Who here thinks addiction -- and let's put it in the context of addiction to narcotic pain medication. Who here thinks that addiction to narcotic -- prescribed narcotic pain medication is a result of poor choices by the addict? Anybody feel that way? Raise your hands. Nobody feels that way?

VENIREMAN ROSEN: Can I ask a question?

MR. SIMON: Yes, sure.

VENIREMAN ROSEN: Can we have some data or studies on this? I mean --

MR. SIMON: You will.

VENIREMAN ROSEN: How do you have an opinion when you don't have any studies on it?

MR. SIMON: I understand. I get it. If you are on the jury, you'll get more information on it than you want.

VENIREMAN ROSEN: I don't know, I like a lot of data.

MR. SIMON: Okay.

VENIREMAN BONNER: But, you know, medicine

really isn't an exact science. Is it? I mean -- and in most instances the physician or the medical providers have a duty to provide information so that the patient can make an informed decision. Right? So, sometimes -- even knowing that the medication might have addictive qualities, the benefits might sometimes outweigh that, and that's a decision for the patient.

MR. SIMON: Okay. All right. Yes?

VENIREMAN LANIER: I think we need to go back to your original question, which is addiction a result -- is it a medical condition or is it a result of poor moral choices. And I think we need to address that. And that it 100 percent is a medical condition. I think another social worker and nurses in here and the psychology UMSL girl, you know that it's in the DSM. So we know that it is certainly a medical condition, and people who suffer from addiction are not bad people, these are not people making these decisions because they want to, they are suffering, and I think that that needs to be, you know, very clear. So --

MR. SIMON: Who disagrees with her? Somebody has to disagree with her. Does anyone disagree with her?

VENIREMAN CURRANS: I'm sitting here listening, and you go back and forth, you are saying oh, it's all the patient's, it's all the addict's fault. Oh, it's all the

doctor's. That's all I'm saying. I'm saying with human people, human beings, you can't call it that easy, it's too complicated of a situation. It doesn't work that way.

MR. SIMON: I'm asking for black and white answers, right?

VENIREMAN CURRANS: It's not a hundred percent this, it's not a hundred percent this.

MR. SIMON: I understand. You know what, I'm trying to start the conversation, which has been fantastic, okay? I'm trying to take the extreme points of view because I want to hear -- it's to get your thoughts on the matter, okay? Get you passionate about it. I want to hear what you really think.

VENIREMAN CURRANS: Well, I'm telling you.

MR. SIMON: And it sounds like it's working. Okay?

VENIREMAN CURRANS: I just think that being a human being, addict or not, we all do things that aren't good for us. We do it out of habit sometimes. Out of enjoyment. Whatever. In this case, it's an added addiction. Maybe we don't know that -- like I said, I don't know that. But I'm saying that doctor is not with the patient 24 hours. The addict has got to want to get help, too. Anybody -- I think, quite frankly, if my doctor told me -- I was on the same medicine for four

years, I would be having a new doctor. I don't think that's right.

MR. SIMON: Okay.

VENIREMAN CURRANS: I mean, most doctors wouldn't put people on it for four years.

MR. SIMON: All right. And it's Miss Love, correct?

VENIREMAN LOVE: And I agree with being your own advocate, and I am a hundred and ten percent my own advocate, and I have fired doctors because I didn't like how they were treating me. But, in practice, in the real world, that doesn't always happen. My parents think their doctor is God. And they're -- my mom is having ill effects from something. Whatever. Details aren't important. But I say why are you -- why aren't you questioning that. Well, he's the doctor. So, I mean, what happens in practice and what we think we all should be doing are two different things.

MR. SIMON: Okay. Thank you.

Back to the issue with addiction. Okay? Does anybody here feel that there's some -- you know, as was pointed out, some moral -- in other words, think less highly if somebody was addicted? I mean, when you think of an addict, I mean, does anybody think that -- you know, not favorably of an addict?

And it's Miss Wallace?

VENIREMAN WALLACE: Yes.

MR. SIMON: I'm sorry. Is it Miss Wallace?

VENIREMAN WALLACE: Yes.

MR. SIMON: Tell us about that.

VENIREMAN WALLACE: I just don't believe addiction is a disease, I believe it's a choice.

MR. SIMON: Okay.

VENIREMAN WALLACE: And I kind of -- I have negative views of addicts, because I grew up with one.

MR. SIMON: Okay. Miss Wallace, now -- thank you.

Who else thinks that way? You know, in part? Okay.

VENIREMAN HOSTUTTLER: (Raises hand.)

MR. SIMON: All right. Negative view of addicts generally? Who has negative views of addicts generally, raise your hands.

VENIREMAN HOSTUTTLER: (Raises hand.)

VENIREMAN KINSELLA: (Raises hand.)

MR. SIMON: Okay. All right. Anybody else? Okay. Yes. And it's Mr. Vancil, correct?

VENIREMAN VANCIL: Yeah. I was just agreeing with your statement.

MR. SIMON: Agreeing with it?

VENIREMAN VANCIL: Yes.

MR. SIMON: And in what way?

VENIREMAN VANCIL: The general negative outlook.

MR. SIMON: Would everybody -- everybody -- is there a general negative feeling toward someone who's an addict? Is it yes or no?

VENIREMAN BRENNAN: No.

MR. VENKER: Well, Your Honor, may we approach?

THE COURT: Yep.

(The following proceedings were held at the bench.)

MR. VENKER: I'm not really up here to object, Your Honor, I think the problem is I think John is airing this issue out, and I don't have an objection with us airing it out, I don't, but we're talking in such abstract terms I think everybody is thinking that addicts are on a spectrum, some are in the gutter, they've ruined their lives, others may have been addicted unintentionally through normal medical treatment. So I think we're just kind of going around in circles with this panel. That's all I'm saying.

MR. SIMON: I think I made it clear it was directed to prescription medication, opioid prescription medication.

THE COURT: I think initially you have. I

think --

MR. SIMON: Made it a little broader?

THE COURT: When you used the term general addicts, I think they're grabbing on to the heroin side of it and not the prescription.

MR. SIMON: All right.

THE COURT: I think it would be a good point to tighten it up. In terms of timing, here's what I'm thinking. It's about 4:35. Are you at a subject we could break?

MR. SIMON: Yeah, sure.

THE COURT: Why don't we wrap up with addiction, because we're going to bring them back tomorrow anyway.

MR. SIMON: I'm at a good stopping point right where we're at, Judge.

THE COURT: Okay. I would like you to end it to say something about -- at least ask your question about --

MR. SIMON: Prescription?

THE COURT: -- prescription. I don't want everybody to leave with the --

MR. SIMON: Got it.

THE COURT: -- battle in their mind of an addict. I think it's a mind frame that's off point. So if you would just clarify.

MR. SIMON: Clarify.

THE COURT: Okay. Then we'll stop.

(Proceedings returned to open court.)

MR. SIMON: Ladies and gentlemen, the question I asked before -- and I know it -- I want to try to add something to it, make it a little bit focused and a little bit more specific.

When I asked about negative views generally of an addict, I was asking in the context of a person who's addicted to narcotic pain medication. Okay? That's really what I was asking. Does everybody understand that? Okay.

And that's really what you're going to be hearing if you're on the jury in this case, that's what this case is about, is addiction to narcotic opioid pain medication.

Does anyone here have a negative or bad feeling about somebody who got addicted to prescription narcotic pain medication? Okay. We've got a few hands.

VENIREMAN BONNER: Rush Limbaugh.

MR. VENKER: I'm sorry?

MR. SIMON: That's the way I asked the question. So --

VENIREMAN BONNER: No, I -- I don't have -- I don't have negative feelings about an addict, but I certainly have negative feelings about the behaviors that are associated with addicts.

MR. SIMON: Okay. All right. And I have trouble -- Hostuttler. Mr. Hostuttler?

VENIREMAN HOSTUTTLER: Yep.

MR. SIMON: You had your hand up?

VENIREMAN HOSTUTTLER: Oh, I agree with her.

MR. SIMON: Okay, Your Honor.

THE COURT: All right, ladies and gentlemen, it is roughly 4:35. As you can tell, we're not going to get done with jury selection today. So I'm not going to keep you any longer than necessary, since you are going to be coming back tomorrow. When you come back tomorrow, you do not need to go back to the jury supervisor, you need to come back to this -- where Ali had you out there in the hallway.

THE SHERIFF: No, Your Honor, we're in the back room.

THE COURT: I'm sorry. If you would come back -- when you first came here this afternoon, you went in our holding room. I need everybody to go back there tomorrow morning 8:30. It's -- just so you know where you are, this is Division 21, we're on the eighth floor, and my last name is Noble. So between those three, 21 is the division, eighth floor, and last name Noble, I need everybody back at 8:30.

Now before you leave I have to read to you an

instruction, or we can say a reminder.

(Whereupon, Instruction 300.04.1 read to the Jury.)

THE COURT: See everybody back at -- I do need to talk to the hardships. The hardship people were -- Rosen, Hercules, Selby, and I believe Lanier are my four hardship people. I do need to talk to you afterwards.

Other than that, I will see everybody 8:30 in that room tomorrow morning. Yes, ma'am?

VENIREMAN HEISLER: I have a question. If I think I know one of the lawyers from a case previously, is that important?

THE COURT: Yes. We'll bring that -- but -- why don't we take that up tomorrow with Mr. Simon when you see him tomorrow morning.

VENIREMAN HEISLER: Well, not him, it's one of the guys over here.

THE COURT: Okay. Since it's his turn, he gets to talk about it first, okay?

All right. Please take everything with you. Do a second look around where you are, these will be your seats until we pick the jury tomorrow morning. We'll try to get you lined back up again, but -- I'll see you tomorrow morning at 8:30 in the morning.

(Whereupon, a short recess was taken.)

(Venireman Rosen approached the bench, and the following proceedings were had:)

THE COURT: We are on the record with Miss Rosen, she is juror number 402, this is in regard to the question about would serving on the panel creating an extreme hardship, and if the person thought it would be impossible for them to serve, anticipating this case may go through Friday.

So, Miss Rosen, tell me your situation.

VENIREMAN ROSEN: I'm a college professor, I work at Webster University, and I -- my assistant who helps me run a graduate program that starts in August left her job last month and we've been in protracted debates to hire her replacement. Those interviews are scheduled for Thursday morning. I'm a member of a research committee, the interviews are scheduled, I have to run the interviews. I don't know if you all would agree it's a hardship, but for me it is.

THE COURT: All right. And so if you were on the jury then there would be no one to do the interviews, or you're just one of the people that does the interviews?

VENIREMAN ROSEN: Two of the people are overseas, and I have to coordinate the Skype interviews. And since the person essentially works for me, me not being there would be a hardship for the others. It's from

7:00 until 11:00 on Thursday. So if things started at 11:30, I could be here, but I don't think you want to delay it for me.

THE COURT: All right. So it would be fair to say if you were on this jury that would be something that would be weighing on your mind instead of paying attention to the evidence?

VENIREMAN ROSEN: Unfortunately, yes.

THE COURT: Your entire program would be in jeopardy without the person?

VENIREMAN ROSEN: Yes, the program cannot run without this person.

THE COURT: Okay. Anybody got any follow-up questions for Miss Rosen?

MR. SIMON: No, Your Honor.

MR. VENKER: I don't think so, Your Honor. Thank you.

THE COURT: All right. Miss Rosen, I'm going to -- if you can hang out in the hall, I'm going to -- I'll talk to the attorneys when I get done with everybody, then I'll let you know whether you need to come back or not.

VENIREMAN ROSEN: Thank you, Your Honor.

(Venireman Rosen left the bench, and the following proceedings were had:)

THE COURT: Can you bring in Miss Hercules,

which is 1044?

(Venireman Hercules approached the bench, and the following proceedings were had:)

THE COURT: Miss Hercules, you said you had a hardship that would make it -- an extreme hardship that would make it impossible for you to serve if this case went past Friday.

VENIREMAN HERCULES: So I have airline tickets to fly out on Thursday.

THE COURT: Where are you going?

VENIREMAN HERCULES: Vegas. I have the itinerary.

THE COURT: All right. Miss Hercules, thank you for serving. You are going to be done. You don't need to come back tomorrow.

VENIREMAN HERCULES: Thank you. I really appreciate it. Thank you.

THE COURT: Trust me, because I have a trip coming up, and I'm going. I wouldn't have you do something --

VENIREMAN HERCULES: My mom would be very disappointed if I couldn't join.

THE COURT: I wouldn't make you do something I'm not going to do. So this counts as your jury service. Make sure you see Ali. I'm discharging you and you're

done.

MR. SIMON: Have fun.

MR. VENKER: Thanks, ma'am, have fun.

(Venireman Hercules left the bench, and the following proceedings were had:)

THE COURT: So that's an easy one, Miss Hercules is gone. So juror 1044 is struck for hardship.

All right. We need juror 996, Selby. Line thirty-three.

(Venireman Selby approached the bench, and the following proceedings were had:)

THE COURT: For the record, this is Mr. Alexander Selby, juror number 996. Response to whether you had extreme hardship that would make it impossible for you to serve if this case went past Friday, what is your situation?

VENIREMAN SELBY: Well, Your Honor, I'm an hourly employee, five days' pay that I don't get is severe. Basically. And I wasn't sure if that qualified or not, but I figured it would be safer to raise my hand than not raise my hand.

THE COURT: So, all right, you're an hourly employee?

VENIREMAN SELBY: I'm going to be very tight on rent, tight on my bills if I don't work for five days.

I've been employed for less than a year at my current employer, so I don't have any vacation time to take. It's a small business.

THE COURT: All right. But you're -- the company knows that you are on jury duty?

VENIREMAN SELBY: Yes.

THE COURT: Okay. All right. I don't want to appear to be insensitive, Mr. Selby, but here's what I'm going to do. I'm going to take that into consideration. I am going to have you come back tomorrow and then, depending on what happens with whether you're picked or not, that will have a direct effect. But as of right now I need all the bodies I can muster. So I will see you tomorrow morning at 8:30.

VENIREMAN SELBY: Okay, thanks.

(Venireman Selby left the bench, and the following proceedings were had:)

(There was a discussion held off the record.)

THE COURT: All right. Next person would be Lanier, juror -- line forty-two. Her number is 1043.

(Venireman Lanier approached the bench, and the following proceedings were had:)

THE COURT: For the record, this is Miss Hillary Lanier, juror 1043, she had a -- she responded to whether she had an extreme hardship that would make it impossible

for her to serve if the trial went past Friday. Can you share with us what's going on?

VENIREMAN LANIER: Well, I'm not sure that it constitutes an extreme hardship, but when I checked in this morning they said to bring it up. I start my new job at Barnes on Monday, and if I don't go to my health screening tomorrow I won't be able to start my job on Monday.

THE COURT: What time is your health screening?

VENIREMAN LANIER: It's at 8:00.

THE COURT: In the morning?

VENIREMAN LANIER: Yeah.

THE COURT: It's the kind of job that's kind of important?

VENIREMAN LANIER: Well, I don't have any income right now, so -- it's kind of my dream job, so, yeah.

THE COURT: Dream job, grad student, or jury duty.

VENIREMAN LANIER: Yeah.

THE COURT: It's a conundrum, what to do. All right. Miss Lanier, I'm going to go ahead -- whether a person is going to lose a job or not, I think that is an extreme hardship.

VENIREMAN LANIER: Thank you.

THE COURT: So I appreciate that you hung in

there today, but you do not need to come tomorrow, I'm discharging you.

VENIREMAN LANIER: Okay.

THE COURT: Make sure you see Ali, she's going to give you something different than she gives to everybody else.

VENIREMAN LANIER: Okay.

THE COURT: All right? Thank you for your service.

MR. SIMON: Good luck with your job.

MR. VENKER: Good luck with your job.

VENIREMAN LANIER: Sorry, I have a lot of opinions.

(Venireman Lanier left the bench, and the following proceedings were had:)

THE COURT: I think those are the only hardship ones. Going back to the first one, I'm torn on that one, but --

MR. SIMON: I don't know, Judge, that's -- I mean, the interviews -- it didn't seem like a hardship enough to get her off, especially if we're just -- we're not even -- I -- I don't think it's a --

THE COURT: I will tell you I'm leaning toward not.

MR. VENKER: The only thing I was going to say,

it's Webster University, you know, they do their best to run with the leanest staff they can, and that's what I'm thinking, it really is her not being there and they're trying to recruit people. That's what I'm thinking.

THE COURT: And the other thing is -- not the words in her mouth, but she said she needed to be there to run the Skype, and I'm thinking that's not the only -- I mean, she said other people are going to work for her, but -- as of right now I'm going to have her come back.

MR. SIMON: Okay.

MR. VENKER: Okay.

THE COURT: And then if it becomes an issue, then we can deal with it later. But as of right now, not knowing what's going to shake out -- so let -- let Miss Rosen know that she needs to come back tomorrow at 8:30.

All right. We're off the record.

(Whereupon, an evening recess was taken.)

TUESDAY, JUNE 21, 2016

THE COURT: We're on the record outside the hearing of the jury to further discuss a comment that Amanda Rosen, juror number 402, made where she asked where the money went with the punitive damages.

Mr. Simon made a response, and then followed it up with that's all I can tell you. The defendants were concerned -- well, I'll let you put it in your words.

MR. VENKER: Sure. Thank you, Your Honor.

My point, Your Honor, is that there was a discussion about punitive damages during that portion of the voir dire, and that the juror, as you I believe have correctly identified -- I think it was Miss Rosen, that's what I remember, too, asked basically something like -- and I know we've had the Court Reporter read back for us the actual words, so we'll just leave that as it is. And basically said who gets the money. To which -- where does the money go. To which Mr. Simon replied, basically, I can't tell you that. I think under these circumstances -- again, I'll defer to what the transcript says. I know we just heard it this morning.

But he also mentioned that it was not to compensate -- he could tell them that it was not to compensate the plaintiff. I think that's really an incorrect statement. I think the punitive damages clearly go in part to the plaintiffs. And I realize that may have been a surprise question by the juror, but at the same time I think, you know, maybe a sidebar could have been requested or something to see what should be done to answer that question.

My concern now is that the jury -- whoever is on the jury will be confused about where the money goes. They could be thinking anything from -- as Miss Rosen's question

asked it, really she said does the defendant -- does it go to the defendant. Now, she might be confused as a lay person as to who is the plaintiff and who is the defendant. But she may also be thinking, in light of some of the comments that were made during the voir dire about the opioid epidemic, the issues -- I think panel member Hostuttler mentioned friends from Afghanistan who had served there and gotten addicted on pain meds and come to the United States and got hooked on heroin and he was saying, hey, this is a way bigger problem than this case.

And, so, does the -- do these jurors now think that the punitive damage award would be -- would go to SLU to somehow fund some regulations, that's what Mr. Hostuttler was talking about, about opioids.

I mean, obviously we're in the realm of speculation here. But I don't think I have any choice but to ask for a mistrial at this point. We're only about halfway through the voir dire of this case. I think this is really an open question for confusion by these ultimate jurors as to what the punitives are, and I don't think they're going to get any better explanation from either the instructions that are offered them or by any other -- any other person in the courtroom. I think it's kind of a dead end canyon in terms of trying to make it clear to them in a way that can be really understood.

So, again, it's reluctant that I do it, but I don't think I have a choice but to ask for a mistrial.

THE COURT: Okay. Mr. Simon?

MR. SIMON: Your Honor, the questioning was appropriate, because punitive damages are fair game during the questioning. The purpose of punitive damages are to punish and deter. The purpose of punitive damages, as the jurors will be instructed, are not to compensate the plaintiff. That's an issue that I -- you know, I'm obligated to go into with the panel. Some individuals have strong feelings one way or another about that concept.

During that questioning one of the jurors -- or the panel members, Miss Rosen, interjected the issue of where the punitive damages go. I think I blunted the issue as well as I could. I mean, she certainly asked the question, I responded to her stating correctly that punitive damages are not designed to compensate the plaintiff, and then I believe I said, after that, you know, I can't tell you where they go, or that's all I can tell you. I didn't suggest whether, you know, they're going one way or another.

And so, Your Honor, again, I didn't interject -- I didn't ask the question, I didn't interject that issue, it was asked, and I believe I certainly tried -- and I believe I did try to end the discussion and blunt the discussion as

appropriately and as efficiently as I could.

THE COURT: I think -- I'm going to deny your motion for a mistrial. I think it's premature at this time. I think the nature of jury selection is that there is always the potential for confusion. This confusion was not initiated or potentially generated by the plaintiff, it was a response. I do believe his response was an attempt to blunt the issue and not further exacerbate the issue. And I think -- having discussions off the record, I think this is a topic that we're just going to stay away from and then leave it at that. I think it's -- there's always things in the trial that are potentially beyond the initial comprehension of jurors, whether it be standard of proof or other types of terms. And part of it is just the nature of it. And I think this was just an inquisitive juror and I -- like I said, I believe Mr. Simon blunted it and then allowed us to move on.

So I'll deny the motion, and -- that's it.

MR. SIMON: Thank you, Your Honor.

MR. MAHON: Oh, just for completeness of the record, we did generally discuss the issue of Mrs. Koon sobbing in the back, and that counsel was going to talk with them, but I just wanted to bring that issue to the Court's attention.

MR. SIMON: We already spoke to her, Judge, and

if she's getting too emotional she's going to excuse herself from the courtroom.

MR. MAHON: Thank you.

THE COURT: All right. You're welcome.

(Whereupon, a short recess was taken.)

THE COURT: Ma'am, what's your juror number? Come on up.

(Venireman Huskey approached the bench, and the following proceedings were had:)

VENIREMAN HUSKEY: Thirteen.

THE COURT: What position? I'm sorry. I'm drawing a blank.

MR. SIMON: Seat sixteen.

THE COURT: Good morning, Miss Huskey.

VENIREMAN HUSKEY: Hi, how are you?

THE COURT: All right, good. It's come to my attention that you may have a hardship that just came to your attention last night?

VENIREMAN HUSKEY: Right.

THE COURT: Can you share with us what's going on?

VENIREMAN HUSKEY: I'm a school bus driver during the year, and I am laid off in the summer, I had some jobs lined up to, you know, subsidize my income for the summer, and I've got a couple that are not willing to

wait for me, and that would be --

THE COURT: When you say not willing to wait, do you mean --

VENIREMAN HUSKEY: Yeah, for the week or week and a half I'm going to be here. I would lose them jobs.

THE COURT: Well, in terms of a timeframe, I -- I'm thinking it -- let's say if it goes over till Monday.

VENIREMAN HUSKEY: Yeah, they want -- I mean, I started the jobs, so I'm right in the middle of them. And they're not, you know -- I called last night, and they said well, you know, we're not going to -- we're going to have somebody finish it for you. And it's, like --

THE COURT: What does that mean, in terms of --

VENIREMAN HUSKEY: What does it mean to me?

THE COURT: Yes, ma'am.

VENIREMAN HUSKEY: It means I don't pay my bills.

THE COURT: Okay. All right. And this is something if you lose this week, then you're -- is it -- are they week -- tell me -- help me out. Is it like a week job, or is it a summer job, or --

VENIREMAN HUSKEY: It's -- well, I'm doing some painting. And if I don't finish it, I'm not getting paid. Then I can't pay my bills. I'm not married, so that's my income.

THE COURT: So this is a hardship?

VENIREMAN HUSKEY: Yes.

THE COURT: Okay. All right. I don't -- I didn't want to --

VENIREMAN HUSKEY: I'm sorry.

THE COURT: I just wasn't sure how the job works in blocks. I didn't know if it was another block coming. So --

VENIREMAN HUSKEY: Right. So I'm laid off from driving, so I have to subsidize to make ends meet during the summer.

THE COURT: Okay. And I appreciate how hard you're working, so -- I didn't -- I didn't mean to make you upset.

VENIREMAN HUSKEY: Oh, it's all right.

THE COURT: Okay.

VENIREMAN HUSKEY: It's just nerve wracking, you know, thinking I'm going to lose it.

THE COURT: No, I can tell it's weighing on you in your heart. So, to be fair to you and to the attorneys, your mind is going to be elsewhere?

VENIREMAN HUSKEY: Yeah. Yeah.

THE COURT: And they would want your hundred percent attention here, and I --

VENIREMAN HUSKEY: You know, I've always -- I've

never done this. I mean, I've always had a good job, and the last couple years it's been rough. So --

THE COURT: Oh, I understand. You know what, I appreciate you bringing it to our attention. All right?

VENIREMAN HUSKEY: Yeah.

THE COURT: I'm going to go ahead and --

MR. SIMON: No questions, Your Honor.

THE COURT: Okay. I'm going to --

MR. VENKER: No questions.

THE COURT: -- discharge you from service.

VENIREMAN HUSKEY: Thank you.

THE COURT: Check with Ali, she will give you some paperwork and you're done.

VENIREMAN HUSKEY: Okay. Thank you.

THE COURT: Good luck, ma'am.

VENIREMAN HUSKEY: Thank you.

(Venireman Huskey left the bench, and the following proceedings were had:)

THE COURT: This is our fireman.

(Venireman Vancil approached the bench, and the following proceedings were had:)

THE COURT: Is this Mr. Vancil?

VENIREMAN VANCIL: Yes.

THE COURT: All right. Juror number 392. Position twenty-five. All right. Mr. Vancil, you had

something brought to our attention regarding your hardship?

VENIREMAN VANCIL: Yes, I'm involved with a national charitable organization, it's Fire and Iron, we're doing our national fundraiser right now out at Westport, and I have a hotel booked for the week out there, and we are the host station, so my job basically is to -- everyone is from out of the state. So, like, rides, basically showing, you know, everyone where to go, kind of basically just a St. Louis liaison --

THE COURT: All right.

VENIREMAN VANCIL: -- for the event. And I thought I was going to be able to do both, and I didn't get out of there until 3:30 this morning. It's just -- I mean --

THE COURT: All right. So, Mr. Vancil, I don't want to make light of what you're doing, I just -- but I'm concerned that there's a -- the firemen aspect, there's a team of you, that you're not the only person.

VENIREMAN VANCIL: There's fifteen of us, but we're taking care of fifteen hundred.

THE COURT: And so if you're here, is there somebody that can cover for you, or what's -- or -- I understand you're doing double duty. It sounds like last night -- you had to do jury duty, then you had to go do

your charitable duties?

VENIREMAN VANCIL: Right.

THE COURT: Other than being exhausted, which I understand how important that is, but is there anybody that can cover for you while you're -- while you're at trial? Because you're not going to be sequestered, so your evenings will be yours.

VENIREMAN VANCIL: Right. I mean, I have invested $600 in the hotel room to be out there, and a lot of the activities are during the day.

THE COURT: Okay. All right, Mr. Vancil. Anybody got any questions of Mr. Vancil?

MR. SIMON: I just have one. Sir, would you be till there 3:30 in the morning every night, thus not getting much sleep every night before coming in here?

VENIREMAN VANCIL: It looks like it's going to be that way.

MR. SIMON: Judge, that's my only question.

MR. VENKER: No questions, Your Honor.

THE COURT: If you'd wait out in the hall, we're going to talk about this a second.

VENIREMAN VANCIL: Okay. Thank you.

(Venireman Vancil left the bench, and the following proceedings were had:)

THE COURT: I'll leave that one up to you guys.

The fact -- if he's going to come in here on limited sleep, I don't think that helps.

MR. SIMON: That's my concern, Judge.

MR. VENKER: I would tend to agree with that. I'm a little frustrated by it, but --

THE COURT: I'm completely frustrated by it, as you, but I don't think he would serve --

MR. SIMON: Be much help on three hours' sleep.

MR. VENKER: Yeah. I don't disagree.

THE COURT: All right. Let's strike juror 392 for hardship.

MR. SIMON: Judge, are we -- Mr. Selby is off our list now also?

THE COURT: Did Mr. Selby show up?

THE SHERIFF: No, Your Honor.

THE COURT: Okay. Let's go ahead and strike line 996, Mr. Selby.

THE SHERIFF: Pay him for one day, Your Honor?

THE COURT: I'm not done with Mr. Selby yet.

THE SHERIFF: I just want to know, because from -- the understanding that I got from the group of individuals is this gentleman had a first employment of this week or something and he chose his employment. I guess it's a new job.

THE COURT: I'm sure that will be a discussion

he and I will have face-to-face shortly. But for today's purposes, no, don't pay him a dime, and he's going to be removed from the panel for failing to follow the Court's order. So -- clearly he indicates he won't be able to follow the instructions as well.

That being said, Ali, let's rock and roll.

(Whereupon, a short recess was taken.)

(Venireman Leible approached the bench, and the following proceedings were had:)

THE COURT: Is this Mr. Leible?

VENIREMAN LEIBLE: Yes.

THE COURT: Come on up, sir. Mr. Leible, I -- one of the things that I do as judge is I kind of look through all these forms, and I was thinking about Miss Houston yesterday, and how she was uncomfortable with -- on -- sitting over there. And I notice that one of our things says that you have a disability. And I wanted to make --

VENIREMAN LEIBLE: Yes.

THE COURT: I wanted to make sure that we were properly accommodating. Are you --

VENIREMAN LEIBLE: Oh, yeah, I'm fine.

THE COURT: Okay. If you don't mind, can you share with me what the disability is?

VENIREMAN LEIBLE: A brain injury.

THE COURT: Okay. And have you been able to -- to -- I'm sorry to hear about that. But have you been able to follow everything that we've been doing so far?

VENIREMAN LEIBLE: Oh, yeah, I'm fine.

THE COURT: Okay. When did you have the injury?

VENIREMAN LEIBLE: About six, seven years ago.

THE COURT: Okay. And are you on any type of medication for it or any --

VENIREMAN LEIBLE: Well, I'm bipolar, so I take some medicine for that.

THE COURT: Okay. Is there anything -- does it -- does the brain injury affect your bipolar, or does it have any other effects on you?

VENIREMAN LEIBLE: No. It's just I got to take medicine every day at the right time. If I take it a little later -- usually I take some medicine at noon, but I have to take it at 5:00 or 6:00, so -- but that's okay. It -- it's a time-released medicine, so it's okay.

THE COURT: All right. And you've been able to understand everything that's been going on so far?

VENIREMAN LEIBLE: Oh, yeah, fine.

THE COURT: No issues with terminology or any of that stuff?

VENIREMAN LEIBLE: No, none.

THE COURT: I just was checking. I just was

looking through the paperwork, and I just wanted to make sure -- with how uncomfortable Miss Houston was --

VENIREMAN LEIBLE: I can understand that.

THE COURT: Okay. All right. Anybody else have any follow-up questions?

MR. SIMON: No, Your Honor.

MR. VENKER: None at this time, Judge, thank you.

THE COURT: Okay. Thank you, sir.

VENIREMAN LEIBLE: Thank you.

(Venireman Leible left the bench, and the following proceedings were had:)

THE COURT: I didn't hear anything that rises to the level, but if there's something statutorily that says it --

MR. BARTH: Your Honor, we did see there was a court order entered from the probate court of this court finding of at least partial incapacity with the brain injury, bipolar, and Mr. Leible's brother has been appointed at least in some context as a limited guardian for him. The order does state that he can still have a motor vehicle license. I'm trying to remember.

MR. MAHON: And boat.

MR. BARTH: And boat. But as far as other decisions, he would have to have somebody else make them

for him. I'm not aware of exactly what the law is. He is a registered voter. But obviously his decision making capability would be at issue, and I think --

THE COURT: So you're saying we have entrusted him with the power to select the President of the United States, but not the power to decide whether a plaintiff or defendant should win in a legal case?

MR. BARTH: This is a new one.

THE COURT: Why don't we do this. Mr. Leible is clearly observing his duty to be a jurist. Let's wait and see if he says anything that rises to the level of cause, and then when we get down to it, we can deal with it when it comes down to the numbers. One, partially because we are losing numbers left and right, and two, so far he hasn't said anything other than I -- I do take seriously that he has been adjudicated, and, so, when we get down to it, raise that again, and then based on -- but I would ask that both of you inquire and get something on him, his comments, other than just his medical condition, to give us a little bit something more to work with if need be. All right?

MR. SIMON: Yes, thank you.

MR. VENKER: All right, Your Honor.

(Whereupon, a short recess was taken.)

THE COURT: Please be seated. Good morning,

welcome back. We have a lot to get to today, so let's get to it.

Mr. Simon, you may continue.

MR. SIMON: Thank you, Your Honor.

Good morning, ladies and gentlemen, welcome back. What I want to start out with is, you went through a bunch of different issues and questions and good conversation yesterday, and at night -- not that you were thinking about all of this last night, but did anybody remember anything or is there any additional information that you want to, you know, provide to make an answer complete? Anything come to anybody?

Yes, sir, Mr. Traubitz?

VENIREMAN TRAUBITZ: Yeah, I had -- when you asked if anybody was actively in the medical field.

MR. SIMON: Yes, sir.

VENIREMAN TRAUBITZ: My father was a doctor, but he died way back in 1948. I didn't -- I don't know if that means anything or not.

MR. SIMON: Okay.

VENIREMAN TRAUBITZ: And after several years of loss I don't think so, but I didn't know if you were interested in past --

MR. SIMON: Sure.

VENIREMAN TRAUBITZ: -- experience or something

like that. So, that's almost seventy years ago that he died. And I have a sister that was a nurse, she lived out in Seattle, and I'm not sure, you know, how -- or, actually, Pennsylvania. But she died a number of years ago, too.

MR. SIMON: Okay.

VENIREMAN TRAUBITZ: And my former wife had some -- I think she had some nursing training in Kansas City, but I don't think she ever actually worked in -- I think she was more of a counselor rather than an actual medical person.

MR. SIMON: Okay.

VENIREMAN TRAUBITZ: But those were all in the past, and the people are long gone, and I didn't know whether to --

MR. SIMON: I appreciate you being complete.

VENIREMAN TRAUBITZ: It was germane to the issue or not.

MR. SIMON: Yes, sir. Thank you, Mr. Traubitz.

Anybody else? Yes, Miss Bonner?

VENIREMAN BONNER: I remembered that I -- I've had treatment at St. Louis U's Dental School. I don't know if that's relevant, but --

MR. SIMON: Okay. There was nothing about that that's going to affect your judgment in this case?

VENIREMAN BONNER: No.

MR. SIMON: Very good. Okay. All right. Anybody else?

All right. Miss Heisler? Okay. Before we left at the end of the day you said that maybe you recognized Mr. Venker?

VENIREMAN HEISLER: No, one on the end. I don't know his name.

MR. SIMON: Okay. Okay. And --

VENIREMAN HEISLER: Can I say how? I was in a civil case, and there was a lawyer that I thought might have been him, but I'm not sure, it's been several years ago. This woman was driving a school bus, and a man was driving a truck with a trailer, somehow his mirror got in her window and she was suing him. So, I don't know if that's the lawyer or not.

MR. SIMON: Okay. Were you involved in the case?

VENIREMAN HEISLER: I was on the jury.

MR. SIMON: Okay. All right. And you think it might have been Mr. Barth? Mike Barth?

VENIREMAN HEISLER: Maybe. I'm not sure. It's been a long time ago.

MR. SIMON: Okay. Anything about that that you think would affect your judgment in this case?

VENIREMAN HEISLER: No.

MR. SIMON: Okay. All right.

Now, Miss Frerichs, you had mentioned -- I'm not asking for any information about it. You had mentioned some issue that you had with St. Louis University. And I'm not asking for any information. You certainly know what it is.

Let me ask you this. Based on your experience, do you think you might not be a good fit for one of the -- either of the parties in this case?

VENIREMAN FRERICHS: I think so.

MR. SIMON: Okay. Thank you very much.

Okay. And Miss Abercrombie. Abercrombie. Okay. We were talking a little bit, you're a medical assistant, right?

VENIREMAN ABERCROMBIE: Uh-huh.

MR. SIMON: And we were talking yesterday about -- about patients being responsible for their -- for their own healthcare. And you seemed to have some pretty strong views on that. Is that correct?

VENIREMAN ABERCROMBIE: Correct.

MR. SIMON: Okay. And from looking at my notes, for what they're worth, you seem to lean on the side of -- of a patient being responsible for their own healthcare?

VENIREMAN ABERCROMBIE: No, it's like I said yesterday, both parties are responsible.

MR. SIMON: Okay. All right. Okay. All right. And let me ask you this. Neither party is starting out a little behind, right? Both parties starting out at the same place?

VENIREMAN ABERCROMBIE: Correct.

MR. SIMON: Okay. All right. And, let's see, it's Miss Griggs?

VENIREMAN GRIGGS: Yes.

MR. SIMON: Miss Griggs, same question. You had mentioned you had some issue -- and I don't need any information about it at this point. You mentioned you had some issue or problem with St. Louis University in the past.

VENIREMAN GRIGGS: Yes.

MR. SIMON: Do you think maybe because of that you might be better suited for a different case?

VENIREMAN GRIGGS: That's correct. I don't think I could be impartial to St. Louis University.

MR. SIMON: Okay. All right. Thank you. Thank you very much.

Is there anything -- you know, I'm always surprised because I come up with all of these, you know -- actually, believe it or not, I think a lot about these questions in writing them out. You might not think so. And I'm always amazed because I hear questions and issues

come up that I hadn't even thought about. And that happened yesterday on -- you know, two or three times, where, as a group, you're coming up with things that I hadn't thought about, and I've been thinking about this for a long time.

Is there anything -- any -- based on what we talked about so far -- and you are Mr. Lehmuth?

VENIREMAN LEHMUTH: Yes.

MR. SIMON: Yes, sir.

VENIREMAN LEHMUTH: I don't know if this is a question you're going to get to at some point in time, but my family was involved in a wrongful death suit, it was a hospital, doctor, nursing home involved. We were not successful in the suit. And I think that's pertinent information.

MR. SIMON: Okay. Was St. Louis University a party in that?

VENIREMAN LEHMUTH: No.

MR. SIMON: Okay. How long ago was that, Mr. Lehmuth?

VENIREMAN LEHMUTH: About five years ago.

MR. SIMON: Okay. And is that going to affect you one way or another in this case?

VENIREMAN LEHMUTH: I don't think justice was served.

MR. SIMON: Okay. And that's -- you know what, that's an experience that you had.

VENIREMAN LEHMUTH: Absolutely.

MR. SIMON: And is any of that, do you think -- you know, and, again, it's not about being fair or not, that's not what I'm asking you. Do you think any aspect of that may influence your judgment in this case for one side or another?

VENIREMAN LEHMUTH: I wish it wouldn't, but I'm not sure if it would or wouldn't.

MR. SIMON: Okay. You can't say for sure at this point that it wouldn't affect your judgment; is that what you're telling us?

VENIREMAN LEHMUTH: Yes.

MR. SIMON: Okay. All right. Thank you, Mr. Lehmuth.

And again, ladies and gentlemen, anything else that anybody can think of that -- let me ask it this way. Based on what you've heard so far about the case, is there anything that anybody can think of in their own life, in their own experience, that they think, boy, maybe I wouldn't be good for this case? Anybody feel that way?

VENIREMAN HEISLER: (Raises hand.)

MR. SIMON: Okay. I'm sorry. It's --

VENIREMAN HEISLER: Heisler.

MR. SIMON: Miss Heisler?

VENIREMAN HEISLER: I had said something about a personal thing, and we were supposed to talk about that privately, and nothing ever happened. It's about doctors.

MR. SIMON: Okay. So, does this involve a personal experience you've had with a doctor?

VENIREMAN HEISLER: Yes.

MR. SIMON: Okay. And let me ask you this, again, without getting into it, would that cause you, you think, to be a little -- leaning one side or another before we get started?

VENIREMAN HEISLER: It may, because there were several incidents in different parts of my family.

MR. SIMON: Okay. And what you're saying, you may not be a good juror for St. Louis University?

VENIREMAN HEISLER: Not the university, no, the doctor.

MR. SIMON: The doctor. Very good. Okay. Okay. And based on that experience, you think one side might be starting out a little ahead of the other, correct?

VENIREMAN HEISLER: Yes.

MR. SIMON: Okay. Thank you very much.

Anybody else? Okay. All right. Okay. Let's start in the front. Miss Nichols?

VENIREMAN COLEMAN NICHOLS: My brother-in-law that is a pharmacist was working for a pharmacy that was investigated by the DEA for filling fake prescriptions. And that's one of the reasons why he's not there anymore. So, I feel like that kind of skews my opinion.

MR. SIMON: Miss Nichols, let me ask you this. So your brother wasn't -- was -- your brother wasn't involved in the -- whatever was going on?

VENIREMAN COLEMAN NICHOLS: He was investigated for it.

MR. SIMON: Okay.

VENIREMAN COLEMAN NICHOLS: Part of the resolution was that he no longer works for them.

MR. SIMON: All right. Okay. And you think that might be a little too close to what we're talking about in this case?

VENIREMAN COLEMAN NICHOLS: Yes.

MR. SIMON: Okay. All right. And based on that experience, what you're saying is you might be a better juror for a different type of case?

VENIREMAN COLEMAN NICHOLS: I would agree with that.

MR. SIMON: Thank you.

Okay. And, Miss Abercrombie, did you have your hand up?

VENIREMAN ABERCROMBIE: Uh-huh. This is -- I said it yesterday. I work for a physician, and, like I said, I have witnessed a prescription written for three hundred quantity, and I just feel like that's just way too much.

MR. SIMON: Okay. Let me ask you this. When you say quantity, are you talking about the MED, the milligrams, are you talking about the number of pills?

VENIREMAN ABERCROMBIE: The number of pills.

MR. SIMON: Okay. So you saw a physician write a prescription for -- one time for how many? Three hundred pills?

VENIREMAN ABERCROMBIE: Correct.

MR. SIMON: Okay. And what kind of medication was it?

VENIREMAN ABERCROMBIE: Opiates.

MR. SIMON: Do you know what kind?

VENIREMAN ABERCROMBIE: Vicodin.

MR. SIMON: Vicodin? Okay. How long ago was that?

VENIREMAN ABERCROMBIE: Recently.

MR. SIMON: Okay. And is it -- it's happened where you work?

VENIREMAN ABERCROMBIE: Uh-huh.

MR. SIMON: Okay. And because of that you think

you may be a little -- you may think one side is starting out a little ahead of the other?

VENIREMAN ABERCROMBIE: Yes. I'm sorry.

MR. SIMON: Do you think that experience may influence your judgment in this case, even before you've heard any of the evidence?

VENIREMAN ABERCROMBIE: Yes, because of how I feel.

MR. SIMON: Okay. All right. Thank you very much.

Okay. And -- yes. And it's Miss Rosen?

VENIREMAN ROSEN: Yeah, I don't know -- I don't know how relevant it is. My father had some terrible medical care provided, including a botched operation, poor pain management, and some other things that caused him to suffer a lot. But I don't think that's relevant, really, in the sense that it was in another state, has no bearing on this doctor. I don't think it will affect my judgment. But just for completeness.

MR. SIMON: I appreciate that. Thank you very much.

I appreciate everybody being honest and forthcoming. As I said, none of this works unless, you know -- I know what you're thinking. Okay? So let's -- the next -- you know, in -- as lawyers, and in law school, they tell

us in voir dire, most important thing -- most important thing is to talk about things that worry you the most. Everybody get that and understand why we would be told that?

In other words, I'm here, and Tim and Erica, we're representing Brian and Michelle, and, you know, twelve of you are going to decide this case. And you're going to decide it one way or another. And one of the things that worries me in this case, and I want to talk to you about it, is this.

Brian is an addict. Today he's addicted to opioids. He's been clean since 2012, he went through the detox and all of that stuff, and the rehab. But he is still an addict. And he'll be an addict for the rest of his life. He's got to fight that and deal with that.

And here's what I'm worried about. Here's what I'm worried about. Does anybody here feel that they would be reluctant to award a significant amount of damages to somebody who is an addict? Everybody get where I'm coming from? Okay? Let me just let you think about that. I'm going to say that again. Brian is an addict, been clean since he went into detox shortly after he left Dr. Walden's care, he's back working, he's been back working for the city, back at his job that he's been at for eighteen, twenty years, but he fights it every day.

Who here -- who here knows -- thinks they know

what I'm talking about? Everybody kind of get it a little bit? Okay. All right. Okay. Do I need to worry about that? Is that a problem?

VENIREMAN TRAUBITZ: No, no.

MR. SIMON: Okay. Anybody? Is anybody here -- when they go back to consider damages in the case, does anybody here think that they're going to -- they just can't put that out of their mind?

In other words, you can't just look at the evidence and the law and the harms and losses, but in the back of your head that's going to have some effect on what you might be willing to award as damages?

Anybody feel that way even a little bit?

VENIREMAN WALLACE: (Raises hand.)

MR. SIMON: Okay. And, Ms.Wallace, tell me about that.

VENIREMAN WALLACE: I just -- like I said yesterday, I have negative views towards addicts, and I don't know even rationally I can hear the information and hear all the testimony and the facts. Rationally I can hear that, but I don't know if emotionally I will be able to set it aside from my views towards addicts.

MR. SIMON: And I think you told us yesterday you had some personal experience dealing -- or living with somebody who was an addict, correct?

VENIREMAN WALLACE: Yes.

MR. SIMON: And, Miss Wallace, I appreciate your honesty, and again that's an issue that, as I said, concerns me. And you feel like, based on your experience dealing with a person close to you who was an addict, that may affect your judgment in deciding damages or any other issue in this case?

VENIREMAN WALLACE: Correct.

MR. SIMON: Okay. All right. And you think my side might be a little behind before we even start, I guess is what I'm saying? Is that right?

VENIREMAN WALLACE: Yes.

MR. SIMON: Okay. Anybody else? Let me ask it the other way. Is everybody here willing -- is everybody okay with that? In other words, is everybody willing to base damages on the harms and losses, on the evidence in the case, and not consider or base it on the fact that Brian is an addict? Is everybody willing to do that?

Okay. Is anybody not willing to do that, even a little trouble with that? I appreciate what Miss Wallace said, that's -- thank you for, you know, telling me what you're thinking. And the reason I'm going on with this is because I see -- I see some frowns, and I'm trying to gauge your facial expressions and your body language, and it just seems like people are having a little trouble with it.

Okay? All right? Anybody --

Okay. Miss Brennan?

VENIREMAN BRENNAN: I don't have any problems trying to -- I mean, I'm 50/50 split, you know, because I haven't heard the facts of the case.

MR. SIMON: Okay.

VENIREMAN BRENNAN: But what if it comes down to we decide that no punitive damages should be awarded, period?

MR. SIMON: And, again, I'm not asking you to commit to an amount or, you know, deciding the case, I'm just -- what I'm asking you is can -- can you decide the case based on the evidence that you hear and the law that Judge Noble gives you?

VENIREMAN BRENNAN: Yes.

MR. SIMON: And can you set aside the issue of -- in other words, give whatever the damages are and not be reluctant to do that because he's an addict. That's what I'm getting at. Are you okay with that?

VENIREMAN BRENNAN: Yeah.

MR. SIMON: Okay. All right. In other words -- another way to put it is are you -- are we kind of behind before we even start presenting the evidence?

VENIREMAN BRENNAN: No.

MR. SIMON: Okay. All right. Very good. Okay.

Anybody else? All right. I don't see any hands.

Okay. Let me talk to you about damages. And I know from experience -- believe me I know from experience people have strong feelings about damages, and I want to talk to you about a specific type of damage, damages for mental anguish. Damages for mental anguish. Everybody understand what I'm talking about?

Now, I have seven sisters, two of them are nurses, and one of them is a year younger than me, she's been a nurse for thirty plus years, and I talk to her all the time about cases. And one thing we disagree about is she is one of those people that does not believe in awarding money damages for pain and suffering. She's my sister, I love her, we fight and argue about it, discuss it, debate it. I know a lot of people feel that way. Okay?

Does anybody feel that way? In other words, have any reluctance -- okay. All right. Any reluctance at all to award money for pain? Money for pain and suffering, money for mental anguish? Some people feel like that's okay, other people have issues with it.

Anybody in the front row here? Okay. Mr. Traubitz, any issue with that?

VENIREMAN TRAUBITZ: I don't think so. I would have no objection to awarding damages.

MR. SIMON: Okay.

VENIREMAN TRAUBITZ: I think I would like to know more about -- about the case, about some of the evidence.

MR. SIMON: Sure. Absolutely.

VENIREMAN TRAUBITZ: And testimony.

MR. SIMON: All right. Mr. Boyd, what do you think about that?

VENIREMAN BOYD: I'm kind of on the fence. I would need to hear more as well.

MR. SIMON: Okay. All right. Let me -- so you would be willing to consider damages based on the evidence, right?

VENIREMAN BOYD: Yes.

MR. SIMON: You're not going in sort of with the preconceived notion that you're really not fond of those damages?

VENIREMAN BOYD: Exactly.

MR. SIMON: Okay. Anybody else in the first row here? Anybody in the second row? Okay. And it's Miss Kinsella?

VENIREMAN KINSELLA: Right. I wouldn't be -- I wouldn't be quick to award for that kind of thing.

MR. SIMON: Okay. And tell me why, please.

VENIREMAN KINSELLA: I don't -- it just seems

like it would be enough if -- to penalize the person, the doctor.

MR. SIMON: Okay.

VENIREMAN KINSELLA: I don't see why there has to be money involved.

MR. SIMON: Okay. And, so, you would have a little reluctance to award those kinds of damages even before you listen to the evidence is what you're saying?

VENIREMAN KINSELLA: Right.

MR. SIMON: Okay. Very good. Okay. And Miss Rosen?

VENIREMAN ROSEN: I mean, definitely depends on the facts of the case. I have an issue with a lot of frivolous lawsuits trying to say you get millions of dollars. I mean, how exactly can you put a dollar amount on someone's pain and suffering? I think it's really difficult. So I don't know that I have a problem with the idea in principle, I think it tends to be overused, and I think it would be difficult to assign a value to it.

MR. SIMON: Okay. There will be evidence in the case, and you'll be instructed -- the law will instruct you on how you're to go about to award damages. So you would be open to -- you're not opposed to the idea of it; is that correct?

VENIREMAN ROSEN: No, as long as it's not

overused. It depends on the facts of the case, depends on -- I do think it's difficult. The thing I struggle with is figuring out the dollar amounts. I guess that's where -- the idea of it, in principle, I'm okay with it, but just the practical application of it is something I might struggle with, which might make me question the principle of it.

MR. SIMON: Okay.

VENIREMAN ROSEN: But it's hard to do it in the abstract.

MR. SIMON: Yeah. You'll be guided -- the law will instruct you on what you're to consider, not to consider, and you have the evidence that will be presented to you. Okay? So, it's -- you will have some guidance, is what I'm telling you. All right?

VENIREMAN ROSEN: Okay.

MR. SIMON: Okay. Anybody else in the third row? All right. Let's move over to the left. And anybody over here on the left have any problem with awarding money damages for mental anguish or pain and suffering? Okay. Nobody in the first row. I don't see any hands. Second row? Okay.

And in the third row, it's Miss Lapierre?

VENIREMAN LAPIERRE: I mean, I think that in a situation which someone has, you know, lost time at work

or had to go to rehab and having the financial burden of those things being, like, compensated for. But I -- I mean, I personally know people who have won outrageous sums of money that allow -- it's just -- it's excessive and inordinate. And I feel as though if, you know, you have someone who has been able to -- you know, by the grace of God, gotten, you know, their life back on track, and they still have their employment, and, you know, they have been able to beat that addiction, that no extra monetary compensation is required. I think the punishment lies in the fact that, you know, the doctor would be -- you know, would be faced with some sort of consequence.

MR. SIMON: Okay. Very well articulated. That's -- you'd get along with my sister on that issue. Okay? She does a very good job of stating her view, and so did you. And I appreciate that. Now let me ask you this. Because you -- those views that you've just articulated, you feel fairly strongly about those, right?

VENIREMAN LAPIERRE: I do.

MR. SIMON: And have you felt that way for some time?

VENIREMAN LAPIERRE: Yes.

MR. SIMON: Okay. And there's nothing anybody here, me or anybody else, is going to say to change that view?

VENIREMAN LAPIERRE: As she said, you know, it's so hard to quantify, to put a quantifiable amount on someone's pain and suffering. You would have -- you would have to do a really, really good job of convincing me -- of convincing me that -- you know, that monetary compensation would be --

MR. SIMON: All right. Well, okay. Let me ask you this. Based on your strongly-held views about, you know, your reluctance to give money damages for pain and suffering, do you think maybe we're starting a little bit behind before you even heard any evidence?

VENIREMAN LAPIERRE: I think if your -- I think if the lawsuit is -- is largely about monetary damages, so if it --

MR. SIMON: You mean economic, like lost wages or medical bills?

VENIREMAN LAPIERRE: Yes, yes. I think if it was -- you know, if it seemed like the principal ruling was that there was going to be some sort of, you know, consequence for the doctor that would prohibit him from, you know, maybe not making, you know, these errors in judgment with another patient, and then, you know, monetary damages were just kind of, like, tacked on and it -- but if the case is about seeking monetary damages, then I think -- I think you just have to work a little bit

harder. I'm sure you could do it.

MR. SIMON: I don't know if I'm up to it.

VENIREMAN ROSEN: I can say she is articulating what I was trying to say way better than I did. But I completely agree with what she's saying.

MR. SIMON: This is a great discussion. I'll tell you, you're not going to hear any economic damages in this case. Brian is back to work. He's not making a wage loss claim. You won't see any medical bills. The damages that you will be presented with in this case will be damages for pain and suffering, damages for mental anguish. You won't see the economic damage. That's why I'm asking.

Now, based on that do you think we're starting a little bit behind?

VENIREMAN LAPIERRE: A little bit.

MR. SIMON: Okay. All right. Okay. Miss Rosen, what about you?

VENIREMAN ROSEN: Yeah, I agree. I wasn't thinking about it quite in those terms, of different kinds of damages, but I agree that if it's -- I'm more comfortable with the idea of economic damages than I am with the idea of just pure pain and suffering damages, and that's where I'm having the issue quantify how much is your pain and suffering worth. When you're talking about

economic damages and wage losses, it's much easier to quantify. And I think it's challenging. So I agree.

MR. SIMON: Let me ask you this, Miss Rosen. Can you conceive of a situation where you would consider awarding five or $10 million purely for mental anguish?

MR. VENKER: Your Honor, may we approach?

THE COURT: You may.

(The following proceedings were held at the bench.)

MR. VENKER: I've let John go pretty far with this damages thing, Judge, now this is going to try to tie people to a number or numbers, and I think that's objectionable, and I object to it.

THE COURT: Yeah, I've got to agree.

MR. SIMON: No, Judge --

THE COURT: Yeah, we're getting --

MR. SIMON: Judge, let me say this.

THE COURT: I'm not closing the door, but putting a number --

MR. SIMON: I won't put a number. Because as you can see there are people sitting in this room who don't want to award, be very reluctant to award damages for emotional distress. That's our case.

THE COURT: I understand that. But when you put a number in, then that's -- yes, I don't know what that

number means to one person and another, which -- but the issue of whether they can award this type of damages, it's an appropriate question. But I would stay away from numbers.

MR. SIMON: Yes, sir.

MR. VENKER: The one thing I would say is I understand what John is saying, but I just -- the panel, what they're saying. But they haven't heard the evidence yet. This is all in the abstract. So I think these people are just struggling, as normally you would.

THE COURT: Right. And I'm okay with that. But I think if we could put a number --

MR. VENKER: Yes, sir, I agree with that.

MR. SIMON: Understood, yes, sir.

MR. VENKER: Okay.

(Proceedings returned to open court.)

MR. SIMON: Thank you. So, Miss Rosen, without putting a number on it, you would have some difficulty -- or reluctance -- in other words, if this case is about mental anguish damages, pain and suffering, based on how you feel about awarding money damages for -- money for those type of damages, is the plaintiff starting a little bit behind?

VENIREMAN ROSEN: I would say so, yes.

MR. SIMON: Okay. All right. Anybody else feel

that way? Okay. All right. Let's start over here in the -- okay. And it's Mr. Hostuttler?

VENIREMAN HOSTUTTLER: Yeah.

MR. SIMON: Okay. Tell me about that, please.

VENIREMAN HOSTUTTLER: Well, I agree with the statement, you know, you can't quantify pain and suffering, you know. I mean, just -- I put context to this, my mother had her foot ran over in a Wal-Mart. Broke her foot. My mom didn't even sue Wal-Mart. She didn't go on Disability. She went back to work. You know, like I said, it's just my -- my context of that is my mother had a huge opportunity to take a lawsuit to Wal-Mart, and have Disability, and she didn't choose to do it. I agree you can't really put a monetary value on pain and suffering.

MR. SIMON: Okay. And let me -- I'm not arguing with you. I appreciate -- I know a lot of people who share those views. It sounds like you have some conviction about this, right?

VENIREMAN HOSTUTTLER: Yeah.

MR. SIMON: Okay. Same kind of question. Are we starting a little behind before you even hear any evidence?

VENIREMAN HOSTUTTLER: I would say so, yes.

MR. SIMON: Okay. All right. Okay. Who else?

Anybody else had their hand up?

Okay. And it's Miss Heisler?

VENIREMAN HEISLER: Heisler. Yeah. If it was for lost wages or lost his job, or something like this, then I would say yes. But I don't think somebody should get millions of dollars.

MR. SIMON: Okay. And, again, do you think, based on your views, we would be starting out a little bit behind?

VENIREMAN HEISLER: Right. Uh-huh.

MR. SIMON: Very good. Thank you.

Anybody else in the jury box here? Okay. Anybody else over on the left? All right. Anybody on the right? Okay. And let me catch up with my notes here.

Miss Carosello?

VENIREMAN CAROSELLO: Yes.

MR. SIMON: Okay.

VENIREMAN CAROSELLO: I think I have a wee bit of a problem with it. As everybody said, economic definitely. We all go through pain and suffering. That's part of life. Most of us don't inflict it on ourselves. So, I mean, it's things that happen. In the case of medication where you would get addicted to, might not be his initial fault. I guess I'm speaking very personally, because I have a son right now who is a norco, and he was

-- he's addicted to heroin and opioids. And the effect it has had on our family. But I look at that's life, and how do you put a price on that pain and suffering. It's something you draw from and you get stronger from, but I don't think you ask money for it.

MR. SIMON: Okay. And, Miss Carosello, same question as before. Based on what you know, or -- the plaintiff would be starting out a little bit behind in this case?

VENIREMAN CAROSELLO: I don't know. I mean, I would have to know more about it. I mean, if that is strictly what the case is about. But then I was under the impression also it had to do with the doctor also. And his responsibility.

MR. SIMON: It does. Absolutely.

VENIREMAN CAROSELLO: Okay. All right.

MR. SIMON: You'll hear evidence about the liability issues, and the damage issues, and you will hear evidence about what the damages are, and what Brian and Michelle went through, what their family went through, and you'll also be given instructions from His Honor in terms of what the law requires you to do in assessing damages.

VENIREMAN CAROSELLO: Right.

MR. SIMON: Do you follow me?

VENIREMAN CAROSELLO: Yeah, I do.

MR. SIMON: Okay. And based on that, I guess, you -- you're saying that you really -- you're kind of in that camp that you're not really in to giving money -- money for pain and suffering damages; is that fair?

VENIREMAN CAROSELLO: Yes.

MR. SIMON: Okay. And, because of that, the plaintiffs -- we're starting out a little behind, right? Even before you hear any of the evidence?

VENIREMAN CAROSELLO: Yeah. But then hearing the evidence could totally change everything, so --

MR. SIMON: Okay. All right. Let me ask you this. I don't want to pry into -- I'm sorry to make you --

VENIREMAN CAROSELLO: It's okay. It's all right. I need the exercise.

MR. SIMON: The issue with your son?

VENIREMAN CAROSELLO: Yeah. He's going through it right now, yeah.

MR. SIMON: Let me ask you. Do you think, based on what you're going through with that, you -- what do you think, do you think this is a good fit for you, this case, or --

VENIREMAN CAROSELLO: Oh, yeah, because I have had --

MR. SIMON: You understand it?

VENIREMAN CAROSELLO: Okay. I have two sons in AA, and I've got one now going through with the opiates and heroin. So, I think I have a very good understanding of it. And I realize addiction is a disease. I mean, I've researched it, all the information. So, yeah, I don't think -- I feel I have a good understanding of what this gentleman has gone through.

MR. SIMON: Okay. Thank you very much.

Okay. Who else did we have? Okay. And Mr. Master, right?

VENIREMAN MASTER: Yes. I just kind of believe that I -- it's more of an issue of not feeling like I have any sort of training or expertise to quantify something like that. So even being given an instruction about here's how you apply, and here's how you try to quantify pain and suffering, I don't think that given any amount of evidence I feel comfortable awarding that, whether it's five dollars or millions of dollars, just because you're taking away money from someone else, in theory, and, so, who am I to make that kind of decision.

MR. SIMON: Okay. Mr. Master, that's how you feel about that issue, right?

VENIREMAN MASTER: Yeah.

MR. SIMON: And you're entitled to feel that way. I have family members that feel the same way.

VENIREMAN MASTER: Right.

MR. SIMON: Based on how you feel about that, you probably wouldn't be a good fit for this case; would you agree with that?

VENIREMAN MASTER: I would say that if the -- sort of the -- if the purpose was -- if the prosecution's purpose was to try to get punitive damages or to get --

MR. SIMON: Damages for pain and suffering?

VENIREMAN MASTER: Then, yeah, I would be better on something else.

MR. SIMON: Thank you, Mr. Master. Okay. Anybody else? All right. I don't see any hands. Oh, I'm sorry. All the way in the back. Is it -- Miss Young?

VENIREMAN YOUNG: I don't think that someone should be due a large amount of money due to pain and suffering, because that really don't fix the problem. I could see if it was going towards treatment for the addiction, then that would be a totally different story.

MR. SIMON: And you feel sort of the same way as Mr. Master; is that right?

VENIREMAN YOUNG: I guess.

MR. SIMON: You have strong feelings about awarding money for pain and suffering or mental anguish?

VENIREMAN YOUNG: Yes.

MR. SIMON: Okay. And because of that you

probably wouldn't be a good fit for this case; would you agree with that?

VENIREMAN YOUNG: I would just say that I guess it depends on what it's used for. Like I said, if it goes for treatment, then, hey, you know --

MR. SIMON: Okay. Let me ask you this, Miss Young. As His Honor pointed out earlier, you know, both sides want to hear what everybody is thinking about these issues. And sort of like, you know, the plane has already taken off.

I mean, you know, are you able to tell us absolutely that that would have no effect on your decision in this case, even before you hear the evidence?

VENIREMAN YOUNG: No, I wouldn't.

MR. SIMON: So it may have some effect on your decision in this case; is that correct?

VENIREMAN YOUNG: Yeah.

MR. SIMON: Okay. Thank you, Miss Young.

Okay. Any other hands? Okay. So, let me ask this. I'm getting to the end, and everybody, I'm sure, is happy about that. You know, Miss Carosello shared with us, you know, some very personal -- you know, having sons -- three sons who are fighting addiction.

Anybody else have somebody close to them, family members, close friend, who is currently or has -- is

fighting addiction? Okay. All right.

(Whereupon, hands were raised.)

MR. SIMON: Okay. And whose hand was here? Was it -- okay. And it's Mr. Hostuttler?

VENIREMAN HOSTUTTLER: Yeah.

MR. SIMON: Can you tell us about that, please?

VENIREMAN HOSTUTTLER: A kid growing up in high school named Josh didn't have a father, grew up with me and my family, would stay at my house for weeks at a time, my brother and sister, started doing opioids in high school because it was the cool thing to do. We kind of distanced ourselves, I went to college, I graduated, came back. He reached out to me, hey, I went through rehab, you know, I have no friends, I'm just trying to find someone to spend holidays with. Yeah, sure, come over. My brother came -- stayed at my brother's house. My cousin's in the Navy. He came back from the Navy. I brought him home to my uncle's house, a week later I got a phone call, basically my brother told me that his medicine cabinets had been raided, my uncle called and said the same thing. I reached out to Josh. First phone call he denied it. Second phone call I just said hey, man, I want you to get better, and he admitted to it, checked himself back in to rehab. He got out -- I think it's a four month thing. My sister works in the medical field, she sells

oxygen for a hospital. She got Josh a job for delivering oxygen to people's houses. He did this for probably six months, and he turned himself back in to the hospital for -- trying to get back into rehab. It turned out that he was setting up fake calls to deliver oxygen to houses to rob them, and he needed the -- he needed the drug that they put you on when you go into rehab because he --

MR. SIMON: Kind of bring you down?

VENIREMAN HOSTUTTLER: -- was addicted to that. He was actually caught trying to break into that medicine cabinet. So, he later went on to overdose on heroin and was in a coma for months, so -- you know, I know a real junkie. So, I -- you know, I was overseas with the military, I see people with mental anguish that were sedated, you know. I'm in physical -- I'm fine physically, but mentally I'm -- I'm hurting, and I'm not going to talk to you about your problems, I'm going to give you something to sedate you, you know, fall in line. And it's tough. It's tough to see.

MR. SIMON: So, do you still see this Josh, still in contact with him?

VENIREMAN HOSTUTTLER: No.

MR. SIMON: Okay. How old is he?

VENIREMAN HOSTUTTLER: He's twenty-eight.

MR. SIMON: Thank you.

VENIREMAN HOSTUTTLER: Yeah.

MR. SIMON: Anybody else? Who else had their hand up in the -- okay. And it's Miss Wallace?

VENIREMAN WALLACE: Yes. My mom had cancer and went through treatment and everything, actually while she was pregnant with me. And all of my life she had a prescription painkiller addiction. Along with an alcohol addiction. And even now in her late age she is still addicted to pain killers. And even though she's in a nursing home, I watch her, and I see how she manipulates them to give her a larger script for these pain killers when I know she's not really in pain, she just like the way that they make her feel. So --

MR. SIMON: Thank you.

Okay. And Miss Brennan?

VENIREMAN BRENNAN: My nephew's fiancee is addicted, but is battling it.

MR. SIMON: Okay. And is it -- how old is the fiancee? Younger, older?

VENIREMAN BRENNAN: She's early forties.

MR. SIMON: Okay. Thank you.

And any -- yes. It's Miss Nunes?

VENIREMAN CALDERON NUNES: Yes, I actually had an ex-boyfriend that I was with for five years, he suffered from back pain, and at first I didn't realize

that it was an addiction, and he had the pain killers, and it kind of evolved to the point that it also became an alcohol addiction.

MR. SIMON: Was it prescription medication?

VENIREMAN CALDERON NUNES: It was prescription. Yes, it was oxycodone. He took it very, very often. And obviously he was in a lot of pain. But at one point I realized it was too much for me to take, going through all the tumultuous situations with him with the prescription pain killers, and later the alcohol involved, and so I had to get out of that relationship.

MR. SIMON: How long were you --

VENIREMAN CALDERON NUNES: Five years. Yeah, it was a long time.

MR. SIMON: Five years. Thank you. Thank you for sharing that.

Okay. Any -- yes, sir. It's Mr. Traubitz?

VENIREMAN TRAUBITZ: I don't know if this is germane to the issue or not. When I was twenty-seven years old I broke my neck in a diving accident and was flat on my back for a month, and the first ten days about every four hours, every six hours, four times a day, was getting a shot of Demerol. And after a week of that I really didn't need the Demerol for pain, but I let them inject it. I can understand how somebody could become

addicted because of that experience. I could see it would be very easy to continue that after -- after the treatment.

MR. SIMON: And those were prescription pain killers you were given?

VENIREMAN TRAUBITZ: No, it was a Demerol injection.

MR. SIMON: But it was prescribed to you?

VENIREMAN TRAUBITZ: Yes.

MR. SIMON: Okay. All right. Thank you. All right. Any hands on the left? Okay. And let's see. It's Miss Huskey?

VENIREMAN SUGGS: I'm Miss Suggs.

MR. SIMON: I'm sorry. I'm on the wrong page. I've been doing that for two days. Miss Suggs?

VENIREMAN SUGGS: I have had a friend that was addicted to OxyContin, who has relatively successfully battled it. I have another friend whose son in the last, like, three months committed suicide -- well, he didn't. He overdosed on heroin, let's put it that way. And my daughter was supposed to get married a week ago Saturday, and pretty much called off getting married because she found out that her fiance had an addiction to cocaine and Valium, and -- actually doesn't really -- isn't even -- anyway, recognizing that he has a problem. So, yeah, I've

got that going on.

MR. SIMON: Thank you for sharing.

Anybody on the left side? And it's Miss Griggs?

VENIREMAN GRIGGS: Yes.

MR. SIMON: Okay.

VENIREMAN GRIGGS: I was married to a man who was addicted to cocaine and drugs, but he recovered, so I would be more inclined to -- to understand the addict's point of view.

MR. SIMON: Okay. Thank you.

All right. Okay. And it's Miss Kuenzel?

VENIREMAN KUENZEL: Yes. My mother is addicted to prescription pain killers. You name it, she's done it. Pick one, she's taken it. She's still an addict. She's currently in a nursing facility due to problems associated with her addiction. I don't think it has any bearing on my -- I don't have any bias, one way or the other, towards the defendant or the plaintiffs. I mean, my mom doesn't represent every single addict in the world. So, each person has to be judged on their own merit and looking at the evidence in this case, and, so, I --

MR. SIMON: Okay. So you have been -- you've seen that close up for a number of years?

VENIREMAN KUENZEL: Yes. My whole life. So --

MR. SIMON: All right. Thank you very much.

Any other hands on the left side? Okay. And that's Miss Lapierre?

VENIREMAN LAPIERRE: My cousin Chris was -- he blew out his knee and was given a prescription to Vicodin and OxyContin, and the OxyContin was a pretty large prescription, which -- I guess he just got out of -- it got out of hand. And when the doctor stopped writing the prescription he -- he, I guess, delved into other drugs, and he ended up overdosing, and he died from a heroin overdose a year ago on Thursday.

MR. SIMON: I'm sorry.

Anybody else on the left? How about anybody on the right? Okay. Miss Fortenberry?

VENIREMAN ALEXANDER FORTENBERRY: I have several alcoholics and drug addicts in my family. My dad was an alcoholic, my three brothers were all alcoholics and drug addicts that are -- they've all passed away. I have a sister who is a drug addict. She had a baby twenty-two years ago that I took over and adopted. And then last year -- well, she will be two. Two years ago she had a baby that was addicted to cocaine. Was born at 4 pounds and 5 ounces. That I'm now raising. And so -- half the time we don't know where she is. She's on the streets all the time. So I get a text every now and then that says can you send me a picture of the baby. So, I deal with it

all the time.

MR. SIMON: Thank you.

Anybody else on the right? Okay. And it's Miss Young?

VENIREMAN YOUNG: Yes. Well, I had a close family member after three years was -- well, he passed away, and he was addicted to Xanax, because he suffered from bipolar and depression, and end up overdosing off the medication that was prescribed to him.

MR. SIMON: Okay. Thank you.

Anybody else?

VENIREMAN TRAUBITZ: Sir?

MR. SIMON: Yes, sir.

VENIREMAN TRAUBITZ: I should add that I mentioned my diving accident and so forth. I had a friend that was about four years out of law school, and I hired him to sue this guy, which he did, and I was awarded -- I did get an award for damages.

MR. SIMON: Okay. Thank you.

So, ladies and gentlemen, I'm kind of at the end of the line. And, again, anything else -- let me ask this question. Is there anything that -- that you think either of the attorneys, either of the parties should know or need to know that I haven't asked about? Anything else? Okay. All right.

And, Mr. -- Mr. Lambert?

VENIREMAN LAMBERT: Well, I mentioned something yesterday, we were going to talk offline about it, you never did, but -- just briefly.

MR. SIMON: Well, let me ask you this, Mr. Lambert. I think Judge Noble was going to take that up during a break with you. Without going -- again, without getting into the details of it, do you think your experience -- it was a lawsuit involving your son? Was it a pharmacy issue? You need to say yes or no.

VENIREMAN LAMBERT: Yes.

MR. SIMON: Okay. Let me just ask you this. Is there anything about that that you think would cause you to lean one way or another even before you hear the evidence for either side?

VENIREMAN LAMBERT: I understand pain and suffering.

MR. SIMON: Okay. All right. Thank you. Thank you very much.

Ladies and gentlemen, thank you.

THE COURT: All right. Will you be doing this?

MR. VENKER: I will be, Your Honor.

THE COURT: Okay. Mr. Venker, you're up next. While Mr. Venker is getting ready, everybody stand up and kind of get the blood flowing. Do the hokey pokey, shake

it all around. All right. Please seated.

VOIR DIRE ON BEHALF OF THE DEFENDANT

MR. VENKER: Good morning, ladies and gentlemen.

(Whereupon, good morning was heard.)

MR. VENKER: My name is Paul Venker, as you well know, and I represent Dr. Doug Walden. Doug, just stand up. I don't know how many people in the back have been able to see you. You heard his name a lot already. Thanks. You can sit down.

I represent also St. Louis University. And Connie Golden in the -- could you stand up, Connie, in the back? I just want you to see her. She may be in and out of this trial. If you're chosen to be a juror, you will see her coming in and out during the trial, so I wanted to introduce them. And, of course, John Mahon is to Dr. Walden's right, and then Mike Barth, who Miss Heisler thinks she might know, is there on the left.

So what I wanted to do was, first of all, thank everybody here, I'm sure I am speaking for all the parties, for your service, even if you're not selected to be on the jury, but for your involvement the jury system. It's an important part of our system of justice. Whether criminal or civil. And I know it can be imposing on everyone's schedule, but all the parties truly appreciate your patience and your willingness to be a part of it. So

I just wanted to say that.

I won't go into my personal background. I was born in St. Louis City, too, at the old St. Anthony's, if anybody remembers the old St. Anthony's, quite a while ago. I knew you would, Miss Heisler. So, anyway, that's as far as I'll go with that.

But anyhow, I'm sure at least at few of you are probably thinking what -- after we've already been asked, what could Mr. Venker possibly, possibly have to ask us at this point. And I just beg your patience, because it is one of those things that everybody does here, as Mr. Simon was saying, you hear questions and answers and you think of things, and, so, I want to go through some of those things with you.

And, so, let's start kind of where it ended, just because that topic is fresh in people's minds. I appreciate the sensitivity of it. I do. So I don't want people to think that I'm just trying to pry, but --

So we've heard a lot of different people talk about personal experiences, everything from dealing with experiences with prescription pain medications leading to other things, sometimes just flat out heroin use. And so I guess the question I have for you all is, with all those experiences that everyone has related, does anyone in the room think that all these experiences mean that pain

medication should just be irradicated?

This case happens to be about opioids. Does anyone here think that because there are bad things that can happen -- and it's true with a lot of products, not just pain medication -- that pain medication should just be done away with and no physician should ever prescribe them again?

And, obviously, I know that's a very -- kind of a pitched question, but I think I need to ask it. Because these stories are very sympathetic, and I want you to understand I feel that empathy. I do. It's hard not to. But in this case, the facts of this case don't involve an overdose, ever, for Mr. Koon, for example. All right?

And Mr. Koon was under Dr. Walden's care until he decided to leave it. I won't get into all the facts about that, but he was under Dr. Walden's care for that -- we're focusing on an proximate four year period of time when he had office visits and saw Dr. Walden. And then that care -- Mr. Koon decided to terminate that care by Mr. Walden.

And, so, will you keep an open mind and listen to the facts about this relationship between doctor and patient in this case, can you do that and not really pull in your other experiences? And you can use your experiences as jurors, you're supposed to, and that's so

important, but not to let those other experiences skew your ability to be fair and impartial in hearing the facts.

Does everyone here think they can do that? All right. I take it by your silence that you all think that you can. Is there anybody who thinks I'm misunderstanding?

Miss Heisler, go ahead.

VENIREMAN HEISLER: I have several things that happened in my past where we've talked to doctors and tried to explain, and they didn't pay attention.

MR. VENKER: Okay.

VENIREMAN HEISLER: My father almost had a bursted bladder because they didn't listen that he couldn't, you know, go to the bathroom. He had to go to the emergency room to have that taken care of. My daughter complained of stomach pains. She was eighteen. He just said oh, take Maalox, or something like. She wound up having bleeding ulcers and needed a blood transfusion. So I'm just not sure, you know --

MR. VENKER: Well, no, I understand. But those were other situations with those others doctors, and we don't have to talk about who they were or anything, but if a doctor did listen to a patient and ask for information, you would think that was an appropriate thing to do,

wouldn't you?

VENIREMAN HEISLER: Yeah.

MR. VENKER: Of course, right? We had a lot of questions yesterday about what that relationship is between physician and patient, where the responsibility lies, if you will, and I guess the -- I'm not going to ask everybody all those questions again, but I certainly got a sense, I thought, and so I'm going to test it right now.

I certainly got a sense that everyone felt that basically that relationship between physician and patient is a two-way street, at the very least, that it's one where both sides owes the other side candor, information sharing, right?

And I think I heard the phrase power dynamic from somebody yesterday. And I'm not sure -- I'm not sure I'm smart enough to know what that means, but if the relationship between the physician and the patient for the issue that we're talking about has to do with communication of how the patient is doing in the course of treatment, does anybody see that as -- as being something the doctor is supposed to somehow -- I think somebody mentioned -- Miss Currans, maybe. That the doctor can't be there 24 hours a day with the patient. Everybody understands that, don't they? And so the patient -- if there's an office visit, would anyone here think that the patient should not have to

tell the doctor answers to questions? Does anybody think that? Okay.

So if the doctor asked the patient about how they're feeling, or how the medication is working, everyone would expect the patient to answer honestly, correct? Everybody is nodding their heads yes. Okay. All right.

And there are times, of course, when a doctor does know more about whatever the medical issue is than the patient. And I'm not suggesting that anybody should have to do research on their own. I don't mean that. I mean, I'm just talking about the back and forth and the respect between the physician and the patient. Everybody is agreeing with that? Yes? I take it by your silence that you do. Okay.

During this process we're doing, the jury selection, we can't really talk a whole lot about the facts of the case, because we're not really supposed to be doing that. But we have to give you enough information to be able to understand, some ability to answer questions. And, so, I sense some of the reluctance in the room to talk specifically about what you might or might not do or whether you could or could not award certain damages in the case.

And, so, I really just wanted to say that,

obviously, this is a case about whether Dr. Walden negligently prescribed opiate medications to Brian Koon over about a four year period. It's one that the parties disagree pretty strongly about, in terms of whether Dr. Walden provided appropriate care. And you will hear the evidence about that relationship between Dr. Walden and Mr. Koon, in terms of how he was doing on those medications.

But everybody understands, don't they, that just because someone files a lawsuit it doesn't automatically mean that they're entitled to recover? That, in fact, things like a jury trial are designed to have a jury decide who is right or wrong? I take it by the nods of head that everybody understands that. I'm not going to conduct a -- didn't mean to conduct a civics class on the functions of a jury trial.

So, Mr. Hostuttler, you talked about your experiences with your -- this young guy Josh, who was trying to be your friend. And do you know any -- what relationship did he have with his physician about any of his medications, do you know?

VENIREMAN HOSTUTTLER: I have no idea.

MR. VENKER: Okay. So you didn't know whether his doctor paid attention to whatever prescription he may have given him, as to whether it was --

VENIREMAN HOSTUTTLER: I don't even know if he went to a doctor.

MR. VENKER: Oh, okay.

VENIREMAN HOSTUTTLER: I don't think his addiction started through a doctor prescribing him. I think his addiction started through a doctor prescribing somebody else a massive amount of these pills, and then them being distributed in high school, and then them consuming them because it's the cool thing to do. I guess it's a culture thing.

MR. VENKER: Okay. All right.

Miss Abercrombie, you had talked about -- I think the phrase you used yesterday was the patient should know their body, or you should know your body. Right? Am I saying that pretty close?

VENIREMAN ABERCROMBIE: Uh-huh.

MR. VENKER: And so I take it by your nod of head that you agree with me?

VENIREMAN ABERCROMBIE: Yes, yes.

MR. VENKER: So when you say that, are you talking about the patient knowing whether -- how the medicine is affecting them and being able to share that information back with the doctor? What did you mean?

VENIREMAN ABERCROMBIE: It's like you go to the dentist and they pull the tooth and they give you pain

medication, you know, temporary until that pain goes away.

MR. VENKER: Okay.

VENIREMAN ABERCROMBIE: So, I'm totally against long-term use of pain medication.

MR. VENKER: Okay.

VENIREMAN ABERCROMBIE: It's supposed to be temporary until the pain goes away.

MR. VENKER: Okay. And when you say that, tell me what that's based on. When you say temporary, what do you mean temporary? A couple of days?

VENIREMAN ABERCROMBIE: I mean, let's say you have back surgery. I mean, that person -- that patient shouldn't be on pain medication past -- at least thirty days after that back surgery.

MR. VENKER: Okay.

VENIREMAN ABERCROMBIE: There should be some type of monitoring there, you know.

MR. VENKER: Okay. And the people that you're providing healthcare to in the setting that you're working at, are they back surgery patients?

VENIREMAN ABERCROMBIE: I'm internal medicine, so we see all kinds of patients.

MR. VENKER: Okay. So some of them have had back surgery, or are they being seen in an orthopedic surgeon's office?

VENIREMAN ABERCROMBIE: Probably, yeah. We'll refer them to a specialist.

MR. VENKER: Okay. All right.

And, Mr. Traubitz, you talked earlier about getting the Demerol shots. Do you remember telling us about that?

VENIREMAN TRAUBITZ: The what?

MR. VENKER: The Demerol shots after your diving accident, right? And when you said after a while you didn't really feel you needed the shots any more for the pain, but it felt good. Right?

VENIREMAN TRAUBITZ: Yeah, it really did.

MR. VENKER: Okay. So did -- so did you tell the healthcare professional that you really didn't need it any more for the pain?

VENIREMAN TRAUBITZ: No, no.

MR. VENKER: Okay. And so did they ask you whether you needed it? I don't mean to put you on the spot.

VENIREMAN TRAUBITZ: No, they just cut it off. The doctor, I think, realized I didn't need the pain medication anymore.

MR. VENKER: Okay.

VENIREMAN TRAUBITZ: So he cut me off.

MR. VENKER: Well -- and so for how long a time

were you -- like you say, was it a couple weeks you kept getting the Demerol?

VENIREMAN TRAUBITZ: I think about ten days, something like that.

MR. VENKER: That you no longer needed it but you got it, or that was the whole --

VENIREMAN TRAUBITZ: Yeah, toward the end of that ten days I don't think I really needed it.

MR. VENKER: Okay.

VENIREMAN TRAUBITZ: The painkiller.

MR. VENKER: Okay. All right.

Ms. Rosen, I'm going to ask you these questions, but I know there's other members of the panel that have some of these same issues, and I'm going to ask you for your help, and we'll kind of just spread it out amongst the group as we need to, with this idea about awarding money damages for pain and suffering, mental anguish, you know, however you want to describe it, that is something that's nonmonetary, like we're not talking about lost wage or medical expenses. And, so, I'm trying to figure out whether you -- the group of you that are saying I don't know if I can award those, whether you're kind of stumped at this point because you haven't heard any evidence, or whether you're thinking, you know what, I don't care what the evidence is, I would never -- no matter how I felt about it,

I would never give money for anybody who had been through something that they put evidence on as being causing mental anguish?

VENIREMAN ROSEN: I don't think I would go so far as to say never. I think my issue is when you're talking about $5 million, $10 million for pain and suffering, I think that that's insane -- an insane amount of money. I mean, unless I'm getting a cut of it I can't award that kind of money. But that's -- but if that's what we're talking about, then I'm all in. You know, I'm not saying that, you know, there can't be some compensation for pain and suffering ever.

MR. VENKER: Okay.

VENIREMAN ROSEN: That's definitely on a case-by-case basis. But when you're talking these insane amounts of money, I don't really think they --

MR. VENKER: Okay. Let's put aside the five or ten million. I'm not talking about millions. I'm just asking, you know, whatever -- could you decide that, in fact, somebody would deserve some amount of compensation for mental anguish if they had been through -- well, let's, you know -- what if somebody had been falsely imprisoned by some person, you know, for three weeks, and other than being falsely imprison they really weren't hurt. Can you see them being worthy of being awarded

money against that person? Strange fact pattern, I admit.

VENIREMAN ROSEN: No, I don't like to deal in hypotheticals. Really, it's a very tough question. Because I would really want to hear the facts of the case. I don't want to say never never. I don't think I could go so far as to say never. But I think part of the reason for that has to do with -- it came up yesterday, but having a thing about deterrent. So if you can't point to any kind of monetary damages in terms of lost wages or things like that, is there a sufficient deterrent. And maybe that's where punitive damages come in. If they're -- if the defendant is really at fault in whatever case you're talking about.

So, I guess to answer your question, I can't say definitively that I would never award damages. But if we're talking obscene amounts of money, then I can't do that.

MR. VENKER: So the question for you then -- and I'll kind of try to go around to the others who I think were asked at the same time you were. So it sounds like you would be able to keep an open mind to hear the evidence in this case to see what you thought about it before -- you know, before you make your decision based on the evidence and the law. Is that a fair statement?

VENIREMAN ROSEN: I would like to think I can always keep an open mind.

MR. VENKER: I'm sorry?

VENIREMAN ROSEN: I would like to think I can always keep an open mind, so I'll say yes.

MR. VENKER: Miss Lapierre, how about you? You've heard this conversation I've been having with Miss Rosen. Do you feel you're in agreement with that?

VENIREMAN LAPIERRE: I think that -- I think you're talking about two very different things. Awarding damages, awarding monetary damages to someone who has been wrongfully incarcerated, that person has lost years of their life, they've, you know --

MR. VENKER: My hypothetical was, like, five days or something.

VENIREMAN LAPIERRE: They're very different hypotheticals.

MR. VENKER: Sure.

VENIREMAN LAPIERRE: I mean, again, I just feel -- I don't know who said it over here, but, you know, everyone deals with pain and suffering. All of us have. Like if you're going to go through and ask every single person, everybody can point to something that was really miserable for them to live through that probably wasn't even by any fault of their own. I just can't see -- I can't see that being a necessary resolution to this unfortunate incident.

MR. VENKER: All right. Thanks, Miss Lapierre. I appreciate that. I really do.

Miss Heisler has given us her own experience with doctors not listening to her and her family members about healthcare. Has anybody else had that experience? All right. Yes, ma'am?

VENIREMAN TAYLOR: Yeah, my mother has gone to doctors and trusts them and expects that they're --

MR. VENKER: Let me interrupt you. You're Miss Taylor, right?

VENIREMAN TAYLOR: Yes.

MR. VENKER: Thank you. Sorry. Go ahead.

VENIREMAN TAYLOR: My mother has gone to doctors, trusts them, takes the medicine that -- you know, she had some type of bladder infection, doctor gave her some kind of a medicine, made her completely sick and throwing up, couldn't stand up. Come to find out that it interacted with other medications that she was taking. The doctor should have known that the interaction would cause a bad reaction. And now she's -- she doesn't know if she can trust doctors. I mean, it's just something as simple as that, you know, cross-medication. I don't -- I don't really feel very good about doctors and, technically, I wouldn't do -- I would feel that I have to do my own research.

MR. VENKER: Okay. That's your own personal experience, or the fact of dealing with trying to help your mom?

VENIREMAN TAYLOR: Well, knowing about things that she's going through. And I've been going to SLUCare for over twenty years seeing doctors, and I have -- I -- I really can't hang on to any of the doctors. Every time I get a regular general doctor, they move away within two years. It's --

MR. VENKER: Sorry. Okay. All right. Thank you, ma'am.

Anybody else with experiences with doctors? Yes, Miss Rosen?

VENIREMAN ROSEN: I mentioned earlier my father has received some tertiary care. But, again, it has no bearing on the doctor in this case.

MR. VENKER: Okay. Anybody else? Miss Votaw, right?

VENIREMAN BLANKMEYER VOTAW: Yes. I also have seen a SLUCare doctor. That's the only reason I really think it might be relevant in this specific case. It wasn't anything very drastic. But just feeling like maybe he kind of already had his mind a little bit made up before we really talked about it. Again, it was not this doctor. I don't know this doctor. But just since it is

related to SLUCare general practitioners, I think I could be unbiased, but it might be relevant to this case if there's maybe a culture of that sort of thinking. I don't know.

MR. VENKER: Thank you, ma'am.

So, anybody feeling good about their doctor?

(Whereupon, hands were raised.)

MR. VENKER: About the exchange they had with their physician and information gathering back and forth?

Yes, ma'am, Miss Brennan?

VENIREMAN BRENNAN: I feel I have a very good doctor. I communicate with him. When I think he might be wrong, I question him.

MR. VENKER: Okay.

VENIREMAN BRENNAN: You know, I take part in my own healthcare. You know, if I have a problem, I bring it up and I discuss it with him, and, you know, if he prescribes a new medicine, I ask him is it going to interact with anything else I'm taking, what can I expect from it.

MR. VENKER: He's accessible to you, you -- he responds to your inquires?

VENIREMAN BRENNAN: Absolutely. Every one of them.

MR. VENKER: Okay. Great.

Mr. Becherer, did you have your hand raised?

VENIREMAN BECHERER: Yeah. I was just saying, you know, obviously I've always had good medical care. I think it's a lot to do with, like she said, communication. You have to take the doctor's word, their advice, but also have to know your own body. I mean, take that into respect as well.

MR. VENKER: All right. That makes sense. Anybody else? Yeah, Miss Currans?

VENIREMAN CURRANS: My doctor is excellent. He will not prescribe any kind of --

MR. VENKER: Can you stand up? Because I'm not sure that Renee can hear you.

VENIREMAN CURRANS: My doctor is excellent. I many times wanted something that I've heard about; no, I'm not going to give you this, you take this, this, and this, you've got that, no, you don't need this. He tells me -- he sits me down and actually talks to my like a child if it's needed. He tells me the side effects, what to look for, the dangers of taking it incorrectly, the high risk of addiction, if there is. I mean, it -- and when I need something, if it's not him, there is somebody from his exchange that deals with me immediately. Like, I've got five major things wrong with me. So I have -- I take --

MR. VENKER: You wouldn't know it to look at

you.

VENIREMAN CURRANS: Thank you. It's all under control. High blood pressure, thyroid, and I'm diabetic. So, I mean, my doctor watches out for me. And -- but that doesn't alleviate me watching out for myself. There are lots of things I see. Like I've got -- supposed to go see him, if I get to go, but I have to -- I ask about certain medications. I can call up and say what do you think about this, or what do you want. No, come on in, we'll talk about it.

MR. VENKER: He's responsive to those --

VENIREMAN CURRANS: Very much so, yeah.

MR. VENKER: That's great. Thank you, ma'am. Anybody else want to comment on their doctor? Yes. Miss Kuenzel, right?

VENIREMAN KUENZEL: Yeah. I have a couple different doctors that I have that I see, and I've had zero problems working with them. I mean, they ask questions about my care that they're managing, they make sure that I give honest answers to that, to those inquiries. And, you know, we have a very good working relationship in regards to my care. So --

MR. VENKER: Okay. Great. Thank you. Appreciate that.

Yes, sir?

VENIREMAN DAVIS: This is totally off subject. I just need to run to the restroom.

MR. VENKER: Oh. Whatever you -- he's probably not alone, Your Honor.

THE COURT: All right. I'm not going to stand in the way of anybody's biological issues. We have been rocking and rolling this morning. I will tell you this. This is my plan. We are going to take a biological break. And then we are going to come back. But we are going to pick the jury before lunch. Would everybody agree with that, or is everybody --

(Whereupon, yes was heard.)

THE COURT: That's the mind frame. This would be a good time to go ahead and use the bathroom, and then know that when we come back we're going to drive on through. So I'm going to give everybody -- slow down. I'm going to give everybody twenty minutes, because I have a feeling it's going to be a mass rush to the bathrooms. But please stay on the floor. Wait, before you go, before you go, I have to read this to you.

(Whereupon, Instruction 300.04.1 read to the Jury.)

THE COURT: See everybody back. Now, this morning we had people late. Because we've got a lot of stuff to do, I'm giving you guys twenty minutes. I need

you back in that room in twenty minutes. Not here, you're going to go back to that room. Once everybody is there, they're going to bring you back. So, again, this is one of those teamwork, community-building exercises. Twenty minutes.

(Whereupon, a short recess was taken.)

THE COURT: Please be seated. You may continue.

MR. VENKER: Thank you, Your Honor.

Miss Taylor, I wanted to follow up with you on your not so good feeling about doctors these days. Let me just ask you this just pointedly. Is that something that you think would probably be a problem listening to the evidence in this case about the -- how the relationship was between Mr. Koon and Dr. Walden?

VENIREMAN TAYLOR: Yeah, I don't know. Because I -- I don't feel very good about doctors, don't trust them very much myself.

MR. VENKER: Okay. All right.

VENIREMAN TAYLOR: And as far as handling drugs like opioids and things like that, I --

MR. VENKER: Just not the confidence level?

VENIREMAN TAYLOR: I really think there should be some kind of a setup where there's a second opinion involved in most cases.

MR. VENKER: All right. So, in this case, it

sounds like -- and I appreciate your candor -- that you just don't think you can trust yourself to be fair and impartial. Would that be accurate?

THE COURT: Was that a yes?

VENIREMAN TAYLOR: Yes.

MR. VENKER: Thank you.

Miss Votaw. Ma'am, you talked about a thing with physicians. Was that SLUCare or not?

VENIREMAN BLANKMEYER VOTAW: Yes.

MR. VENKER: So you told us about that. Anything about your experience that you think would cause you to doubt whether you could be fair and impartial listening to the evidence in this case?

VENIREMAN BLANKMEYER VOTAW: Right. I think that I could listen just to the evidence in this case.

MR. VENKER: Okay. All right. Thanks, ma'am. I appreciate that.

Miss Vikesland is it?

VENIREMAN VIKESLAND: Yes.

MR. VENKER: I found my notes. I'm sorry, I attributed that phrase to you, and I apologize.

VENIREMAN VIKESLAND: I think I did say it. I did say it.

MR. VENKER: Tell me what you meant by that. Tell me what you meant by that. Because I think the

phrase before that I have in my notes is doctors have power, or they're powerful. Just maybe tell me what you meant by that.

VENIREMAN VIKESLAND: Well I think where I'm coming from is, like -- because I taught within the Wash U med school, like if I took my kids to the doctor, it's -- you know, you usually see a resident, and so it's a different experience than an experienced doctor. But I guess I see them differently, and they see me differently if they know that information, especially a resident or young doctor, and I think I take their responsibility more seriously, because I've -- I, like, had a number of medical students in classes I've taught. And that just -- it affects my sense of their own training, knowledge, what I expect. At the same time I feel, you know, that could easily be me who is a doctor. I almost was. Like, I have sympathy for someone in that position as well.

MR. VENKER: I hope I'm not being -- so are you saying --

VENIREMAN VIKESLAND: Just keep going, that's your job.

MR. VENKER: -- power because they're educated? I'm not sure -- I wasn't sure if you were implying that the doctors are somehow, you know, acting indifferently to people because they have power. I wasn't sure if that's

what you meant.

VENIREMAN VIKESLAND: No, but I think, you know, the power that comes with someone with privilege, you have more education, someone's going to you, they're in a state of pain, or, you know, some kind of weakness in that relationship. And someone said something about a teacher, you know, with a student/teacher, you know, there's a power relationship there. Parent/child, there's a power relationship there. If I came to you for legal help, there would be a power relationship there. And I feel like I'm sensitive to that because at times I have been the person in power in that situation, or I can imagine myself in that situation, and I know that you have to hold that very carefully.

MR. VENKER: Sure.

VENIREMAN VIKESLAND: It doesn't mean you're always responsible if something goes sideways, but, like, you have more responsibility --

MR. VENKER: Right.

VENIREMAN VIKESLAND: -- of some kind.

MR. VENKER: But you're not saying, are you, that you don't see physicians, at least -- again, let's not say every physician. I guess we can't say that, because we don't know who they are. But that physicians are also people who want to help other people?

VENIREMAN VIKESLAND: Well, certainly. I would hope. I mean, I would trust that, you know, they all at least go into it with that intent.

MR. VENKER: Okay.

VENIREMAN VIKESLAND: That's why they're there.

MR. VENKER: Okay. All right. I appreciate it, ma'am, thank you.

Oh, I'm sorry, yes, Miss Calderon Nunes?

VENIREMAN CALDERON NUNES: The way I interpreted those comments as I heard them yesterday, it lead me to believe there was some kind of authoritative interaction going on there, like there was a person in authority.

MR. VENKER: Right. And, so, I've made -- that's what I took from it, too. We talked about this, some of the -- let's talk about it a little bit -- the decision making, I guess, is really what I would like to explore with you next. And that is we've talked about the relationship between the doctor and the patient, and, so, your observation has got me thinking about, okay, let's just say there is a situation where it is a complicated medical issue, and you're interacting with your doctor on it. Say it's a serious condition. So there's either medication involved or some kind of treatment like chemotherapy or radiation.

Who in that situation would say that in the end

the decision as to whether you undergo the treatment belongs to the patient, or would you assume that you think the doctor is the one making the decision? Or does it just depend upon the exchange of the information between the two?

So, Miss Calderon Nunes, why don't you tell me what you think about that.

VENIREMAN CALDERON NUNES: I think it would be in a case-by-case scenario. There have been situations that I've been in that I've had a strong opinion about my care and I suggested otherwise, and it's been taken into account, where other times I just kind of follow the lead of my doctor.

MR. VENKER: Okay. All right. Miss Kuenzel, how about you, how do you feel about that?

VENIREMAN KUENZEL: I feel that it's a case-by-case basis as well. I mean, each person is different, each doctor is different, and relationship -- each person has a different relationship with their doctor. So, you know, in these cases you have to look at the evidence as presented and make a determination, you know, based on the evidence. You can't generalize a relationship, I guess.

MR. VENKER: Okay. Anybody else wants to offer a comment on that? Yes, Ms. Bonner?

VENIREMAN BONNER: I'm thinking in practically

all instances the doctor is going to have the duty to make certain that the patient is adequately informed based upon best practices in the industry. And that -- but that -- based upon that information and the doctor's recommendations, the patient has the ultimate decision-making authority.

MR. VENKER: Okay. Anybody disagree with what Miss Bonner said? By your silence, I take it that no one does.

So, let's discuss that a little bit further then. I think that's a great point. So, any -- any number of medical treatments may have a risk or risks to them, right? Everybody understands that, don't they? It's not something new. They also have benefits, otherwise why would you be considering doing the procedure, the treatment, or whatever it was.

So if a doctor informs a patient of the risks, and the care is appropriately given, and one of those risks actually comes into fruition where the person gets -- you know, the outcome is what is in the risk range. For example, if you have heart surgery, you know, there's a vessel that's punctured, or something of that sort, but the patient knew of the risk. And you have to assume everything was done appropriately. Is that something that the healthcare provider then is -- where

does that fall?

Yesterday Mr. Simon was talking about responsibility. I'm not sure that's the accurate term. But where does that fall then when the patient is fully informed, and they're appropriately cared for, and then one of these identified risks comes to fruition? Yes, ma'am, Miss Currans?

VENIREMAN CURRANS: Should I stand up?

MR. VENKER: Yes, I'm sorry.

VENIREMAN CURRANS: Okay. I believe that if the patient is fully informed, if they are made aware of the risks -- risks and the benefits, it's up to the patient to make the final decision, knowing full well that if you have an operation on your heart you could die. It doesn't mean the doctor is negligent. You take that choice on the conditions. Some people say have surgery when they're not supposed to have surgery. Depends on case to case. But, basically, if you have all that knowledge, it's up to you. It's your body, it's your life.

MR. VENKER: Okay. All right. Thank you, ma'am. Mr. Nasser?

VENIREMAN NASSER: Yes, sir.

MR. VENKER: Do you have an opinion on that issue about this decision making?

VENIREMAN NASSER: Not particularly.

THE COURT: Please stand, sir.

VENIREMAN NASSER: Yes, sir.

MR. VENKER: I was just asking whether or not if the person was given full information about the risks, and with appropriate care given one of these risks comes to fruition, and the patient suffers from injury because of it, is that something that the healthcare provider is still responsible for, or does the fact the patient was informed, accepted that course of treatment --

VENIREMAN NASSER: A patient should not be completely -- it's not such that he has to have a choice of making a full -- be fully responsible, even being fully informed.

MR. VENKER: Tell me what you mean by that.

VENIREMAN NASSER: In a number -- in a number of situations, way beyond medical, even full disclosure will not absolve someone from -- from liability.

MR. VENKER: Okay. I hear your statement, but what do you mean by that?

VENIREMAN NASSER: The -- the doctor can -- or the provider, whatever service it is, can give the patient all he can give him, and I think what you might be alluding to is there are some cases of strictly ability. So that would mean that even full disclosure will not absolve someone from total -- from some kind of liability.

MR. VENKER: Yeah, well, this is not a strict liability case. I'm just saying -- I'm just asking what your opinion was on that. Okay. I appreciate that, sir. Thank you.

VENIREMAN NASSER: Thank you.

MR. VENKER: Miss Suggs, did you have your hand up?

VENIREMAN SUGGS: Yes. I think -- on this whole realm, I think as an individual I believe I have the knowledge and the ability to counter a recommendation by my doctor and suggest that maybe, you know, we explore other avenues. And I think probably a lot of people in here have that ability. Some people don't.

I think particularly when someone is in pain, and they're looking for answers, and they have a doctor who, again, is a power figure, authority figure, they're going to, you know, rely on their ability to make a recommendation that's going to help them alleviate their pain, which is what they're there for.

I think you've got very -- whether it's pain, whether it's just even the educational background, the experience, a younger person might not advocate for themselves the same way someone who's an adult might. And experience helps play into that.

So, you know, we've had lots of questions back and

forth about is it the patient's responsibility, is it the doctor's responsibility. It's a shared responsibility. But then there's all kinds of shades of gray in between that. And I think all of those factors need to be taken into account.

MR. VENKER: Okay. All right. Thanks, ma'am.

Anybody else? Yes, Miss Kuenzel?

VENIREMAN KUENZEL: I was just going to say that I think that you have the initial conversation with your doctor and they do explain all the risks and benefits to your treatment, but there also has to be kind of an ongoing dialogue between you and your doctor through the whole course of your treatment. So it's not just a one-time thing that you're having these conversations, it should be every time that you're discussing your care with your doctor you're having these conversations so that you're continually aware of the risks and anything else that could come up while you're ongoing treatment. So --

MR. VENKER: All right. Thank you, ma'am.

Anybody else on that decision-making issue? This case is going to involve a lot of testimony about and evidence about pain, and it will be described by different people as chronic pain, as intractable pain, as severe pain. I think we've talked a little bit about that, but we haven't really gotten into it too much.

So, is there anyone here -- and again, not to be too personal, but -- you know, you don't have to identify yourself if it's too personal. Anybody here who knows someone or is dealing with someone who has chronic ongoing pain, one that's lasted for certainly more than two or three months?

Miss -- we'll start in the front here. Yes, ma'am. Miss Frerichs?

VENIREMAN FRERICHS: Me. I have -- I can't remember what it's called. I have no cartilage in my one big toe at the base of my big toe. My one big toe has diminished cartilage. My feet hurt every day.

MR. VENKER: Sorry. Okay. And are you on any medication for that?

VENIREMAN FRERICHS: No.

MR. VENKER: How long have you had that condition?

VENIREMAN FRERICHS: Several years.

MR. VENKER: And is this something that impairs your ability to function every day? Sounds like it would.

VENIREMAN FRERICHS: No.

MR. VENKER: Okay. You're able to get by?

VENIREMAN FRERICHS: Uh-huh.

MR. VENKER: Okay. All right. Anybody else? Yes, Mr. Hostuttler? I'm sorry. Go ahead.

VENIREMAN HOSTUTTLER: My father broke his back in 1988, he hasn't been able to sleep in a bed with my mom since then, he sleeps on a couch. He takes up to ten prescriptions. As of last year they put him on Xanax because he has high blood pressure, elevated cholesterol, his -- I couldn't even tell you what pain medicine he's on, but he's been on chronic pain medicine.

MR. VENKER: Your dad broke his back you say ten years ago?

VENIREMAN HOSTUTTLER: 1988. So twenty-eight years ago.

MR. VENKER: So he's been on some kind of pain medication throughout that entire time?

VENIREMAN HOSTUTTLER: Ever since.

MR. VENKER: Do you know whether it was opioid or opiates?

VENIREMAN HOSTUTTLER: I do believe at one time he was taking OxyContin, Vicodin.

MR. VENKER: Do you know for what period of time?

VENIREMAN HOSTUTTLER: I do not.

MR. VENKER: All right. Miss Abercrombie, what were you going to say?

VENIREMAN ABERCROMBIE: I get recurrent pancreatitis, and I take pain medication as needed.

MR. VENKER: Okay. Over what period of time was that? Oh, just as needed? You're saying it's still -- okay. Is it opiate medication?

VENIREMAN ABERCROMBIE: (Shakes head.)

MR. VENKER: Can I ask what it is?

VENIREMAN ABERCROMBIE: Dilaudid.

MR. VENKER: So you take that kind of periodically, as you say, as needed?

VENIREMAN ABERCROMBIE: As I need it.

MR. VENKER: Okay. And when you do, do you take it for more than a couple days at a time, or how long do you have to take it?

VENIREMAN ABERCROMBIE: Usually a -- yeah, about two or three days before everything resolves.

MR. VENKER: Okay. All right. I had somebody else. Miss Brennan?

VENIREMAN BRENNAN: You mentioned three different types of pain when you talked about -- in the case. You said chronic pain, and I missed the next two.

MR. VENKER: There's chronic -- well, it will be described as chronic pain, which means long-term. Intractable pain, tractable, which is just very strong pain. And then severe pain. So, different people use different adjectives. But you'll hear evidence of the pain that Mr. Koon was having and still has, I think the

evidence will show. And, so, that was my question to anybody about -- anybody who has -- who's here suffering that.

Mr. Traubitz?

VENIREMAN TRAUBITZ: I take medication for a neuropathy thing. I called my doctor one time I said, you know, I really don't like taking all this medication. And he said that, well, you don't have to. That was the end of the discussion. It's up to me.

MR. VENKER: Okay. So, do you still --

VENIREMAN TRAUBITZ: I stop the medication and hurt or continue with it with those side effects, you know.

MR. VENKER: So do you take the medication now?

VENIREMAN TRAUBITZ: Yes.

MR. VENKER: And so how long have you been taking it?

VENIREMAN TRAUBITZ: About fifteen years now.

MR. VENKER: Okay. Is it an opiate or another --

VENIREMAN TRAUBITZ: Oh, yeah. Oh, yeah.

MR. VENKER: Okay.

VENIREMAN TRAUBITZ: It's very effective, I just don't like taking a lot of medicine.

MR. VENKER: Can I ask what it is? What is it?

Is it OxyContin or Vicodin?

VENIREMAN TRAUBITZ: No, no, it's not opioid. Gabapentin. Pretty benign.

MR. VENKER: Gabapentin, okay. Does your -- with the medication then you're able to function?

VENIREMAN TRAUBITZ: Oh, yeah, yeah.

MR. VENKER: Okay. And without it would functioning be more difficult?

VENIREMAN TRAUBITZ: I guess it would -- it would depend on pain tolerance. But pretty much it would be. I know a lot of people that have had a similar condition and refuse to take anything, but they hurt all the time.

MR. VENKER: Okay. All right. Are they limited --

VENIREMAN TRAUBITZ: And complain about it.

MR. VENKER: And they're limited in their ability to do physical activities?

VENIREMAN TRAUBITZ: No, they just grimace through it.

MR. VENKER: They grimace through it? Okay. Thank you, sir.

Yes, Miss Rosen?

VENIREMAN ROSEN: I mentioned my father. He's been on pain medication for at least five years, some of

it -- at times it's been opiates. He sees a pain management doctor.

MR. VENKER: Okay. And, so -- remind me of what his -- he has a back issue?

VENIREMAN ROSEN: It's complications from kidney failure resulting from a botched operation several years before. But as a consequence of that, and some other mobility issues, he's had a number of health things, which I'm not going to go into.

MR. VENKER: Okay. Sure. All right. Anybody else know somebody? Yes, Miss Currans?

VENIREMAN CURRANS: In January I was attacked by an eleven year old student to the point where I was beaten. So as a result, on the 13th of January I -- I've had neck injuries, my shoulder and my back, nothing broken, very, very, very badly bruised, as the doctor put it. At first he put me on OxyContin, but I didn't realize that that was just too --

MR. VENKER: Too strong?

VENIREMAN CURRANS: So now I just take Tylenol. I do take it twice a day. But I asked my doctor about what the -- I went to two specialists at Concentra first, because it was regulated. And they got them. So now he put me on some medicine. I said I can't do this. I said what can I do instead. So I just take over-the-counter

medication for it. And the only limitations I got, I can't lift or push over twenty pounds. And I have to sit down periodically when I teach. Other than that, it's fine.

MR. VENKER: Okay.

VENIREMAN CURRANS: But I have conferred with my other doctor as well what's going on.

MR. VENKER: Okay. All right. Thank you, ma'am.

Anybody else? Yes, ma'am. Miss Fortenberry?

VENIREMAN ALEXANDER FORTENBERRY: Fortenberry, yes.

MR. VENKER: Yes.

VENIREMAN ALEXANDER FORTENBERRY: I have migraines which I take Dilaudid for. I have three herniated discs in my back I take Percocet for and hydrocodone. I take -- I've been taking hydrocodone for the last six years. I take them every day. The Dilaudid I take as needed for the migraines, whenever they come. So --

MR. VENKER: Okay. Thank you, ma'am. I appreciate that.

Anybody else dealing with chronic pain or knowing somebody who is? Okay. I take it by your silence that there isn't. I appreciate your responses.

We'll hear some terminology in this case, and people have already talked about it, in terms of the medications. So in terms of some of these opioids, people have talked about the Dilaudid, the Vicodin, the -- does anybody know what Tramadol is? Or Ultram? I see a few hands have gone up.

Miss Wallace?

VENIREMAN WALLACE: Tramadol?

MR. VENKER: Yes.

VENIREMAN WALLACE: I'm currently on Tramadol.

MR. VENKER: Okay. All right. How long have you been taking that?

VENIREMAN WALLACE: Just a few months.

MR. VENKER: Okay. All right. Anybody else? Yeah, Miss Suggs?

VENIREMAN SUGGS: I'm not on it, but I broke my wrist a few years ago and was on it for pain.

MR. VENKER: Okay. All right.

VENIREMAN SUGGS: It's a synthetic opioid, is the way it was described to me.

MR. VENKER: Right. It is a synthetic opioid, that's correct, yes, ma'am.

Miss Currans, did you want to add anything?

VENIREMAN CURRANS: Yes, I was additionally put on Tramadol, whatever you want to say, for a very limited

time. After a while I just decided I would rather live with a little bit of pinching rather than -- in something common rather than take the risk.

MR. VENKER: Yes, ma'am, Miss Brennan?

VENIREMAN BRENNAN: I was -- I was on OxyContin after I broke my elbow, and it was severe pain, but it was absolutely too strong, and they switched me to Tramadol.

MR. VENKER: And you say it was too strong? So you talked to your doctor about it?

VENIREMAN BRENNAN: Oh, yeah.

MR. VENKER: Okay. All right. And Miss Currans, you mentioned, too, that you had talked to your physician about some pain medication being --

VENIREMAN CURRANS: He said Tramadol was one thing that I could take that wouldn't negatively knock me -- well, for a lack of a better term, make me an airhead. And, so, it was about a week, two weeks until I saw the other doctor, and he said, well, they had -- they came up with a wrap -- some kind of wrap that you could get from a doctor, and it's not that kind of a drug that would make you addicted. It applies pressure to the right spots. So we went with that treatment.

MR. VENKER: Okay. So you brought up a good point. You said something you couldn't get addicted to. When your doctor talked to you about these different --

like the Ultram or the Tramadol, did they tell you it could be addictive?

VENIREMAN CURRANS: Oh, yes, it's highly addictive. And that it creeps up on you. You just got to be aware of the changes in your body and your mental state. With me, it was more my mental state than my body, because it just didn't seem to -- you know, it wasn't worth the risk walking around like I wasn't there. You know what I mean?

MR. VENKER: I do. I do.

Miss Suggs, how about you, did the doctor tell you about the risks of the drug?

VENIREMAN SUGGS: Yes.

MR. VENKER: That it could be addictive?

VENIREMAN SUGGS: Yes.

MR. VENKER: Could be -- could result in dependency, too?

VENIREMAN SUGGS: Yes.

MR. VENKER: Okay. All right. Anybody else who's been given opiate medication by a physician, did the physician tell you that the drug could be addictive? People who have talked about that?

Miss Wallace?

VENIREMAN WALLACE: I'm trying to -- I'm sitting here trying to think, and I don't remember my doctor

telling me that it could be addictive.

MR. VENKER: Okay. Miss Abercrombie, how about you? Of course you probably already knew anyway, right?

VENIREMAN ABERCROMBIE: (Shakes head.)

THE COURT: Is that a yes?

VENIREMAN ABERCROMBIE: Yes.

MR. VENKER: Yes, Miss Brennan?

VENIREMAN BRENNAN: I knew the drug was addictive, but I also read the little labels on the medicine bottles that tell you it's addictive. It's a big hint.

MR. VENKER: That's a good point. Miss Brennan is saying that she looks at the pamphlet that comes with the medication. Just a raise of hands, who, when you get medication, especially opiates or painkiller, do you read the package insert that comes with it to know what the dangers are?

(Whereupon, hands raised.)

MR. VENKER: I see a lot of hands.

VENIREMAN CURRANS: But the pharmacist will tell you that when you get your medication; did you know this is this, and it could counteract with your medication. Any registered pharmacist will tell you when you get a prescription. They tell you when you get your medication.

MR. VENKER: Okay.

VENIREMAN CURRANS: Or even if you get a medication with your child, they tell you what works, what doesn't work, and is it addictive. Even for children.

MR. VENKER: Okay. Thank you, ma'am.

So Mr. Simon talked to you some about addiction this morning, so let's talk a little bit -- let's talk a little bit about that. Different people have said different things about addiction, that it's either a bad choice or it's a disease.

How many of you feel like you have a really good sense of medically and psychologically what an addiction is? Raise your hand.

(Whereupon, hands were raised.)

MR. VENKER: Mr. Lambert, how about you? What do you think it is?

VENIREMAN LAMBERT: I mean, it's --

MR. VENKER: I'm sorry?

VENIREMAN LAMBERT: Addiction is real.

MR. VENKER: No, I understand. Do you think it's psychological, or physical, or both, or --

VENIREMAN LAMBERT: No, I think it's physical.

MR. VENKER: Okay.

VENIREMAN LAMBERT: I think that there are psychological elements to it, but -- especially when you're talking about in the context of these drugs. I

think it's very definitely physical.

MR. VENKER: We've heard earlier some statements, may have been yesterday, about how some people are just, you know, predisposed to be addicted. Do you agree or disagree with that?

VENIREMAN LAMBERT: No, I agree.

MR. VENKER: Miss Brennan, how about you? Do you agree with that idea, that some people are predisposed to being addicted to some substance?

VENIREMAN BRENNAN: I think -- totally upon their -- I mean --

MR. VENKER: You're thinking about choices?

VENIREMAN BRENNAN: It's proven that it's -- some addiction is hereditary.

MR. VENKER: Okay.

VENIREMAN BRENNAN: Okay. That's -- you know, it's proven. I do believe that. But then there's also the person who just decides, like he said, I want to be cool and starts out very young, and they have made that choice, and maybe years down the road they're running into lots of health problems. It can be -- it can be either. I think it is more physical than mental.

MR. VENKER: Okay. Miss Love, how about you? What do you think about this issue of addiction? Is it mental, physical, a disease, do you -- do you feel you

have a good sense of what -- at least in your own mind what you think it is?

VENIREMAN LOVE: I think it's all of the above.

MR. VENKER: Okay.

VENIREMAN LOVE: I think you could psychologically become dependent on something. Psychologically that may manifest into a physical/medical addiction as well.

MR. VENKER: Okay. All right. So, addiction -- it sounds like we have a pretty good sense that it's not just a one -- there's not just one profile to addiction, people agree with that? I think you can think about somebody being in the back alley, shooting up heroin, right? But it isn't that simple.

Do we all agree on that, that it can happen in other settings, obviously, correct? And, so, the question really is, if a patient agrees to have certain medications that can be addictive, and they do become addictive, what information would you like to know about that before you decide whether the doctor or the patient has that responsibility?

Mr. Hostuttler, how about you?

VENIREMAN HOSTUTTLER: I don't even understand your question.

MR. VENKER: Oh, I'm sorry.

VENIREMAN HOSTUTTLER: I'm trying to think about that, but you kind of lost me.

MR. VENKER: Fair point.

VENIREMAN HOSTUTTLER: So you're addictive --

MR. VENKER: Let's say somebody's addicted, right? They're addicted to pain medication, right?

VENIREMAN HOSTUTTLER: Yeah.

MR. VENKER: What information would you --

VENIREMAN HOSTUTTLER: Expect them to give?

MR. VENKER: What information would you -- before deciding is it the patient who didn't get enough information, or they did get the information they're addicted anyway. Do you see what I mean?

VENIREMAN HOSTUTTLER: Yeah. Man, I don't know. Like, I would think your doctor is going to come up with a medical plan that he thinks is best for your treatment and your care in a situation where you are going to have either an operation, or something traumatic happened and they recommended a painkiller as part of your healthcare plan. So I'm under the assumption that he understands your biometric levels of your body. Right?

And, by the way, your body in homeostasis right now. This drug that I'm going to recommend you take could be chemically addictive and change the homeostasis of your body, changing its chemical makeup and dependency, and may

drive you to physically need this. At that point, if a person becomes chemically addicted, right, I think that that person would be inclined to continue to feed their chemical addiction, they wouldn't be as forthcoming about that.

On the other side of that is the doctor, during his medical plan, as you're going through the dates, is he reviewing those biometric levels? Do you monitor for that? I have no idea. But would you look and say, hey, you know, your so and so is elevated, this tells me this about your body. Okay. So let me tell you what you're saying, let me tell you what your body is telling me. They don't match up and this is what I think. Or, hey, they match up. You know, that's that -- the patient/doctor trust thing, I assume.

MR. VENKER: Right.

VENIREMAN HOSTUTTLER: At that point I don't think that -- if a person's not forthcoming because they're addicted to something and they're chemically addicted to it, I think it would be very hard for them to be honest because they know what they're going to do is take themselves off, and they're going to go through withdrawal. I think that's different than a mental addiction, you know, where they just feel the need to mentally do something. Because humans are a creature of habit, right? You wake up every morning, you drink a cup

of coffee, it's, like, got to get up, got to have my coffee, you know. Is caffeine addictive? I don't know. But that's another thing, right? Say, oh, I do this, you know. So, I think it's also a mental repetition as well.

MR. VENKER: Right. Sure. Okay. So in terms of that -- like you say, that circumstance that you just played out, I assume that, you know, the -- the patient needs to be getting information to the physician, if the physician is requesting it, about how they are doing with the medication. Is that fair?

VENIREMAN HOSTUTTLER: Absolutely forthcoming, hey, this is how I'm feeling, you know, you are prescribing me this, and, you know, I -- this is just throwing off -- I don't feel right, can you look at this, can you look at this. I'm getting the shakes and I'm getting the night sweats. You know, I have become agitated. So, sure.

MR. VENKER: Okay. All right. Yes, ma'am, Miss Love?

VENIREMAN LOVE: You had asked what questions would you need answered.

MR. VENKER: Yes.

VENIREMAN LOVE: I would like to know what other pain management approaches were taken during that four years. Any referrals or -- or such.

MR. VENKER: Right. Something that was non-opioid you're saying? Some other --

VENIREMAN LOVE: Or if they were referred to a pain management doctor for that. Just what other --

MR. VENKER: Sure.

VENIREMAN LOVE: -- steps were taken to manage that pain.

MR. VENKER: Okay. I appreciate that. Thank you.

Anybody else? Okay. Let's talk about --

VENIREMAN CALDERON NUNES: (Raises hand.)

MR. VENKER: Let's talk about whether anybody here has ever -- just talk about claims. So the question is whether or not anybody has had -- has filed a lawsuit against anybody for money damages. We don't have to talk about the details yet, I just want to know -- raise your hand, anybody who has done that.

Mr. Lambert, that was your experience you told us about earlier, was it?

VENIREMAN LAMBERT: (Shakes head.)

MR. VENKER: So I understand that. We'll take that up at sidebar. Miss Bonner?

VENIREMAN BONNER: Well, as an attorney I certainly have. Also, personally, I've filed a lawsuit against my condominium association.

MR. VENKER: Okay. Thank you.

Miss Calderon? Yes?

VENIREMAN CALDERON NUNES: Yes, it was a counter lawsuit against a landlord.

MR. VENKER: Okay. Anyone else who has brought an action? Yes, sir. Mr. Davis, right?

VENIREMAN DAVIS: I was in a real bad car accident, and I was awarded a lump sum settlement.

MR. VENKER: Okay. All right. Thank you, sir. Anyone else? Miss Suggs?

VENIREMAN SUGGS: I don't know if this is what you're looking for, but we had to sue our insurance company for a claim.

MR. VENKER: Okay. All right. Anyone else? Yeah, Mr. Lehmuth?

VENIREMAN LEHMUTH: Yeah, basically a wrongful death suit against --

MR. VENKER: You mentioned that earlier, did you?

VENIREMAN LEHMUTH: Right.

MR. VENKER: All right. Anybody else? Mr. Traubitz?

VENIREMAN TRAUBITZ: The broken neck incident.

MR. VENKER: You did talk about that, too.

VENIREMAN TRAUBITZ: There was a jury trial and

there was an award.

MR. VENKER: So to the group of you -- I'm sorry, Miss Kuenzel?

VENIREMAN KUENZEL: This is probably completely irrelevant, but I am a part of all kinds of class action litigation against corporations for something, and I -- like I just got a notification today that said I've got $10 in my Amazon account because of a class action claim against Apple. I'm, like, okay, sure.

MR. VENKER: How many other people have gotten notices from class actions they know nothing about?

(Whereupon, hands raised.)

MR. VENKER: Right? Okay. Fair enough. I appreciate the thoroughness of your thinking, Miss Kuenzel. That's great.

So to the group of you that answered, anything about your experiences in that other litigation that you think would cause you to doubt whether you could be a fair and impartial juror in this case? I take it by your silence that none of you feel --

Mr. Lehmuth, you mentioned earlier about that. We'll take it up at sidebar. I appreciate that, sir.

Other than that, nobody has any concerns about being fair and impartial? I take it by your silence that you have no such concerns. Okay.

Anyone who has been sued -- so the first question was whether you've sued somebody. The next question is have you ever been sued. Have you ever been a defendant in a case.

Miss Bonner, you've had that?

VENIREMAN BONNER: Yes, several.

MR. VENKER: Go ahead, ma'am. Just generally how long ago and --

VENIREMAN BONNER: Well, I've been the head of certain governmental agencies and I've been sued --

MR. VENKER: In that capacity?

VENIREMAN BONNER: -- as a named person. And I've also been sued -- I was sued by a lender over a dispute, a contract dispute.

MR. VENKER: Okay. All right. Anything about that that would cause you to have concerns about whether you could be fair and impartial here, ma'am?

VENIREMAN BONNER: No.

MR. VENKER: All right. Miss Calderon Nunes?

VENIREMAN CALDERON NUNES: It was a counter lawsuit. Our landlord tried to sue us first because the rental property we had signed up for was not in living conditions, and so before we took him to court he ended up taking us, and the whole thing played out and we won.

MR. VENKER: Anything about that experience that

would cause you to doubt whether you could be fair and impartial here?

VENIREMAN CALDERON NUNES: No.

MR. VENKER: Somebody up here in the box?

VENIREMAN LAMBERT: It was me.

MR. VENKER: We've talked about this. So this is where you've been a defendant, correct?

VENIREMAN LAMBERT: I was sued. As a reporter.

MR. VENKER: Okay. How long ago was that, sir?

VENIREMAN LAMBERT: Twenty-eight years ago. At least.

MR. VENKER: About a story that you wrote?

VENIREMAN LAMBERT: Yes.

MR. VENKER: Okay. Anything about that experience that would cause you to doubt whether you could be -- that experience would cause you to doubt whether you could be fair in this case?

VENIREMAN LAMBERT: No.

MR. VENKER: Okay. Anybody else? Okay. I take it by your silence that there is nobody else. So --

This is a little broader question, has anybody had any demand made on them for money, even outside of a lawsuit? All right. I take it by your silence that no one has had that experience. All right.

In this case the plaintiffs have the burden of

proof, and I just want to explore that a little bit with you. The standard in Missouri is, in civil cases, whether it's more likely true than not is the way the language is worded. And so the plaintiffs have that burden, to prove their case of negligence against Dr. Walden and St. Louis University.

So that means listening to the evidence and making a decision on that as to whether the plaintiffs have met that burden. Is there anyone here that feels they're not sure whether they could follow the instructions of the Court and -- based on the law and evidence in the case and decide the case based on using that burden of proof? Okay. I take it by your silence that everyone understands that.

I need to know, too, whether there's anyone here who believes or feels that they would have difficulty deciding against Mr. and Mrs. Koon, knowing what you know up till now, that no matter what the evidence or the law was that you would have a difficult time finding against them and in favor of Dr. Walden and St. Louis University? Okay. I take it by your silence that no one feels that way.

I want to take it one more notch on that same issue and say that no one is going to ask you not to feel sympathy. As this case goes on, this certainly has been a

-- a trying aspect of their lives, and we'll hear more about their lives before this even -- these chain of events. But I need to know whether or not you feel you couldn't push sympathy aside that you might feel for Mr. and Mrs. Koon in making your decision in the case? Because sympathy can't be part of your decision, you have to base it on the law and the evidence.

Does anyone here feel they would have difficulty putting their sympathy -- any sympathy aside they might have in making their decision in the case, even if it meant turning the Koons away with no money at all? I take it by your silence that no one has that concern. All right. I appreciate your responses.

The way this proceeding goes, too, as you've seen a little bit of an example of it, Mr. Simon and the plaintiffs get to go first, just like they're doing here in jury selection, and the defendants go second, and that's the way the trial will go in terms of presentation of evidence. We'll do opening statements after the jury is selected, then evidence is presented, and then closing arguments.

Some people like to -- I guess I've heard some people say they like to go to the end of the book, see what's at the end before they start reading, they want to figure out, you know, where this is going. That's not how

trials work.

And, so, what I need to know is whether or not you can keep your mind open all the way through all the evidence as it comes in, and not -- not prejudge the case until you've heard all the evidence? In other words, can you just wait till all the evidence is in?

Is there anyone here who feels they can't do that? Raise your hand.

(Whereupon, hands were raised.)

MR. VENKER: Miss Frerichs?

VENIREMAN FRERICHS: I don't know if I can do that.

MR. VENKER: We've talked already. And we'll probably talk at sidebar with you, ma'am.

Miss Wallace?

VENIREMAN WALLACE: I just tend to really make my mind up quickly, so usually by the end I have already decided one way or the other.

MR. VENKER: And are you saying that based on your jury service?

VENIREMAN WALLACE: Yes.

MR. VENKER: Okay. Okay. I appreciate your candor.

Anybody else feels they can't? Yes, Miss Griggs?

VENIREMAN GRIGGS: I -- I don't know.

MR. VENKER: You told us earlier about your concerns, I think, so --

VENIREMAN GRIGGS: I don't think I can -- I'm, like -- when I make up my mind, I make up my mind, and I don't think that I would necessarily keep an open mind all the way through if I felt one way towards --

MR. VENKER: So you just don't have the confidence that you could do that; is that what you're telling me?

VENIREMAN GRIGGS: Right. That's correct.

MR. VENKER: I appreciate your candor, ma'am, thank you. I really do. Anybody else? All right. Thank you.

Now, the -- some of the testimony in the case will be -- some of the evidence will come in different forms. Some of it will be live witnesses, some of it will be people testifying through what's called a deposition, some of those will be videotaped and you'll get to see a videotape, others will be read by people. And it's all appropriate.

But does anybody have any problem with believing testimony that isn't necessarily from the person that's in front of them as opposed to it being on a video or having two people read the transcript of the questions and answers? Anybody have a problem with that? Okay. I take

it by your silence that no one does. All right.

And there's a thing about order of witnesses, too, in this case. Sometimes people might -- I've heard from other jurors before that they say, well, gee, you know, I wanted to see Mr. Smith get on, you know, right then or something. And I'll just say scheduling of witnesses is something the lawyers don't always have control over, either side. So sometimes witnesses just have to be put in the order that we can put them in to meet their own schedules. So I just wanted to bring that to people's attention, in terms of sometimes how those timing -- the timing goes.

Okay. Let's talk a little bit about -- I just want to talk a little bit with each of you, maybe not the entire panel, just to go through --

Miss Presberry, hi. We haven't heard from you much. You're a school bus monitor?

VENIREMAN PRESBERRY: Yes.

MR. VENKER: And tell us what that involves.

VENIREMAN PRESBERRY: I assist the driver with the students.

MR. VENKER: Okay.

VENIREMAN PRESBERRY: So the bus driver can get the students to and from school and home safely.

MR. VENKER: Okay. So, that's, what, kind of a

peacekeeper on the bus?

VENIREMAN PRESBERRY: I try to be.

MR. VENKER: Okay. All right. Thank you, ma'am.

Mr. Lambert. You mentioned your father was a hospital administrator?

VENIREMAN LAMBERT: For a short time.

MR. VENKER: Which hospital was that, sir?

VENIREMAN LAMBERT: Paxton, Illinois. It was a small town hospital.

MR. VENKER: Oh, okay. And you said your sister is in healthcare. I'm not sure I wrote down what she -- what her field is.

VENIREMAN LAMBERT: My niece. She's a nurse.

MR. VENKER: I'm sorry. And where does she work?

VENIREMAN LAMBERT: My mom was a surgical nurse.

MR. VENKER: Oh, okay. And where does your niece work?

VENIREMAN LAMBERT: Down in southern part of Florida.

MR. VENKER: Okay. All right. And you're in communications for the National Corn Growers?

VENIREMAN LAMBERT: Yes.

MR. VENKER: Is that a PR, public relations

position?

VENIREMAN LAMBERT: Uh-huh.

MR. VENKER: How long have you been there?

VENIREMAN LAMBERT: Seven, eight years. But I worked for the State organization for a long time before that. I have been working for Corn Growers for about twenty-eight years.

MR. VENKER: Okay. Thank you, sir.

Mr. Boyd?

VENIREMAN BOYD: Yes.

MR. VENKER: You were talking earlier about -- I think the relationship between the physician and the patient. I remember you talking about that. And, so, if I understood you correctly, you were basically saying, yeah, we don't have a whole lot of factors for you to decide?

VENIREMAN BOYD: Right.

MR. VENKER: That it is a two-way street between the physician and the patient, correct?

VENIREMAN BOYD: Yes.

MR. VENKER: And the information needs to be shared openly between the two, correct?

VENIREMAN BOYD: Yes, yes.

MR. VENKER: Okay. And in terms of that, you would have to hear the evidence to know what you really

thought about where the pendulum swings between the two, correct?

VENIREMAN BOYD: That's correct.

MR. VENKER: You could be fair and impartial doing that, couldn't you?

VENIREMAN BOYD: Yes, I can.

MR. VENKER: Okay, great. Thank you, sir.

Miss Calderon Nunes, it says you just -- you are co-founder of Bottoms Up Coffee. Where is that?

VENIREMAN CALDERON NUNES: Yes. I have a coffee shop I own in Columbus, Ohio, that my sister runs for me while I'm here.

MR. VENKER: Okay. All right. So how long has that been in business?

VENIREMAN CALDERON NUNES: We are just getting ready to open up our doors next month.

MR. VENKER: Okay. Great. Thank you.

Miss Nichols, I think you said you have a brother-in-law who's a pharmacist.

VENIREMAN COLEMAN NICHOLS: Yes.

MR. VENKER: All right. And how long has he been a pharmacist?

VENIREMAN COLEMAN NICHOLS: Thirty years.

MR. VENKER: Okay. Thanks, ma'am.

Miss Thomas, you work at The Quarters Des Peres?

VENIREMAN THOMAS: Yeah. Skilled nursing rehab center.

MR. VENKER: Okay. And so do you have any interactions with any of the physicians from SLUCare at all?

THE COURT: Can you stand for me, Miss Thomas?

VENIREMAN THOMAS: I don't think any of our doctors are. We have Mercy, MoBap, Des Peres. It's a rarity we get SLU.

MR. VENKER: Okay. Do you -- do you deal at all with any kind of pain medications for patients there at the center?

VENIREMAN THOMAS: I'm a social worker there. I don't. If they ask, I ask the nurse. But I don't handle any of that.

MR. VENKER: Okay. Thanks, ma'am. I appreciate it.

Miss Taylor, you're a graphic artist?

VENIREMAN TAYLOR: Yes.

MR. VENKER: Tell us about that a little bit.

VENIREMAN TAYLOR: Well, I'm a production artist at a print shop, we do trade show stuff. You know, things that get printed, temporarily used, and -- yeah, it's a lot of printing on fabric.

MR. VENKER: Okay. All right. Thanks. That's

good.

Miss Griggs, how about you, what do you do? It says you're a specialist -- senior specialist at the Federal Reserves. That sounds pretty --

VENIREMAN SUGGS: It's Suggs. Yeah, I work in organizational development. So I do training development with existing employees. I have done orientation of new employees. And I do some work in the diversity inclusion space. And I work with our employee resource groups.

MR. VENKER: Okay. And it says here your spouse is an attorney?

VENIREMAN SUGGS: Yes.

MR. VENKER: Where does he -- is he working with a law firm in town, or --

VENIREMAN SUGGS: He's a plaintiffs attorney in labor and employment. He's at Schuchat, Cook & Werner.

MR. VENKER: Okay. Now my notes say that you worked -- you worked at the School of Medicine at SLU for a while?

VENIREMAN SUGGS: I worked at SLU prior to my position at the Fed. I have been at the Fed for four -- little over four years. I worked for the med school for five years prior.

MR. VENKER: Okay. And so when did you leave the medical school then in that position?

VENIREMAN SUGGS: 2012. March.

MR. VENKER: Okay. Okay. I see -- obviously you've got healthcare providers in the family, but I think you told us you believe you can be fair and impartial in this case?

VENIREMAN SUGGS: Uh-huh.

MR. VENKER: All right. Thank you, ma'am.

Miss Griggs, just tell us briefly what you do in your position at Citi Bank?

VENIREMAN GRIGGS: I work in the back office at Citi Bank, we do transactions that the branch can't handle, they send it to us, and we transfer funds from account to account. We accept payments through the mail. It's just banking that the branch can't handle.

MR. VENKER: Okay. All right. Thank you, ma'am, I appreciate that.

Miss Jacox, hi.

VENIREMAN JACOX: Yes, hi.

MR. VENKER: Says here your spouse works for the City of St. Louis.

VENIREMAN JACOX: Yes, at the airport. Lambert Airport.

MR. VENKER: Okay. The airport?

VENIREMAN JACOX: Right.

MR. VENKER: And how long has he worked there?

VENIREMAN JACOX: About twenty-five years.

MR. VENKER: And you work in sales for Grainger?

VENIREMAN JACOX: Right.

MR. VENKER: I'm sorry. Tell me what that company is.

VENIREMAN JACOX: It's a wholesale distributor; maintenance, janitorial, safety.

MR. VENKER: How long have you worked there, ma'am?

VENIREMAN JACOX: Thirty-seven years.

MR. VENKER: Okay. I appreciate that. Thanks.

Miss Currans, we've talked a lot, so I think we're good.

Miss Votaw, we've talked a lot, too. So --

Mr. Brown. Hi. I can't quite see you there. So you're a barber?

THE COURT: Can you stand for me, Mr. Brown, sir?

MR. VENKER: Sorry. How long have you been a barber?

VENIREMAN BROWN: For about ten year. Professionally two.

MR. VENKER: Okay. How did you -- I mean, people in the family barbers?

VENIREMAN BROWN: Older sister and my brother.

MR. VENKER: Okay. So did you work with them?

VENIREMAN BROWN: No.

MR. VENKER: Oh. Where is your shop?

VENIREMAN BROWN: In the Delmar Loop.

MR. VENKER: Okay. Okay. Thank you, Mr. Brown, I appreciate it.

Miss Kain? Gateway Science Academy. Tell us a little bit about that.

VENIREMAN KAIN: It's a charter school in the city.

MR. VENKER: Okay. What's your position there?

VENIREMAN KAIN: Assistant program coordinator for the before and aftercare program.

MR. VENKER: Okay. And how long have you been doing that?

VENIREMAN KAIN: Four years.

MR. VENKER: Okay. Where is that one located? Gateway Science.

VENIREMAN KAIN: We have three different buildings. The one I'm at is right at the corner of Gravois and Kingshighway.

MR. VENKER: Okay.

VENIREMAN KAIN: And then there's one on Fyler close to Kingshighway.

MR. VENKER: Okay.

VENIREMAN KAIN: And then the other one is in the old Epiphany Catholic School.

MR. VENKER: Okay. Maybe that's where I saw it. Because I know where that is. Okay. Thanks, ma'am, I appreciate it.

VENIREMAN KAIN: You're welcome.

MR. VENKER: So, Miss Kuenzel, I know we've talked some but, Enterprise Bank, credit analyst, what do you do there?

VENIREMAN KUENZEL: I analyze commercial customers' financial statements, identifying risks within their business industry to come to credit decision for loans.

MR. VENKER: Okay. How long have you been there?

VENIREMAN KUENZEL: I've been at Enterprise for a little over a year. I've been in banking for four, and within the accounting/finance realm for about ten years.

MR. VENKER: Okay. Thanks, ma'am. Appreciate it.

Miss Vikesland? So you are a teacher at Westminster?

VENIREMAN WIKESLAND: I am.

MR. VENKER: So what subjects do you teach there?

VENIREMAN VIKESLAND: Eighth grade science.

MR. VENKER: Okay.

VENIREMAN VIKESLAND: I've just been there a year. I was at Wash U before that, so --

MR. VENKER: Okay. So, is it boys and girls you're teaching, or just one or the other?

VENIREMAN VIKESLAND: It's boys and girls, thirteen year olds.

MR. VENKER: Oh, okay. All right. Sounds challenging. It does. Thanks, ma'am, I appreciate it.

Mr. Nasser, we've talked a little bit. You're an attorney?

VENIREMAN NASSER: Yes.

MR. VENKER: And you are retired now?

VENIREMAN NASSER: Yes.

MR. VENKER: How many years retired?

VENIREMAN NASSER: About twenty.

MR. VENKER: Okay. Okay. And, so -- just out of curiosity, where did you go to law school?

VENIREMAN NASSER: U of L. Big rivals of SLU.

MR. VENKER: There you go. Absolutely. Okay.

Miss Lapierre, tell us about teaching literacy at Clayton High School. That's what it says.

VENIREMAN LAPIERRE: It's not the high school, it's at Wydown Middle School. So I teach sixth grade.

Kind of like eighth graders, but they cry a little bit more.

MR. VENKER: And, so, is literacy a different term for --

VENIREMAN LAPIERRE: Literacy is English, LA, communication skills, communication arts, language arts, it's whatever they're calling it in Washington, so --

MR. VENKER: Okay. And how long have you done that?

VENIREMAN LAPIERRE: This is my first year in Clayton. I spent thirteen years in Hazelwood before this.

MR. VENKER: Thanks, ma'am, I appreciate that.

So, Miss Scott, it says on here that you're a homemaker. So, are you -- do you have kids or family there with you, or --

VENIREMAN SCOTT: Unfortunately, yes.

MR. VENKER: Okay.

VENIREMAN SCOTT: I'm doomed.

MR. VENKER: So extended family with you, you mean?

VENIREMAN SCOTT: Yes.

MR. VENKER: Okay.

VENIREMAN SCOTT: Yes. I can't wait for the holidays.

MR. VENKER: Okay. Thank you, ma'am.

Mr. Lehmuth, I think we talked already some, so I think we're good.

Miss Klumb, you're a teacher at Rockwood?

VENIREMAN KLUMB: Yes.

MR. VENKER: Tell us what you teach there.

VENIREMAN KLUMB: Eureka High School. I teach calculus, algebra II.

MR. VENKER: How long have you been teaching that?

VENIREMAN KLUMB: About twenty-six years.

MR. VENKER: Okay. How big are your classes when you're teaching these math courses, number-wise?

VENIREMAN KLUMB: Number-wise, usually around twenty-six, twenty-eight.

MR. VENKER: Okay. All right.

Miss Fortenberry, we've talked pretty much already, I don't know that I have any questions for you, so I'm going to pass on.

Mr. Leible, you haven't said a whole lot to us during this time. It says in the information we have that your brother is a pharmacist?

VENIREMAN LEIBLE: Yeah, for about thirty-five years, and my sister used to be a nurse, but she's laid off.

MR. VENKER: Okay. Where did your brother --

did he work at one pharmacy or more than one?

VENIREMAN LEIBLE: No, he's changed quite a few times.

MR. VENKER: Okay. All right. Are they both in the St. Louis area?

VENIREMAN LEIBLE: Oh, yes.

MR. VENKER: Okay. You said your sister was a nurse?

VENIREMAN LEIBLE: Yes. She's laid off.

MR. VENKER: Okay. Where was she working, do you know?

VENIREMAN LEIBLE: At Cardinal Glennon.

MR. VENKER: Okay. All right. Thank you, sir. I appreciate it.

Mr. Brown?

VENIREMAN BROWN: Yes, sir.

MR. VENKER: Can you tell us what your background is? Are you working now, or --

VENIREMAN BROWN: Well, I'm not -- I'm unemployed right now.

MR. VENKER: What did you do before that?

VENIREMAN BROWN: Well, I worked at the airport.

MR. VENKER: Okay.

VENIREMAN BROWN: So I work at Flight Kitchen for the airplanes.

MR. VENKER: Right, right.

VENIREMAN BROWN: I also do jobs with the -- subcontracting by UPS for parcels, filling up their plane with their packages.

MR. VENKER: Okay.

VENIREMAN BROWN: My wife and I started a business with a daycare in the '80s.

MR. VENKER: Okay.

VENIREMAN BROWN: She just deceased a couple years ago.

MR. VENKER: I'm sorry.

VENIREMAN BROWN: January 26th, 2014.

MR. VENKER: I'm sorry.

VENIREMAN BROWN: And we tried to keep the daycare open, it didn't work out too well. Everything in St. Louis is a memory of her, so I've been barely functioning. As of this year I've been trying to bounce back and get back to working.

MR. VENKER: Okay. I'm sorry for your loss, sir.

VENIREMAN BROWN: Thank you, sir.

MR. VENKER: Thank you so much.

VENIREMAN BROWN: Thank you.

MR. VENKER: Miss Love, it says -- what I've got here is sales, Zebra Tech. I don't know what that means.

VENIREMAN LOVE: I work for Zebra Technologies, we manufacture everything bar coding.

MR. VENKER: Oh, okay.

VENIREMAN LOVE: So from the media to the scanners to the printers. Probably best known in Wal-Mart where you -- somebody scans your little return and then a bar code comes up. I work for the healthcare division, and so I'm responsible for negotiating contracts with, like, group purchasing organizations, hospitals, buy-in groups.

MR. VENKER: Okay. All right. That sounds interesting. One thing you said earlier that I want to kind of follow up on was you talked about people -- I think you said your mother, you think, relies on her doctors too much and is not willing to challenge them.

VENIREMAN LOVE: Yes.

MR. VENKER: Right? And, of course, that is -- every doctor/patient relationship is unique, right?

VENIREMAN LOVE: Correct.

MR. VENKER: All right. And so in that situation have you been able to make any real headway with your mother's reluctance?

VENIREMAN LOVE: I don't know that it's my headway to make. But they have become more informed and able to -- to use the tools available, Internet, and what

have you, yes.

MR. VENKER: Okay. That's good. Okay. I just want to make sure. You feel like you could be a fair and impartial juror if you were selected for this case, don't you?

VENIREMAN LOVE: Yes, yes.

MR. VENKER: Okay. Good. Thank you, ma'am.

Mr. -- is it Edinger or Edinger?

VENIREMAN EDINGER: I've heard it both ways.

MR. VENKER: There's probably more than two ways. Okay. So, I've got to ask, civilian fingerprint is what they have down. So what do you do?

VENIREMAN EDINGER: I'm a civilian employee of the St. Louis Metropolitan Police Department. I read the fingerprints of people who have been arrested to make sure they are who they say they are.

MR. VENKER: Wow. So is that like a fingerprint analyst?

VENIREMAN EDINGER: Well, it's not what you see on television. I do not do latent stuff, okay? A person is arrested, he's in this building next door, they put his fingerprints on a screen, it prints out in the office that I'm at on Olive, I take it and I compare them to what's in the master file, if he's claimed to be somebody we've had before, and I verify whether or not that person is. If

the person is new, they could have a record in another part of the country, they might have an FBI number, or another part of the state which would give them a State ID number, I look up what names, birthdates they've had.

MR. VENKER: Okay. So I've got to ask. How did you start that job?

VENIREMAN EDINGER: Well, that's real simple. I was a 911 dispatcher for seven years, okay? And I went to the lieutenant and said look, I'm not slamming my foot down or nothing, but I got to do something else. And the guy who was the lieutenant was the head of the ID section, and he got promoted, and he liked me, because I show up to work every day, and he said come over here, Larry, I'll put you in fingerprints. So I've been there since 1998, and I should retire at the end of September.

MR. VENKER: That sounds amazing. Thank you, sir, I appreciate it.

Mr. Davis, you work out at the airport it sounds like?

VENIREMAN DAVIS: Yes, sir.

MR. VENKER: And for Southwest Airlines?

VENIREMAN DAVIS: Yes, sir.

MR. VENKER: What do you do for them?

VENIREMAN DAVIS: I'm the one that marshals planes in. I'm the one that takes your bags on and off

the aircraft.

MR. VENKER: How long have you been doing that?

VENIREMAN DAVIS: Eight years.

MR. VENKER: Okay. All right. Thank you, sir.

Miss Carosello, I see that your husband works at St. Louis University?

VENIREMAN CAROSELLO: Yes, sir.

MR. VENKER: Maybe was already covered, but what does he do there?

VENIREMAN CAROSELLO: He -- he's in a retirement job there now, but he delivers mail.

MR. VENKER: Okay. And how long has he been there at the university?

VENIREMAN CAROSELLO: This is his eighth year.

MR. VENKER: Anything about that relationship, your husband being employed there, that would cause you to doubt whether you could be fair and impartial if asked to serve as a juror on this case, ma'am?

VENIREMAN CAROSELLO: No.

MR. VENKER: Okay. Thank you very much.

Miss Wampler?

VENIREMAN WAMPLER: Yes, sir.

MR. VENKER: You're the CFO/accountant at We Rent It. So your own business?

VENIREMAN WAMPLER: Yes.

MR. VENKER: How long have you been operating that?

VENIREMAN WAMPLER: I've been there since '98. The business has been in the family since 1960.

MR. VENKER: Okay. So how many people do you employ, just out of curiosity?

VENIREMAN WAMPLER: Myself, my husband, my son, and one employee.

MR. VENKER: And, so, what kind of things do you rent?

VENIREMAN WAMPLER: Lawn and garden equipment, ready-mix concrete, tillers, bobcats.

MR. VENKER: Okay. All right. My information says you went to SLU for nursing school. Anything about your having gone to nursing school there that would give you concerns about being fair and impartial if chosen to serve as a juror in this case?

VENIREMAN WAMPLER: No.

MR. VENKER: You think you could be fair and impartial, I take it?

VENIREMAN WAMPLER: Yes.

MR. VENKER: Thank you, ma'am. I appreciate it.

Ms. White?

VENIREMAN WHITE: Yes.

MR. VENKER: It says you're a -- is it

psychology teacher?

VENIREMAN WHITE: No, I'm a psych tech. Psychiatric tech.

MR. VENKER: So tell me what you do in that job, ma'am.

VENIREMAN WHITE: I oversee to make sure the clients don't harm themselves, we take them out on trips, we have to restrain them at times, interact with them.

MR. VENKER: Okay. Sounds like a challenging job.

VENIREMAN WHITE: Yes, it is.

MR. VENKER: How long have you been doing that job?

VENIREMAN WHITE: Nineteen years.

MR. VENKER: Okay. Thank you, ma'am. I appreciate it.

Mr. Nolan?

VENIREMAN NOLAN: Yes, sir.

MR. VENKER: I think you told us already a little bit about what you -- what your role is there at the -- is it the Hilliard Davis Company?

VENIREMAN NOLAN: Yeah, so, it's a federally qualified health center with a ridiculously long name, that's why it's not on there. But it's Myrtle Hilliard Davis Comprehensive Health Centers. So --

MR. VENKER: Okay. That's what I've got. I just wasn't sure it was all part of the name. Remind us how long you've been there.

VENIREMAN NOLAN: Just a year and a half.

MR. VENKER: Okay. And you're doing business development for them?

VENIREMAN NOLAN: Business development, marketing, and a little bit of PR.

MR. VENKER: Okay. And where did you work before that?

VENIREMAN NOLAN: I was in school before.

MR. VENKER: Okay. And you went to St. Louis University?

VENIREMAN NOLAN: Correct.

MR. VENKER: Anything about that fact that would cause you to be concerned whether you could be fair and impartial in this case, sir?

VENIREMAN NOLAN: No.

MR. VENKER: I appreciate it. Thanks very much.

All right. Ms. Young?

VENIREMAN YOUNG: Yes.

MR. VENKER: You're a receptionist at the St. Louis City Justice -- is that center? Where is it?

VENIREMAN YOUNG: The Justice Center right here on Tucker.

MR. VENKER: How long have you been there, ma'am?

VENIREMAN YOUNG: Three years.

MR. VENKER: Okay. So, hopefully, as a receptionist you don't have to deal with too many exciting events there. Is it a pretty calm job for you there?

VENIREMAN YOUNG: Pretty much. Nothing too exciting really.

MR. VENKER: Okay. I appreciate that, ma'am. Thanks very much.

Mr. McNair? I just thought I'd ask what your employment is or occupation?

VENIREMAN McNAIR: Auto mechanic, Improved Landscaping.

MR. VENKER: Okay. And, so, just been doing that for a number of years, or --

VENIREMAN McNAIR: About thirty, forty years. Automotive.

MR. VENKER: Okay. You work alone or with other people?

VENIREMAN McNAIR: Other people.

MR. VENKER: Okay. Okay. Thank you, sir.

Okay. I'm real close to wrapping this up. So let me ask a question. After all that's been asked of you up till now, is there anything that anyone is thinking

about that you are thinking, gee, I wish Mr. Simon or Mr. Venker would ask me this question, because, you know, it's a problem? I know we've already identified some that we're going to deal with. But anybody now who hasn't talked about an issue who's now thinking that they have kind of thought of one? I take it by your silence that no one is having that experience. Okay.

I don't think I have any further questions. I appreciate your patience everybody.

THE COURT: Ladies and gentlemen, what we're going to do is a take a recess so that we can pick the jury. I'm going to ask that everybody please remain in the hallways, because there are certain people we need to pull in, or if there's something we need to further clarify, it's hard when everybody is spread out. So if you can kind of remain nearby in case we need to pull you out. Also keep in mind -- I think there might be a couple other trials going on, so if you could keep your voices down.

(Whereupon, Instruction 300.04.1 read to the Jury.)

THE COURT: Just a couple people we need to talk to, so if you can remain by the door we'll pull you in quick.

(Whereupon, a short recess was taken.)

(Venireman Lambert approached the bench, and the following proceedings were had:)

THE COURT: We're back on the record outside the hearing of the whole panel. I think there was some things -- I don't know if we needed to further explore some things with Mr. Lambert, but if we do, this would be the time. Because I know there was a -- there was an issue about a lawsuit, and thought --

VENIREMAN LAMBERT: Yeah, they --

THE COURT: Can you share that with us?

VENIREMAN LAMBERT: My son was put on a new medication, and it was supposed to have been 10 milligrams, and they misprescribed it, it was a hundred, and they almost killed him. He was four years old at the time.

THE COURT: Okay. And was he a patient of -- was this at St. Louis University?

VENIREMAN LAMBERT: No, this was in Central Illinois.

THE COURT: So it's got nothing to do with the parties involved in this case?

VENIREMAN LAMBERT: No.

THE COURT: Okay. Any follow-up questions, Mr. Simon?

MR. SIMON: Mr. Lambert, are you able to be fair

and listen to the evidence in this case and decide this case based on the law and the evidence that you hear?

VENIREMAN LAMBERT: Yes, I think so.

MR. SIMON: No questions, Your Honor.

MR. VENKER: I don't think I have any further questions, Your Honor.

THE COURT: Okay. Thank you, Mr. Lambert.

(Venireman Lambert left the bench, and the following proceedings were had:)

THE COURT: Okay. Was there anybody else that we needed to talk to?

MR. CRONIN: I don't think so. I think the other people have already kind of gotten themselves off that we would have had side questions on. Unless Mr. Venker has an idea on the other people.

THE COURT: The way I like to do this is go with plaintiffs first, and then defense, and we go page by page. If you think you've got somebody for a cause, if you are on the other side of it, and you know you're going to consent to it, if you would just chime in. So we'll do a name, and then ask for a consent, if there's no consent then tell me why. But if we can just get consent --

MR. SIMON: Is it okay if I sit through this?

THE COURT: Oh, yeah, you can sit.

MR. SIMON: Just to make it more easy to go over

the notes with Tim.

THE COURT: I agree completely.

All right. So let's start with Page 1. Are there any for plaintiffs for cause?

MR. CRONIN: So we're starting in the jury box with the seated numbers, Judge?

THE COURT: Yep.

MR. CRONIN: Okay. Seated number two, Denise Wallace, Judge, we would move for cause.

THE COURT: Is that by consent?

MR. BARTH: Yes, Your Honor, by consent.

THE COURT: All right. Juror number 156 will be struck for cause by consent.

MR. CRONIN: Juror seated number three, Mr. Becherer. Judge, to be fair to the other side, he said that he knows John's -- he said he would be biased against the defendants.

THE COURT: Is that by consent?

MR. VENKER: Yes.

THE COURT: All right. Juror number 32 will be struck for cause for his admitted bias, it's by consent.

MR. CRONIN: Juror seated number four, Miss Rosen. Your Honor, she said she's not comfortable with pain and suffering, she would have a difficult time doing it, she can't conceive of a situation where she

could award five to $10 million for mental anguish.

THE COURT: Hold it. Is that by consent or not by consent? Miss Rosen.

MR. VENKER: I thought she basically was just saying it was too abstract for her to really say. I thought in the end she said, yeah, if I hear evidence, that's what I need to hear to be able to decide the case.

THE COURT: All right. So since it's not by consent, go ahead and give me your whole --

MR. CRONIN: Sure. Judge, it was clear she has a preconceived limit without knowing the evidence on how much she can award for pain and suffering, and that's not permitted, she can't conceive of giving big numbers no matter what the evidence is. She basically said it has to be small numbers.

MR. VENKER: I think she also said she would have to see what the evidence was, Judge. I mean, I think to say to somebody without any facts do you think they should get $10 million, I don't think that's unusual for somebody to say they couldn't. Until you see the evidence, how do you know.

MR. SIMON: Judge, the issue is, nobody should have a predetermined amount of anything until they listen to the facts in the case. And this woman -- and I -- I think she picked up on five to ten because of my question.

But she certainly, throughout the course of my questioning her on this issue, and Paul's, you know, has a problem with awarding money for pain and suffering. And has a problem with awarding money for mental anguish. That's the only element of damages that we're going to have in this case, other than, you know, possibly punitives. She just has in her mind a preset limit or cap, whatever that is, we didn't get into, but certainly no one should have a predetermined limit or cap of what damages are in a case before they've heard evidence. And that's why I think it's important to strike her.

MR. VENKER: Well, some of the problem I'm having with it, Judge, some pretty big numbers were thrown out for -- the average person would seem to be big, big numbers. And so I feel like she's kind of being saddled with those because she was repeating back the numbers that John had mentioned. So I just think she really was saying, look, those are big numbers, I would have to see what the evidence is.

THE COURT: All right. One, when we do this process you guys do not have to stand, otherwise we're going to be up and down fifty more times. I appreciate the respect you're showing the bench, but let's just drive on through this.

In addition, Miss Rosen did bring up a hardship

issue that was an additional factor. So for the totality of her responses, I'm going to strike Miss Rosen for cause over the defense objection.

MR. CRONIN: Judge, seated eight, Miss Heisler.

THE COURT: All right. We'll do page by page. All right. Anybody else -- anybody else on Page 1 for the plaintiffs?

MR. CRONIN: No, Judge, sorry.

THE COURT: Anybody on Page 1 for the defense? Let's do page by page, that way I can keep track, make sure we've got enough bodies.

MR. BARTH: Your Honor, we would move for cause to strike Mr. Lambert. He has disclosed that his son received a dose in excess. I think judging his credibility he became pretty angry when talking about that situation and the lawsuit. I know there was an attempt to rehabilitate him, but I think it was pretty clear that he could not be fair to the doctors in this case.

MR. CRONIN: Judge, I don't think he ever said that. He never said he couldn't be fair to either party in this case. In fact, the only time he was asked was by Mr. Simon on sidebar, and he said he could be fair and impartial.

THE COURT: Yeah, I'm going to deny, he has not -- none of his responses indicated that he couldn't be

fair or that he couldn't follow the Judge's -- the Court's instructions. And, actually, when pulled out from the rest of the panel he did specifically say he could be fair and impartial. So, the cause request for the defense on number six will be denied.

Any more on Page 3 for the defense -- I'm sorry, Page 1. Page 1. All right. That's three bodies.

All right. Page 2, plaintiffs?

MR. CRONIN: Judge, seated number eight, Miss Heisler, which is juror number 74.

THE COURT: Is that by consent?

MR. BARTH: Yes.

THE COURT: Juror number 74 will be struck for cause by consent.

MR. CRONIN: Nine is already gone, right?

THE COURT: Yes, nine is already gone. She was struck for hardship.

MR. CRONIN: Judge, juror number ten. I think -- I anticipate defendants are going to move for cause, and I think they have good basis, so we would consent to it in the event --

THE COURT: On line ten, is that by consent? Miss Frerichs?

MR.BARTH: Yes, Your Honor.

THE COURT: All right. Juror number 40 will be

struck for cause by consent.

MR. CRONIN: Judge, plaintiffs will then do juror number -- move for cause on juror number eleven.

THE COURT: Is that by consent? Mr. Hostuttler? He specifically said the phrase I am biased.

MR. BARTH: Hold on. I'm checking my notes on that one, Your Honor.

THE COURT: I've got it circled and highlighted. If it helps you, he said I am pro plaintiff.

MR. MAHON: This is Mr. Hostuttler?

THE COURT: Yeah.

MR.MAHON: Okay.

MR. BARTH: That's fine.

THE COURT: Okay. Juror number 1144 will be struck for cause by consent.

MR. CRONIN: Judge, we would then move on juror number twelve. Ms. Kinsella. She -- within the first five minutes of starting voir dire, I think said she is biased, the plaintiff is starting behind, her father worked at SLU as a professor of medicine.

THE COURT: Your response, the defense, on Miss Kinsella?

MR. BARTH: I think she probably talked herself out of this one, Your Honor.

THE COURT: So it's by consent. 396 will be

struck for cause by consent.

Does the defense have any issue with line seven, Miss Bonner?

MR. BARTH: I guess the only issue we have with number seven, Your Honor, was the potential close personal relationship. Miss Bonner does know Mr. Simon's sister.

MR. VENKER: Right. Who's a lawyer.

THE COURT: Yeah, but I think it's fair to say Miss Bonner said at least a half a dozen times that she can set aside all of that because she's a professional. So as a member of the bar I'm going to take her at her word she can set those things aside. So that does not reach the level of cause for Ms. Bonner. So that's one body from that page. We're up to four.

Page 3?

MR. CRONIN: Yeah, Judge, juror fifteen, Miss Nunes said her husband is an MD at Wash U, she has bias, she's more inclined to side with the medical side.

THE COURT: Any objection to Ms. Nunes? Is that a no? Did I hear -- I'm sorry, I didn't hear you guys.

MR. BARTH: Just one second, Your Honor.

THE COURT: Sure.

MR. BARTH: She did say she was biased.

THE COURT: All right. Juror number 327 will be struck for cause by consent.

MR. CRONIN: Judge, juror number -- I think sixteen is gone. Juror number seventeen plaintiffs would move for cause on.

THE COURT: All right. First, sixteen is gone for hardship.

MR. CRONIN: Yes.

THE COURT: All right. And you asked for seventeen?

MR. CRONIN: Yes, Judge.

THE COURT: All right. Why on seventeen?

MR. CRONIN: Judge, I don't think she said which side she would be leaning towards, but she said her brother-in-law was a pharmacist who was investigated by the DEA for filling prescriptions, she said it's too close to home, she would be a better juror for a different case. I don't think anybody said, well, which side would you have a predisposition for. But she did say it's too close to home, would be a better juror for a different case. And that is pretty close to the issues in this case.

THE COURT: Bring in Miss Nichols. Can you bring in juror number 340?

THE SHERIFF: Yes, sir.

(Venireman Nichols approached the bench, and the following proceedings were had:)

THE COURT: Good afternoon, Miss Nichols.

VENIREMAN COLEMAN NICHOLS: Hello.

THE COURT: How are you?

VENIREMAN COLEMAN NICHOLS: I'm good.

THE COURT: You guys can sit down. All right. Miss Nichols, so, I am not the best note taker in the world, so I'm just trying to make sure I got my notes right and jiving with some of the things you said. All right. I remember you saying, I think it was yesterday, that your brother was a pharmacist.

VENIREMAN COLEMAN NICHOLS: Brother-in-law. I'm an only child.

THE COURT: Brother-in-law. And today I think you said that he had done it for sixteen years -- or he --

VENIREMAN COLEMAN NICHOLS: Well, he is fifty-three. So he started doing it before I got married. So I'm not exactly sure.

THE COURT: Okay. But he's been doing it -- I don't know if I have ten or sixteen.

VENIREMAN COLEMAN NICHOLS: Thirty.

THE COURT: Okay, thirty years.

VENIREMAN COLEMAN NICHOLS: Probably.

THE COURT: And then my notes are horrible. I wrote down brother, invest, pill. So, did you say something that he was investigated? And can you --

VENIREMAN COLEMAN NICHOLS: This is kind of a

long, drawn-out story, but he opened a pharmacy in Florida with another guy. And there was a wreck, the lady in the wreck had a script that was filled by the pharmacy that was later found to be fake. So he was part of the investigation. And they were in the process of selling the pharmacy. So in order for the sign-off to occur on the sale of the pharmacy he could no longer be employed there, and he moved to Michigan.

THE COURT: Okay. At any time was he -- not trying to get into your family personal business.

VENIREMAN COLEMAN NICHOLS: No, it's fine.

THE COURT: But at any time was he found liable or anything?

VENIREMAN COLEMAN NICHOLS: No. Nothing has happened with it in the past year, probably year and half. We don't really talk too much --

THE COURT: Anything about the fact that your brother was investigated because someone tried to do a fake script -- is that going to have an effect on your ability to be fair and impartial in this case?

VENIREMAN COLEMAN NICHOLS: I say this only because I don't think he should be liable for filling the fake script. Like, that's not his -- as a pharmacist, I don't think it's his responsibility to investigate every script that comes in.

THE COURT: Okay. So knowing in this case there's no pharmacy and there's no issue of fake scripts or anything like that --

VENIREMAN COLEMAN NICHOLS: Right.

THE COURT: Those are two different fact -- the fact pattern in this case has nothing to do with the fact pattern of your brother. Can you be fair to the plaintiffs and to the defense when you listen to the evidence and make your determination based solely on the evidence that you hear?

VENIREMAN COLEMAN NICHOLS: Yes.

THE COURT: I sense a pause, or is that a thought?

VENIREMAN COLEMAN NICHOLS: I'm thinking. Pausing. I can try.

THE COURT: Okay. I've got to nail you down, because this is a pretty important case, and kind of need -- and here's the thing. It's okay. We all have life experiences. I think someone talked about, like, I couldn't sit on a case talking about the Rams. I'm so angry that I wouldn't be able to be fair and impartial to that situation. So if this hits too close to home, it's okay.

VENIREMAN COLEMAN NICHOLS: It would be hard for me to come into this with an open mind. I would -- I

mean, that's all I can say.

THE COURT: So who would be at the disadvantage? Would the plaintiffs kind of be starting below --

VENIREMAN COLEMAN NICHOLS: Yes.

THE COURT: -- or would the hospital be starting below?

VENIREMAN COLEMAN NICHOLS: Yeah, plaintiffs.

THE COURT: Okay. And you're pretty set on that?

VENIREMAN COLEMAN NICHOLS: Yeah. I mean, I have pretty strong feelings towards responsibility when it comes to those types of issues with drugs and --

THE COURT: Okay. All right. Anybody got any follow-ups?

MR. SIMON: No, Your Honor.

THE COURT: Thank you so much for your candor. I appreciate it.

(Venireman Coleman Nichols left the bench, and the following proceedings were had:)

THE COURT: All right. Miss Nichols will be struck for cause for inability to be fair to the plaintiffs. Over the defense's objection.

All right. Anybody else for plaintiffs?

MR. CRONIN: Nobody else on that page, Judge.

THE COURT: All right. Page 3 for the defense?

(There was a discussion held off the record.)

MR. BARTH: Yes, I'm sorry, checking my notes here. We would move to strike juror thirteen, Mr. Traubitz, for cause. And the main issue we have with him was his calling of Mr. Simon after hours in violation of the court admonition not to have contact with the parties, and it was not disclosed at all by him during questioning this morning.

MR. CRONIN: Judge, I don't think he was admonished not to, and we didn't talk to him, there's been no improper contact between the two of us.

THE COURT: All right. I want the record to reflect that I don't think Mr. Simon did anything inappropriate --

MR. BARTH: We're not insinuating that at all.

THE COURT: I would just like the record to be clear.

MR. SIMON: Your Honor --

THE COURT: If there's no issue with Mr. Simon on this one, I do -- I will agree that -- with the defense that I didn't specifically say you couldn't call, but I have to think that that falls within the realm and I am concerned about it. I don't think there was any negative intent, but I do think that that is a violation of a specific order, even though I didn't say the words, that

it was clear that there should be no contact with attorneys. I believe the last phrase was the attorneys representing the plaintiffs and the defendant are under a duty not to do anything that may even seem improper, therefore at recesses and adjournments don't say anything but good morning. In doing so they do not mean to be unfriendly, they're simply doing their best to avoid even the appearance that they are you doing anything improper. They are not permitted to talk to you about any subject connected with the trial, you're not permitted to talk to them about it. So I'm going to grant that strike for failure to follow a Court's instruction. Over the plaintiffs' objection.

Any more on Page 3 for the defense?

MR. MAHON: Number eighteen, Monica Abercrombie. I have one part of my notes here that says something about her work would influence her judgment, and that one side in this case is already ahead of the other before she's heard any evidence. Like the other juror, I don't know if she specifically said which side that was, but I have that in my notes. So I think that's a concern and move to strike her for cause on that basis.

MR. CRONIN: Judge, I don't think she said one side was starting ahead of the other. She did talk about not liking long-term use. I do have that in my notes.

THE COURT: I have that during Mr. Simon's portion -- because the way I did this was blue ink yesterday, black ink today, and then red ink for defendants. More information than you need to know. That's how I know what section it came in, and I wrote prejudge the case.

MR. VENKER: Yeah.

THE COURT: So I'm going to strike her for cause for her inability to keep an open mind and wait till the end of the case to make a determination. So she'll be struck for cause over plaintiffs' objection.

All right. Any more on Page 3?

MR. MAHON: No, Judge.

THE COURT: All right. We've got Mr. Boyd. We have one more body. We're up to five. All right. Page 4?

MR. CRONIN: Judge, as I understand it, twenty was already dismissed yesterday?

THE COURT: Oh, yes, Miss Houston, number -- line twenty, is struck for hardship.

MR. CRONIN: Judge, twenty-three.

THE COURT: Said I can't follow --

MR. CRONIN: This is not for us. She said she has an issue with SLU.

THE COURT: Said can't follow instructions. Her

exact words. She will be struck for cause. Is that by consent?

MR. MAHON: With consent, Your Honor.

MR. CRONIN: That's it for that page, Judge.

THE COURT: All right. Page 4 for the defense?

MR. BARTH: Judge, number twenty-one, Jill Taylor, I have to look back at my notes.

THE COURT: She specifically said she cannot be fair and impartial.

MR.BARTH: Cannot be fair.

THE COURT: Is that by consent?

MR. BARTH: Doesn't feel good about doctors was her exact words.

THE COURT: All right. Miss Taylor will be struck for cause by consent.

MR. BARTH: I think that does it for Page 4, Your Honor.

THE COURT: That's three bodies. So we're up to eight. All right. Page 5.

MR. CRONIN: Judge, I don't think we have any.

MR. SIMON: Mr. Vancil.

MR. CRONIN: Mr. Vancil is gone.

THE COURT: Mr. Vancil was released for hardship, that's line twenty-five, juror 392.

MR. CRONIN: And plaintiffs have no additional

cause strikes on that page.

THE COURT: All right. Any strikes by the defense for Page 5?

MR. BARTH: Just one second, Your Honor.

THE COURT: Yes.

MR. BARTH: None for cause, Your Honor.

THE COURT: All right. That gives us five more bodies. That gets us up to thirteen.

All right. Page 6? Plaintiffs? Mr. Selby on line thirty-three was -- didn't show up today. So he's struck.

MR. CRONIN: Judge, juror thirty-four, Miss Lapierre. I can say quite a few things, but I'll see if they consent first.

THE COURT: Do you consent on Miss Lapierre?

MR. BARTH: Despite Paul's attempt to rehab her, I don't think she said she could be fair on this one.

THE COURT: All right. So she'll be struck by consent?

MR. BARTH: Yes, Your Honor.

THE COURT: All right. By consent.

MR. CRONIN: No others on that page for plaintiffs, Judge.

THE COURT: All right. Any on Page 6 for the defendants?

MR. MAHON: Yeah, I think number thirty-six, Mr. Lehmuth. He had the family involved in a wrongful death suit.

MR. CRONIN: We'll consent, Judge.

THE COURT: Yep.

MR. CRONIN: He did say that.

THE COURT: Line thirty-six will be struck for cause by consent. You're good?

MR. BARTH: We're good with 6, yes.

THE COURT: Three more bodies. We're up to sixteen. All right. Page 7, plaintiffs?

MR. CRONIN: Judge, we would move on juror thirty-eight. Miss Fortenberry.

THE COURT: Is that by consent?

MR. VENKER: I thought she said she could be fair. I never heard her say she couldn't be fair.

MR. CRONIN: Judge, she said a lot of things about a lot of medical conditions, and she's a heavy opioid user, she has a lot of addicts in her family, she's on opioids now.

THE COURT: All true, but she didn't say anything about not being able to be fair and impartial, she didn't -- she said -- I got it. She's got migraines, she takes Dilaudid, she's got disc, six years, no end in sight on the Percocet. Pain medicine doctor, hereditary

things, genetic, alcoholism in family.

MR. CRONIN: Judge, we thought it would be by consent, so no problem.

THE COURT: Okay. So next -- any more on --

MR. CRONIN: I don't think we have any more on that page, Judge.

MR. BARTH: What do you guys want to do with Mr. Leible? Do you want to agree, or --

MR. SIMON: Which one is he?

MR. CRONIN: Mr. Leible is the gentleman that came in that has a brain injury.

MR. SIMON: The order, I think, is actually more far reaching than others.

MR. CRONIN: Judge, if they would like to we will consent to Mr. Leible. We understand he has some issues that we didn't really explore, but based on an order it seems like --

THE COURT: So you'd like to -- so on the plaintiffs' motion for consent, are you guys consenting to Mr. Leible?

MR. BARTH: Yes.

THE COURT: Okay. Mr. Leible will be struck for cause by consent.

MR. BARTH: We have no others on that page, Judge.

THE COURT: All right. Any more for the -- any on Page 7 for the defense?

MR. CRONIN: Forty-two is already gone, I think.

THE COURT: And forty-two is already gone. I didn't say this beforehand, but are the parties okay if we seat two alternates?

MR. SIMON: Yes.

MR. VENKER: We're fine with that. Judge, can we go back to Mr. Ray Brown?

THE COURT: Yes.

MR. VENKER: Just out of concern -- Mr. Brown seemed pretty despondent. He said he lost his wife two years ago, and he's been trying to kind of bounce back since. They had a -- I think he said he and his wife operated that child care center, and then she died, and I just -- I mean, we didn't do a thorough examination. It seemed a little bit kind of intrusive to do that. But I just didn't think -- he just didn't seem like he was really with it.

MR. SIMON: Judge, I asked the general question several different times, is there anything here we need to talk about, anything we need to be concerned about, anything that we did not cover, anything that we have not asked. And, as a matter of fact, it got a lot of responses. Mr. Brown was okay with all of those, he had

multiple opportunities to bring that issue up if, in fact, it was an issue. There's nothing on the record indicating that this man is not qualified to be a juror in the case.

THE COURT: All right. I'm going to deny the cause for Mr. Brown. He -- I have nothing in blue. That means he didn't respond to any answers yesterday. I have nothing in black, that means he didn't respond to any of the plaintiffs' answers, and then I have the -- the information that the defendants got out of him and none of it was negative. He didn't indicate that the -- the only thing that the widow informed the Court on was that that's why he is currently unemployed, he's struggling for employment, but he has not made any other indications that this would be any kind of hardship. So that will be denied on Mr. Brown.

Any more for the defense on Page 7?

MR. BARTH: No, Your Honor.

THE COURT: All right. Draw a line under Fortenberry, because that gives us eighteen bodies. And then let's go to Page 8. And the question is, does anybody have any issues with juror forty-three or juror forty-four?

MR. CRONIN: No, Judge, plaintiffs do not.

THE COURT: The top two.

MR. VENKER: We have no problem we either of

those two.

THE COURT: Draw a line after Ronald Davis. So within the first eighteen, you both get to use three peremptories, and then in the last four you each get one. So we will seat two alternates.

(Whereupon, a short recess was taken.)

THE COURT: I'm going to check back with you in fifteen minutes. You don't have to be done in fifteen minutes, but I'm going to check back with you in fifteen minutes. All right. Just so I'm not hovering over you.

(Whereupon, a short recess was taken.)

THE COURT: We are back on the record to do peremptory strikes. Would the plaintiffs proceed with their peremptory strikes?

MR. CRONIN: Judge, plaintiffs' peremptory strikes were five --

THE COURT: Line five?

MR. CRONIN: Number five. Number twenty-six.

THE COURT: Hold on. Five, twenty-six.

MR. CRONIN: And thirty-eight.

THE COURT: Thirty-eight. So line five is Miss Brennan, 196 for the plaintiffs' first one.

MR. CRONIN: Yes.

THE COURT: Juror line twenty-six, which is Currans, will be the plaintiffs' second one. And line

thirty-eight, Fortenberry.

MR. CRONIN: Yes, Judge.

THE COURT: P3. All right.

Defense peremptories?

MR. BARTH: Yes, Your Honor, we did number one, Miss Presberry.

THE COURT: D1, Presberry.

MR. BARTH: Number seven, Miss Bonner.

THE COURT: Bonner will be D2.

MR. BARTH: And then --

THE COURT: Then who?

MR. BARTH: Thirty-one, Miss Vikesland.

THE COURT: Thirty-one, Miss Vikesland, will be D3.

MR. BARTH: Then for the alternate we struck number forty-four, Mr. Davis, Junior.

THE COURT: Alternate, Davis, Junior, D alternate.

MR. CRONIN: Judge, our alternate was forty-three, Mr. Edinger.

THE COURT: Mr. Edinger, plaintiffs' alternate. All right.

MR. CRONIN: Judge, plaintiffs would like to make a Batson challenge. Three out of four jurors stricken were African Americans, and two of them didn't

say anything to justify striking them from the case.

THE COURT: All right. Let's deal with -- let's deal with -- are you talking about --

MR. CRONIN: Number one, first, Judge.

THE COURT: All right. Plaintiffs are making a Batson challenge on Presberry. Please state a non race-related reason for line one.

(There was a discussion held off the record.)

MR. BARTH: Number one, Your Honor, for Miss Presberry, we didn't get much information out of her, so she was not particularly forthcoming. This is a complex medical negligence case, and I think she is a bus monitor, and she had some -- has lower education. The other thing we saw, Your Honor, is part of the time she may have been sleeping as well. So those were our main reasons.

THE COURT: Your response?

MR. CRONIN: Judge, I didn't hear a single legitimate reason stated.

THE COURT: As to Miss Presberry -- I don't know that the standard is a legitimate reason. As long as they're able to articulate a non race-related -- and she did make the response that -- her cadence was slower than the rest of the individuals. I did not see her sleeping. But the response and her cadence was significantly slower.

MR. BARTH: And, Your Honor, we would add, too, she did mention early on -- we did not want to embarrass her in the front of the others -- she had a caseworker, who was another juror, early on, Miss Houston. We didn't want to get into that personal basis. But that was another issue that we had.

THE COURT: Anything else, Tim?

MR. CRONIN: No, Judge.

THE COURT: All right. Miss Presberry -- I'm going to deny the Batson challenge on Miss Presberry.

Next one will be Miss Bonner?

MR. CRONIN: Yes, Judge. I will say Miss Bonner had a lot to say, so I'm sure they can give -- she's an attorney, can give multiple reasons. So I'll pass on Miss Bonner.

THE COURT: All right.

MR. CRONIN: But we would like to make a challenge for Mr. Davis.

THE COURT: All right. Are you withdrawing --

MR. CRONIN: The Batson challenge for Miss Bonner, yes.

THE COURT: Okay. All right. And then third one -- so then you want to jump to Mr. Davis? All right. There's a Batson challenge on the alternate, Mr. Davis, by the plaintiffs.

MR. BARTH: Yes, Your Honor, Mr. Davis was -- the only information we got out of him was that he had the prior car accident in which he received a settlement from a personal injury plaintiff. He also works out at the airport. And we also note that we did not strike number forty, who is Mr. Brown, who also is African American, and we didn't remove him for cause. So I don't think there was any racial reason for that. We had a legitimate reason.

THE COURT: Being a party to a lawsuit is legitimate non race-related. I'm going to deny the Batson challenge on Mr. Ronald Davis.

All right. Does that conclude any more challenges to the panel? All right. That being said, let's make sure we have the same people.

I have juror number one being Lambert -- if I'm wrong, chime up. Juror number one is Lambert. Juror number two is Boyd. Juror number three, Thomas. Juror Number four, Suggs. Juror number five would be Jacox. Juror number six is Votaw. Seven is Brown. Eight is Kain. Nine is Kuenzel. Ten is Nasser. Eleven is Scott. Twelve is Klumb. Alternate one is Brown. Alternate two is Love.

Does that comport with everybody's strikes?

MR. BARTH: Yes, Your Honor.

MR. VENKER: Yes, Your Honor.

THE COURT: Plaintiffs, does that comport with your strikes?

MR. CRONIN: Yes, Judge.

THE COURT: All right. Ali --

THE SHERIFF: Hold on, I missed three and four.

THE COURT: Three is Thomas, Jennifer Thomas. Four is Lisa Suggs. And five is Jacox.

All right. Rack them and stack them.

(Whereupon, a short recess was taken.)

THE COURT: Please be seated.

All right. Counsel, are the jurors as seated in the jury box and the two alternate seated in the chairs at the end the jury you have selected for this case?

MR. CRONIN: Yes, Judge.

MR. BARTH: Yes, Your Honor.

THE COURT: All right. Those of you who have not been selected, I have one piece of good news. Your jury service over. Yay. All right. We talked to the jury supervisor, and you do not have to go back over, they're bringing a whole fresh crop of people in tomorrow. So your service is over.

But -- I know this has been a drawn-out process, but as you can see, you are vital to the administration of justice, and if we don't have civilians to take the time

to come and serve, we cannot facilitate the judicial system.

So, on behalf of the circuit, on behalf of Division 21 and my staff and the lawyers that are trying this case, we thank you for your attention, your patience and your willingness to serve. So you are free -- you are discharged and you're free to go. If you need anything from Ali, Ali will be out in the hallway, and she will take care of you out in the hallway. So if you would please leave at this time and go and enjoy lunch.

Those of you that have been selected, everything I said goes for you as well. Thank you for your service, you are a valuable part of this. We will try to make this experience as painless as possible.

The first thing I'm going to do is let you guys go get some food as well. It looks like it's about 1:35. I'm going to ask that you come back at 2:35. I will tell you what my plans are. My plans are today to get through opening statements and to at least begin with a witness. I'm going to try to utilize a full day every day. My goal is to get you out of here before 5:00, but if there is a situation where I think we're going to go long, I will let you know beforehand so that you can make any arrangements you need to do. But unless I tell you anything different, my goal is to get you out the door before 5:00. Or as

close to that as possible. But if it does run late, it is not the attorneys, it's my job to manage the trial. So if there's any kind of time issues, please don't hold anything against the attorneys. Like I said, it's my job to move it along and make sure it goes on time. So just keep that in mind.

So with that being said, you will hear this ad nauseam while you are here, but I am required to say this every time we do a recess. So, please bear with me.

(Whereupon, Instruction 300.04.1 read to the Jury.)

(Whereupon, a lunch recess was taken.)

THE COURT: We will be in lunch recess until 2:30.

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(The following proceedings were had in open court, out of the presence of the jury:)

THE COURT: We're on the record outside the hearing of the jury to take up some of the objections presented by the defense regarding the deposition of Dr. Walden.

MR. CRONIN: Yes, Judge.

MR. MAHON: That's right.

THE COURT: So proceed.

MR. MAHON: Thank you, Judge.

The first objection is page 21, lines 2 through 7. We filed, by the way, our third deposition objections and counter designations of the defendants which should have been filed on June 17th, and so we incorporate that into my argument here.

But the first one is page 21, lines 2 to 7.

THE COURT: All right.

MR. MAHON: The issue here is to the form of the question. I think the question posed to Dr. Walden was -- there was some testimony in the preceding page, but then it says, in not doing that, what he discussed earlier, would be a violation of good medical practice.

So the objection there is to the form of that because I don't know what good medical practice means. It's not the standard that's going on in this case as to the standard of care.

THE COURT: Your response?

MR. CRONIN: Judge, this is a medical malpractice case. This is a defendant's deposition. We're asking if he thinks something would or would not be good medical practice. Every single question does not have to include the word standard of care.

THE COURT: That's my understanding as well. Those aren't the -- it doesn't have to be just the magic words; it has to make sure that it's talking about the

direct subject.

So on the issue as to form of the question, I'm going to deny -- I guess the proper term would be overrule.

MR. MAHON: Okay.

THE COURT: Because you're making an objection?

MR. MAHON: That's right.

THE COURT: So overruled as to form.

MR. MAHON: Okay. The next one comes up on page 37. And there's a series of them that I grouped here because it's really just kind of one run of questions.

THE COURT: All right.

MR. MAHON: Starting on line 9 and basically goes through to line 25.

THE COURT: Okay.

MR. MAHON: These are questions like, can a doctor follow his own judgment and still be beneath the appropriate standard of care; does medical malpractice exist; do you believe it occurs; are physicians sometimes negligent.

I objected to the form of these questions that are vague, they're overbroad, there's no facts; and I don't see what the relevance is to this case.

THE COURT: All right. So you hit me with vague, overbroad, insufficient and relevance.

MR. MAHON: That's right.

THE COURT: Your response?

MR. CRONIN: Judge, it's a medical malpractice case. Their defense is that it's all within the clinical judgment of Dr. Walden and thus everything is within the standard of care, and we are cross-examining him on that topic.

THE COURT: All right. In terms of relevance, I think it's relevant and not prejudicial. In terms of vague, overbroad and insufficient, I think that's a line of questioning, and I think the jury will give it its proper weight. But as to the form -- as to form, I'm going to overrule; and as to relevance, I'm going to overrule.

MR. MAHON: Okay, Judge, the only thing I would say, I don't think it's in dispute in this case that medical malpractice exists. The dispute is whether it exists in this case. So that's really, just to clarify my objection for the record.

THE COURT: I understand your objection, but I think that there's -- since this is going to be a battle of the experts, I think those issues will be able to be fleshed out between the parties.

MR. MAHON: Okay. And there's one other question that's kind of lumped into that same group that's a little different, page 38, lines 14 to 23. And this is

a question, do you agree that above all else a doctor should serve the highest interest of the patient.

I think this might be some part of -- some sort of reptile tactic. I don't know what the highest interest of the patient means, it wasn't ever defined, and so I objected for the same reasons there.

MR. CRONIN: Judge, I think it's part of the Hippocratic Oath. I don't know what counsel means by reptile tactic. I think he means good Plaintiff lawyering.

THE COURT: The objection is noted. I'm going to overrule. Yeah, I think it's tying into the Hippocratic Oath, so I'm going to overrule 38, both the page 38 one as well as the page 37.

MR. MAHON: Okay. The next one jumps ahead to page 106, Judge. It's 106, lines 2 to 7. And so there's some questioning up on page 105 about three different drugs OxyContin, oxycodone and hydrocodone. And then there's a question on 106, line 2, and the longer you're on it, the more likely you would become addicted.

I think I objected to the form of the question there. I think it's vague and confusing, insufficient facts. There's no information provided as to which drug is the subject of the question, what type of patient, the duration. There's just no facts whatsoever other than to

say the longer you're on it, the more likely you can become addicted.

THE COURT: Are you wanting me to take these in a vacuum? Because if you pull them out in a vacuum, I get where you're going, but this -- we're on page 100 of a deposition, and I don't know how it corresponds. But I think the -- in terms of form, I think the context is important, and I think with the preamble that the question was yeah, opioid addiction, the addiction to opiates, the OxyContin, the oxycodone, those were said in a question earlier, I think that adds frame of reference to the following question. So I'm going to overrule for form on the 106.

MR. MAHON: The next one is on page 116, line 20 through page 117, line 4.

THE COURT: Okay.

MR. MAHON: And this -- the context here is there's some discussion and some questions about hydrocodone.

THE COURT: Right.

MR. MAHON: And there's a question, do you believe that hydrocodone has a high potential for abuse? And so I objected to the form of the question there because, I mean, again, I don't think there's any context provided in any of the preceding questions about what type

of a patient, what's the duration that you're on the drug, what's the amount. It's just an extremely vague question that has no real direction to it, so I think it's an unfair one.

THE COURT: Your response?

MR. CRONIN: Judge, I don't really understand the objection. These are central issues in the case. I cannot for every question that is asked in a depo or at trial describe the entirety of any particular patient. I'm asking if a drug has a high potential for abuse, and he agreed.

THE COURT: Overruled as to form.

MR. MAHON: All right. The next one is on page 117, lines 5 through 13. It kind of fits, kind of fits in with the last one, but it's talking about I think three different drugs, hydrocodone, oxycodone and OxyContin. The question is, all three of those drugs can lead to severe psychological or physical dependence.

And so the objection there again is to form. It's combining all three different drugs, and it's asking really two different questions, psychological dependence or physical dependence. And so I think it's improperly combining a lot of different concepts into one question. So I'm not sure how it can be fairly answered.

MR. CRONIN: Judge, my response would be the

same. These are from the DEA schedule classifications. The language comes from there and says that is true for all of them. We're asking the doctor if he agrees, and he does.

THE COURT: Overruled as to form.

MR. MAHON: Okay. Also on page 117, lines 11 through 13, this just finishes out that series of questions. It says all three, presumably referring to those three different types of drugs, they're all considered dangerous by the DEA.

So really the objections are the same, but I think there's also a foundational issue about what connection Dr. Walden has to the DEA, what would he know about what the DEA considers dangerous or not, and even the word dangerous.

THE COURT: It looks like three, form, foundation, and relevance.

MR. MAHON: That's right.

THE COURT: Your response?

MR. CRONIN: Judge, they are dangerous. The DEA has designated them as dangerous. Dr. Walden agrees they are dangerous. The question in this case is about whether he prescribed dangerous drugs to our client.

THE COURT: You said something earlier about the DEA or --

MR. CRONIN: These are from the DEA; the

language is from the DEA classifications.

THE COURT: All right. In terms of relevance, I think that is relevant to the lawsuit. Foundation, as long as it's pulled from a reasonable belief to these questions that he's asked and a reasonable source from it and as well as I believe the form, while it might not be the cleanest question, it still doesn't rise to the level of objectionable.

MR. MAHON: All right. So the next ones are kind of a large group, starting 152, line 16, and there's a whole series that are objections that we filed, and ending on 182, line 8.

And really, these are all grouped together because as I mentioned just before we went on the record, these concerned questions posed to Dr. Walden about some opioid guidelines out of the State of Washington. So we raised this issue in our motion in limine, I believe, number 18, that these guidelines from a state outside of Missouri or ones that were not even in existence at the time of the care at issue, there's no evidence in the case that they're authoritative or relevant.

We know that guidelines such as this do not set the standard of care, so I'm not sure what else they would be probative of or how else they would be used in this case, except to infer that maybe they're the standard of care.

And so if they're not met, that somebody like Dr. Walden would be somehow violating the standard of care. So we want to preserve that issue and raise that objection again.

THE COURT: All right. Let me read 152 to 153. Your response?

MR. CRONIN: I think the Court has ruled on that and has denied the motion in limine on it. Specifically for this section we're talking about a Washington guideline that John pulled out, presented to the doctor and went through each of the recommendations on it. And the doctor literally agreed to every single one of them in his deposition.

MR. MAHON: My only point is whether he agreed to them or not is irrelevant to the issue. I mean, he can find anything he likes from any date and any country. And just because a doctor agrees to something doesn't make it authoritative, doesn't make it relevant to the care at issue in this case.

THE COURT: I think it is relevant. I think the doctor's answers are -- the jury will give it the appropriate weight, whether it thinks that he should have -- whether they think that he should have or should not have consulted whichever specific guideline is quoted, they'll give that the appropriate weight.

I do believe that this issue is consistent with

motion in limine 18, and so I do not think it's an area that should be excluded and I do think it's relevant. I believe that's the objection there. So as to relevance, I'll overrule.

MR. MAHON: Okay. The next one is a large group, starting at page 207, line 16. And in our written objections that we filed, it ends on 229, line 12.

But basically these are grouped together because Dr. Walden was questioned in the deposition about a summary table that contained calculations of morphine equivalent doses for the years 2008 to 2012 for Mr. Koon that Plaintiffs' counsel had put together.

I believe they have a similar table that the parties have stipulated to that will be used here at trial, but that the numbers on the table that's going to be used here at trial are not identical to the number on the tables that was used at the deposition because corrections are made, new information came to light.

So I think it would be confusing and misleading and will really misstate what the evidence is by allowing these questions to go forward and the jury to hear about certain numbers that are not going to be displayed in any of the stipulated exhibits in the trial. I think it's confusing.

MR. CRONIN: Judge, Mr. Mahon does correctly

state that we have put our heads together and stipulated to a summary table. The numbers are a little different now than they were in the version that existed at the deposition. But I think they've all gone up from what they were in the deposition. And what is borne out by the testimony is that the defendant did not know the doses that he prescribed. I think it's important for the jury to understand that.

MR. MAHON: I'll just say, I think some went up; some went down. The point is, they're different. The numbers are not the same. It's highly confusing. And I also disagree that the defendant did not know what doses were being prescribed. I don't think there's any evidence of that in the case.

MR. CRONIN: If your Honor likes, I believe Dr. Walden's taking the stand, and Plaintiff will withdraw these designations and we can handle it live.

THE COURT: All right. So tell me what you're doing.

MR. CRONIN: I'm helping you avoid having to go through all these designations and I'm withdrawing them. This section.

THE COURT: Okay. So this section you're withdrawing.

MR. CRONIN: I'll withdraw these designations.

THE COURT: Okay, withdrawn by Plaintiff. All right.

MR. MAHON: Okay. The next section here is -- I think your Honor's ruling's going to be same because it's concerning the Washington guidelines again, but it's page 216, line 12 to 227, line 22.

But really my argument and the objection is the same as set forth in motion in limine number 18 that we've just gone through on the preceding section.

THE COURT: All right. I'm going -- my decision in motion in limine number 18 remains the same, so I'm going to overrule.

MR. MAHON: All right. Then there's a final section here, Judge. It starts on page 231, line 13, and it goes -- well, we'll just take the first one here, really 231 and 232, these kind of all go together.

The first one is, you're aware that prescribing any amount of narcotic opiates creates a probability of dependency and addiction. So the objection is to the form. There's no information, again, about the type of opioid, the type of patient; and I think it's compound because they're combining the concepts of dependency with addiction. So that was the basis stated in the deposition, which I'm stating here as well.

MR. CRONIN: Judge, this is a central issue in

the case. Again, I believe the defendant agreed to it. And we are saying any opioid, regardless of the type or the amount, and he agrees.

THE COURT: Yeah, I'm going to overrule. I will agree it's not the cleanest question. But to the person that's being asked, I don't think it's confusing, and I think it's up to the jury to give the answer the weight that's necessary. So it's overruled.

MR. MAHON: Okay. Page 231 --

MR. CRONIN: I think that's the one we just did.

MR. MAHON: Yeah, but it just goes on from there, line 21 through 232, line 3. It fits in with -- this is kind of a run of questions, but the higher doses that a patient is on, those risks increase. Same objection as to the -- as I set forth in the preceding one, which is no information.

THE COURT: I'm going to maintain my ruling on that. It's overruled.

MR. MAHON: All right. Would the same be true on the last one of this run is page 232, lines 4 through 14. No information provided and also combining the concepts of dependency and addiction.

THE COURT: I'm going to overrule. My ruling will be the same for that one.

MR. MAHON: Okay. And page 233, there's two

questions that appear on this page, still kind of fitting in this same grouping. The longer they're on it, the higher the probability the risk will, I guess, come about.

Same objections, Judge. There's just no information about what the patient is on, who the patient is or what risks we're talking about.

THE COURT: Same response?

MR. CRONIN: Yes, Judge.

THE COURT: Same response from the Court. Overruled.

MR. MAHON: Okay. The final one on page 233, would you agree that prescribing 1,500 milligrams of narcotic opiates creates a high probability of dependency? I think there was some confusion in the answer with what the question was about, but I made the same objections there to the form of the question.

MR. CRONIN: Same response, Judge.

THE COURT: Same response from the Court. He does say, I'm not sure what you mean, and then he proceeded to answer. So I'm going to maintain my overrule.

MR. MAHON: Okay. Okay. Page 234, lines 6 through 15. There's a question here, the problem with this is the compound nature of it, talking about dosages that Mr. Koon was on created a -- he says, a probability

of dependency or a risk of dependency. So I think we're talking about two different things, a probability on the one hand or just a risk on the other. They're combined together. And there's an answer in the affirmative, but I don't think anybody knows which one of those two things he was responding to.

MR. CRONIN: Judge, it seems as though the doctor understood what I was asking, and he said he was aware of it. This goes directly to our punitive damages claim of the knowledge of the harms that Dr. Walden knew were being inflicted upon Brian.

THE COURT: Yeah, the response shows that he understood the question. I agree it's not the cleanest, but I don't think it's objectionable so I'm going to overrule as to the form.

MR. MAHON: Okay. I think the final question appears on page 259, line 25 through 260, line 7. And the question is, a person who has withdrawal symptoms is one sign that they were dependent or addicted to that substance.

And so I think, again, it's combining two concepts of physical dependence with psychological addiction. And it's compound, and I think it's confusing as to which one the question was intending to reach and which one the answer was intended to respond to.

MR. CRONIN: Judge, it seemed as though the doctor understood the question. And dependency and addiction, as the Court likely knows, go hand in hand. You cannot have addiction without also dependency. You can have dependency without addiction; but the claims in this case are clearly are that Brian was both, and I believe that the doctor understood that when answering the question.

THE COURT: I agree, I'm going to overrule. I think there is a foundation for it.

MR. MAHON: I think those are all the objections for the Dr. Walden deposition.

THE COURT: All right.

MR. MAHON: And there may be a couple other things to take up, but I think this is going to be the one played tomorrow.

THE COURT: All right.

MR. CRONIN: Thank you, your Honor.

THE COURT: All right. So with that being done, are the parties ready for opening statements?

MR. SIMON: Yes, your Honor.

MR. VENKER: Yes, Your Honor.

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(The proceedings returned to open court.)

THE COURT: All right. Please be seated.

Before we get started, are there any witnesses that need to be excluded from the courtroom at this time?

MR. CRONIN: I don't think so, Judge.

THE COURT: Okay. All right. First order of business, ladies and gentlemen, I'm going to have Maureen swear you in.

(At this time the jury was duly sworn by the deputy clerk.)

THE COURT: All right. Please be seated.

I'm going to read you an instruction that's applicable to this case. This instruction and other instructions I will read to you near the end of the trial are in writing. All of the written instructions will be handed to you for your guidance in your deliberation when you retire to your jury room. They will direct you concerning the legal rights and duties of the parties and how the law applies to the facts that you will be called upon to decide.

The trial may begin with opening statements by the lawyers as to what they expect the evidence to be. What is said in opening statements is not to be considered as proof of a fact. However, if a lawyer admits some fact on behalf of a client, the other party is relieved of the responsibility of proving that fact.

After the opening statements, the Plaintiffs will

introduce -- the Plaintiff will introduce evidence. The defendant may then -- correction. The Plaintiffs will introduce evidence, and the Defendants may then introduce evidence. There may be rebuttal evidence after that.

The evidence may include the testimony of witnesses who may appear personally in court, the testimony of witnesses who may not appear personally but whose testimony may be read or shown to you, and exhibits such as pictures, documents and other objects.

There may be some questions asked or evidence offered by the parties to which objections may be made. If I overrule an objection, you may consider that evidence when you deliberate on the case. If I sustain an objection, then that matter and any matter I order to be stricken is excluded as evidence and must not be considered by you in your deliberations.

When the trial is in progress, I may be called upon to determine questions of law and to decide whether certain matters may be considered by you under the law. No ruling or remark that I make at any time during the trial will be intended or should be considered by you to indicate my opinion of the facts.

There may be times when the lawyers come up to talk to me out of your hearing. This will be done in order to permit me to decide questions of law. These

conversations will be out of your hearing to prevent issues of law which I must decide from becoming mixed with issues of fact which you must decide. We will not be trying to keep secrets from you.

Justice requires that you keep an open mind about the case until the parties have had an opportunity to present their cases to you. You must not make up your mind about the case until all the evidence and the closing arguments of the parties have been presented to you.

You must not comment on or discuss with anyone, not even amongst yourselves, what you hear or learn in the trial until the case is concluded and then only when all of you are present in the jury room for deliberations of the case under the final instructions I give to you.

During the trial, you should not remain in the presence of anyone who is discussing the case when the court is not in session. Otherwise, some outside influence or comment might influence a juror to make up his or her mind prematurely and be the cause of a possible injustice. For this reason, the lawyers and their clients are not permitted to talk with you until the trial is completed.

Your deliberations and verdict must be based only on the evidence and information presented to you in the proceedings in this courtroom. Rules of evidence of procedure have developed over many years to make sure that

all the parties in all cases are treated fairly and in the same way to make sure that all the jurors make decision in this case based only on the evidence allowed under those rules and what you hear or see in this courtroom.

It would be unfair to the parties to have a juror influenced by information that has not been allowed into evidence in accordance with those rules of evidence or procedure or to have a jury influenced through the opinion of someone who has not been sworn as a juror in this case and heard evidence properly presented here.

Therefore, you must not conduct your own research or investigation into any issues in this case. You must not visit the scene of any of the incidents described in this case. You must not conduct any independent research or obtain any information of any type by reference to any person, textbooks, dictionaries, magazine, use of the Internet or other means about any issues in this case or any of the witnesses, parties, the lawyers, medical or scientific terminology or evidence that is in any way involved in this trial.

You are not permitted to communicate, use a cell phone, record, photograph, video, email, blog, text, tweet or post anything about this trial or your thoughts or opinions about any issue in this case to any other persons, to the Internet, Facebook, Myspace, Twitter or any other

personal or public website during the course of this trial or at any time before the formal acceptance of your verdict by me at the end of the case. If any of you break these rules, it may result in a miscarriage of justice and a new trial may be required.

After all the evidence has been presented, you will receive my final instructions. They will guide your deliberations on the issues of fact that are for you to decide in arriving at your verdict. After you receive my final instructions, the lawyers may make closing arguments.

For those closing arguments, the lawyers have the opportunity to direct your attention to the significance of evidence and suggest the conclusions that may be drawn from the evidence. You will then retire to the jury room for your deliberations. It will be your duty to select a foreperson, decide the facts and arrive at a verdict.

When you enter into your deliberations, you will be considering the testimony of the witnesses as well as other evidence. In considering the weight and the value of the testimony of any witness, you may take into consideration the appearance, attitude and behavior of the witness; the interest of the witness in the outcome of the case; the relation of the witness to any of the parties; the inclination of the witness to speak truthfully or untruthfully; and the probability or improbability of the

witness' statements. You may give any evidence or the testimony of any witness such weight and value as you believe the evidence or testimony is entitled to receive.

All right. At this time, counsel for the Plaintiffs, you may make your opening statement.

MR. CRONIN: Thank you, Judge.

OPENING STATEMENT ON BEHALF OF COUNSEL FOR THE PLAINTIFF

MR. CRONIN: Ladies and gentlemen of the jury, good afternoon.

THE JURORS: Good afternoon.

MR. CRONIN: I've not had the opportunity to introduce myself to you yet. My name is Tim Cronin. And along with John, who you got to meet for a few hours yesterday and today, we have the pleasure of representing Brian and Michelle Koon, who have been here in the courtroom.

Now, you've been very patient with us so far. And I know you all have places you'd rather be. But I'm going to ask you to bear with us because this is an important and timely case. The decisions that you make in this case can make a real difference.

This case is about the over prescription of opioids, as you probably well know by now, by the defendants, Dr. Walden and St. Louis University, to my

client Brian Koon who became a drug addict. Prescription opioids are pain pills like Vicodin, Percocet, OxyContin, Fentanyl. Heroin is also an opioid, but that's not the type of opioid we're talking about in this case, but it affects the receptors in your brain the same way.

Ladies and gentlemen, our country is in the middle of a prescription opioid epidemic. It's an epidemic that is claiming the lives of 165,000 Americans since 1999. Upwards of 20,000 people are dying every year from it. Prescription opioid overdoses have quadrupled since 2000. And, again, we're not talking about heroin with these numbers. We're talking about prescription opioids that are prescribed by physicians.

You probably saw on the news, Prince just died from a prescription opioid overdose. Since 2002, deaths from prescription opioids have surpassed those of cocaine and heroin combined. Over 2 million people in the U.S. suffer from substance abuse disorders related to prescription opioids. The number of prescriptions filled in our country every year is equal to our population. Not the number of pills; the number of prescriptions.

Physicians have called it the worst man-made epidemic in the history of modern medicine. And the evidence will bear out that it is caused by the type of conduct that you're going to see in this case.

MR. VENKER: Your Honor, may we approach?

THE COURT: You may.

(Counsel approached the bench, and the following proceedings were had, out of the hearing of the jury:)

MR. VENKER: I just want to make sure, Judge, we're making a record on the objection to the opioid epidemic. I think you gave even the earlier rulings for Plaintiffs to go into prescription medicines in this issue, and I'm not sure that I'm hearing that kind of focus here. But I want to renew our objection to this whole area of opioid epidemic.

MR. CRONIN: I think I made it very clear that I was talking about prescription opioids and not anything else.

THE COURT: I'm going to overrule your objection, but let's keep it tight.

MR. CRONIN: Okay.

(The proceedings returned to open court.)

MR. CRONIN: Ladies and gentlemen, Brian Koon will tell you that the reason we are here is to ask you to stop it. The well-known risks of opioids are dependency, addiction, overdose, respiratory failure and death. These are things the defendants knew going in.

The type given to Brian are classified as Schedule II narcotics by the DEA. Now, one of them at the time was a

Schedule III, Vicodin, but it has since been bumped up to a Schedule II. Schedule II means that they are highly addictive and by definition have a high potential for abuse potentially leading to severe psychological or physical dependence.

It is undisputed that the defendants in this case prescribed their patient over 37,000 Schedule II narcotic opiate pills for over four years or undiagnosed lower back pain.

Some opioids have different degrees of strength. So to compare apples to apples, we try to convert them -- or we do convert them to what we call morphine equivalent doses. So if you hear the term MED, it means morphine equivalent dose.

As low as 40 milligrams MED of opioids can be a lethal dose for some people. Every guideline that we have found that makes dosing recommendations says not to go over around 100 milligrams a day and not to go longer than 90 days. Those are the recommendations they make.

One of the defendants' experts you will hear wrote a letter to the FDA I think in 2012 stating that opioid labels should have a maximum daily dose of 100 milligrams MED for maximum duration for 90 days. So you're hearing some consistency.

The defendants in this case put Brian on opioids

for four and a half years. And during 2012 alone, they had their patient on 1,500 milligrams morphine equivalent dose per day. 1,500 per day. That is not disputed in this case. Forty pills a day is what Brian was being given by his doctor.

In a recent study, one in 32 patients escalated to doses over 200 MED die of an opioid overdose. And we're talking about over 1,500. And the defendants are still doing it. They still think it's okay to do that. They have other -- Dr. Walden will tell you that he has other patients on that much. And you are here to decide if that's okay.

Can a physician prescribe dangerous, highly addictive narcotics without regard to the risks and harms? Is the sky is the limit mentality acceptable? Or is this something that we need to put an end to? And those are the decisions that you're here to make.

Now, a lot of information is going to get thrown at you. Too much information. And some of it is going to be more important than others, and a lawyer's job -- the attorneys for both sides' job is to try to put that information together and present it to you in a way that's digestible, which is basically quite simply to try to tell you the story of what happened. So let me tell you a little bit about the parties in the case.

Dr. Henry Walden is an internal medicine doctor,

and as you know by now is employed with St. Louis University. Dr. Walden teaches at SLU Medical School, and his primary care office is just off of South Grand by Cardinal Glennon.

From 2001 to 2012, my client, Brian Koon, was a patient of SLU and Dr. Walden. In 2001, Dr. Walden became Brian's primary care doctor. Brian was 30 years old at the time. He had survived a battle with cancer in his twenties and in his words had been given a second chance at life.

He went back to school. He went to Ranken Technical College and got a degree in heating and cooling, and I think that was in 1998. And when he got out, he was fortunate enough to get a job right away with the City of St. Louis in the Parks Department, which is where he works to this day. Brian is employed in the same job as a mechanical maintenance worker for the City Parks Department since 1998.

Brian -- and you've seen Michelle. Brian and Michelle first met each other when they were younger, but then there was a gap before they met again. They ran into each other again in around -- or in 2005. Romance blossomed, and they started dating, and they got married in 2006.

According to Michelle, Brian was, quote, the sweetest, most soft-spoken man that she had ever met. They

had their first and only daughter Emily who was born in July of 2009. But by that time, something was already changing in their life together, which is what you're going to hear about in this case.

And as we go through the evidence, there's a phrase that I want you to remember. And that phrase is conscious disregard for safety. There are a couple very simple safety rules that everyone in this case I think agrees with that will provide some context for what happened. And I want to show them to you. Can everybody see that? Okay.

Above all else, a doctor must serve the highest interest of his patient. Doctors, just like everybody else, must never needlessly endanger their patients.

Ladies and gentlemen, those are very simple safety rules. And if they're broken, patients and the public are put in danger. And if they're broken and somebody gets hurt, the person breaking them is responsible for the harm that they cause.

The next rules about prescribing opioids that, again, I believe everyone agrees with. Opioids should not be given if safer alternatives are available. The lowest possible effective dose of opioids should always be used. Opioids should be used for the shortest time necessary.

And finally, we have a couple rules about

monitoring patients that are on opioids. I'll get out of your way. First, a physician must continuously evaluate the safety and effectiveness of opioid therapy. And second, the doctor must monitor the amount of opioid narcotics given to a patient and monitor for signs of misuse or addiction. The reason being we know that those are the risks of it.

Prior to 2008, as I told you, Brian had been treating with Dr. Walden since 2001. Brian had acute back pain a few times. It always resolved after some chiropractic visits or a few days of pain medication. Dr. Walden had treated him for a few instances of back pain.

In 2008, at the page of 36, January, February, Brian's back started hurting again. It was low back pain. Low back pain is a common ailment that affects millions of people all over our country. It's one of the leading reasons people go to the doctor. Brian tried the chiropractor, but that didn't quite clear it up so he went to Dr. Walden. Dr. Walden had been treating him for seven years at that point, and Brian trusted him to know what the right treatment for him would be.

Dr. Walden never, you will hear, determined the precise cause of Brian's low back pain, but I believe he will testify he thought it was similar to a low back sprain. The expert physicians from both sides agree that managing low back pain requires a multi-prong approach. You don't

just try one thing.

There were dozens of treatment options available to Dr. Walden. And after only a week of trying conservative muscle relaxer and Advil, and this is not in dispute in the case, Dr. Walden chose to place Brian on long-term standing doses of chronic narcotic opioid pain medication for an unfixed duration.

Dr. Walden didn't tell his patient to take up any kind of exercise to maintain strength and flexibility or suggest massage therapy, heat, ice, acupuncture, meditation, rest. He didn't send him to physical therapy. Just opioids.

Three months later in May of 2008, he referred his patient to an orthopedic surgeon for a consult with a neurosurgeon. He had already had Brian on opioids for three months at that point. An MRI was done. The MRI showed some minor lumbar arthritis. Something a lot of people, I'm sure, are familiar with and have dealt with.

Both the orthopedic surgeon, Dr. Place, and the neurosurgeon, Dr. Heim, concluded that there was nothing wrong with Brian's back that was severe enough to require surgical intervention. Dr. Place then referred Brian to physical therapy, which Brian did, and it provided some relief.

The neurosurgeon, Dr. Heim, left open the

possibility of considering a fusion if the symptoms worsened and referred Brian -- he referred Brian to a pain management specialist. Pay close attention because it was not Dr. Walden who referred Brian to physical therapy or pain management. That was the surgeons that he went to see.

The pain management special list, Dr. Christopher, gave Brian some spinal injection therapy in July and August of 2008 and then another one in March of 2009. I know this is a lot of information already, folks. You're going to get to hear all about it from the witness stand.

None of these other doctors I just mentioned prescribed or recommended opioids. And throughout this entire time in 2008 and in to 2009, Dr. Walden kept increasing his patient's dose of opioids.

After 2008, Dr. Walden didn't send Brian anywhere else or try anything else for the back pain. I think he sent him to a rheumatologist, actually. I misspoke. But mostly, just bigger and bigger doses of opioids.

And over the course of next four years, despite never determining the cause of the pain, Dr. Walden prescribed his patient over 37,000 opiate pills. He had him on three different types of opioids at once, Vicodin, oxycodone and OxyContin. Doctors control the access to these medications. Patients don't have prescription pads.

Dr. Walden is going to tell you in this courtroom,

I believe, that he was aware prior to his treatment of Mr. Koon that as a general rule, a doctor should not prescribe more than 120 milligrams per day, which is pretty close to that around a hundred range that we talked about earlier. He will tell you that he thinks it was okay for Brian and some other patients he treats. But I want you to remember the number that he agrees to is a good guideline, 120.

In 2008, Brian's average daily dose in the first year that he was on them was about 50 milligrams per day. 2008. Now, the following year, Dr. Walden made a four-fold increase. Up to an average daily dose of 208 morphine equivalent milligrams per day. That number is undisputed. It's almost double the number that he thinks is a good general guideline for a maximum.

In 2010, he nearly tripled that to 545 morphine equivalent milligrams per day. In 2011, Dr. Walden more than doubled it again hitting 1,173 morphine equivalent milligrams per day. Until finally, in 2012, Dr. Walden was prescribing Brian an average daily dose of 1,555 morphine equivalent milligrams a day of narcotics. That's over 13 times higher than his own general guideline that he agreed to. Those are the undisputed facts of this case, ladies and gentlemen. Nobody's going to tell you that those numbers are wrong.

Mike, can you pull up exhibit -- Exhibit 37, please? This is -- the numbers from this exhibit, ladies and gentlemen, are also not disputed. They're agreed to by the parties.

The top shows the number of days for each year that Brian was on the opioids that Dr. Walden was prescribing because in 2008 he didn't get on them until the end of February, so we have 307 days. 365 days for the next three years. And then in 2012, it's 255 days up until Brian checked himself into rehab at Centerpoint Hospital. You can also see the total milligrams for each of those years that were prescribed to Brian by his doctor.

Can you go to the next section?

These are the numbers I just showed to you. This is the average daily dose morphine equivalent per year. There's some decimal points I rounded down for the board so it wouldn't be too cluttered, but we have just seen those numbers on the boards.

This is the total number of pills that Brian was prescribed by his physician in each year. 2011 you can see it's higher 13,542 because he was on them for the whole year. Whereas in 2012, he stopped in September.

Go to the last section. This is the average number of pills per day. 2011 is 37 pills a day. A combination of three different types of opioids. I don't

know how you keep track of that schedule. 2012, it's almost 40 pills a day. We're not awake 24 hours a day. So 40 pills over 16 hours.

The last exhibit, ladies and gentlemen, and I'll just show it to you, this is just a bar graph which is the numbers I just showed to you. This is the average daily dose in 2008, '9, '10, '11 and '12, and I'll point out that a hundred is here. We got up to here.

Inevitably, Brian was guided by his doctor into the throes of drug addiction that he could not control or recognize. And you're going to hear about what it did to his life and to his family. And it's a tough testimony to hear, especially from Michelle, his wife.

Early on in the first year, 2008, before he sunk too deep, Brian went to Dr. Walden. And he went to his doctor with a desire to have Dr. Walden wean him off the pills. That's the communication Brian had with his doctor. He told him he wanted to wean off the pills. If that's not a clear communication that you think it's a problem, I don't know what is. Dr. Walden didn't do it.

There are several entries in the records from 2008 to 2010 where Dr. Walden discusses weaning with his patient Brian off the pills, but he never does it. He admitted he began -- in his deposition he admitted he began to think it was a good idea to reduce Brian's dose and begin to wean him

off the medication on and before February of 2010. But from 2008, 2009, 2010, 2011 to the middle of 2012, Brian's dose was never reduced. To the contrary, it was chronically upped and escalated.

Can you pull up Exhibit 36?

This is also a chart, I believe, that is agreed to. This is all the prescriptions that Brian had filled, it comes from his pharmacy records, by Dr. Walden from his office to Brian. And I know it's pretty small, there's a lot of them on there, we'll go through them. But if we can kind of scroll through the pages, you see 2008, 2009, you get into 2010. We keep going. We hit 2011, then we hit 2012.

And what I'd like, Mike, if you can do, is take April 3rd, 2012 through May 5th, 2012. I just want to blow up a month in 2012.

This prescription chart, ladies and gentlemen, tells a story of constant early refills and increased dosages of three different types of narcotics. And if we just look at April and the very beginning of May, 2012, Dr. Walden prescribes Brian 600 pills of 15-milligram oxycodone on April 3rd. 240 pills of 60-milligram OxyContin on April 3rd. 180 pills of hydrocodone, which is, ten is the hydrocodone and then the second number I think is acetaminophen on April 7th.

And then we see the same three prescriptions, again, less than a month, April 30th, 600; April 30th, 240; May 5th, 180. This is just a snapshot at the prescriptions. We're going to go through Dr. Walden's own records with you, and they tell a very clear and scary story. You'll have a chance -- there's too many of them for me to go through them with you now, but you'll have a chance to see what is, and more importantly what is not, in those medical records.

You will hear from the doctor that he is and was aware that prescribing any amount of narcotic opiates creates a probability of dependency and addiction, and that higher doses and longer usage both result in an increase in that risk which makes common sense.

You will hear that he was aware that the dosage prescribed to Brian in 2010, 2011 and 2012, which you've seen the numbers, created a probability of dependency and addiction. And you will hear him agree that Brian became dependent on the drugs.

And let me tell you what else you're going to hear. Dr. Walden has up to five other patients like Brian on equivalent doses of opioids, and we'll see if we can figure out a reason.

We're going to present information for your consideration about Dr. Walden's compensation plan and about St. Louis University's relationships with pharmaceutical

companies that manufacture and sell opioids and clinical trials that they do. And the evidence, I think, ladies and gentlemen, will show that Dr. Walden wasn't trying to figure out what was really going on with Brian and didn't take a second to think about what he was doing instead of just giving higher and higher prescriptions.

Because here's something else you're going to learn. All these prescriptions that he was writing to Brian, the constant rewriting of new, bigger prescriptions, Brian was going through his pills nearly every single prescription early. And that is something his doctor was aware of every time because he couldn't get a new early prescription without telling his doctor he's out of his old one and his doctor gave him a new one and often for more.

He was often a week early on a 30-day cycle for all three types of pills. Brian is not going to deny that he couldn't control himself. He's going to tell you that, and he's going to tell you what this addiction was like and what he was able to recognize and what he wishes he could have recognized sooner and what he did when he did recognize it.

A phone call would be made to Dr. Walden's office. They would tell a secretary they went through all the pills early, to find out what they should do with their doctor. And Dr. Walden wouldn't ask Brian to come in for an office

visit or ask him to inquire what was going on. A nurse would call Brian or his wife back and tell them that a new script was ready to be picked up in Room 207, sometimes with higher doses. Without an office visit. For six months.

You will repeatedly see new prescriptions for higher doses written while the current prescription period has not expired. Done over and over and over again without Brian seeing his doctor or without the doctor even talking to his patient. You remember that phrase I asked you to remember? Conscious disregard for safety?

Ladies and gentlemen, I'm just a lawyer. I'm not a physician. I'm not the one that's going to be explaining to you what's wrong with the defendant's conduct. I'm just here to tell you what the facts are and to make sure they get presented to you on the witness stand. I'm not the one that can show or explain to you how this conduct deviates from the standard of care for physicians.

We hired a Yale physician to look into this, and he will be here, I think you're going to meet him today to tell you what he sees. His name is Dr. Paul Genecin. He is a board certified internal medicine physician just like the defendant Dr. Walden. He is the Director of Yale Health, a clinical associate professor of medicine in the Department of Medicine at Yale, an attending physician at Yale New Haven Hospital. He practices in an outpatient clinic and

treats close to a thousand patients on an outpatient basis. He also supervises a neighborhood clinic that provides care to indigent patients.

Dr. Genecin is going to explain to you from the witness stand how dangerous these opioids are. He'll explain that long-term opioid prescriptions are simply not appropriate for back pain. A finite prescription for a few days for an acute back injury is fine. There's an end point. And that's to be a reasonable amount. A few days or a week after a back surgery or a few weeks is fine. There's an end point. And it's because you just had an acute injury.

But chronic prescriptions for years for undiagnosed back pain is never acceptable, and Dr. Genecin's going to explain that to you. He will tell you there's no scientific evidence that it provides any benefit to those patients and that it in fact causes patients a world of harm. In fact, the defendants' own experts agree that there is no long-term study showing benefits of chronic opioid prescriptions. None. Because once you prescribe someone opioids for chronic low back pain that you don't expect to go away, you are making a decision to keep that person on powerful narcotics for the rest of their life. And as you develop a tolerance, you just have to keep going up on them.

Dr. Genecin's opinion is that each and every

prescription that Dr. Walden wrote was in flagrant violation of the standard of care and prescribed with no legitimate medical purpose. Placing non cancer patients on long-term standing daily doses of chronic opioids should simply not be done. Dr. Genecin will tell you.

He'll explain to you that even in the rare cases that long-term opioid therapy is appropriate, and there are cases where it is appropriate, such as when a patient has terminal cancer or chronic pancreatitis or sickle cell anemia, the CDC recently published guidelines, and they were published this year, that recommend doctors never prescribe more than 90 milligrams a day and never chronically prescribe opioids beyond a duration of three months. Notice, those are basically the same numbers that we're hearing throughout the case.

And Dr. Genecin will tell you that while the CDC only recently did publish those guidelines, that range for a maximum daily dose of around a hundred and for 90 days, has been the standard of care for physicians for years and years. And it shows how outrageous the doses here are. And yet I believe the defendants are going to take the position in this trial that to this day it is not only acceptable to exceed those recommendations, but vastly exceed them with no maximum number in sight.

Dr. Genecin will tell you that Dr. Walden

prescribed excessive and then colossal doses of opioids to a patient that was not benefiting from them because it was not controlling his back pain. It gave him some relief, but his back pain wasn't going away. He was still having functional problems.

He did continue to work, and that's not disputed in this case, and that's why Brian is not making a lost wages claim. But Dr. Genecin will tell you it's clear from simply reviewing the medical records that he was actually injuring Brian from chronic intoxication with dangerous drugs. He'll tell you Dr. Walden failed to appropriately weigh the risks and benefits to the patient, which was a concept that was discussed with you in voir dire.

He will discuss with you the huge risks that Brian was exposed to, many of which came to fruition, and that the public was actually placed at risk by putting anybody on that massive amount of narcotics and sending them out.

Dr. Genecin will tell you that Dr. Walden missed or ignored clear signs that Brian was dependent and addicted to opioid narcotics. There are instances where Brian called his doctor; and it's clear he was going through withdrawal, having shakes, having chills and tells the office, I took more pills and then I felt fine. This is in '08 or '09. All the textbook signs were present. Repeated early refilling prescriptions, a week early or more almost every

single time. Constantly needing higher and higher doses to achieve the same relief. Telling his doctor instances in which it's causing problems.

Dr. Walden continued to prescribe them. Other physicians refused to get involved in the treatment when they saw it. Pharmacies refusing to fill prescriptions. Dr. Walden simply sent him to another one and continued to prescribe them.

As we addressed in the beginning, we have a prescription opioid epidemic. SLU knows about this epidemic. The corporate rep acknowledges that he knows about it. And the evidence will be that there are primary care doctors out there like Dr. Walden that are prescribing massive amounts of opioids without having the proper knowledge and training to do so and now here we are.

The huge increase in prescription opioid misuse mirrors the increase in prescriptions by physicians. Dr. Genecin will tell you that this kind of prescribing is what kills people. He has seen doctors in other states investigated by the DEA or had their licenses under review for prescribing far less. He reviews such cases for the State of Connecticut. It is a miracle that Brian isn't dead.

You're going to hear from a corporate representative of St. Louis University, and you're going to

hear that SLU does absolutely nothing to monitor the amount or the dosage of opioid prescriptions given to its patients. Nothing.

Dr. Genecin will tell you that patients on opioids need to be monitored, and the standard of care requires a medication management system be in place. He will tell you that Dr. Walden prescribed narcotic opioids without setting any parameters, any goals or a finite end point. He failed to monitor or inquire into the actual facts of what was going on in Brian's life as a consequence of these drugs. He failed to assess how Brian was tolerating them or how they were interfering with his social or family life.

And remarkably, Dr. Walden did not at any point during these four years -- you've probably had pain scales. Five out of ten, seven out of ten, eight out of ten. He didn't do that one time. Not once did he quantify what his pain level was to see if it was getting better or getting worse.

And Dr. Genecin is even more troubled by the fact that there are vastly more prescriptions than visits. Meaning that to get narcotics, all that was needed was a phone call, come to Room 207 and pick up a new prescription.

The real beginning of this story, ladies and gentlemen, starts and continues to this day with Brian and Michelle. While the defendants' involvement with them has

ended, their story goes on and will continue to go on. They are going to continue to live with the repercussions long after we leave this courtroom.

You're going to hear from both Brian and Michelle on the witness stand, and they will tell you what their life was like before this, how happy they were, how in love they were, how they spent their time together. You're going to get to know them, their dreams about the future. And then you're going to hear about what this did to them and not just Brian, their family, both of them. Brian was pushed deeper and deeper into an opioid addiction, becoming a shadow of his former self.

Dr. Genecin put it simply with these amount of opioids, Brian became the functional equivalent of a zombie. His brain was literally marinating in narcotic analgesics.

Brian, as I said, somehow continued to do his job. He continued to go to work, but his foreman knew that there was a pain pill problem, and Brian's going to tell you about it. He gave Brian simpler tasks. But Brian's performance reviews that had been glowing before 2008, with citizens calling in complimenting about he was the most wonderful person from the Parks Department that ever helped them. Beginning in 2008, they go down. They go down steadily through 2012. And then he gets off them, and in 2013 is the first year Brian gets a merit raise since 2008.

Brian's foreman also took him off the road, wouldn't let him drive a city truck on the road for fear of Brian hurting another person. He had somebody else drive Brian around so that Brian wasn't doing it.

Michelle is going to be tough to listen to. She paints a terrifying picture of Brian's downward spiral. She explains his sole focus during those years became the pills, getting the pills, taking the pills, refilling the pills. Not focused on her, and how that hurt her as a woman.

As the prescriptions piled up, they stripped away everything that made Brian Brian. Everything that made him human. His ability to feel emotions like joy, love, happiness and to interact with others, including his newborn daughter, all taken away by the opioids prescribed by his doctor.

In her own words, Michelle's whole life was turned upside down. She spent sleepless nights lying next to her husband wondering if he was still breathing because when people overdose on these things, that's what happens, you just stop breathing. Sometimes she would awake to find him passed out on the front porch with a lit cigarette in his mouth. Another time Brian was in the bathroom trying to flush books down the toilet. Didn't know what was going on.

She felt alone, unwanted, unloved, and like she had lost the man that she had married because she had. And

while Brian is not in the same place now that he was then, they haven't been able to get it back. And you're going to hear that they just separated this year because Michelle was holding on to what existed before 2008 and despite their efforts, they haven't been able to get back to where they were.

Brian became dangerous to himself and to the public. One time he fell asleep at the wheel while his wife and daughter were in the car. Michelle did her best to hide Brian's medication and get involved in controlling his addiction by giving him a day's supply at a time and locking up the rest, but Brian would find them, sometimes taking a month's worth of medication in two weeks. Dr. Walden was only a phone call away.

Michelle didn't know what to do. She would call to say Brian went through his medicine early, and a nurse would call back and just say to pick up another prescription. Don't bring him in for an office visit, no call from the doctor. According to Brian's doctor, he needed the pills. That's how Brian felt, my doctor says I need the pills to keep working. And sometimes Dr. Walden prescribed morphine to fill in the gaps when he couldn't write another prescription earlier. That happened four times.

Brian doesn't remember much of these four years.

He remembers some things that were particularly painful. He remembers some things early on more so than later things. But most of his memories come from photographs and from his wife. He was mostly absent from his family's life. He doesn't remember holidays. He barely recalls the birth of his daughter. He doesn't remember her baptism. He doesn't remember her taking her first steps.

He wasn't a father to her for the first three to four years of his life. And he's going to tell you about that, and it's going to be hard for him, but he's going to tell you about it. And now he has to live with that forever. He's doing his best, and they're doing their best to mend their relationship. But those first three, four years are pretty important.

What Brian does remember is the feeling of losing control and his inability to do anything about it. He couldn't recognize or admit that there was a problem until it was too late.

He remembers -- this is graphic. Opioids cause constipation. He remembers having to reach around, put his fingers up his rectum and physically pull the hardened stool from his body due to opioid-induced constipation all the time. Dr. Walden never had Brian on a bowel regimen ever.

Brian and Michelle did not have sex for years. None. Brian did have some erectile dysfunction issues

before 2008; he acknowledges that. But it was nothing like what happened once he was on all these pills. He couldn't be intimate with his wife. His testosterone went from the low range of average, and it was at the low range of average before, and then it dropped to the basement.

In April of 2012, Michelle called Dr. Walden to say that something had to be done, that this had to stop. She wanted a referral to a pain management specialist to see what should be done, and Dr. Walden did not get back to her for two weeks. And remember that was Michelle's request to go to a pain management specialist, not a Dr. Walden idea.

When Dr. Berry saw Brian, he couldn't believe the amount he was on and would not get involved with his opioid treatment. He assessed him with an opioid dependency, told him to investigate a treatment program. He ordered more MRIs and x-rays, which had not been done for four years. They show a disk bulge and nerve root impingement.

Dr. Barry gave Brian some epidural injections to help and referred him, said you need to go see a psychiatrist for counseling for your disorder, which is also something Dr. Walden never did. Now after that, Michelle ended up finding a psychiatrist on her own, finding one for Brian, and getting him to see one and I'll tell you about her in a second.

But after that, Michelle called Dr. Walden's

office on April 30th, 2012 to beg him to wean Brian off these pills. He didn't call her back for two weeks. Then five days after she finally did get to talk to him, Dr. Walden wrote Brian three more prescriptions for the same amount as before. 240 OxyContin, 600 oxycodone, 180 Vicodin. And according to his records, he only expected them to last 22 days.

Three days after that, Michelle took Brian to Dr. Walden's office to talk to him. Brian sat in Dr. Walden's office sobbing, begging for help, asking to be taken off the pills. And it is in the SLUCare records that Brian told him, it is running my life, and Dr. Walden didn't do it. Didn't reduce it.

Brian then went and saw the psychiatrist, Dr. McKean that Dr. Barry recommended and Michelle found. And that's not something, again, that Dr. Walden recommended. Dr. McKean said she would try to connect with Dr. Walden and collaborate to get Brian off the opioids, but it still didn't happen.

And shortly after that in the beginning of September of 2012, Brian stopped seeing Dr. Walden completely and checked himself into rehab. Brian is going to tell you about the withdrawals he went through and how he felt like the muscles were literally pulling off his bones. And he'll tell you what led him to decide that he just had

to cut it off and go to rehab. In his own words, he just remembers being in a world of hurt and that I couldn't see any light.

Brian remembers sitting on the edge of his bed with a loaded gun in his mouth because he saw no way out. And luckily the thought of his daughter kept him from doing it, and he went and got help. Help that Dr. Walden didn't give him.

Brian is going to tell you what he went through in rehab treatment, how difficult it was, how difficult it was encountering his family again when they came to see him at Centerpoint and after. You'll hear Michelle talk about her two visits to see Brian at Centerpoint.

One of them, the second one, was their sixth wedding anniversary that they spent at a rehab center together, and Michelle brought Emily to see Brian. And they went outside and Emily started running and she was talking. And Brian turned to Michelle and said, I didn't know she could do that. Michelle had to tell him she had been doing those for a year. He didn't know his daughter could walk or talk for the past year. He broke down. He wept. He couldn't take it. And they had to leave. It was just too much for him. He was filled with regret and shame, and how do you make up for that?

Since Brian got out of Centerpoint, he's had four

back surgeries, two for his cervical spine and two for his lower back. One of them, a fusion in his neck, was just a month after getting out of rehab in 2012. He had no idea. It was masking his pain. He had no idea his neck was hurt that bad.

Then he had two discectomies in his lumbar spine. He had one in 2013 and one in 2014 and one discectomy in his neck, and I think that was in 2015. I may have those mixed up, but it was four surgeries, two to the neck and two to the lumbar. And they helped relieve his pain. Brian is not taking the medication that Dr. Walden had been giving him. He has been given pain medications and courses of opioids following his surgeries prescribed by his surgeons. But they were finite periods. They've never gone more than 90 morphine equivalent dose on any given day, and they average about 30 or 40 per day, for the days he was on them.

One of those times, Brian started feeling himself getting pulled back in and that he couldn't take them as prescribed, and he went back to his doctor and said you've got to take me off.

Brian hurt his toe earlier this year. He was given 5 milligrams of Vicodin pills. He took a couple for the first two days to sleep, and then he threw them out.

Brian currently takes 30 milligrams of morphine equivalent dose of Tramadol. He's been on it for a year,

the same dose, which is technically an opioid and has similar pain receptor effects, but it's not a narcotic like the ones he was getting prescribed before. And it's two schedules lower on the DEA's classification schedule than OxyContin, Vicodin and oxycodone. And Brian's had no problems. The abusing pills part of his life is over, but the consequences aren't.

We hired a psychologist in the area, Dr. Mary Fitzgibbons, to evaluate Brian. She's going to come and talk to you and she'll be on the witness stand. Dr. Fitzgibbons has a Ph.D. in counseling and is a licensed psychologist. She does not treat people herself for substance abuse. She is not treating Brian and is not offering opinions about treatment of substance abuse. What she does is give a diagnosis of mental health as a psychologist.

She evaluated him and diagnosed him with any mental health illnesses as a result of the opioids prescribed to him by the defendants. She met with Brian seven times and made her diagnoses. She has over 30 years experience and many hours taking training in diagnosing mental health disorders.

She diagnosed Brian with opioid withdrawal, that he had experienced when he got off of them, and major depressive disorder and opioid use disorder. Brian did have

some depression bouts before 2008 but not like what he went through towards the tail end of this and what he went through since.

And this is important. The defendants' addiction expert, Dr. Gunderson, agrees with all three of those diagnoses made by the Plaintiffs' expert, opioid use disorder, opioid withdrawal and major depressive disorder.

Their addiction specialist will also tell you the following: Addiction is not a moral or mental weakness; it is a brain disease that causes permanent neurological effects on the brain. Opioid addiction alters circuits in the brain including those responsible for mood, behavior control, judgment, decision making, learning, and memory. Opioid addictions strip away a person's ability to feel emotions, joy, love, happiness. He also agreed that opioid addictions tear apart families, create trust problems between spouses, make spouses feel neglected and can result in child neglect, create emotional distance between the addict and his children and potentially harms that relationship permanently. And often, even after a parent gets off of the drugs, they forever live with the guilt how they may have emotionally harmed their child during those years.

And Dr. Gunderson also agrees that all those things appear to have happened to Brian Koon and his family.

That's the defendants' addiction expert. He will explain the scars this has left on Brian and his family. He is ashamed that he became an addict. He knows he let his family down. All trust has been destroyed between himself and his spouse.

Dr. Fitzgibbons explains Brian has difficulty being close with people. He feels isolated especially from his wife and daughter. They've not been able, as I pointed out to you, to return to where they were before, and they've separated. Emily now spends the weekends with Brian, and they're finally starting to develop a better father-daughter relationship.

Let me tell you -- you know who we are suing, and let me tell you why. There are three claims in this lawsuit against Dr. Walden and SLU. And under the law, St. Louis University is responsible for Dr. Walden's conduct because he is their employee.

The first claim is for negligence against Dr. Walden and SLU brought by Brian himself, and it includes four subparts. That the defendants failed to weigh the risks and benefits of prescribing opioids, that defendants over prescribed opioids, that defendants failed to monitor the opioid treatment and failed to assess for dependency or addiction, and that they were negligent in all four of those ways. And you've heard what the evidence will be on those

again, and I won't repeat it to you.

The second claim is brought by Michelle. She's a Plaintiff in the case. It's called a consortium claim, and it is for the harms and damages that Michelle sustained as a direct result of the injuries to her husband.

And the third claim is for punitive damages for consciously disregarding the safety of Brian and the public. And the Judge, as has been pointed out, may allow us to submit that claim to you at the conclusion of the evidence.

One of the questions the Judge will give you to deliberate on is how much money it will take to make up for the harm that the defendants did to Brian and Michelle. Those are called compensatory damages. And when figuring that out, the only things that you're allowed to take into account is the extent of the harms and losses they suffered, nothing else. No outside reasons.

We're not showing you, as Mr. Venker pointed out, what they went through to get your sympathy. We're showing you what they went through because we have to show you what they went through in order for you to do your job.

Brian's harms and losses can be broken into a few categories. The immediate injuries he suffered, including becoming dependent and addicted, losing four years of his life, the withdrawals he went through, the damage to the relationship with his wife and child. And then second, the

consequences of those injuries. Including pain, suffering, emotional difficulties, concerns about the future, what this did to Brian himself, his human losses, the mental anguish that he has gone through and will continue to go through.

The same holds true for Michelle. Michelle didn't take a single pill. Nobody in this case is going to suggest that Michelle was taking any of Brian's pills. But she went through four years of hell, and she had to do it with sober eyes. She watched it happen. She watched it tear their life apart while she was trying to take care of her little girl. This was the first time she was a mother. She went through as much or more than Brian did, and she still lives with the lingering consequences to this day.

A verdict is supposed to speak the truth. That's what the word means, in fact. The truth that a verdict must speak is what it will take to equalize and balance the harm that the conduct caused.

And finally, because of the defendant's conduct in this case, in addition to compensatory damages, the Judge may allow you to consider punitive damages. They apply if the defendants consciously disregarded or showed indifference to the safety of others. The evidence will be clear and convincing that they did. They knew the risks. They ignored them. The purpose of punitive damages is to punish the defendants' conduct and to deter this type of

conduct both by the defendants in this case and from others in the future.

That's what we're here to ask you to do. That's why Brian and Michelle are here. Not just for what happened to them. But so that it doesn't happen to somebody else.

Thank you.

THE COURT: All right. Defense counsel, would you like to make an opening statement at this time?

MR. VENKER: Yes, your Honor.

THE COURT: All right. You may proceed.

OPENING STATEMENT ON BEHALF OF COUNSEL FOR THE DEFENDANT

MR. VENKER: Good afternoon, ladies and gentlemen.

As you know, my name is Paul Venker, and I represent both Dr. Douglas Walden, who is here in the courtroom, and St. Louis University. Connie Golden is here to represent St. Louis University as their representative here. It's my honor to represent Dr. Walden and St. Louis University.

I told you during jury selection that the parties disagree on the facts of this case and that you're going to hear now a part of that disagreement. But I can tell you that we dispute many if not a hundred percent of the facts as Mr. Cronin was trying to portray them to you.

One word of caution to you all is opening statements are not evidence; they are what the lawyers are telling you the evidence will be. And so that's even true for me. So whatever I say, you can test by seeing what the witnesses who testify provide the information to you and you can listen to them yourselves and decide.

This case is really about Dr. Walden, Dr. Douglas Walden, trying to help Brian Koon keep his job in the physically demanding Parks and Recreation position that he had in the City of St. Louis. It's also about, it seems, the misdirected anger and frustration that both Michelle and Brian Koon have towards Dr. Walden and St. Louis University.

So what we need to do is step back and look at the relationship that Dr. Walden had with Mr. Koon, which started in 2001. Because at that time, Brian Koon came to Dr. Walden to be his primary care physician. So for a lot of years there, seven years before any of this opiate medication started, Dr. Walden was Mr. Koon's primary care doctor and saw him for a whole host of things, and we'll go through those visits and what they were about.

He did have and was diagnosed with Hodgkin's disease in his early twenties. That was before Dr. Walden knew him. But the radiation treatment that Mr. Koon had affected his health otherwise for things that now Plaintiffs are claiming are due to the opiate medication, the

hypothyroidism, the testosterone issues are related. We can see some issues also that carry over where they're claiming that the opiate medication caused Mr. Koon's ED, or erectile dysfunction, when you'll see in the records Dr. Walden was prescribing medications for Mr. Koon for that condition back in 2002 in the records it's clear and obvious.

What we will present to you is a clear demonstration that Dr. Walden was a caring and careful doctor who did watch Mr. Koon, shepherded him through this process, which again, with opiates, we know there's a risk to taking those drugs, there are. We'll talk about that in terms of what the dialogue was between Dr. Walden and Mr. Koon.

But let me tell you first what we expect the evidence to show in the case, and that is as I've already said to you that Dr. Walden was a caring physician who knew Mr. Koon well, had known him for years before he ever came to him with this level of pain to prescribe these opiates. He had come earlier on for pain, and there was actually a time in 2003 or 2004 when Mr. Koon was prescribed opiates, Vicodin, a prescription for pain. But that wasn't needed after that. And so because Mr. Koon's pain was not of the severity that it became later, that wasn't necessary to have that level of pain.

You will hear Dr. Walden testify that he does

believe that if opiates are to be used, the lowest effective dose is to be used. So what that means is, he's always looking to give the least amount of that drug if it is an appropriate drug to give, and he'll tell you that himself.

He will say that in general patients should get by with or not need more than, say, 100 milligrams of morphine equivalent dosing. And that morphine equivalent dosing phrase is used because different medications have different concentration levels. So the medical community has devised a way to make them all so you can tell what's apples to apples, so to speak. All right?

So that 100-milligrams of morphine equivalent daily dose is one that works for most patients. As a general rule, that's true. There's no dispute about that in this case. What is in dispute is that the Plaintiffs are acting as if there are no exceptions to that rule. You will hear from their own expert Dr. Genecin that there are exceptions to that rule. And there are patients, for example, with levels of pain where they need more pain relief.

There are also patients who can handle the additional opioid dosing. And as we heard just from the people in the panel talking and we know, different people can handle the morphine at a different level. It is patient dependent in terms of how that person reacts to it. There's

different explanations and theories for that, but the fact is that's the case.

You can give 10 milligrams of Vicodin to someone and they may be, you know, loopy. You may be able to give someone else 80 milligrams, and they are fine. There's a concept in this called tolerance. And so just like somebody can develop a tolerance to, well, I guess things like alcohol, for example. Opiates are much the same way because the body is an amazing organ, if you will, a complex structure where the body can adjust. And you will see in this case that there is no set limit, a daily limit for opioid administration to a patient.

Now, that's in the abstract. That's not to say that a doctor doesn't have an obligation to make sure that the patient can handle that dose. And that's done by starting them out on trial dose, and you'll hear about that from Dr. Walden. And then when that patient, if they need more pain relief, they have that dialogue with the doctor. You know what, I've got this physically demanding job. And that's what Mr. Koon was telling Dr. Walden.

You know, by the time Mr. Koon had such a back problem that he needed opiates, he had been with Dr. Walden for about seven years, he knew him very well, and he was asking Dr. Walden, can you please help me keep my job. This is 2008. The recession was here. He was very paranoid

about whether he could keep his job with the City Parks and Recreation Department. You'll hear about the requirements of that job, the potential of having to lift 50-pound items, operating heavy machinery, working with tools and equipment that can be dangerous. And you'll hear about that from both Mr. Koon, I think, also the -- we have two depositions from two workers from the -- coworkers from the City Parks and Recreation Department who knew Mr. Koon, still do; he still works there. And throughout the entire time he continued this job, he they didn't know he was on pain medication.

MR. CRONIN: Objection, your Honor. That misstates the evidence in the case.

MR. VENKER: Well --

MR. CRONIN: Sorry, your Honor.

THE COURT: Proceed.

MR. VENKER: You'll be able to listen to the testimony from the witnesses.

The first time they would have found out was when he went to the treatment center in 2012. So you'll hear their testimony about how capable he was. You'll see the evidence of the performance ratings he received from his job, all through these almost four years or approximately four years.

So unlike what has been described as Mr. Koon becoming a zombie, with the functional equivalent of a

zombie, that's not true at all, far from it. He was able to function at high levels, and there's no dispute, these were high doses, ladies and gentlemen. But he's not the only person who has those high doses, and he's not going to be the only person who will.

Different patients with different specific conditions such as sickle cell disease, that's true. That's a condition that there is no cure for, and some of those patients are on very high doses. And the sickle cell disease patients, and you'll hear this in the case, although in years past may have only lived to be in their twenties, now are living well into their forties and fifties.

And so I think Plaintiffs are suggesting that those individuals don't deserve to have their pain treated, when if they're able to tolerate it, it is an appropriate medical course. Not common. You may describe it as rare. But it's there, and these people are benefiting from that pain treatment as an example of how high the doses can go.

Let me tell you a little bit about Dr. Walden. He is a St. Louis native. You'll find that he has traveled around the country through his childhood years. His father worked for Boeing, or McDonnell Douglas, so he traveled here and there, but he came back to St. Louis, went through medical school on a -- I'll let him tell you the details -- on a national scholarship where he traded off going to

medical school for community service in underprivileged, underserved areas here in the St. Louis area. He chose internal medicine to be able to help people.

He went through his residency there at St. Louis University and was chosen to be one of the chief residents, and he'll tell you more about that, but that means somewhat of status, they're that group of residents and -- medical residents are already medical doctors that are going to the next level of having a specialty. Internal medicine is one of those specialties.

And so, he then did those four years of medical service in the local community, and then all that time was an adjunct faculty member at St. Louis University. And then he went back to St. Louis University and began his career there, his academic career teaching. So he is affiliated with the University. He's been a professor there for 20 plus years, and you'll hear more about it from Dr. Walden himself in terms of who he is.

He'll tell you also that quite frankly he admired Brian Koon when he first told him that he wanted to -- he was willing to take the risk of -- again, any time someone is prescribed an opiate, there is a risk of dependency; there's a risk of addiction. Addictions are rare. It's a small percentage. And you'll hear about that as well. But still, it's still there.

And Dr. Walden admired him for the willingness to get out and work because he has patients who, with that level of pain that he understood Mr. Koon to have, would not choose to continue working, would say I can't do this job. And yet Mr. Koon did. So at that point Dr. Walden was, you know, admiring that quality in him that he was very diligent in wanting to provide for himself and then later for his family after he got married in 2006. So that was something important to him.

There's another aspect of this case that really talks about the science or the medicine, and you're going to hear from our expert Dr. Gunderson who is an addiction specialist. Dr. Gunderson went through internal medicine, he went medical school up in New York City, went to undergrad at Yale and medical school at New York City, and then did an addiction fellowship at Columbia University School of Medicine at New York Presbyterian Hospital.

He'll tell you that some people are predisposed to dependency and addiction, and there's a huge genetic makeup part for that, and that that's what happened here. That Dr. Walden prescribing these opiates did not cause the dependency. You'll also hear opioid use disorder, and of course addiction is what the Plaintiffs are terming that part of it.

What Dr. Gunderson will tell you is basically

Mr. Koon was susceptible to becoming dependent and having an opioid use disorder with opioids. So the intersection of Mr. Koon and those opiates is what brought that to happen. It wasn't that these opiates caused it in him. And so you'll hear that from Dr. Gunderson. He'll talk to you about that in more detail than I will here today. But I think that's an important aspect of this case.

In terms of the withdrawal that Mr. Koon underwent, let's talk about that a little bit just because I know you've been listening to a lot already. So the course that you'll hear -- we'll have evidence on all the different issues that Mr. Cronin's talked about. In terms of the prescriptions, why Mr. Koon got them early, why Dr. Walden was observant of that and felt that that was appropriate and could be appropriate, and that's going back to this tolerance concept I was telling you about. It's natural, and it's an expected part of opiate prescription medications that the person will become more tolerant to them. So the person may well need to have more of the pain medicine to get the same level of relief. That's just how it works.

So through those times, Dr. Walden, you'll see it when he testifies, it's in his records, he had a number of visits, once approximately every three months, which is, to me is an appropriate level of review with a patient to see how Mr. Koon was doing. And in those visits you'll see in

the charting, he asked him again about dependency, the potential for dependency and addiction to make sure he understands it. He asks him questions about how are you feeling? Are you light-headed? Are you drowsy? Are you impaired in any way when you're driving or doing your job? He would ask him those questions, ladies and gentlemen.

So he wanted to know, because he is a careful doctor, how is this affecting you. All through this time through 2008 to 2012, no indication from Mr. Koon. And you'll hear testimony from Mr. Koon himself that he wasn't as forthright with Dr. Walden as he should have been. He didn't really tell him what was going on with him and somehow managed to mask it.

Now, that's not to say Dr. Walden doesn't have a good skill set for keeping an eye on patients who might be getting off the track so to speak. And you'll hear him tell you about that. He has had patients where that's happened. He knows how to spot those trends, assuming the patient is providing the information they should be providing in terms of how they are functioning with this medication.

So in terms of that course in the spring of 2012, in early April, I think it was April 2nd, Dr. Walden's office gets a call from Mr. Koon who says he wants to get a pain management referral. Dr. Walden doesn't ask why. He says, okay, you're entitled to do that. Maybe he wanted to

get the steroid injections because that's what pain management doctors do a lot of. They don't do a lot of managing opiate medication like Dr. Walden does, but they do a lot of these epidural shots.

So Dr. Walden filled out that order for that pain management referral that day; and within a couple weeks, Dr. Barry, Dr. Tad Barry, you'll hear that name mentioned, who is a pain management specialist, saw Mr. Koon. They had a visit. He talked to him about his course, and he suggested that he think about a pain -- going to a treatment center to see about, you know, his pain level and his medications. He did order an MRI for him to see what his back pain situation was.

And then within a couple weeks after that, Mr. Koon saw Dr. Walden; and that was on April 24th, I believe. And so it might have been May, but he came to Dr. Walden and said, I'm not in control with my life with these meds; they're running my life. That is the first time, ladies and gentlemen, that Mr. Koon ever told Dr. Walden I've got a problem here, okay? There was no phone call before that. There was no voice mail, nothing to say, I'm having some trouble here.

And so what was the degree of trouble? Well, he didn't have an overdose. He didn't fall asleep and have a car wreck. He was still working at his job. But that's

okay. The least bit Dr. Walden wanted to know if you're having any hesitation about this being okay for you, I want to know about it. That's what Dr. Walden's position is because if we can take the doses down or if you say you want to get off them totally, that's fine. That's great. He's all for that because opiates are a potentially dangerous drug. Why would Dr. Walden want him to be on those, I mean, if he doesn't want to take that risk himself, Mr. Koon. It doesn't make sense.

So he talked to Dr. Walden about it, and so Dr. Walden knew that Mr. Koon had already seen Dr. Berry. So he said, okay, well, continue with Dr. Berry, pain management. So he's not trying to say don't go see Dr. Berry, you know, stay with me, let's write some more pain meds. Go see Dr. Berry in accordance with that and let's see where that goes.

But he did think he should stay on the medicines he was on for now in conjunction with Dr. Berry. So he went back to see Dr. Berry again who then suggested -- because in the first visit Mr. Koon said he was going to investigate pain treatment centers.

In the second visit when he saw Dr. Berry he hadn't done that. And so Dr. Berry said, okay, well, you know, let's do this. Why don't you -- I've got a psychiatrist for addiction that you should see, and that's

Dr. Melanie McKean. And that's who he ended up seeing, by the way, in July of 2012. And you need to go see her.

So that visit happened, and you'll hear a lot from Dr. McKean mostly through her records, that she had a visit with Mr. Koon in early July, and that she said, okay, let's start the process of getting you down off these meds. That's what we're going to do; let's do that.

So she was then collaborating with Dr. Berry, the pain management doctor, Dr. Walden, to make this happen. And so you don't just snap your fingers. It has to happen over time. There is a process, you've heard it from the Movant already in opening statement from Mr. Cronin called weaning. Weaning can be an adjusted level downward in the meds. It might be all the way to zero, which means you're getting off. Or it can be an adjustment that can be made because that person doesn't need the pain medicine.

You'll throughout Mr. Koon's history with Dr. Walden that there were times where weaning was considered, it's true. And if you look will find that there are different instances where Mr. Koon thought he could do it, but then he had a workplace injury. He hurt his foot or he wrenched his back additionally or something of that nature where he said, you know, I'm not sure I can do this yet. So let's let some time go by. Again, Dr. Walden is always there. He can call him and say, you know, what I

need to do, I need to get down lower.

So in this time frame then in July, the evidence will be that Dr. Koon -- I mean, Dr. Walden talked with Dr. McKean, the addiction psychiatrist, and she said, here's what I think should happen. We should ratchet these down. So we'll do basically two weeks at a certain level and then the next two weeks will be lower. We'll start that weaning process. And you'll hear the details about how that can be done safely for a patient, if you will, without the withdrawal symptoms, which are really flu-like symptoms. It's not this dangerous to go through withdrawal physically, but it's pretty unpleasant.

And so usually, if it can be done by tapering downward, that's what's done. And that's what the plan was. So the prescription at the end there was written on August 17th. So that would run a full month to September 17th. And that prescription was picked up, and what happened was there was an effort to get Mr. Koon's prescription -- this was with no refills by the way. So they had to go back to get more if they needed more. It turns out that Mr. Koon had gone through those pills in about three weeks, not two weeks, three weeks, and he ended up going to St. Mary's Hospital out in Clayton just for withdrawal because he had run out of medication. And so that's where he was, and then the decision was made to go

ahead and go to Centerpoint.

Now, the evidence will be that Mr. Koon -- or Ms. Koon did not call Dr. McKean, the psychiatric addiction specialist. They didn't call Dr. Berry. They didn't call Dr. Walden before they went to St. Mary's or before they went to Centerpoint for treatment. So they just didn't talk to any of those doctors for whatever reason.

So we will show you that the evidence is that this withdrawal episode, and it must have been unpleasant, could have been avoided if Mr. Koon had stayed on the tapering dose he was supposed to stay on. And if he had called one of these doctors, he may have been able to communicate with them his problem, but that just didn't happened.

So then he went through Centerpoint, and we'll hear a lot of detail about that. And afterwards he had these four back surgeries over time over about a two-year period, I believe. One early in November of 2012. And then a lumbar fusion. That first one was a neck surgery, cervical area, and then a lumbar fusion and then revisions on those later.

I think the evidence will be in dispute as to how much those surgeries have helped. Mr. Koon is still in pain. He was in pain through all of those. There will be evidence when he missed work for any appreciable period of time. He missed work from the surgeries he had. He didn't

miss it because he was on pain medication. He missed it because he was doing these surgeries and out for extended periods of time for some of that. So I think that's important for you to know.

In terms of this issue of the functional zombie that he's been characterized as, I mentioned the city workers, you'll hear testimony from the family members, his parents, Michelle Koon's dad and her brother, about how they perceived Mr. Koon to be when they were around him in this time period. And, again, I believe the evidence will show that none of them had any idea that he was on pain medication or had any issues with it until he went to the treatment center in September of 2012. But before that time, they did not suspect anything or think that he was somehow impaired and certainly nothing close to being a zombie.

We will bring you, as I mentioned, Dr. Gunderson who is this addiction specialist. He is supportive of Dr. Walden's care, says he handled it appropriate, and you'll hear him tell you that certainly on -- on certain aspects Dr. Walden was ahead of the curve of what doctors then were paying attention to with patients because he focused on Mr. Koon's function. He said functionality currently now is something that's very much a guiding principle in terms of these opiates. But he said he

observed through the charting and through Dr. Walden's testimony that he was focusing on functionality back then in this 2008 to 2012 time frame.

It's hard to believe really that the end of this care we're talking about is coming up on four years ago. That's a long time. But even then, Dr. Walden was doing a very outstanding job of monitoring this situation. Again, no question, high doses.

Now, we also have Dr. Anthony Guarino, who's here in town at Washington University. He's the Director of the pain management clinic out at Barnes Jewish West County Hospital. He's on faculty at Washington University School of Medicine. He will tell you that as a pain management physician, he is also supportive of the care that Dr. Walden provided Mr. Koon. Also thinks that functionality was what Dr. Walden was paying attention to.

He does have patients in this high dose range and has had patients on that level for a long time. Again, it's a function of what the patient -- what can the patient deal with, what can they handle, what do they need. So he'll talk to you about that.

But don't get me wrong. It's not every patient that a pain management physician has who's on these kind of doses. They're high doses across the board, whether you are a pain management physician or not. And the statistics on

how many internal medicine physicians are prescribing opiates in America is a pretty significant number. Well over 50 percent of them are prescribed by internal medicine physicians, and of course they have a varied degree of experience.

You'll hear from Dr. Walden that he has a significant amount of experience before he started prescribing opiates for Mr. Koon in dealing with patients who needed opiate medication. And he does have a very small handful of patients who have been on high dose and are on high doses now. But, again, not a large number of people, and they have serious conditions. He's treated patients who have sickle cell disease. He's treated hospice patients. He's treated patients who are receiving palliative care or close to end of life care who have needed opiates.

And, again, it's not that you can just -- I'm assuming that nobody thinks just because someone's a cancer patient that they're being medicated to the point of oblivion. Because I don't think that's what people are talking about in terms of how high a dose a cancer patient can handle. I think it's a question of how much pain they're suffering.

You're going to hear a lot about Mr. Koon's pain. It's been described here as back pain, but I think you're going to see from the records and the physicians who were

helping him, that he had a lot more than back pain. He had pain in his lower extremities. He had pain in his arms and his hands. This is pain that sounds -- it sounds very challenging, quite frankly, in terms of how he's functioned.

You'll hear he had difficulty sleeping because of pain. He had difficulty driving because of pain. And he still does even to this day. Even with the surgeries he's had. So that is information that we'll bring to you.

I'm not going to detail for you everything that Mr. Cronin touched on because you'll hear it from the witness stand. You'll hear it from the -- you'll see in the documents that get produced. But the notion that St. Louis University or Dr. Walden are somehow not looking out for the best interest of Mr. Koon and other patients, I don't know where we get into that, but Mr. Koon is -- you'll see, I think, is just not supported at all and borders on the ridiculous.

Dr. Walden is, again, a caring physician, a careful physician; and St. Louis University basically is lucky to have him, and he is somebody who has been providing care to patients for many years and will for many years to come.

At the end of the evidence that's presented to you, ladies and gentlemen, I'll ask you to return a verdict in favor of both Dr. Douglas Walden as well as St. Louis

University.

Thank you for your time.

THE COURT: All right. Counsel for the Plaintiff, would you call your first witness.

MR. SIMON: Your Honor, Plaintiffs will call Dr. Paul Genecin to the stand, please.

THE COURT: While we wait for the witness, if the jury would stand and stretch a little bit and get that blood flowing and lunch moving.

All right, Doctor, my clerk is going to swear you in.

***PAUL GENECIN***,

having been duly sworn by the deputy clerk, testified:

**DIRECT EXAMINATION**

THE COURT: Ladies and gentlemen of the jury, have a seat.

Doctor, have a seat right over here. I'm going to ask that you make yourself comfortable. If you would please state your first name and last name for my court reporter.

THE WITNESS: My first name is Paul; my last name is Genecin.

THE COURT: Doctor, from time to time you may hear the attorneys say objection. If they say objection, if you will pause and let me rule on it before you answer. Thank you, sir.

You may inquire.

MR. SIMON: Thank you, your Honor.

BY MR. SIMON:

Q Dr. Genecin, what kind of doctor are you?

A I'm an internal medicine physician. I provide care to adult patients in office setting as well as in the hospital.

Q And where do you practice, Doctor?

A At Yale University, which is in New Haven, Connecticut.

Q Doctor, you were retained by my office in this case; is that correct?

A That is correct, yes.

Q We asked you to review depositions; we asked you to review medical records of Brian Koon, correct?

A That is correct.

Q Have you completed your review, Doctor?

A Yes.

Q Are you prepared to discuss your opinions with us today?

A I am.

Q Okay. And Doctor, would you agree with us that the opinions and testimony you give today will be based upon a reasonable degree of medical certainty?

A Yes.

Q Doctor, before we get into your opinions, I want to talk to you about, tell the jury about your background, your education and training. Let's start with your education.

A I went to college at Princeton University in New Jersey. I was not a premed student so I took a couple of years out at Columbia University to prepare for medical school. I applied to and was accepted for medical school at Columbia University College of Physicians and Surgeons.

When I graduated from medical school, I then was an intern and resident in the field of internal medicine and also at Columbia at Presbyterian Hospital in the city of New York.

After my residency training I became board certified in internal medicine and went to Yale University for additional training in a fellowship. So that was another three years of training. That brings us up to 1989. And that's the end of my training and education.

Q Okay. And, Doctor, professionally what have you done since you completed your training? What kind of work have you done and where?

A I started out at an organization where I now still work as director, working as a primary care internal medicine doctor in clinic. I continue to be a primary care internal medicine physician.

In addition, I work as a clinical associate professor of medicine at Yale School of Medicine and maintaining physician at Yale New Haven Hospital, which is the teaching hospital for Yale University. And in that capacity, I work as a hospital attending providing care to patients who are admitted to the hospital for medical illness.

So I continue to see patients in the office like I do hospital work. I also supervise a clinic for patients who are clients of the neighborhood food pantry in New Haven, mostly indigent patients, many of them homeless. And I supervise a group of students from the medical, nursing and PA schools at Yale, physician associate schools at Yale in providing care to those patients.

Q And, Doctor, what is the name of that clinic?

A That's the Neighborhood Health Project. It's located at a church in the center of New Haven where there's a neighborhood food pantry.

Q How long have you been involved with that clinic?

A Many years, I think approximately ten years.

Q And how much time do you spend there?

A About ten hours a month.

Q And what is your -- do you have a title or

position there?

A I am one other faculty member or the basically the faculty coordinators of the program that -- it's a volunteer organization, and the students run it internally, but they have to have supervision. So I'm on it to supervise.

Q So, Doctor, what part of your practice involves seeing patients?

A Well, I see patients in all aspects of my clinical practice; but I see patients in appointments whom I follow for primary care at Yale Health, which is a health care clinic where I'm also director of a clinic. I see patients for with whom some of them I've followed for many years in appointments, both for preventive care and also for treatment of illnesses and problems that they present with.

Q So, Doctor, how many patients do you have currently?

A I would estimate about a thousand.

Q And, Doctor, what if any experience do you have in treating patients with back problems or back pain?

A Well, back pain is one of the most frequent complaints of adult patients. So it would be -- any internist, myself included, any primary care doctor would have loads of experience in treating back pain, both acute

back pain and chronic back pain. It's one of the most frequent problems that afflict us.

Q And, Doctor, have you had occasion to prescribe opioid narcotics to your patients?

A Yes.

Q Tell us what experience you've had with that.

A Well, doctors who prescribe narcotic analgesics, which are pain medicines, are required to be licensed by the Drug Enforcement Agency, or DEA. And to prescribe medication in a way that's appropriate with respect to selecting the patient's dosage and so on.

I treat patients who have acute pain, patients who have injuries, patients with migraine. I treat patients with sickle cell disease, patients who need palliative care, end of life care, cancer care. But many other indications, headache, postsurgical care, there are many indications for prescribing narcotics analgesics for patients with pain.

Q Doctor, you said narcotic analgesics. What's an analgesic? What's a narcotic?

A May I have a little water possibly?

Q Sure?

A Thank you.

Yes, a narcotic is -- opioid and narcotic are similar terms. Analgesic is pain reliever. And drugs of

this category are derived from opium, from the poppy. And the drugs of this class are all molecules that are similar, modified in some way to the opium that comes from the poppy. They're called opioids or narcotics.

Q Go ahead, Doctor. And then the narcotic, is that a classification of drug? What does it mean to be a narcotic as opposed to some other type of drug?

A Narcotics are drugs that are related to opium. Heroin is an example, morphine is an example; there are many others, codeine, oxycodone, hydromorphone, hydrocodone, there are many of them. They're all derivatives of a similar molecule. They're used for the treatment of pain. When used legally, they're used as prescription drugs that are used for the purposes of relieving pain.

Q So, Doctor, I want to talk to you about what materials -- what you've done in this case up to today, the materials that you've reviewed.

A Yes.

Q What have you reviewed?

A I reviewed Mr. Koon's medical records, notably the records of his care with Dr. Walden, but also of other providers who provided care to him, both at the same time as Dr. Walden but also subsequently. I've also reviewed depositions of Dr. Walden, of Mr. and Mrs. Koon, and of a

variety of doctors who are serving as experts in this case.

Q Okay. And specifically, Doctor, did you receive and review the deposition of Dr. Anthony Guarino?

A Yes.

Q Did you receive and review the deposition of Dr. Mark Itskowitz?

A Yes, I did.

Q Did you receive and review the deposition of Dr. Erik Gunderson?

A I did.

Q And who are those doctors?

A Those are experts for the defense.

Q Okay. For St. Louis University?

A Correct. Right, for Dr. Walden and for St. Louis University.

Q And you were also provided, Doctor, a deposition of Mary Fitzgibbons?

A Yes, that's correct. She's a psychologist who evaluated Mr. Koon.

Q Doctor, what generally, what is the standard of care? What does that mean when we hear that term, the standard of care?

A The standard of care is the care that a reasonable adequately trained, reasonably trained and

competent clinician --

MR. VENKER: Your Honor, may we approach?

THE COURT: You may.

(Counsel approached the bench, and the following proceedings were had, out of the hearing of the jury:)

MR. VENKER: I'm not sure I have a problem with him giving what he thinks is the standard of care definition, but I'm not sure -- it just seems like -- I'm not sure what we're going to get at the end of this.

MR. SIMON: He's going to be giving opinions as to whether or not Dr. Walden and SLU breached the standard of care. It's appropriate for him to define what that standard of care means.

MR. VENKER: Well, according to Missouri standard, yes.

MR. SIMON: I'll put it -- that's what it is, it's Missouri standard. I'll put it up on the chart.

MR. VENKER: I'm not sure I want it shown to the jury that way. If he can say it, I'm not sure about the visual.

THE COURT: What exactly is your objection?

MR. VENKER: My objection is he's not stating the standard of care correctly.

MR. SIMON: I'll put it up on the board. It's from the MAI, and it's the standard of care in the jury

instruction that will be used in this case. That's what I provided to this doctor before his deposition. That's what he's basing his opinions on in this case. This is a med mal case. This doctor is here to give his ultimate opinion as --

MR. VENKER: He can say what he thinks it is.

THE COURT: Okay. I think your issue is that he's about -- the way he's talking about it is as if it is the standard of care, but he's not using the identical words.

MR. VENKER: Yes.

THE COURT: Is that your issue?

MR. VENKER: Yes, your Honor.

MR. SIMON: I'll fix that.

THE COURT: Thank you.

(The proceedings returned to open court.)

MR. SIMON: Mike, can you puts up exhibit --

MR. VENKER: Wait a minute, your Honor. Can we approach?

(Counsel approached the bench, and the following proceedings were had, out of the hearing of the jury:)

MR. VENKER: I'm sorry. I thought you said when you were going to fix it you were going to ask the question a certain way or have him say something. I think putting it up is basically a leading question.

MR. SIMON: Judge, I can put it up there. It's an expert witness. I can ask him to assume whatever set of facts or -- in order for me to get opinions from this witness as to whether this doctor violated the standard of care in this case, I have to provide this witness, my expert, with that standard.

MR. VENKER: Then ask him to assume that's the standard, but you don't have to put it up on the board.

MR. SIMON: I'm going to put it up on the board and ask him to assume that's the standard. If you think it's incorrect, you can correct me on it. It's from the MAI.

THE COURT: Okay. I'm going to take this as an objection to leading.

MR. VENKER: Yes.

THE COURT: I'm going to overrule the objection, but let's tighten it up.

MR. SIMON: Yes, sir.

(The proceedings returned to open court.)

Q (By Mr. Simon:) Mike would you please put up Exhibit 60-5?

Doctor, I'm going to ask you to assume for your testimony in this case, that this is the standard of care that is used in Missouri and applies in this case. And that is using that degree of skill and learning ordinarily used

under the same or similar circumstances by members of defendant's profession.

Do you see that, Doctor?

A Yes.

Q Okay. Will you assume, Doctor, that that is the standard of care that needs to be complied with by physicians in the State of Missouri?

A Yes.

Q Okay. Doctor, let's move on to the next topic, and I want to talk to you about opioids. What are they?

A Again, opioids are medications used for the treatment of pain. It can also be used for anesthetic. They are molecules that are related to and derived from the opium that comes from the poppy. The illegal street drug heroin is an example of a drug that is a derivative of opium.

There are also drugs that are synthetic, in other words, not derived from poppy but made in the laboratory, but the molecules are all similar, they're all charged with similar properties. Some of them are stronger, some of them are less strong in terms of their effects, but all of them are drugs that have similar action on the brain and on the brain's perception of pain. They also are drugs that cause sleepiness, called narcotics because narcosis is being put to sleep.

They are drugs unfortunately that have risk of addiction, they're potently addictive. And there are a variety of other risks associated with opioids, but all of them are molecules that are related to the opium from poppy.

Q So, Doctor, how do they work?

A They work on the brain, on receptors in the brain, and those areas of the brain that perceive pain are affected by these molecules. Unfortunately, they also affect receptors in the brain that remind us to breathe. And so patients who are on excessive doses of opioid medications will have what's called respiratory depression.

They also cause changes in the brain that make the body both dependent on the medication so that physically a patient can't do without it, and also addiction which is the physical dependency plus the craving for the medication that characterize addiction.

They are drugs to which we develop what's called tolerance. Which means that for a given pain problem, a patient will tend to need more and more over time in order to achieve the same effect on pain relief or on the same effect of getting high or euphoric, which is why people abuse opioids.

In addition though, there are other aspects to

which we develop tolerance. So for example, a person who is slowly increased on medication of the opioid class can tolerate a colossal dose of opioids without getting into respiratory depression and dying because of this phenomenon of tolerance.

The reason though why there's an epidemic of prescription --

MR. VENKER: Your Honor, may we approach?

THE COURT: Yes.

(Counsel approached the bench, and the following proceedings were had, out of the hearing of the jury:)

MR. VENKER: My objection is two levels. One, this is non-responsive to the question asked. Now he started to talk about an epidemic, which is not the question that John asked him.

Secondarily, I want to make sure I'm protecting the record on this opioid epidemic concept. This is the first time in evidence we've heard the mention of this. I want to renew our earlier motions in limine, Judge, to the fullest and again say that this is not a part of this case, it should not be a part of this case, whatever this opioid epidemic is, and again, if I can incorporate the motions we made earlier, the objections.

THE COURT: As I understand it, two objections on the table. One that this is non-responsive. I'm going

to sustain the objection to non-responsive.

Second, you are renewing your objection to the opiate discussion that we've previously ruled on. My ruling remains the same that I'm going to overrule that objection. With a caution in terms of because he's potentially non-responsive, I'm going to ask you to tighten --

MR. SIMON: Rein him in?

THE COURT: Rein him in.

MR. VENKER: I'm not trying to break the cadence of the questioning, can my objection stand to this area, to this opioid epidemic stand from now on, or do I have to continually make objections?

THE COURT: My ruling is for every witness you need to renew your objection. The topic that we talked about, the Court will treat that in your opinion is objectionable throughout his testimony, but each witness requires a new objection.

MR. VENKER: I appreciate that, your Honor.

MR. SIMON: Thank you, your Honor.

(The proceedings returned to open court.)

Q (By Mr. Simon:) Doctor, we were talking about opioids.

A Yes.

Q And I was asking you how do they work, and you were explaining that. Would you continue telling us how

they work and what effect they have on people who are prescribed opioids?

A Well, the primary effect that we seek is to relieve patients of pain. That's the desired effect. So we try to give opioid medications to patients who have the kind of pain that will respond to opioids. There's an obvious downside to opioids. They're dangerous medicines with a tendency to cause, as I said, addiction, dependency which is not exactly the same but which is related.

They can actually cause something called sensitization, where paradoxically the patient's pain problem gets worse as a result of treating patients with daily pain medication. They interact with other medications, so there's a lot of caution that has to go into using them.

And we talked about tolerance. No one has total tolerance. So there's always a dose at which a person is at risk of dying even if they can take enormous amounts of opioids on a daily basis and not stop breathing as a result of it. And that's the reason for the epidemic of deaths from prescription opioid analgesics prescribed by primary care doctors.

Q What are some examples of prescription opioid narcotics?

A The prescription opioid narcotics, one is

morphine. That's commonly used in the hospital. It's a -- another that's commonly encountered, Percocet, oxycodone is one of the very common ones. Codeine, which is commonly found in cough syrup in small doses can also be used for analgesic pain relief.

Some of the more potent ones, hydrocodone, which is Vicodin, is another one. Dilaudid is another. There are many other medications that are narcotic analgesics. Fentanyl is another one. So there's a long list of opioid analgesics, all of which are compared to each other by comparing their potency to that of morphine.

So in order to understand how strong one of these medications is we always compare it to an equivalent dose of morphine. So morphine is the basis for talking about the strength of different narcotics. The differences in them are that some of them are shorter acting, some of them are longer acting. Some of them are used under some clinical circumstances more than others.

Another common one is Demerol. Used to be much more commonly prescribed than it is today, Demerol. But these are all of them narcotic analgesics or opioid analgesics.

Q And, Doctor, do the opioid narcotics -- is hydrocodone, oxycodone and OxyContin, are those opioid narcotics?

A Yes. Hydrocodone is Vicodin, commonly called that's one of the trade names for it. OxyContin and oxycodone are both oxycodone medications. The difference is OxyContin is long acting. It's a preparation that's released gradually. So they're both the same drug, oxycodone and OxyContin. OxyContin is long acting.

Q And oxycodone IR, what does that mean?

A That's immediate release. IR means that it's short acting.

Q That's the short term?

A Yes.

Q And then the OxyContin is the long-term?

A Right. So drugs that are longer acting, for example, there's also morphine, or MS Contin, which is morphine sulfate contin, long acting morphine versus immediate.

These are drugs that can be given by mouth, that can be given by injection either into the vein or into the muscle. They're drugs that can be given as a patch on the skin in some instances. There are some drugs of this class that can be taken under the tongue for rapid absorption. And some of the differences of the drug are in how they're prescribed in terms of the root of entry into the body, how quickly they act and so forth. But they're all related drugs.

Q And, Doctor, you touched on it a little bit, but what I want to move to next is I'd like to talk to you in detail about the risks associated with using opioid narcotics, okay?

A Yes.

Q And you mentioned some of them.

But, Mike, if you would, please, let's put up Exhibit 60-6?

And what are we looking at here, Doctor?

A That's the list of the most important risks and the reasons why there are such a high level of concern and warning to prescribers about the use of these medications.

So first of all, they're addictive. That means that patients who are susceptible to addiction, and many patients are, may become addicts and need to be treated as such, diagnosed and treated for an illness they didn't start with. So, in other words, the medication is necessary in order to bring the addiction about.

Dependency. All patients get dependent if they're on medication for long enough. What that means is that the patient has to taper off medication gradually in order to get off of it.

Addiction and dependency are not the exact same thing. All patients with addiction are dependent, but not all dependent patients are addicts.

Abuse means using the drug for purposes other than pain relief such as to get high, to get that state of euphoria that patients, or people who abuse drugs, can experience.

The misuse is the fact that sometimes very large numbers of pills are diverted to being sold on the street and those are drugs that can be bought. And part of the epidemic of street drug related complications is the fact that people take legally prescribed opioid analgesics, in other words not just heroin, but also these medicines you get at the drugstore, the pharmacy, and use them for sale.

Respiratory depression is really the mechanism of death in overdose. So for example, I'm sure you've read about Prince or heard about him on t.v., a rock star who died of prescription medication overdose. The reason why patients die from opioids is because they depress a center in the brain that keeps us breathing. So wake or sleeping we're always breathing because our brain functions in a way to make that automatic.

And part of the nervous system that keeps us breathing is actually put to sleep by high doses of narcotic analgesics. Patients go to sleep and literally forget to breathe. And that's a fatal complication when you hear about people with overdoses of narcotic analgesics. That can happen in the hospital after

surgery. It can happen at home from patients who take too much or for patients for whom too much prescription opioid is prescribed. And then of course in abuse situations where people use them in order to get some other benefit besides pain relief may overdose, and the reason why they die is they stop breathing.

Q And that would be the last one on there, death?

A Right.

Q And Doctor, let's put up if we could, Exhibit 50-1.

And before we blow up -- what are we looking at here doctor?

A Well, so far I see a page.

Q Let's see if we can do a little better. All right?

A All right.

Q Do you recognize it now?

A Yes. So the Drug Enforcement Agency, or DEA, there's a Federal oversight organization that basically does what's called drug schedules. Schedules are categories of drugs.

For example, Schedule I drugs are illegal drugs like heroin. Schedule II drugs are the drugs that we're most worried about because they have the most risk of addiction or respiratory depression and death or misuse

and abuse. So those are the Schedule II.

Schedule III and IV are drugs that we're less and less concerned about in terms of their abuse potential or potential to harm patients. So the most potent legal drugs that we have the most concern about because of the potential to do harm are Schedule II.

Q And, Doctor, does this document contain information from the DEA about Schedule II drugs?

A I think so. I think it gives a list of each of the schedules.

Q Mike, if we could blow up what's under Schedule II, please?

What are we looking at here?

A So Schedule II drugs, those are the medications with the high potential for abuse. They're not as high abuse potential as Schedule I, like heroin, but they can lead to very severe what's called psychological and physical dependence. And that combination, psychological and physical dependence, that's addiction.

They're considered dangerous, and some examples are given. And they include Vicodin, cocaine, methamphetamine, methadone, hydromorphone, which is Dilaudid, Demerol. Some of these drugs we mentioned, OxyContin, Fentanyl and so forth.

There are some drugs there that are not

narcotics. Those last three are actually amphetamines. You may have heard of them also. They're used for patients who have attention deficit or have problems with staying awake; but again, they're very dangerous drugs, highly addictive and can cause death.

Q So, Doctor, we see Vicodin there, and that's hydrocodone, correct?

A It is, yes.

Q And that is a Schedule II drug?

A It's a Schedule II drug.

Q And we also see oxycodone. That's also a Schedule II drug; is that right?

A Right, right, and OxyContin is the long acting.

Q Okay. And OxyContin would be again the long-term and then oxycodone was the IR, or immediate release?

A Yes.

Q Okay. And you've certainly reviewed all of Brian Koon's medical records?

A I have, yes.

Q Which of those, if any, was Brian on and when?

A The three that he was on pretty much for the majority of those years, the majority of months of those years, he was taking three of those medications. The hydromorphone -- I'm sorry, the oxy -- excuse me. The

oxycodone, both preparations, the immediate release as well as the long acting or OxyContin; and then the other one was the hydrocodone which is Vicodin. Those were the three drugs, one form of hydrocodone and two forms of oxycodone.

Q Doctor, was he being given those drugs at different times, or were they overlapping, given at the same time?

A They were given simultaneously. So in other words, he had those three prescriptions; and he had all these medicines to take each day. Not right at the very beginning. At the first prescriptions, he was just taking oxycodone. But I believe, I can't remember exactly, but as time progressed, if you look at the pharmacy records, he was filling prescriptions for all three.

Q Doctor, at one point, hydrocodone was not a Schedule II; is that correct?

A Yes, it used to be Schedule III.

Q And now it's a Schedule II?

A That's correct.

Q And just so everybody is following us, Vicodin is hydrocodone, correct?

A It is. And the reason why it got moved up is because again it's a drug with -- of legal drugs that a physician can legally prescribe, it's one of the most

dangerous. That relates to the potential for addiction, for dependency, for misuse and abuse and for respiratory depression and death.

Q And Doctor, what is a PDR?

A PDR is the Physicians' Desk Reference. And it used to be a big book. It still is a big book but mostly people look at it online.

What it basically is is a collection of all the labeling information about every drug, and so it's updated on a regular basis. It's republished yearly, but there are supplements all the time.

And what it gives is the basic information about what the drug is, what the chemical is, how it's dosed, what it's used for, what it's approved for, whether there are warnings about the safety, whether there are adverse reactions, drug interactions, information about the pharmacology, in other words, how long before the onset of action and how long does it act, and a number of other types of things like that.

So every drug that's available out there legally in the U.S. is published in the PDR.

Q Is that information, where does it come from?

A It comes actually from the manufacturer. It's actually manufacturer's labeling, but that labeling is mandated through the drug administration, the FDA.

Q So there would be a PDR for OxyContin and oxycodone, correct?

A What you'd say is that OxyContin and oxycodone have their little chapters in the PDR, in the Physician's Desk Reference, which is this big reference. Then you can look up those drugs.

Q And so, Doctor, if we were to look at the PDR for oxycodone or OxyContin, would it list in detail all of the risks or adverse effects associated with the medication?

A It would. Both what it's used for in terms of its desired effects, but also then the downside for those.

Q All right. And, Mike, if we could, please, let's go to Exhibit 50-3. And we'll blow that up for you, Doctor, before I ask you what it is.

What are we looking at here?

A So we're looking at a part of a page from the online PDR, Physician's Desk Reference. It is prescribing information for the drug OxyContin, which is a extended release form of oxycodone, an opioid analgesic which we've been talking about.

Q Doctor, what does this show? What does it tell us, and what does it mean?

A Well, one thing that it shows is that there's a warning in a box. And a boxed warning is something that

has very specific meaning for prescribers and for regulators, regulatory agencies like the Food and Drug Administration.

A boxed warning is the highest level of warning about safety for a drug. So drugs that have a boxed warning are ones that doctors know they must attend to. And actually when a boxed warning is added to a drug, the drug company has to send all prescribers a letter that tell them.

Basically what it says about OxyContin is warning: Addiction, abuse and misuse; life-threatening respiratory depression; accidental ingestion, neonatal opioid withdrawal syndrome. That's when the mother is on OxyContin and the baby is born with withdrawals from narcotics at birth. And then also an interaction relating to how the liver works.

And then there's some more writing under there, I can't quite read it, but it gives additional information about special risks that are posed and which a doctor has to bear in mind when choosing OxyContin and thinking about the ratio of benefits to risks to be realistic about what the downside is for these drugs are for patients.

MR. SIMON: Your Honor, would now be a good time to break?

THE COURT: Yes, it would be.

All right. I promised I'd get you out of here before five, got you at 4:55.

I do want you to know, we do appreciate, we know this has been a long day. So that's why I'm trying to be very cognizant of your time.

So the Court again reminds you what you were told at the first recess of the court, until you retire to consider your verdict, you must not discuss this case among yourselves or with others or permit anyone to discuss it in your hearing. Do not form or express any opinion about this case until it is finally given to you to decide. Do not do any research or investigation on your own about any matter regarding this case or anyone involved in the trial, and do not communicate with others about the case by any means.

I'm going to have you back here tomorrow, 8:30. Last time you went down there; this time you get to come back to the jury room. There will be coffee, and there will be doughnuts for you, really good, healthy doughnuts for you, full of sugar to keep you energized.

I will tell you tomorrow we will take more breaks during the day. Now that we're kind of rolling, we're not going to go all morning and then have lunch. We'll take some breaks and give you guys a chance to kind of get the blood circulating.

So I will see everybody again tomorrow at 8:30.

And again, remember, we can't get started until all 14 of you are here, not just the first 12. All 14 have to be here so please be mindful of your fellow citizens. All right? Recess until 8:30.

(Court was adjourned until 8:30 a.m., June 22, 2016.)

Wednesday, June 22nd, 2016

THE COURT: Please be seated. Good morning, ladies and gentlemen, welcome back. All right. Doctor, I will remind you that you are still under oath, and, Mr. Simon, your witness.

MR. SIMON: Thank you, Your Honor.

BY MR. SIMON:

Q. Good morning, ladies and gentlemen. Doctor, we left off yesterday afternoon talking about the PDR for OxyContin. Do you recall that?

A. Yes.

Q. Okay.

MR. SIMON: And, Mike, if you could, let's go back to Exhibit 50-3.

BY MR. SIMON:

Q. And this is -- this is the black box that we looked at that you described, correct?

A. That's correct, yes.

MR. SIMON: And, Mike, could you go up -- right

up at the top where it says OxyContin, could you blow that up?

BY MR. SIMON:

Q. Now, Doctor, this document is created by the company that makes the drug, right?

A. Yes. Purdue Pharma.

Q. Okay. And, so, Purdue Pharma is the manufacturer of OxyContin?

A. That's correct.

Q. Okay. And, Doctor, are you familiar with Abbott Labs?

A. Yes.

Q. Okay. Does Abbott Labs make any opioid drugs?

A. I believe they make Lortab or Vicodin.

Q. Okay. All right.

A. One of those.

Q. So, let's turn, if we could, please -- and, Doctor, what I would like you to do, this document, this PDR, it's got information about risks and warnings and indications for use, right?

A. Yes, sir.

Q. And side effects; is that correct?

A. Right. Dosing and so forth.

Q. What I want to do with this document is have you go through it with the jury, see what's on it, and explain

what it means. Is that okay?

A. Yes.

Q. Okay. Let's go, please, to the second page. Okay. And we've got -- this is also black box information, but it's a little more detail. Is that right, Doctor?

A. That's correct.

Q. Okay.

MR. SIMON: And, Mike, can we blow that up so we can read that?

BY MR. SIMON:

Q. Okay, Doctor, how about that? Can you read that?

A. I can, yes.

Q. Can you take us through that, Doctor, tell us what it says, what it means, and why it's important?

A. Sure. So the headline of it is Black Box Warning, which, again, is -- the Food and Drug Administration mandates that the drug manufacturer put a special warning, which is the highest level of warning mandated by the FDA, it's called a black box warning or box warning.

And the headline is that, you know, OxyContin is a drug that can cause addiction, abuse and misuse, life threatening respiratory depression, which is decreasing

someone's breathing, they will actually stop breathing and die, accidental ingestion, effects on a newborn fetus if the mother was taking the drug, and then some interactions involving the liver metabolism.

Then the subheading. The first one is addiction, abuse and misuse. And it states that OxyContin exposes patients and others to the risks of opioid addiction, abuse and misuse and can lead to overdose and death, and the importance of assessing each patient's risk prior to prescribing OxyContin and monitoring the patient's risk of, for example, becoming addicted or abusing the drug or misusing it or coming to grievous result of complications of therapy. And then the importance of monitoring all patients regularly for development of behaviors or conditions that the doctor should be alert to.

Q. Doctor, can I stop you right there? So it says assess each patient's risk prior to prescribing OxyContin, correct?

A. Yes.

Q. Is that important?

A. Well, it's very important. In the first place, with each of the complications of opioid therapy there are some patients who are more at risk than others. So, for example, respiratory depression is something that we're

most likely to see in patients with chronic lung disease, and in patients with obstructive sleep apnea, which is at night when patients have episodes where they don't breathe during the night. And those patients can forget to breathe and actually die from these drugs.

Addiction and abuse are correlated with certain risk factors; family history of addiction and abuse is one. But, very importantly, psychological or psychiatric illnesses, such as depression, and in addition to addiction to tobacco, tobacco use disorder, those are contraindications to putting a patient on long-term opioid therapy, because those patients are more at risk for addiction.

Q. Okay. And, Doctor, the other item right here, it says, "and monitor all patients regularly for the development of these behaviors or conditions."

Does that mean monitor them after they're on it on a regular basis?

A. That's right. Because the patient has to get the medication prescribed, and the doctor needs to be alert to a phenomenon of a patient needing more and more drug, seeking drug sooner and sooner, needing to take drug in unorthodox ways, such as many doses at once, running into problems with the use of the drug that would suggest that they are not just becoming dependent, but also

addicted.

And that's a disease addiction that has to be diagnosed and treated as a disease, it can't be maintained by prescribing opioids in increasing amounts. A patient who has addiction and is treated in that way, that's reckless and hazardous to that patient.

Q. And so that's something that the prescriber needs to look out for when the person -- when the doctor's patient is on opioid narcotics?

A. It's just one aspect of it. There are multiple issues that need to be monitored for a patient on this therapy, because these are orchestrated. They have to be used for the appropriate patient, and then monitoring includes monitoring for evidence that a patient is developing abuse or addiction.

Q. Okay. And so, Doctor, down to the next item or the next section that says life threatening respiratory depression. There's one thing I want to ask you about. Right where it says -- it says, "serious life threatening or fatal respiratory depression may occur with the use of OxyContin, monitor for respiratory depression."

And we talked about that yesterday, right?

A. Yes.

Q. Okay. But it says, "especially during initiation of OxyContin." Is that important, and why?

A. It is. It's a long-acting opioid narcotic, it's on board at night when the patient is asleep, and the patients are at risk for obstructive lung disease, like COPD, chronic obstructive lung disease, or obstructive sleep apnea, and also anybody with a high enough dose can have their breathing center of their brain put to sleep and can actually die from this drug. That's the mechanism of death from overdose from OxyContin and for drugs like it.

Q. Okay. Thank you, Doctor.

MR. SIMON: Mike, can you please turn to the next page, up at the top it says indications and usage. And could you blow that up, please?

BY MR. SIMON:

Q. Okay. And, Doctor, this says indications and usage. What is this all about?

A. This is explaining the patients for whom the medication is appropriate. This is at a very high level, it's not -- not intended to give specific diseases for which the OxyContin is used, but to indicate that it is indicated for severe enough pain that a patient needs daily, around-the-clock, life long opioid treatment. And so that's very long-term treatment, not treatment that is for minor condition, or for a finite period of time, and for which alternative treatment options are inadequate.

So that means all of the nonnarcotic treatments, those employed, the anti-inflammatory medicines, muscle relaxants, antiseizure medicines, anti-depressants, there's a whole slew of medicines and intervention, physical therapy, and other kinds of manipulation to help people with pain syndromes. Topical treatments. Many other interventions. And then many other narcotic analgesics that are short acting before you would get to OxyContin. So you think of it as a drug of last resort.

Q. Okay. That's what I was thinking. So, Doctor, what this is telling us is you need to run out of other things before you get to this?

A. Right. And the reason for that is because the risks of this drug are so serious that you would never use it unless the patient's need for it was very serious.

Q. Okay. And, Doctor, what about the next section that says limitations of use --

MR. SIMON: I'm sorry, Mike, still up at the top.

BY MR. SIMON:

Q. What is that telling us?

A. So basically the -- it's informing the prescriber -- so remember the PDR, Physician's Desk Reference, is information for the prescribing physician, because of the risks of addiction, abuse and misuse with

opioids. Now this is all opioids, even at recommended doses, and because the greater risk of overdose and death with extended release formulations, that's the Contin. OxyContin, and that's Contin. These drugs, such as OxyContin, are reserved for patients for whom alternative treatment options are ineffective or not tolerated or would be otherwise inadequate to provide sufficient pain management. It's not indicated at all as an as-needed analgesic.

Q. Okay. Thank you, Doctor.

MR. SIMON: Mike, if we could go down to the bottom of the page.

BY MR. SIMON:

Q. And, Doctor, this is a titration and maintenance of therapy. What is this about?

A. This is starting a patient on -- low on dose and going up slowly in order to reach an effective point. It states that patients have to be individually managed, titration is that gradual increasing of the dose to a point where the patient gets adequate pain relief and minimizing adverse reactions.

So you're looking for that point where the benefit is optimal, the risk is minimal. The patient has to be continually re-evaluated on OxyContin to assess the pain control, and also in order to monitor for adverse

reactions and to monitor for the development of the signs and symptoms of addiction, of abuse, and misuse.

It emphasizes the importance of frequent communication from the prescriber, and other members of the healthcare team and caregiving family. And also, especially during periods of changing analgesic requirements, because that's when dose goes up, risk goes up for adverse reactions.

And, then, during chronic therapy, the patient must be assessed for continued use, the point being that this drug should be stopped as soon as it possibly can be. Always doing a risk/benefit analysis at every point along the way.

Then there's another paragraph that talks about breakthrough pain, and that's for people who may need extra or rescue medication -- this is generally -- understand OxyContin is primarily used as a medication to treat cancer pain. So patients with bone metastases or other cancer pain. And rescue doses are doses that you need to give of a short-acting opioid while carefully increasing the dose of OxyContin to a point where it's effective.

MR. SIMON: Mike, if you could, go to the -- skip to the two page -- Page 5 of 17 of the document -- I think it's two pages ahead. Right up at the top. Could

you pull that up?

BY MR. SIMON:

Q. And, Doctor, this is under the section that talks about warnings and precautions. And right up here it says, "while serious life threatening or fatal respiratory depression can occur at any time during the use of OxyContin, the risk is greatest during the initiation of therapy or following a dose increase."

Do you agree with that?

A. Yes, that's correct.

Q. Why is that, Doctor?

A. Because OxyContin is a potent and long-acting opioid, and it's on board for extended periods of time in the patient's system, it's not sort of peaking and then immediately the level dropping. And when a patient is relaxed and going to sleep they may stop breathing from respiratory depression.

Q. Now, Doctor, there's a long list in this document of adverse reactions to this medication. Is that correct?

A. Yes.

Q. Okay. And I'm not going to go through every one of them with you, but we've got a chart that I may want you to comment on.

A. Sure.

Q. But before we get there --

MR. SIMON: If we could, Mike, jump ahead to Page 7 of 17 of Exhibit 50-3. Where it says drug interactions. If you could blow that up, please.

BY MR. SIMON:

Q. Okay. What is this about, Doctor?

A. OxyContin does not mix well with other drugs that may have similar effects on the central nervous system. So specifically other narcotic analgesics have to be used with very extreme care, and we avoid using sedatives and sleeping medicines. Examples of those are -- Ambien is a famous one, and other ones are benzodiazepines, Ativan, Restoril, Diazapam, Xanax. And then, very importantly, also alcohol. So mixing alcohol with narcotic analgesics is very dangerous.

So it's a drug that must be administered with extreme caution and care relevant to other medications that a patient may be prescribed. Because the risk of sedation, central nervous system depression, breathing risks, stopping breathing, and death, that's the lethal combination.

Q. And drugs like sleeping medication, is that because they do the same thing?

A. Yes.

Q. They depress the central nervous system?

A. That's correct.

Q. So in combination you really are risking stopping your breathing?

A. That's correct. That increases your risk that a patient will stop breathing and dying. And that's a mechanism of death from -- when we read about an epidemic of deaths from prescription medications, this interaction of opioids and other medications that cause sedation is an important cause.

Q. So, Doctor, you've reviewed all of Dr. Walden's records about his treatment of Brian Koon, correct?

A. I have, yes.

Q. Okay. And let me ask you this. During the time that Dr. Walden was prescribing these different opioids, he was prescribing three different kinds at the same time, right?

A. That's correct.

Q. Okay. During the time he was prescribing these three different opioids, at the same time was he prescribing any sleep medication or sedatives to Brian?

A. Yes. He did. And that was Ambien, which is a sleeping medication, Diazapam or Restoril, which the patient took for a long time while also taking narcotic analgesics, and then also Xanax. All of those were extremely negligent and reckless to be combining.

MR. VENKER: Your Honor, may we approach?

THE COURT: You may.

(The following proceedings were held at the bench.)

MR. VENKER: My objection, Your Honor, is that it was nonresponsive. This witness clearly blurted out what he wanted to. I also object to him saying whether it's negligence or not. He's supposed to be talking about what's the standard of care. So I think it's wrong for this witness to say what is or isn't negligence. That's for the jury to decide.

MR. SIMON: I'll rephrase, Your Honor. I'll rephrase.

THE COURT: Okay. So I'm going to sustain the objection. You've got to keep him tighter.

MR. SIMON: I will. I will.

(Proceedings returned to open court.)

BY MR. SIMON:

Q. Dr. Genecin, do you have an opinion about Dr. Walden prescribing these sleeping and pain -- or sedatives and sleeping medications to Brian Koon at the same time that he's prescribing three different opioid narcotics?

A. I do.

Q. Would you tell the jury what that opinion is?

A. Well, the -- my opinion is that that's an

extremely risky practice that exposes the patient to a risk of death that's really unacceptably high. These are drugs that, in combination, can depress respirations, that also depress -- or alter the brain's function, ability to think straight, to reason, to remember, to interact with others, to drive safely, operate machinery safely.

So putting a patient on this combination of medications is an extremely risky thing for the patient. It's also an extremely risky thing for someone who's driving a car, someone who may be responsible for caring for others. It's a -- when you see a -- this kind of interaction, the doctor has to take that very seriously and not give medication in combination that could be harmful. Because to do so is reckless. And we are --

MR. VENKER: Your Honor, may we approach?

THE COURT: Yes.

(The following proceeding were held at the bench.)

MR. VENKER: My objection is nonresponsive to his question. Secondarily, to put reckless in his testimony, I think that should be stricken, he's not -- I don't think he can say this doctor was reckless or not. That is for the jury to decide.

MR. SIMON: That's not true. I'm sorry. Dr. Genecin is an expert. Your Honor, this is a civil case, witnesses are allowed, under Missouri law, by statute, to

testify as to the ultimate issue in a civil case. This case is also about punitive damages. Reckless nature of this doctor's conduct and SLU conduct is appropriate in a punitive damage claim. This witness has testified about this conduct being reckless in the four corners of his deposition. He's testified about it under oath, I've asked him what his opinion is on this issue, and he's allowed to give his opinion.

THE COURT: All right. I'm going to agree with both of you. All right. So, when you think he's being -- I just drew a blank.

MR. VENKER: Nonresponsive.

THE COURT: Yes. When you think he's being nonresponsive, I'm okay with you objecting from the table, saying your objection, nonresponsive.

Number two, he is allowed to talk about the ultimate issue, but from everything that I've read on it, the way he needs to couch it is this would be a factor toward determining whether someone is -- he can comment on the factors, the issues which lead up to the ultimate conclusion as to whether the person is reckless. So if this is a -- if this is reckless behavior, the wording needs to be more concise as this would be --

MR. SIMON: The system.

THE COURT: Right. Because the way he's saying

it now, it is the ultimate decision, but it -- he can talk about the ultimate factors that lead to the decision for reckless when you're dealing with punitive. On the other issues, yes. But punitive you need to address the factors, the jury takes those factors into consideration and determines punitive.

MR. SIMON: Yes, sir.

MR. VENKER: I just want to make clear that this is really a renewal of earlier objections we've done pre-trial and the Court has ruled on. So objection, again, at this time about Dr. Genecin offering these ultimate opinions of recklessness.

THE COURT: The objection is noted. I think -- if you work on focusing on the factors with that language, I think it's tighter. But if you do think he's nonresponsive, you don't have to come up here, you can just say it and I'll rule from up here.

MR. VENKER: Thank you, Your Honor.

(Proceedings returned to open court.)

BY MR. SIMON:

Q. Doctor, giving sleeping medication along with three different narcotic opioids all simultaneously by Dr. Walden, do you believe that the evidence supports a finding of reckless conduct?

A. I do.

MR. SIMON: Mike, if we could, please, turn to Exhibit 60-7.

BY MR. SIMON:

Q. And, Doctor, as I said, there are many more side effects in the PDR, correct?

A. Yes.

Q. Okay. And I just wanted to put some of them up here so that we could go through and have you identify them. Can you generally go through these with the jury? What are sides effects and --

A. Side effects are undesirable adverse reactions to medicines. Of course, number one is constipation. That's an extremely important side effect of chronic opioid therapy, and every patient who is taking chronic opioid therapy needs a bowel regimen to protect them from getting severe or serious constipation.

A whole host of other GI side effects, but also then central nervous system, lack of energy, loss of strength, headache, drowsy, lethargy, mood changes. There's a very long list of -- of problems. And then in terms of brain functioning, mental clouding, impairment of mental performance, and physical performance, and so forth.

Q. So, Doctor, you mentioned a bowel regimen. What is it and why is it needed?

A. A bowel regimen is a laxative management that enables a patient to move his bowels while taking chronic opioid therapy. Basically, opioid drugs paralyze the gut, and the normal contraction of the gut that's called peristalsis that moves food and waste along in the digestive tract becomes very inactive or hypoactive. I've seen patients who had to be admitted to the hospital to be disimpacted who developed what are called stercoral ulcers, which are basically ulcers from basically rock-like stool forming in the colon that the patient can't pass.

So in order to protect the patient from that problem, patients on chronic opioid therapy, such as OxyContin and the other -- you know, hydrocodone, oxycodone, patients need to be counseled about that and advised about what medication regimen to take in order to avoid that -- the very serious forms of constipation that can develop from chronic opioid therapy.

Q. So, Doctor, did Brian Koon experience constipation?

A. Yes.

Q. Okay. Was that constipation caused or contributed to be caused by the opioids that were prescribed by Dr. Walden?

A. Yes.

Q. What, if anything, did Dr. Walden do to address that issue during the time Brian was his patient?

A. I could not find a mention in any note, not in a single note, that he ever counseled the patient about a bowel regimen while taking the opioid analgesics.

Q. Okay. Is that something you believe a physician should do if they're complying with the standard of care?

A. Yes, every physician prescribing opioid analgesics, both for short-term and for long-term use, must meet the standard of care by counseling the patient about side effects, notably constipation and how to manage it so that it doesn't become a serious problem.

Q. So, Doctor, you were here in the courtroom during opening statements; is that correct?

A. I was.

Q. Okay. And did you hear statements from counsel for Dr. Walden that Dr. Walden was very careful?

A. I did.

Q. Okay. And, Doctor, let me ask you this. Any physician who's prescribing opioid narcotics to a patient, should any physician -- every physician doing that should be very careful, correct?

A. That's correct.

Q. Okay. Doctor, I'm going to switch -- we're going to switch topics now. We've talked about the risks

of opioid narcotics. And, Doctor, let me ask you this. This is no surprise or secret, these risks and side effects that we've been going through this morning, correct?

A. No, they're well known.

Q. Okay. And anybody prescribing opioid narcotics certainly should know about them, correct?

A. They must know about them in order to be able to safely use these medications. Because in doing the risk and benefit analysis, some of the risks are treatable.

MR. VENKER: Your Honor, I'm just going to object as nonresponsive at this point.

THE COURT: Sustained. Rephrase.

BY MR. SIMON:

Q. Okay. Doctor, they are well known, correct?

A. That's correct.

Q. Okay. Doctor, is there a -- a recognized problem with the overprescribing of opioid narcotics?

A. Yes. There's been a market increase in prescription of opioid narcotics, and that's been going on for the past 15 to 16 --

MR. VENKER: Your Honor, may we approach?

THE COURT: Yes.

(The following proceedings were held at the bench.)

MR. VENKER: Your Honor, I'm going to object to this line of questioning for two reasons. One, I don't think I need to renew it, but I'm doing it out of an abundance of caution relating to opioid epidemic. And second, Dr. Genecin didn't talk about the epidemic in his deposition or render any opinions on how this related to this case. So I object on those grounds.

MR. SIMON: Your Honor, I did. It was all about opioid prescription, it was about mentoring programs that need to be in place because of abuse by doctors and abuse by patients. I mean, we can reread the deposition, it will -- he certainly testified about that. This kills people.

MR. VENKER: Well, that's not an opinion about the opioid epidemic, how it relates to this case. If you look at Dr. Genecin's deposition, you will see how his only opinions were about Dr. Walden's prescribing practices, how --

MR. SIMON: Judge --

MR. VENKER: Not about this social policy issue.

MR. SIMON: It went way beyond that in his deposition. He talked about the problem, how widespread the problem is, he talks about how it kills people, how it's a serious issue, how there needs to be, you know, limitations in place to prevent it from happening. It's

the whole basis of his deposition. If there was no problem with it, he wouldn't be advocating that there be some monitoring system in place. And he talked about the monitoring system in place at his facility, at other facilities. This is a central issue in the case.

MR. VENKER: Judge --

MR. SIMON: And we've already gone through this, Your Honor.

MR. VENKER: To hear John talk it sounds like if it weren't for the opioid epidemic they wouldn't be bringing a case against Dr. Walden. I can't believe that that would be an accurate statement to make. They've got a claim against Dr. Walden based on Dr. Genecin's opinions about his negligent prescribing practices. The opioid epidemic has nothing to do with that. And to let this witness now talk about it as if somehow it bore on what happened here is --

MR. SIMON: Judge, we are rearguing the motion in limine. This is an issue that he tried to keep out. You will remember the phrase of the term none of this happens in a vacuum. Okay. It doesn't happen in a vacuum. We're judging the doctor's conduct, we're judging the doctor's conduct in the environment in which the doctor practices. This is -- we're re-arguing the motions in limine. These are all the same points this doctor has

testified about, these issues in his deposition, and we should be able to -- this is our case. We should be allowed to present our case.

MR. VENKER: No, this is so irrelevant for this whole issue, it's prejudicial to have this witness talking about the opioid epidemic and how it relates to this care in this case. They want to talk about the opioid epidemic in some general sense, you allowed them to do that, but to have this witness now become a mouthpiece for the issue --

MR. SIMON: We argued the same thing in motions in limine.

THE COURT: My previous ruling is in effect. I do think it's relevant to talk about. I think the probative -- the value -- I do agree that there is some prejudice, but I think the probative value outweighs the prejudice. But my big concern is making sure that he answers your question.

MR. SIMON: Yes, sir.

THE COURT: Because I feel like he's --

MR. SIMON: Saying too much?

THE COURT: Yeah.

MR. SIMON: I'll do a better job controlling him.

THE COURT: You need to take that up. Because I think that's -- let's focus on that. But I do note your

objection, all right, I think a tighter dialogue would manage that better, but I'm not foreclosing the door to it. I just think it needs to be tighter dialogue.

MR. VENKER: So my objections are overruled, then, Your Honor?

THE COURT: Yes, sir.

MR. VENKER: All right. Thank you.

(Proceedings returned to open court.)

THE COURT: You may proceed.

MR. SIMON: Thank you, Your Honor.

BY MR. SIMON:

Q. Doctor, have articles -- journals, medical articles been written on the topic of opioid prescription use and misuse?

A. Yes, very many.

Q. All right. And has it been covered in the media?

A. It's been covered in the media, it's been covered in continuing medical education, in medical journals, in popular media. It's all over.

Q. Okay. And, Doctor, let me ask you this. Are you familiar with the CDC guideline for prescribing opioids for chronic pain?

A. Yes.

Q. Okay.

MR. VENKER: Your Honor -- are you going to be talking about that now? Your Honor, may we approach?

THE COURT: You may.

(The following proceedings were held at the bench.)

MR. VENKER: All right. I just want to renew the objections we made earlier to issues that involve events or standards of care or guidelines that are after the care involved. I know the Judge has overruled our objections, I believe, but I just want to make sure that it was limiting. I'm making the same -- I'm renewing that objection now about the CDC guidelines from -- of 2016, Your Honor, they were not in effect in 2008 to 2012. So I'm objecting again.

THE COURT: All right. So the record will reflect that you are renewing your objection. And I'm overruling the objection. Just -- it would help if you give -- I'm not going to tell you how to try your case, but it's clear -- if you give time -- to make sure we have time frames, reference points.

MR. SIMON: Yes, sir.

MR. VENKER: All right. And so this is good for this whole line of questioning, Your Honor, for this aspect of it? I don't have to renew that objection?

THE COURT: Anything regarding CDC guidelines

and your objection, yes.

(Proceedings returned to open court.)

MR. SIMON: Mike, could we please put up the first page of Exhibit 50-6?

BY MR. SIMON:

Q. Okay. And, Doctor, this is the CDC guideline for prescribing opioids for chronic pain and it's dated 2016; is that correct?

A. That's correct.

Q. Okay. And, Doctor, can you tell the members of the jury generally what the CDC is and what CDC guidelines are?

A. So the Centers for Disease Control and Prevention is the CDC. It's an agency -- it's a Federal agency in Atlanta that looks at epidemic diseases. We hear about it with Ebola, about Zika virus, about influenza, meningitis, and about prescription opioids, because they affect large numbers of people.

Their periodical is called the MMWR, which is Morbidity and Mortality Weekly. And in that is the published guidelines for opioids in order to address these -- patient safety priority of making prescribing of chronic opioid therapy safe.

Q. Okay. And, Doctor, is this guideline something that is typically relied on and used by members of your

profession?

A. Yes, it is. It's a reflection of what the medical literature says and what the epidemiology shows, and it's very heavily relied on by practicing physicians.

Q. Okay.

MR. VENKER: Your Honor, I'm just going ask that last answer be stricken as nonresponsive.

THE COURT: Sustained. The jury will disregard the last answer and it will be stricken from the record. Rephrase.

BY MR. SIMON:

Q. Okay. Doctor, this guideline -- is this guideline relied on by practicing physicians, including internists, in the course of their practice?

A. Yes.

Q. Okay. And, Doctor, what I want to do, does this -- does this guideline provide or contain information about problems with overprescribing of opioids?

A. Yes, indeed, it does.

Q. And is it a compilation going back several years of information?

A. Yes.

Q. Okay. All right.

MR. SIMON: Can we please, Mike, go to -- I think it's Page 003. Okay. And can we blow that up,

please?

BY MR. SIMON:

Q. Okay. And this is under the section that says introduction and background. Is that correct, sir?

A. Yes.

Q. And it says, "opioids are commonly prescribed for pain. An estimated 20 percent of patients presenting to physician offices with non-cancer pain symptoms or pain-related diagnoses, including acute and chronic pain, receive an opioid prescription. In 2012, healthcare providers wrote 259 million prescriptions for opioid pain medication, enough for every adult in the United States to have a bottle of pills. Opioid prescriptions per capita increased 7.3 percent from 2007 to 2012, with opioid prescribing rates increasing more for family practice, general practice, and internal medicine compared with other specialties."

Have I read that correctly, Doctor?

A. Yes.

Q. Okay. Doctor, do you agree with those statements?

A. Yes.

Q. Do those statements support the opinions that you are giving in this case?

A. They do.

Q. Okay.

MR. SIMON: Mike, would you please turn to the next page. If you could blow up the highlighted section on the left. And I don't know if I identified the exhibit. It's Exhibit 50-6.

BY MR. SIMON:

Q. The highlighted portion states, "on the basis of data available from health systems, researchers estimate that 9.6 to 11.5 million adults, or approximately 3 to 4 percent of the adult U.S. population, were prescribed long-term opioid therapy in 2005.

Opioid pain medication use presents serious risks, including overdose and opioid use disorder. From 1999 to 2014, more than 165,000 persons died from overdose related to opioid pain medication in the United States. In the past decade, while the death rates for the top leading causes of death, such as heart disease and cancer, have decreased substantially, the death rate associated with opioid pain medication has increased markedly. Sales of opioid pain medication have increased in parallel with opioid-related overdose deaths. The drug abuse warning network estimates that more than 420,000 emergency department visits were related to the misuse or abuse of narcotic pain relief in 2011, the most recent year for which data are available."

Doctor, have I read that correctly?

A. Yes.

Q. Do you agree with those statements, Doctor?

A. Yes.

Q. Do those statements support the opinions that you're going to give in this case?

A. They do.

MR. SIMON: And, Mike, if you could please go down to the bottom.

BY MR. SIMON:

Q. The document further states, "in 2013, on the basis of DSM-VI diagnosis criteria, an estimated 1.9 million persons abused or were dependent on prescription opioid pain medication. Having a history of a prescription for an opioid pain medication increases the risk for overdose and opioid use disorder, highlighting the value of guidance on safer prescribing practices for clinicians."

Have I read that correctly, Doctor?

A. You did, yes.

Q. Do you agree with that?

A. Yes.

Q. Does that information support the opinions that you're going to give in this case?

A. Yes.

Q. Okay. Doctor, it further states, "for example, a recent study of patients aged 15 to 64 years --

MR. SIMON: And, Mike, if we could go up to the right-hand column. There we go.

BY MR. SIMON:

Q. " -- receiving opioids for chronic non-cancer pain and followed for up to 13 years revealed that one in 550 patients died from opioid-related overdose at a median of 2.6 years from their first opioid prescription, and one in 32 patients who escalated to opioid dosages above 200 morphine milligram equivalents died from opioid-related overdose."

Have I read that correctly, Doctor?

A. Yes.

Q. Do you agree with those statements?

A. Yes.

Q. Does that information support the opinions that you're going to give in this case?

A. I think so, yes. Very strongly.

Q. Doctor, I want to talk to you about that. This study that's referred in the -- this is a government document, correct, Doctor?

A. That's correct, yes.

Q. From the United States Federal government? That's where these statistics are from, correct?

A. That's correct.

Q. Okay. And what is this telling us? It says that -- I'm sorry.

MR. SIMON: Go back to the -- go back to the earlier page, please, Mike. Yeah, there we go.

BY MR. SIMON:

Q. It says, "for example, a recent study of patients, ages 15 to 64 years, receiving opioids for chronic non-cancer pain and followed for up to 13 years revealed that one out of 550 of these patients died from overdose."

Is that what that's telling us?

A. Yes.

Q. Okay. And then it goes further to say, "when the -- when the doses were at 200 morphine equivalent -- I'm sorry, morphine milligram equivalence -- or morphine equivalent doses" --

In other words, once these patients -- the patients that were on a dose of more than 200 per day died at a rate not -- 500 -- I'm sorry. Died one out of every 32 patients, correct?

A. That's correct.

Q. Okay. So one out of 32 patients receiving 200 milligrams or more a day died from overdose. Is that your understanding?

A. Yes. So, if everyone in this room were taking --

MR. VENKER: Your Honor, may I object? I'm going to object as nonresponsive.

THE COURT: Sustained. Rephrase the question.

BY MR. SIMON:

Q. Doctor, I'll ask you a question. So, Doctor, let me ask you this. You agree with this study, Doctor?

A. Yes.

Q. So, Doctor, at this rate -- this is the rate, I believe, in 2009. Right? This is what Dr. Walden was giving Brian Koon on average per day, correct?

A. That's milligram -- that's morphine equivalent doses, and, yes, that was 2008.

Q. Okay. So that's the same thing they're talking about in the study, correct?

A. That's right, yes.

Q. Okay. And at this dose -- at this dose -- he was on this dose for an entire year, correct?

A. I think 2009.

Q. 2009. Fair enough.

A. Yeah.

Q. And at this dose one out of 32 people on this dose died of overdose, correct?

A. That's correct.

Q. And the dose that Brian ended up with was what, Doctor?

A. In 2012 he was taking a daily dose of 1,555 morphine equivalent doses.

Q. So according to the CDC study one in 32 people on 200 milligrams were overdosing and dying, correct?

A. Yes.

Q. And Dr. Walden had Brian for a year on a dose of seven and a half times that amount, correct?

A. That is correct.

Q. Doctor, let me switch gears a little bit. Let's talk about the decision to use or not use opioid narcotics, okay?

A. Yes.

Q. When should -- let's talk about long-term use for chronic pain. Let me ask you this, Doctor. Opioids are sometimes used for cancer, correct?

A. That's right.

Q. Or severe burn injuries, correct?

A. That's correct.

Q. Or end of life issue, correct?

A. Correct.

Q. Okay. And what I want to talk to you about is, you know, using -- when to use -- let's talk about back pain.

What is your understanding of the injury -- the back -- the injury that Brian -- for which Brian was receiving these opioids?

A. There was no detectable abnormality on MRI scan, so he had a lumbosacral strain type of a condition with chronic low back pain very frequently seen in primary care.

Q. Okay. And, Doctor, when should long-term opioid narcotics be used for chronic low back pain?

A. In essence, never. For this kind of pain, never. Young man, functioning, working, with musculoskeletal pain, no detectable etiology or abnormality on the scan, there's no reason for a patient like that to be put on chronic opioid therapy. To do so adds a second disease to the patient's chronic back pain, which is opioid dependency and possibly addiction.

Q. Doctor, is chronic opioid -- what is -- by chronic -- what does chronic opioid therapy mean?

A. Well, 90 days, basically, is the cutoff for acute to chronic. So it may be quite appropriate to treat a patient with an acute flair of severe low back pain, the patient that throws his back out, the patient with a slipped disc may need to have a short course of opioid medication, and prescribing oxycodone for that is perfectly fair. But understanding that you're setting a

target of a short duration of therapy.

One of the reasons for that is because it has not -- opioid narcotics have not been found to be useful in treating long-term low back pain. So, in terms of selecting patients for whom the treatment is likely to work, low back pain patients are not likely to benefit from long-term opioid therapy, in terms of pain control.

MR. VENKER: Your Honor, I'm just going to object again. I think we're getting beyond nonresponsive.

THE COURT: Ask another question.

MR. SIMON: I'll ask another question, yes, sir.

BY MR. SIMON:

Q. So, Doctor, you're getting to my next question, and my next question is, is chronic opioid therapy, long-term opioid therapy, is that an effective treatment for low back pain?

A. No. As I said, it's a fair treatment for short term, very severe flareup of low back pain, but it's not appropriate for long term chronic treatment with opioids.

Q. Okay. Doctor, do you have an opinion as to whether or not Brian Koon should have been on long-term opioid narcotics for his back pain?

A. Yes, I do.

Q. What is that opinion?

A. That this was an inappropriate treatment for

Mr. Koon for his low back pain.

Q. Okay. Doctor, I want to switch subjects a little bit again. We were looking at the PDR. Remember when we were looking at the PDR and it talked about a risk/benefit assessment?

A. That's correct.

Q. Okay. And I think it says you need to do a risk/benefit assessment at the get-go, before you even put a patient on opioid narcotics. Correct?

A. That's correct.

Q. Okay. And I want to talk to you a little bit more about that. And we know it's important to do that, correct, Doctor?

A. It's mandatory, sure.

Q. Okay. And I really want to talk to you about what that consists of. Do you follow me?

A. Yes.

Q. In other words, when we say, well, we need to do a risk/benefit assessment, what does that mean?

A. Well, it means that the doctor, with the patient -- very importantly with the patient, looks at the pros and cons and ensures that the pros outweigh the cons for using a medication or undertaking a treatment, doing a test, any kind of medical service needs to be looked at in terms of the pros and cons, risks and benefits, and there

should be a strong argument in the pro, in the benefit column, relative to the risks in order for that to be an appropriate or safe treatment.

Q. Okay. Doctor, does the standard of care require that a proper risk/benefit assessment be completed and documented by a physician before the doctor gives opioid narcotics to the patient?

MR. VENKER: Your Honor, I have an objection. May we approach?

THE COURT: Yep.

(Whereupon, the following proceeding were held at the bench.)

MR. VENKER: My objection is only as to one part of this opinion that Mr. Simon has asked about, and that is the documentation. Dr. Genecin talked about the risk assessment benefit needing to be done, but he didn't have any opinion in his deposition about the documentation for it, so I object to that part of this question. And I --

MR. SIMON: I disagree, Judge. I think it was covered thoroughly in his deposition.

THE COURT: All right. I'm going to overrule, and you can proceed down this way.

MR. SIMON: Yes. Thank you.

(Proceedings returned to open court.)

BY MR. SIMON:

Q. Doctor, I think I was asking you to -- we were talking about the fact that the doctor needs to do a risk/benefit assessment, right?

A. Yes.

Q. Okay. And it's important to do that, correct?

A. Yes.

Q. Okay. And you've done that before, correct?

A. Yes.

Q. Okay. And you believe it's -- it should be done, correct?

A. Yes. For undertaking a serious intervention like starting a patient on chronic opioid therapy, it's mandatory.

Q. Okay. And, Doctor, does the standard of care, a good practice, require that that be done?

A. Yes.

Q. Okay. And can you tell the members of the jury how -- how you do that, how a doctor goes about doing that?

A. Well, a doctor has to talk with the patient and weigh the risks and benefits with the patient. Because it's not just the doctor saying this, that the benefits outweigh the risks. You have to talk about what the risks are so that a patient can understand and make informed

consent to undertaking treatment.

So is this treatment likely to be helpful, and if so, what kind of treatment, what duration of treatment, and in what way is it likely to be helpful, how will we monitor effectiveness and so forth. Those are in the pro column.

The cons are what's the down side, what's the risk to me, what can happen to me as a result of this treatment, how likely are those bad outcomes, what should I -- what do I need to know about that I might not, as a patient, know to ask. What are the cons, the down sides to taking this treatment.

And then, really, ultimately, the patient has to decide. But the doctor has to be willing to provide a prescription or an order, and patients rely on the doctor's recommendations, trusting that a doctor has leveled with them about the risks and benefits.

Q. Okay. And, Doctor, a part of this risk/benefit assessment, is it -- should the risk/benefit assessment be documented in writing in the doctor's records?

MR. VENKER: Object as leading, Your Honor.

THE COURT: Rephrase.

BY MR. SIMON:

Q. Do you have an opinion as to whether or not this risk/benefit assessment should be documented in the

doctor's records?

A. I do.

Q. What is that opinion?

A. My opinion is that the doctor needs to record the essential points that went into the decision to use the medication, and that the patient was informed of risks and what those risks were and why that decision was made.

That's an essential part of keeping a medical record.

Q. Okay. And -- again, I'm asking you the same thing. You looked at -- did you look for a risk/benefit assessment when you were reviewing Dr. Walden's records?

A. Yes.

Q. Okay. What did you see?

A. There was never any statement that resembled the content of a risk and benefit, although Dr. Walden used the term risk/benefit. What he meant by that was not clear. And this was in a setting where, in my opinion, the risks far outweighed the benefits.

Q. Okay. And, Doctor, what I'd like to do now with you is go through a few pages of Dr. Walden's actual medical records with the jury. Correct? Is that okay?

A. Yes.

Q. Okay.

MR. SIMON: Let's -- Mike, if we could, let's go

to Page 14 of Exhibit 1-1.

BY MR. SIMON:

Q. And, Doctor, this is a SLUCare record, right?

A. Yes.

Q. Okay. And this is part of Brian Koon's medical chart from Dr. Walden's office, right?

A. Yes. I assume so. I can't read what's written there.

Q. Okay.

MR. SIMON: And let's go to the highlighted portion, please, Mike.

BY MR. SIMON:

Q. Okay. The date here, Doctor, is February 21st of '08; is that right?

A. Yes.

Q. Okay. And was this -- this was the time -- about the time that Dr. Walden first put Brian on long-term opioid therapy, correct?

A. Yes.

Q. Okay. And, so -- matter of fact, this would be the visit -- I'm sorry, the visit right before he was put on long-term opioids; is that your understanding?

A. Yes. That visit he was not prescribed opioids, but he started opioids very soon after.

Q. About eight days later, right?

A. Yes.

Q. Okay. Let's look at this. So this would have been an office visit, right?

A. Yes.

Q. Okay. And it says, "patient is 36 year old male, hypothyroidism, hyperlipidemia, depression and smoking who is here for follow up. He complains of back pain. It is in the thoracic region. He states he threw his back out toweling off after a shower. It causes him significant pain, midline location. He has seen a chiropractor who has done some manipulation of the spine with some improvement of his lumbosacral pain. He does heavy lifting on his job and has been on a restricted lifting schedule over the past month since his injury. He noticed no radicular pains. No numbness or tingling is present. He otherwise feels much better after the increase in thyroid medication in '07."

Let's go down to assessment. Dr. Walden did a physical examination, correct?

A. Yes.

Q. And it's in the middle, right? And then there's an assessment and plan. And that's what Dr. Walden -- how he assessed the situation and what he planned to do, right?

A. That's right.

Q. Okay. And let's look at what Dr. Walden put in there. He says, "back pain, tender to palpation over the thoracic spine. Will check PA -- what's PA, Doctor?

A. That's posterior -- posterior anterior. It's the two views of the X-rays that were ordered were -- having the patient posterior anterior, and then lateral. Those were the two views that were used to look at the X-ray.

Q. Okay. So Brian goes to Dr. Walden on 2/21/08, tells him about the back pain, and Dr. Walden wants to do an X-ray, right?

A. Yes.

Q. Okay. And then he says continue, and there's two medications there. What are those?

A. One of them is a muscle relaxant. I think cyclobenzaprine is Flexeril, I think. And Advil, which is Ibuprofen, it's an over-the-counter nonsteroidal anti-inflammatory drug.

Q. Either of those opioids?

A. No.

Q. Either of those narcotics?

A. No.

Q. Either of those Schedule II medications?

A. No.

Q. Okay. And, so -- down at the bottom, that's Dr.

Walden's signature we see, correct?

A. Yes.

Q. All right. Okay. And let's turn to the following page, please, Exhibit -- Page 15 of Exhibit 1-1. And this is the X-ray that was taken, right?

A. Yes.

Q. And what do we see on the X-ray? What's the finding?

A. There was -- negative. There was no -- there were no findings.

Q. No fracture, nothing broken, right?

A. Yes.

Q. Okay. All right. And, so, let's turn then to the next page, Exhibit 1-1, Page 16. And just to put this in context so everybody can follow, on February 21st, that's when he came to visit Dr. Walden with the complaint of back pain, correct?

A. Yes.

Q. And Dr. Walden gave him the medications and did the X-ray, right?

A. That's right.

Q. Okay. So this is 2/29/08, right?

A. Yes.

Q. And what's that, eight days later?

A. Yes.

Q. Okay. And what's going on here, Doctor?

A. This is a telephone message -- this is the record of a telephone transaction that Mr. Koon had in which he said that he had been in on February 21st and had X-rays for his back, and that he still -- that the back is still giving him discomfort, muscles and vertebrae, Advil is not helping, so wanted him to call in something -- he said it's been going on for some days. I can't read it very well.

Q. Okay. And his back is still giving him --

A. Patient discomfort. Yeah.

Q. Okay. So back is still giving patient discomfort. That's how it's described, discomfort?

A. Yes, discomfort.

Q. Okay. All right.

A. And then Advil is not helping --

Q. On some days?

A. On some days. Correct. On some days.

Q. So, in other words, he's calling back in and he's saying he still is experiencing some discomfort on some days, right?

A. That's correct.

Q. Okay. And so what do we see up here, Doctor?

A. What we see is -- Dr. Walden -- he would like Dr. Walden to prescribe another medication, and Dr. Walden

by telephone calls in a prescription for Vicodin, which is hydrocodone, 5 milligrams with acetaminophen, which is Tylenol 500 milligrams. That's a combine drug with both of those medicines. And calls in 30 of those pills with the instruction to use one of them, I believe, every six hours as needed. So 30 of them would be approximately seven to eight days.

Q. Okay. And he gets one refill, right?

A. That's correct.

Q. Okay. So eight days later Brian calls him, says he's still having some discomfort on some days, and does it look to you as if Dr. Walden talked to Brian on this date?

A. It's not clear that he did or didn't. It's a message that was taken.

Q. Taken by this person?

A. But there's no statement that Dr. Walden talked with the patient.

Q. Okay. So Dr. Walden -- somebody -- Brian calls in Dr. Walden's office and talks to somebody other than Dr. Walden, it looks like, correct?

A. Yes. Yes. That's correct.

Q. Okay. And Dr. Walden, in response to a telephone call, without talking to Brian, prescribes 60 narcotic opioid pills, correct?

A. Yes.

Q. So, Doctor, let me ask you this. There was no visit associated with this, correct?

A. That's correct.

Q. Do you see any risk/benefit analysis in this record?

A. No. He just called in the medication to the drug store, and -- with an instruction for the patient to use it.

Q. Okay. And, so, let's turn, if we could, please, to Page 17 of Exhibit 1-1. Okay. And we were just looking at the date of 2/29/08, right?

A. Yes.

Q. Okay. And this is 3/31. That's about a month later, right?

A. Yes.

Q. Okay. What's going on here?

A. It's another phone call, it's a message for Dr. Walden, the date and time are given, the patient's information, and wife, and her phone number are given, pharmacy phone number is given. And Mr. Koon wanted a refill on Vicodin, and the directions that he had been given are one tablet every six, but it states that Mr. Walden(sic) is taking two pills every six, and he wants pain med called in and stronger pain med.

Q. Okay. This is another phone call, not a visit, right?

A. That's a phone call.

Q. Okay. And this is about 30 days after Dr. Walden prescribed 60 opioid narcotic pills to Brian, right?

A. Yes.

Q. Okay. And, so, Dr. Walden here prescribes a refill of another 60 pills, right?

A. That's right.

Q. Or another prescription of another 60 pills with three refills, right?

A. That's right.

Q. So how many pills is that altogether?

A. It's 180 pills -- or 240 pills.

Q. Okay. So thirty days later, still without seeing him, right?

A. Yes.

Q. Still without doing a risk/benefit assessment, correct?

A. That's correct.

Q. He now, over the phone, prescribes an additional 240 narcotic opioid pills, correct?

A. That's correct.

Q. Okay. So at this point, in this 30 day -- about

30 day period of time he's given him -- was it 360 pills total?

A. Yes.

Q. Right? 240 here, and then the first time was 30 with one refill, right?

A. Yes.

Q. Okay. So, as of this point, over a 30 day period, he's prescribed 360 opioid narcotic pills to Brian, correct?

A. I think 300. I'm not exactly sure.

Q. 300? Okay.

A. Yeah.

Q. Well, it was 30 with one refill. So it's 300 pills, you're right, Doctor.

A. Yes, yes.

Q. So he's prescribed at this point 300 opioid narcotic pills for low back pain with a negative X-ray, right?

A. That's correct.

Q. Okay. And he hasn't seen the patient yet, right?

A. He just saw him the one time for pain.

Q. Okay. All right. So -- let's go to -- well, Doctor, do you see any information about talking about risks, about side effects, about addiction, about

overdose? Do you see any of that information in this record?

A. No, none whatsoever.

Q. Did you see any such information up to this point in the medical records?

A. No.

Q. So he's prescribed 300 pills at this time, opioid narcotic pills, and you don't see one mention in the records of risks, addiction, death, overdose, or any side effects; is that correct?

A. That's correct.

Q. Okay. All right. Is that what a careful doctor would do, in your opinion?

A. No, of course not.

Q. Okay. So, Doctor -- now this -- again, we're at 3/31, March 31st of '08, right?

A. Yes.

Q. Okay. And let's go to the -- let's go to the following page, Page 18 of Exhibit 1-1. Correct? Okay. And this is an office visit, and this would be the very next day, right?

A. April 1st, yes.

Q. Right? This is April 1st, and it's an office visit, correct?

A. Yes.

Q. Okay. And, so, Doctor, what happens at this point? This is the very next day, the day before he got 240 pills, right?

A. Yes.

Q. Okay. What is the -- what does Dr. Walden do as far as prescribing pills on this day?

A. He prescribes more.

Q. Say that again.

A. He prescribes more. Additional.

Q. The next day?

A. Yes. The following day.

Q. Okay. And how many does he prescribe this day?

A. I need to remind myself. I don't remember exactly.

Q. Okay. All right. Let's do this. Doctor, you've also been provided and reviewed the pharmacy records, right?

A. That's correct.

Q. Okay. And I would like to direct your attention, Doctor, to Exhibit 30. And these are records from Walgreens pharmacy.

MR. SIMON: And, Mike, if you could go to Exhibit 30, Page 29. If you blow that up, please.

BY MR. SIMON:

Q. So these are the Walgreens records, right,

Doctor?

A. Yes.

Q. Okay. And we see up here, the highlighted -- we see what's highlighted here, this is the -- this is -- remember he called in on the 29th of February, right?

A. Yes.

Q. And so this documents that Dr. Walden's prescribing 30 pills, right?

A. Yes.

Q. Okay. And what is this here?

A. That's -- that's the -- I'm not sure.

Q. Let's see. Refills? Days?

MR. VENKER: I'm just going to object to lack of foundation, if the witness doesn't understand the exhibit.

THE COURT: Sustained. Rephrase the question.

BY MR. SIMON:

Q. Okay. Doctor, it says here 30. And you understand that to be the number of pills, right?

A. Yes.

Q. Okay. And down here we know on 3/31/08 he prescribed 60 pills with three refills, right?

A. Yes.

Q. Okay. And for a fifteen day supply, correct?

A. That's correct.

Q. Okay. And if it's all the same here, that would

mean it would be one refill up here, and that's consistent with the medical record, right?

A. That's correct.

MR. VENKER: Object as leading, Your Honor.

THE COURT: Overruled.

BY MR. SIMON:

Q. So what we're looking at here, Doctor, is these would be the first three prescriptions of opioid pain -- or opioid narcotics, correct?

A. Yes.

Q. Okay. And, so, we've got the 30 pills with one refill. That's 60 pills, right?

A. Yes.

Q. And then -- and that's on a telephone call, right?

A. That's right.

MR. VENKER: I'm just going to object as leading and asked and answered, Your Honor.

MR. SIMON: I'm moving on to the next one, Your Honor.

THE COURT: All right.

BY MR. SIMON:

Q. And then, Doctor, we see 3/31/08, and it's 60 pills, three refills, for fifteen days, correct?

A. That's correct.

Q. And that would be -- we talked about that before. That would be -- 60 and 180 would be 240, right?

A. Correct.

Q. Then what do we see down here, Doctor? What's the date there?

A. April 2nd.

Q. Okay. Just a couple days after this call in, right?

A. Two days.

Q. Two days later. So he gives him 240 pills here, and then --

A. That's correct.

Q. -- according to these records from the pharmacy he gives him another 240 pills --

A. That's correct.

Q. -- forty-eight hours later?

A. That's correct.

Q. As of this point, Doctor -- so he's got 240 -- that's 540 opioid narcotic pills at this point, right?

A. Yes.

Q. Okay. In a matter of about a month, about thirty days, right?

A. Yes.

MR. VENKER: Object to leading questions, Your Honor.

THE COURT: Rephrase.

BY MR. SIMON:

Q. Doctor, up to this point, up to April 2nd of 2006(sic), up to this point where Brian has now received 540 opioid narcotic pills from Dr. Walden, did you see anything in the records about some type of risk/benefit analysis?

A. No.

Q. Did you see anything in these records about Dr. Walden carefully sitting down with Brian and Michelle and talking to him about all these risks that we've seen this morning?

A. No.

Q. Is that something that you would expect a careful doctor or a good doctor to do?

A. Definitely, yes.

Q. Okay. Let's --

MR. SIMON: Mike, let's go back to Page 19 of Exhibit 1-1. Can you blow that up? Perfect. Okay.

BY MR. SIMON:

Q. And, Doctor, the date here is 4/16/08, correct?

A. Yes.

Q. So this is -- this is fifteen days after the last visit, correct?

A. Yes.

Q. Okay. So fifteen days before he got another 240 pills, what's going on here?

A. Well, in the interim of that visit -- we didn't go through the whole thing -- Dr. Walden sent Brian Koon for an MRI. So Mr. Koon is calling for the results of the MRI, and he stated that he -- so the person who's writing this message, it's a phone message, "having to take more than the prescribed dose of meds. They work, but he just has to take more of them."

The -- and then the result of that message is Dr. Walden wrote a note saying, "discussed with patient, refer to ortho spine", and the name of a doctor or another doctor. I can't read the names. And then he increased the dose of Vicodin to -- from the 5-milligram pills to the 7.5-milligram pills, and he wrote for 90 of them, and it looks like three refills.

Q. Okay. So the last visit we're talking about -- which was on April 1st, right?

A. Yes.

Q. So this is -- this is fifteen -- two weeks later, right?

A. Correct.

Q. Okay. And it's a phone call, right, not a visit?

A. It's a phone call.

Q. Okay. And I noticed here, too, Doctor -- so he gets -- Brian gets another prescription from Dr. Walden, and we're in about -- we're about six weeks now, right?

A. Six weeks.

Q. Okay. Six weeks. And he gets another prescription from Dr. Walden for 90 and three refills. Three refills would be 270, right?

A. 270, and milligram of dosage of Vicodin is 50 percent higher.

Q. So it would be 360 altogether, right? So he gets 360 -- 360 more pills here on 4/16, right?

A. Right.

Q. Okay. He's got over a thousand pills at this point, right?

A. Right. And these last ones are a higher dose.

Q. And by that you mean -- right here -- I don't want to get in anybody's way. Right here, Doctor, is what you're talking about?

A. Right.

Q. In other words, before they were 5/500?

A. Yes.

Q. 5 milligrams, right?

A. Correct.

Q. And, so, he increases the dose, the potency of each pill by 50 percent, correct?

A. That's correct.

Q. Okay. And he gives him 360 of those, right?

A. That's right.

Q. Okay. And this -- all of this is happening in the first six weeks, right?

A. That's correct.

Q. For undiagnosed low back pain?

A. Right.

MR. SIMON: Okay, Mike, if we could turn to Page 20 of Exhibit 1-1.

BY MR. SIMON:

Q. So, Doctor, this is the next day, right, 4/17?

A. Yes.

Q. Okay. What's going on here?

A. It's a message to Dr. Walden from Mr. Koon, giving demographics and pharmacy information, and I think the pharmacy is actually the caller here, it's not the patient, and the pharmacy is drawing attention to the fact that there are two different Vicodin prescriptions that are overlapping and asking if Dr. Walden is aware and if this is okay.

So this is the pharmacy concerned about the amount of narcotic and the frequency of these prescriptions.

Q. So you've got the pharmacy calling Dr. Walden's

office?

A. That's right.

Q. What is Dr. Walden's response?

A. He just okays it. He writes okay and signs.

Q. Right here (Indicating)?

A. Yes.

Q. And, Doctor, I'm not going to go over all of Dr. Walden's records with you, but you've reviewed all of them, correct?

A. I have.

Q. Okay. Doctor, we also saw in the PDR, and we talked a little bit about -- earlier today about the importance of monitoring. In other words, once you make a decision to put a patient on long-term opioid therapy for back pain, or for whatever you've got them on them for, you need to watch the patient, correct?

A. That's correct.

Q. Okay. And the same thing, you've already told us why that's important, it's noted in the PDR, correct?

A. Yes.

Q. Okay. Can you tell the jury what that -- what that consists of? What should a good doctor be doing if the doctor is monitoring one of his or her patients who are on opioid narcotics?

A. Well, monitoring against -- with an explanation

to the patient at the start of therapy that monitoring will be necessary, that that will mean regular visits, and it starts with how effective is the patient's medication.

So there's a -- there are scales that are used where -- one to ten scale is one, or faces with a smiley face at one end and a frown at the other. These are called Likert scales, and they're pain scales, and they're used to try to get the patient to give you as objective as possible a measure of how he's doing.

If he's improving, then -- pain that was eight out of ten, where ten is the most severe pain, now six out of ten, then that's an improvement. If a patient had pain that was four out of ten, but now it's nine out of ten, then that patient is much worse. That's -- so that's the severity of pain.

The other aspect of the treatment that the doctor is monitoring is function. So, for example, a patient who says -- you know, works as a waitress, hypothetically has severe foot pain due to a problem and gets put on an opioid for pain relief, then the question would be, well, how long can you stand up before, you know, the pain comes back. And if the patient is saying I can now stand up for two and a half hours before I need a break, and before it was only one hour, then that's an improvement. You have something about the patient's

function that you're objectively measuring.

So it's those two facets, how well is the patient doing in terms of the desire to pain relief and improvement and function, and then monitoring for problems and monitoring for side effects specifically, and those include all those ones that are listed; the bowel regimen, the other types of experiences the patients have complained about in using these medications.

One of the important roles that the doctor has in prescribing chronic opioid therapy --

MR. VENKER: I'm just going to object as nonresponsive, Your Honor.

THE COURT: Ask another question.

BY MR. SIMON:

Q. Okay. And, Doctor, what is opioid -- I'm sorry, Doctor, let me ask you this. You've talked about monitoring for issues or problems with a patient, correct?

A. Yes.

Q. Okay. And that also would include monitoring for issues involving possible addiction, right?

A. Yes. I was just going to say that the -- one of the ways that the doctor monitors for addiction is through the pattern of opioid use. So looking at how frequently the patient is calling and what's happening with the doses that are increasing. That's one way of assessing it.

Another very important way is doing drug testing. So the patient at visits will have a urine test, and that's to look for the presence of the drug that should be in the patient's urine, and to make sure that the drugs of abuse or other drugs are not in the patient's urine. So you can't safely be prescribing to a patient who's not using his medication or who's taking other drugs, legal or illegal drugs, that the doctor doesn't know about.

So drug testing is another aspect of monitoring. And it's required in order to ensure that a patient is getting appropriate care.

Q. So, Doctor, the monitoring of the patient would be looking at how the -- what the pain situation is, documenting that, right, to see if they're getting a benefit, correct?

A. Yes.

Q. And also looking out for these other signs of possible problems?

A. Problems that may be recognizable through the pattern of refills and pharmacy communications, what the patient tells the doctor about how he's having to use the medication, is it more and more in order to get the same effect. Side effects, toxicity, and then monitoring for the presence of other drugs that the doctor's not

prescribing.

Q. Okay. And, Doctor, is it important that monitoring -- patient monitoring be documented in the doctor's records?

A. Absolutely. And the patient who's on regular opioid therapy long term is seeing his doctor every two to three months when he's at a stable dose. When a patient is increasing his dose rapidly, that should be done in the context of a visit and always with the risk and benefit assessment being redone to ensure that the parameters are safe, the patient is not getting too much medicine and that you're not exposing the patient to a risk of harm.

Q. And, Doctor, what is sensitization, as far as somebody who's on opioid medication?

A. Sensitization is a phenomenon of pain worsening as a consequence of pain medication. A patient who tells you as he's taking his pain medication the initial symptom is discomfort. But then he's taking medication he has pain and more pain and has to take more and more, one of the issues that you're alert to is that this patient is --

MR. VENKER: Object again as nonresponsive, Your Honor.

THE COURT: Rephrase.

BY MR. SIMON:

Q. Doctor, are you familiar with sensitization?

A. Yes.

Q. Can you please explain to the members of the jury what sensitization is and how -- what are the signs and symptoms?

A. Sensitization is a -- is the phenomenon of pain worsening as a consequence of the drug treatment. It's recognized in all kinds of pain, including daily headaches, including back pain, and other kinds of pain. And signs of sensitization are pain that is paradoxically increasing, getting worse despite the presence of this medication.

So one of the things the doctor has to be alert to with a patient whose problem starts with discomfort and then it gets to be more and more pain is that the pain medication is actually causing part of this problem. It didn't cause the problem to start, but it's a factor in the pain worsening and worsening. And the treatment for that is to stop the narcotic medication.

And I think that more likely than not Mr. Koon had sensitization. And you can read that through the -- the notes starting with the discomfort, then pain, and more pain, and taking more medication in order to manage the pain. That's a pattern of drug use that may reflect abuse and addiction tolerance, but it's also a pattern of use that may reflect sensitization.

And that's where a doctor is inadvertently harming his patient by actually making the purpose for pain relief worse with the prescription.

Q. So, Doctor, we talked about monitoring the patient.

A. Yes.

Q. And now I want to talk to you about monitoring the medication. In other words, is it important to monitor the amount, the number of pills, the dose that a patient is receiving?

A. Absolutely mandatory. Because there are safe parameters for prescribing narcotic analgesics, and doctors cannot meet the standard of care and bring it through those limits and overdosing their patients.

Q. And, Doctor, do you believe that Dr. Walden and St. Louis University should have monitored the amount of opioid narcotics given to Brian Koon?

MR. VENKER: Your Honor, may we approach?

THE COURT: Yes.

(The following proceedings were held at the bench.)

MR. VENKER: Your Honor, we're going to object to any opinions about St. Louis University. We raised this in pretrial motion in limine. I have copies of Dr. Genecin's deposition testimony here to renew again and

show he does not have any opinions about St. Louis University and monitoring. I'm prepared to show the Court the actual pages.

THE COURT: Why don't we do this. This would be a good time for our morning break. That way we can do it outside the hearing of the doctor and the jury.

(Proceedings returned to open court.)

THE COURT: All right, ladies and gentlemen, we're going to take our first morning break.

(Whereupon, Instruction 300.04.1 read to the Jury.)

THE COURT: We'll take a fifteen minute morning recess.

(Whereupon, a short recess was taken.)

THE COURT: We are on the record outside the hearing of the jury and the witness regarding the objection. I believe this is a renewal of the motion in limine 17.

MR. VENKER: It's dealing with St. Louis University, Your Honor. It's about St. Louis University. I'm not sure -- I didn't memorize the number. But it is the only motion in limine with St. Louis University.

So Mr. Simon asked the question of Dr. Genecin regarding Dr. Walden and St. Louis University. I objected. So we want to renew our motion that Dr. Genecin never gave

opinions about St. Louis University, and his opinions were only about Dr. Walden. And I would point the Court to a couple of different pages in the transcript, which I've Post it noted on Page 27, where I asked the question of Dr. Genecin to tell me -- I said why didn't you tell me -- I guess I'll ask you what I call headline fashion or main headings of your opinions that are in the case and then we'll go back and talk about them, all right? Let's try to get a list. And basically he says yes, my opinions are quite narrowly focused on Dr. Walden's prescribing practices. And he says with reference -- with specific reference to opioid analgesic, and then he mentions a little bit more.

And then on Page 30 he talks about monitoring, about line twelve. Okay, yes, with respect to monitoring there are vastly more prescriptions than there are visits and a patient taking high doses he goes on to say.

And then he says on lines 19 and 20 of Page 30, "in my opinion had Dr. Walden met the standard of care in doing that assessment" -- meaning monitoring. So he's talking about Dr. Walden again. And then on Page 31 I asked him just -- any idea how many opinions it is. Because he had talked for quite awhile in his testimony. He said I think it's all basically one opinion with a number of sub statements that are the basis for the opinion. Any other

opinions I asked him that you have, Doctor, other than what you haven't told me about in terms of main opinions, I believe we're going to discuss these, no, he said no apart from his management of Mr. Koon's pain, that there was nothing of note in terms of deviations from the standard of care. Further down on 31, I was reading from Page 31 of his deposition, lines 20 through 22, and again I asked him, he said there's no other headlines. And then later on in the deposition -- 112. I'm sorry. On Page 112, which is towards the end of my questioning, I asked him if there are any other opinions, he said there were not. And then I believe that -- Mr. Simon said he had just a few follow-up questions, and he went through, and there's nothing in any of those questions about SLU.

And so his deposition has nothing in it other than his opinions more than once, several times, described as being singular to Dr. Walden's practices. So that's the basis for our objection, that this witness should not be allowed -- Dr. Genecin should not be allowed to give any standard of care opinions about St. Louis University on any issue.

MR. CRONIN: Judge, we have argued this three times. The jury is getting visibly frustrated, because every five minutes we're coming up here and rearguing the same thing all over again. We're going to be here for

three weeks. So --

THE COURT: But you do understand that they're allowed to make --

MR. CRONIN: I understand.

THE COURT: Our initial arguments were in limine, so --

MR. CRONIN: I understand.

THE COURT: -- the attorney has a duty to put it on the record. So while I understand that interferes with the flow, it's --

MR. CRONIN: I apologize.

THE COURT: -- appropriate legal practice.

MR. CRONIN: On Page 30 Dr. Genecin specifically says oh, yes, with respect to monitoring --

THE COURT: Wait. Hold on. I've got it.

MR. CRONIN: Yeah, there are vastly more prescriptions than there are visits, and the patient taking high doses of opioid analgesics should be both regularly seen and reassessed, but also should have random drug testing and be regularly reassessed weighing the risk for medication treatment. So patients on this need to be monitored, that's what he's saying.

MR. VENKER: But --

MR. CRONIN: I'm not done.

MR. VENKER: I'm sorry. Go ahead.

MR. CRONIN: Judge, if you go to Page 55, line four, he starts talking about medication management systems. The medication management system in which we work does not allow doctors to prescribe in the way that Dr. Walden prescribes. The reason for that is not just good sense, and then he talks about also there's state legislation that doesn't allow doctors to do it. In most states you can't get away with it.

If you go a little bit lower, Page 56, line four, everyone who is prescribing -- Brian is SLU's patient, not just Dr. Walden's patient, he's SLU's patient, they're prescribing -- is required to go through training and is required to have systems in place to ensure that the patients are not getting too much.

And then, Judge, if you go to Page 57, line 23, Mr. Venker says are you familiar with what Missouri has, does it have the same legislation as Connecticut. Trying to say Missouri is different so the same systems don't need to be in place. Line three, the standard of care is still the same.

I think that ends it, Judge. He says medication management system standard of care is the same, that they be in place in Connecticut or Missouri regardless of what the State legislation says.

MR. VENKER: He's talking about Dr. Walden. And

his monitoring requirement of the state. He didn't mention SLU once.

MR. CRONIN: Judge, you can't ask an expert trick questions and say all your opinions are about Dr. Walden and not about anybody else when he already gave opinions about something. You can't get rid of his opinions. It's in the depo. Sounds like Mr. Venker has some cross-examination he can do, but he very clearly says standard of care requires medication management system.

THE COURT: Okay. I don't know that there was any trickery, but -- let's go to Page -- go back to your Page 55. Discuss that again. Is that line four?

MR. CRONIN: Yeah.

THE COURT: All right. The question is -- all right. Contacted by the DEA -- all right. Go ahead. What were you -- your thoughts on Page 55?

MR. CRONIN: Sure, Judge. Dr. Genecin is talking about needing to have medication management systems in place that don't allow doctors to prescribe in this way. Not just because it's good sense, but because -- also because there is state legislation in Connecticut that has it and requires it to monitor doctors and patients in terms of their prescribing. And then everyone who is prescribing, on Page 56, line four, is required to go through training and is required to have systems in

place to ensure that the patients are not getting too much.

THE COURT: All right.

MR. CRONIN: SLU is prescribing. They are his healthcare provider.

THE COURT: Okay. So, here's -- here's my ruling. It is thin, but it's in. And, so, while it is -- it -- it is a thin mention within this thickness, but -- so, here's my ruling. I'm going to overrule your objection. But you guys got to have a tight question that matches this. Because he didn't -- he didn't elaborate anywhere in here, and I can make a -- an inference that this is -- and I get it. It's thin. But as thin as it is, that's as much as you guys get with it.

MR. CRONIN: Understood, Judge.

THE COURT: And you guys got to -- you need to talk to -- you need to have a discussion with him about this, tell him what you're going to ask him and tell him where he gets to go with it. Because he doesn't get the whole --

MR. CRONIN: Expanding on this?

THE COURT: Expanding.

MR. SIMON: There's a system in place, there should be a system, but not to elaborate on the system.

THE COURT: There. Because he didn't say

specifically SLU this, and SLU that. But he does say there should be a system in place. And I will agree that the prescribing falls under the envelope -- my read of it is it falls under that you have the persons doing the actual prescribing, but he does -- is an employee for SLU. But you guys don't get -- this is what I talked about, the door is open. But this isn't a Mack truck. This is a -- you got to be tight to this.

MR. CRONIN: How about this, Judge? Because we want to make sure we're sticking to your ruling. A healthcare provider that is prescribing -- a healthcare provider that is prescribing is required by the standard of care to have a medication management system in place to monitor the patient?

THE COURT: Yeah.

MR. VENKER: Okay. Well, Judge, I'm just going to -- so just so I understand, I mean, just -- you're going to overrule my objections on this, right?

THE COURT: Yes.

MR. VENKER: So really I'm without an expert to respond to this issue, because my experts haven't been retained for that, so I don't have an expert on the issue, so I don't have a choice but to move for mistrial at this point, if that's what's going to happen, because I don't have an expert to respond specifically to this allegation

that SLU should have had some monitoring system in place.

MR. SIMON: Judge, he had the deposition before he chose his experts. That's not on us, it's not on the Court, it's what he would need to do. He had every opportunity to get whatever expert he wanted. And the other thing I would point out, too, we talked about earlier, there is no separate set of standards, rules, regulations, policies or procedures for St. Louis U and Dr. Walden, they are one and the same, they are the same entity, they are the same provider. So to pull them apart doesn't make, you know -- doesn't make sense in the context of the case. He's an employee. But, anyway, I understand your ruling, and we will --

THE COURT: All right. So, in regards to a mistrial --

MR. VENKER: Yes, sir.

THE COURT: All right. I don't think it's -- the Court can't determine what you -- what either party asks or doesn't ask in these depositions, and so the Court will leave that up to trial strategy, or whatever. You know your case better than the Court does. It's you ask the questions you think are appropriate or don't think are appropriate.

I think the -- both parties knew that SLU was a named party at the time of this case, at the time of the

deposition, so the questions you ask are -- and the cross that you give are up to you two. I think this does touch on the topic of systems. We differ in our interpretation of this. I don't think that the plaintiff should be precluded from going down this road because you don't have -- that you made a determination that they didn't reach a certain level in that.

But -- so the mistrial is denied. But by what I previously said I think you need to make sure that the witness stays within this phrase. And then the jury will give -- can make the interpretation whether they think that applies to SLU, and you can make an argument that that's a general -- I'm not going to preclude you from making an argument that that's a general statement, and the jury give it the amount of weight that they want to give to it. I'm not going to preclude it from testimony that comes in, and you can argue that that's addressed to SLU. But I think it's the jury to decide whether they want to make that application or whether they think you've met that burden.

MR. SIMON: Judge, just for clarification, he did mention that the hospital system in which he works has a pain management system that would preclude that. I would like to ask him that.

THE COURT: That, I think, is too -- that's his

system. That's got -- I think --

MR. SIMON: Supports his opinion that there needs to be one, is what I'm getting at.

THE COURT: I get it supports it, but I think that goes too far. I think I'm going to --

MR. SIMON: Just there should be a system in place?

THE COURT: I don't think you need to do the -- I understand things are not in a vacuum, and I think you need to put things in context. That, I think, is too much, since we don't have -- we do not have the true counter argument to it. I think he --

MR. SIMON: Okay. I'll just ask him --

THE COURT: I think you need to make sure he's read this and he knows what he can and can't say. Your objection is noted and your move for motion for mistrial is denied.

MR. VENKER: Thank you, Your Honor.

MR. SIMON: Thank you, Judge.

(Whereupon, a short recess was taken.)

THE COURT: Please be seated. All right, Mr. Simon, you may inquire.

MR. SIMON: Thank you, Your Honor.

BY MR. SIMON:

Q. Ready, Doctor?

A. Yes.

Q. Doctor, does the standard of care require that a prescribing -- that prescribing healthcare providers have a medication management system in place to make sure patients do not receive excessive or too much dosage of opioids?

A. Yes, of course.

Q. Okay. And, Doctor, we also talked about assessment, and that includes assessment for dependency, correct?

A. That's correct.

Q. Okay. So, Doctor, let's move on to the topic of amount. The dose. Ready to talk about that?

A. Sure.

Q. Okay. Doctor, are there the dosing guidelines or standards -- let's put it into context of -- we're not talking about cancer patients or burn patients, or end of life issues, we're talking about long-term opioid treatment specifically for back pain. Low back pain.

A. I guess to answer that question I need to ask, is the hypothetical that using it long term is appropriate?

Q. Yeah. Well, let me rephrase the question. That's a good point. Long-term opioid therapy for low back pain, are there any guidelines or standards as to

dosages?

A. Well, long-term therapy -- opioids for low back pain --

MR. VENKER: I'm just going to object, nonresponsive, Your Honor.

MR. SIMON: I think it --

MR. VENKER: Well, you asked were there any guidelines.

BY MR. SIMON:

Q. Okay. Are there guidelines?

A. Yes.

Q. Okay. What are they?

A. For any patient who's on long-term opioid therapy, and what the -- assuming that it's the right therapy for the -- pain therapy for the patient to be on for the condition the patient has, the guidelines are to start low, to go up slowly, and not to exceed a safe maximum dose.

Now for a primary care clinician, a primary care internist, or family physician prescribing narcotic -- opioid analgesics in the office setting, not a cancer patient, not a sickle cell patient, or some other -- not a trauma victim, just an ordinary patient with a chronic pain condition, the guidelines that are published are all circling around 100 milligrams of morphine equivalence.

Some of them are 90, some of them are 120. I've never encountered one that's higher than 120 morphine equivalent dose.

So that would translate -- for whatever narcotic analgesic that we're talking about, can be translated into a maximum dose around 100 milligrams morphine equivalent.

Q. Doctor --

MR. VENKER: Your Honor, I just want to renew defendant's objections to reference to these guidelines in this case. We've done in it in our motions in limine. Can I just reincorporate those objections here, Your Honor?

THE COURT: You may.

MR. VENKER: And they're overruled?

THE COURT: They're overruled.

BY MR. SIMON:

Q. Doctor, these guidelines are standards for long-term opioid therapy as you described for back pain or non-cancer pain?

A. Yes.

Q. Did they just come about in the last six months or two months?

A. No, they've been in place for many years, and the purposes of them are --

MR. VENKER: Object as nonresponsive, Your

Honor.

THE COURT: Ask another question.

BY MR. SIMON:

Q. What is the purpose of the standards, Doctor?

A. The purpose is to give primary care doctors guidance in safe prescribing, and to give a threshold beyond which a primary care doctor really should be referring a patient to a pain specialist.

So, at or around 100, or 120 in some instances, milligrams, which is a lot of morphine -- a lot of narcotic analgesic, a primary care doctor who has a patient whose condition is not adequately controlled with that much opioid needs to be referred to a pain specialist.

Q. Okay. And, Doctor, are these guidelines or standards well recognized in the medical profession?

A. They are. And the -- the threshold of 120 -- 120 of the morphine equivalent in other narcotic analgesics, it's at that point that the risk of dying takes off very steeply. So it's when you get up to the high doses of opioids that the risk of respiratory depression, of addiction and abuse, become most serious and the high risk of dying. Really about 200. But a patient should be in -- in treatment with a pain management specialist long before they're at the 200 mark.

Q. Okay. And so, Doctor, the treatment, the prescribing of opioid narcotics by Dr. Walden and St. Louis University to Brian Koon, that took place from 2008 to 2012?

A. That's correct.

Q. Okay. The standards that you've just described, were they in existence and well known by the medical profession during that period of time?

A. Yes, they were.

Q. Okay. And, Doctor, is that -- is that a standard -- is the standard that you just described of hovering around 100 milligrams MED, morphine equivalent dose, is that a standard particular to Missouri, or Illinois, or is it a standard that applies throughout the country?

A. Throughout the country. It's a standard that's in place to protect the patient from adverse effects of overdose.

Q. Okay. And, Doctor, are these standards, or these guidelines as you have described them, are they evidence of the standard of care in terms of prescribing opioid narcotics?

A. Yes, they reflect the standard of care. Exactly. The CDC, for example. The CDC guideline. But there are many others that come from different sources,

and all of them are to give guidance to doctors in safe management of patients in light of the risk of these drugs.

Q. Okay. And, Doctor, that's where I was going to go to next. The CDC does have dosage guidelines, correct?

A. It does.

Q. Okay. And that's the document we looked at before?

A. Yes.

Q. And before we go there, there's one thing I want to cover with you. We've been talking about, and you heard in opening statements, about the morphine equivalent dose, and I know you mentioned something about it. I want to make sure everybody understands and is clear.

Generally the concept of morphine equivalent dose, what is it?

A. Morphine equivalent dose -- so it's a means of standardizing the dosage of other narcotic analgesics by comparing them to morphine. So, for example, hydrocodone, which is one of the medications here, that's Vicodin or Lortab, it's one to one. So 30 milligrams of morphine equals 30 milligrams of Lortab.

However, some medications are more potent, so they may make it fewer milligrams to equal the 30 milligrams of morphine. Other drugs are less potent.

It may take 45 milligrams, for example, of oxycodone to get 30 milligrams of hydrocodone. And so it goes. So all of these medications are translated into morphine equivalent doses.

And the way we do that is with a simple online calculator. I mean, so, you can look on -- I can then look on my phone -- when I have a patient who's taking, for example, a combination of medications, I can calculate very quickly what the morphine equivalent dose is for this patient by putting it into an online table and it calculates the results for me.

Q. So, Doctor, you said that if you have 30 milligrams of hydrocodone, you know from experience that's equal to 30 milligrams morphine equivalent dose?

A. That's right.

Q. So it's one to one with the hydrocodone?

A. That's correct.

Q. But other medications like oxycodone or OxyContin are more potent, correct?

A. That's correct.

Q. For instance, 20 milligrams of oxycodone or OxyContin will be approximately 30 milligrams -- morphine milligrams?

A. Right. Because milligram for milligram it's stronger.

Q. So, in other words, if we had 40 milligrams of oxycodone it would really equate to 60 milligrams morphine equivalent dose?

A. That's correct.

Q. And so on and so forth?

A. Exactly. So the way it works is very simply the doctor uses a table on which all the various prescription narcotics are listed, and you can say, well, the patient is taking 60 milligrams a day of oxycodone and taking a certain amount of Dilaudid, a certain amount of morphine, a certain amount of oxycodone, and put in those numbers and it will translate those -- roll it up into morphine equivalence so you can then say, well, I'm going to move that patient to another medication adding those doses together and giving them an equivalent medication.

Q. Okay. So, Doctor, the CDC guideline, does it also have recommendations for prescribing opioids for chronic pain outside of active cancer, palliative and end of life care?

A. That's right. Yes.

Q. And that's what we're talking about, correct?

A. That's what we're talking about.

Q. Okay. And I'd like to go over those with the jury at this point. Okay?

MR. SIMON: Can we go to Exhibit 50-6, Page 18,

please. Mike, if we could, let's go to the first section determining when to initiate or continue opioids for chronic pain. Okay.

BY MR. SIMON:

Q. And, Doctor, this is part of the CDC, correct?

A. That's correct.

Q. Publication from the Federal government, correct?

A. Yes.

Q. And again, Doctor, these guidelines were put together and based on years of experience and input from different experiences and physicians throughout the country, correct?

A. That's correct.

Q. In other words, it's a consensus of the medical community, experts in the medical community?

A. It's the -- it's the consensus of a panel of experts brought together in order to create these guidelines.

Q. Okay. And under determining when to initiate or continue opioids for chronic pain, that's something we talked about earlier, correct?

A. Yes.

Q. And it says, "non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic

pain. Clinicians should consider opioid therapy if -- only if expected benefit for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with non-pharmacologic therapy and non-opioid pharmacologic therapy as appropriate. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is a clinically meaningful improvement in pain and function that outweighs risks to patient safety. Before starting, and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy, and patient and clinician responsibilities for managing therapy."

Have I read that correctly, Doctor?

A. Yes.

Q. Okay. And do you agree with those statements?

A. Yes.

Q. Does -- do those statements support the opinions that you've given in this case?

A. Yes, they do.

Q. Okay.

MR. SIMON: Mike, if we could, go to the next section.

BY MR. SIMON:

Q. And this has to do with selection, dosage, duration, follow up, and discontinuation; is that correct?

A. Yes.

Q. Okay. And under number four it says, "when starting opioid therapy for chronic pain, clinicians should prescribe immediate release opioids instead of extended release/long-acting, ER, slash, LA opioids."

A. That's correct.

Q. Okay. When opioids are started, clinicians should prescribe the lowest effective dosage. Do you agree with that, Doctor?

A. Yes.

Q. "Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to greater than 50, greater or equal to -- equal to or greater than 50 morphine equivalents a day."

Do you agree with that?

A. Yes.

Q. Okay. It further states, "and should avoid increasing dosage to equal to or greater than 90 morphine equivalent doses a day or carefully justify a decision to

titrate -- is it titrate dosage above 90 MME a day."

Have I read that correctly, Doctor?

A. Yes.

Q. Okay. And do you agree with those statements?

A. Yes.

Q. Okay. And do these guidelines, Doctor, reflect the standard of care in the medical community?

A. Yes, they do.

Q. Okay. Number six says, "long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate release opioids and should prescribe no greater quantity than is needed for the -- than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient, more than seven days will rarely be needed."

Do you agree with that statement, Doctor?

A. Yes.

Q. Does that statement reflect the standard of care for prescribing opioids?

A. Yes.

Q. Okay. And, Doctor, there's another guideline from the -- there are multiple written guidelines, correct, Doctor?

A. Yes, there are.

Q. I want to go through another one with you briefly. And this is the guideline from the Agency of Medical -- the Agency Medical Directors Group.

You've seen that before, Doctor?

A. Yes, I have.

Q. Can we go --

MR. VENKER: Just for a second, Your Honor, I want to renew our objections to these guidelines outside the CDC. If I can renew that for all guidelines. We've raised this in our motions in limine. I'm assuming that's going to be overruled again, Your Honor?

THE COURT: Yes.

MR. VENKER: Okay.

THE COURT: Those were ruled on previously outside the hearing of the jury, and your objections will be noted for any further guidelines.

MR. VENKER: Thank you.

MR. SIMON: Okay. Mike, could we please put up Exhibit 50-4?

BY MR. SIMON:

Q. And this is the -- what we were talking about, right, the Agency Medical Directors Group?

A. Yes.

Q. It says, "intra-agency guideline on opioid

dosing for chronic non-cancer pain, an educational pilot to improve care and safety with opioid treatment." Correct?

A. Yes.

MR. SIMON: If we could go down to the bottom, Mike, I want to look at the date. Way down at the bottom where it says published by.

BY MR. SIMON:

Q. Okay. This is back in March of 2007, right, Doctor?

A. Yes.

Q. Okay. Okay.

MR. SIMON: And if we could, Mike, please go to Page 3 of Exhibit -- and I believe this is Exhibit 50-4.

BY MR. SIMON:

Q. And it says, "guidelines for initiating, transitioning and maintaining oral opioids for chronic non-cancer pain." And let me jump over to the right-hand side. It says, "in general, the total daily dose of opioids should not exceed 120 milligrams of oral morphine equivalence. Rarely, and only after pain management consultation, should the total daily dose of opioid be increased above 120 milligrams oral morphine equivalents. Safety and effectiveness of opioid therapy for chronic non-cancer pain should be routinely evaluated by the

prescriber. Assessing the effectiveness of opioid treatment should entail tracking and documenting both functional improvement and pain relief. A specialty consultation may be considered at any time if there is evidence of frequent adverse effects or lack of response to an opioid trial."

Have I read that right, Doctor?

A. Yes.

Q. Okay. And do you agree with those guidelines?

A. Yes.

Q. Do those guidelines reflect the standard of care on this issue back in March of 2007?

A. They do, with the caveat that the guidelines all have a total daily dose that is slightly different. They all fluctuate around 100. This one is at the high end of the ones that I've encountered, the 120. Other ones are 90. I use 100. But it's in that neighborhood. That order of magnitude.

Q. Okay.

MR. SIMON: And, Mike, if we could go please to Page 4 of Exhibit 50-4.

BY MR. SIMON:

Q. And on the right-hand side, Doctor, there's a column that says principles for prescribing opioids. Do you see that?

A. Yes.

Q. And it lists the principles, correct?

A. Yes.

Q. It says single prescriber, correct?

A. Correct.

Q. It says single pharmacy, right?

A. Yes.

Q. Okay. Was that done in this case, single pharmacy?

A. No.

Q. Okay. Patient and prescriber sign opioid agreement. Was that done in this case?

A. No.

Q. Okay. Lowest possible effective dose should be used. Is that what that says?

A. Yes.

Q. In your opinion, was that done in this case?

A. No.

Q. Okay. It says, "be cautious when using opioids with conditions that may potentiate opioid adverse effects, including COPD, CHF, sleep apnea, history of alcohol or substance abuse, elderly, or history of renal or hepatic dysfunction. Do not combine opioids with sedative hypnotics, benzodiazepines or barbiturates for chronic non-cancer pain unless there is specific medical

indication for the combination."

That's what we talked about before, the sleeping medications, sedatives?

A. That's right.

Q. Okay. All right. It further says, "assess function and pain status routinely." And it gives tools for assessing pain and function, right?

A. Correct.

Q. It further states to monitor the medication misuse for a lis -- monitor for medication misuse, and it provides resources for a list of drug-seeking behaviors, reasons to discontinue opioids, or refer to addiction management, right?

A. Exactly, yes.

MR. SIMON: And then, Mike, if you could scroll down further.

BY MR. SIMON:

Q. It says, "random urine drug toxicology screening to objectively assure compliance."

A. That's right.

Q. Okay. It says, "instituting opioid treatment for chronic non-cancer pain. Prior to initiating chronic opioid therapy, the prescriber should comprehensively assess the risks and benefits of treatment. The prescriber is responsible for routinely monitoring the

safety and effectiveness of opioid therapy in providing pain relief and improving function."

Have I read that correctly, Doctor?

A. Yes, you have.

Q. Okay. And, Doctor, do you agree with these principles for prescribing opioids?

A. Absolutely.

Q. And do these principles that we've gone over reflect the standard of care on this issue?

A. Yes, in my opinion, they do.

Q. And, Doctor, are there generally recognized patient safety rules for prescribing opioids long term for non-cancer pain?

A. Yes.

Q. Okay. And I want to -- the jury saw some of these in opening. I want to go over them with you, if we could. Let's go --

MR. VENKER: I'm going to object as leading. If the doctor can answer the question asked, I think that would be more appropriate. So I object as leading.

MR. SIMON: Sure.

THE COURT: All right. Rephrase.

MR. SIMON: Yes, sir.

BY MR. SIMON:

Q. Exhibit 60-9 --

MR. VENKER: Your Honor, I think the witness ought to say what the rules are, not see them up on the board. That's my objection. I think that's leading, to put them up there for him to see them.

THE COURT: Approach.

(The following proceedings were held at the bench.)

THE COURT: All right.

MR. VENKER: This is leading, Your Honor. He's putting up basically a piece of paper and saying read this and tell me that it's this patient safety rule thing.

What's said in opening is not evidence. This is evidence. So I object to that. If the doctor can recite what those safety rules are, then he can recite them.

MR. SIMON: The question -- if the objection is leading, I will rephrase the question. I can ask a non-leading question. I guess -- is that the objection?

MR. VENKER: Well, you have to ask -- we're trying to figure out what this witness knows about these patient safety rules. I don't think showing them to him up on the board is the same as him testifying from his own knowledge about them.

MR. SIMON: I've already established that by asking him if there are well recognized safety rules for prescribing opioid narcotics. He said yes. I want to

talk to him about it.

THE COURT: Okay. The way I'm hearing this, I'm hearing two different issues. Is this something that the doctor relied upon to come up with his opinion?

MR. SIMON: This is sort of a summary of what we've covered. In other words, the rules that we saw in opening, it's a summary of basic rules for prescribing -- it's a summary of the material that -- the documentation that we've gone through. And, Judge, we went through this with Dr. Walden, and we went through this with the defendant's experts, and I believe these are agreed to. They're not even -- they don't even disagree with them. Dr. Walden agrees with these issues.

MR. VENKER: Well, he didn't testify about patient safety rules in his deposition. I can tell you that. So if he's saying it's some opinion he has, it's not been expressed, clearly not. So I have that problem, first of all. But I just -- certainly to just say here they are up on this board and let's do them --

MR. SIMON: They're basic rules. It takes five minutes, and I'd like to show them to the doctor and ask him if he recognizes the rules and agrees with them.

MR. VENKER: I object to that, Your Honor, for the reasons stated.

MR. SIMON: It's certainly relevant, Your Honor,

they're rules for prescribing opioid narcotics. That's what the case is about.

THE COURT: He's not objecting to relevance. If I'm hearing you right. You're objecting that -- that you -- you want him to state what he knows.

MR. VENKER: Yeah, it's supposed to be his testimony, what does he know about it.

MR. SIMON: It's a summary chart of what he said in his deposition, it's a summary of what we've gone over already, I just want to put it in context. It will take two minutes. It's nothing new.

THE COURT: Can I see what it is that we're talking about just so I can --

MR. SIMON: Sure. That's it.

THE COURT: And you're saying this is a summary of --

MR. SIMON: These are all the concepts that he has testified to in his deposition or has already testified to this morning. General safety rules for prescribing opioid narcotics to patients.

MR. VENKER: Well we've got a lot of testimony about that already, Your Honor.

MR. SIMON: It will be very brief, Your Honor, not going to take a lot of time with it.

THE COURT: Okay. In regards to your objection

for leading, I'm going to overrule. All right?

MR. SIMON: Go through it quick?

THE COURT: Yeah.

MR. SIMON: Got it.

(Proceedings returned to open court.)

THE COURT: You may inquire.

MR. SIMON: Thank you, Your Honor.

BY MR. SIMON:

Q. Dr. Genecin, there are recognized safety rules for prescribing opioid narcotics to patients, correct?

A. Indeed there are, yes.

Q. Okay. And -- and you have -- you have put together a set of these rules, correct?

A. I have.

Q. Okay. And I'd like to go through them very briefly.

MR. VENKER: Your Honor, may we approach? I'm going to object to this.

THE COURT: Okay. Approach.

(The following proceedings were held at the bench.)

THE COURT: Go ahead.

MR. VENKER: I am objecting to the representation that the doctor has generated these. That's not true.

MR. SIMON: I went over them with the doctor, and he made changes to these, and we're presenting them to the jury.

MR. VENKER: Then why couldn't he give them to you when you asked the question?

THE COURT: All right. These are opinions that he has expressed?

MR. SIMON: Yes, sir.

THE COURT: You're summarizing them?

MR. SIMON: Yes, sir.

THE COURT: Okay. Then do it like that so they can -- everybody knows --

MR. SIMON: Okay.

THE COURT: -- what it is.

MR. SIMON: Got it.

THE COURT: Your objection is overruled.

(Proceedings returned to open court.)

MR. SIMON: Mike, would you please put up 60-9?

BY MR. SIMON:

Q. General safety rules. Above all else, a doctor should serve the highest interest of his or her patient.

Doctor, do you agree with that?

A. Yes.

Q. Doctors are not allowed to needlessly endanger their patients. Do you agree with that?

A. Yes.

MR. SIMON: Could you go please to 60-10, Mike?

BY MR. SIMON:

Q. Rules for prescribing opioid narcotics. Opioids should not be used if safer alternatives are available.

Do you agree with that, Doctor?

A. Yes.

Q. When prescribing opioids, the lowest possible effective dose should always be used.

Do you agree with that?

A. Yes.

Q. Opioids should be used for the shortest time necessary.

Do you agree with that?

A. Yes, that's correct.

Q. Okay.

MR. SIMON: And could you go to 60-11, please, Mike?

BY MR. SIMON:

Q. Rules for monitoring patients. A physician must continuously evaluate the safety and effectiveness of the opioid therapy.

Do you agree with that, Doctor?

A. Yes.

Q. The amount of opioid narcotics given to a

patient must be monitored.

Do you agree with that?

A. Yes. Monitored and regulated.

Q. The patient must be continuously monitored for signs of abuse, misuse, and/or addiction.

Do you agree with that, Doctor?

A. Yes.

Q. Okay.

MR. SIMON: And, Mike, if you could please go to 60-12.

BY MR. SIMON:

Q. Rules for treating addiction. Addiction to opioids is a known risk.

Do you agree with that, Doctor?

A. Yes.

Q. If a doctor suspects a patient is addicted the doctor should help the patient get off the opioids.

Do you agree with that?

A. Yes.

Q. A doctor must never continue opioids just because the patient is addicted.

Do you agree with that?

A. Yes.

MR. SIMON: Okay, Mike, could we please go to Exhibit 36? Okay.

BY MR. SIMON:

Q. And, Doctor, you're familiar with this document, correct?

A. Yes, I am.

Q. Okay. And this is -- it's a summary of all of the prescriptions written for Brian Koon by Dr. Walden for narcotic opioids. Is that your understanding?

A. That's correct.

Q. Okay. And I'm not going to go through just in detail with you, Doctor, but if we could just go up to the top heading so the jury understands what this shows. And this was prepared by looking at the pharmacy records, right, Doctor?

A. Yes.

Q. Okay. And you reviewed this document, correct?

A. I have.

Q. Okay. All right. And the first column is the date of service, right?

A. That's correct.

Q. And then it lists the doctor, correct?

A. Right. The prescribing doctor.

Q. Okay. SLUCare. And then it lists the pharmacy, right?

A. Yes.

Q. Okay. And then it lists the particular narcotic

or controlled substance, correct?

A. That's correct.

Q. And quantity would be the number of pills for that particular prescription, correct?

A. That's correct.

Q. Okay. And then the next column is days supplied, right?

A. That's correct.

Q. Okay. And then there's a daily dose in milligrams, correct?

A. That's right.

Q. And then there's a conversion, what we were talking about before, to daily dose morphine equivalent dose, right?

A. That's right.

Q. And then there's the total milligrams for the entire prescription, correct?

A. That's correct.

Q. And then there's the total milligrams per prescription in MED?

A. That's right.

Q. So, for instance, on 2/28/08 -- I'm sorry, 2/29/08, that was the one we looked at earlier, was a prescription of hydrocodone, 30 pills, seven day supply, and it's dated 2/29/08. Correct?

A. That's correct.

Q. Okay. And this goes from that first date all the way --

MR. SIMON: What's the last page, Mike?

BY MR. SIMON:

Q. Goes from 2/29/08 through 8/28/12; is that correct?

A. That's correct.

Q. Okay.

MR. SIMON: Mike, could you please put up what we marked as Exhibit 37? Okay.

BY MR. SIMON:

Q. And, Doctor, let me go over this document with you. And we're going to go over a section at a time. Is it your understanding this is -- this is a summary of the information that we saw in the earlier document in 36?

A. Right. These are dated, derived directly from that document.

Q. Okay. So, in other words, the information here is an average or a summary, depending on what's listed, correct?

A. That's correct.

Q. And these are all doses of opioid narcotics prescribed by Dr. Walden and St. Louis University to Brian Koon?

A. That's right.

Q. Okay.

MR. SIMON: Let's take a look at the first section, Mike.

BY MR. SIMON:

Q. What are we looking at here, Doctor?

A. We're talking about the dose, milligram dose, in morphine equivalent doses per year.

So the medications he got, adjusted so that they're like morphine, tells us that he got a total in the year in 2008 of 15,250, and that was divided over 307 days, because the prescriptions started after the start of the year. Those -- the number of milligrams increased year after year until nearly 400,000 milligrams -- 396,765 milligrams morphine equivalent dose in 255 days. The first 255 days of 2012.

Q. Okay.

MR. SIMON: Mike, could we please go to the next section?

BY MR. SIMON:

Q. What is this, Doctor?

A. This is -- this is the average daily dosage. That's the -- the dose that the doctor is managing in terms of the number of milligrams per day in morphine equivalence.

And in 2008 it was 49.67. That increased almost -- well, by four fold in 2009. And then it continued to increase thereafter until, in 2012, on average, Mr. Koon was being prescribed by Dr. Walden 15 -- 1,555 milligrams of -- in morphine equivalent doses.

Q. So, Doctor, that would be about a thirty -- thirty fold increase from what he was getting in 2008 to what he was getting in 2012; is that right?

A. That's correct, yes.

Q. And, by the way, the 2012, 2011, that's what he got for the whole year. That's the average for the whole year, correct?

A. Yes. He was taking these medications for the complete years of 2009, '10 and '11, partial years in 2008 and 2012.

MR. SIMON: Okay. And, Mike, if you could please go to the next section on Exhibit 37.

BY MR. SIMON:

Q. And this lists the number of pills per year, to put things in context, correct, Doctor?

A. Yes.

Q. Okay. And started out in '08 with 2,020 pills, correct?

A. Yes.

Q. And, actually, the last full year was '11,

right?

A. The last full year was '11. 2012 was only two-thirds of a year.

Q. Okay. And so the last full year he would have received 13,542 opioid narcotic pills from St. Louis University and Dr. Walden, correct?

A. That's correct.

Q. Okay.

MR. SIMON: The last section, please, Mike.

BY MR. SIMON:

Q. Okay. And this shows the average number of pills per day by year, correct, Doctor?

A. Yes, it does.

Q. Okay. And he's at six -- a little over six and a half pills a day in 2008, correct?

A. Yes.

Q. And then by 2012 he's -- Dr. Walden has him on -- on almost forty opioid narcotic pills a day, correct?

A. That's correct.

Q. Okay.

MR. SIMON: Okay, Mike, if we could please go to Exhibit 38.

BY MR. SIMON:

Q. And this is another document the jury has seen in opening, Doctor. But I want to go over it with you.

What are we looking at here? There you go. Probably a little bit better.

A. What we're looking at is the average daily dose exhibited as a bar graph for years. And this is for Mr. Koon for each of those five years, starting with the low end in the first year of approximately 50 milligrams in morphine equivalent doses, and as you can see steeply escalating up to more than 1,500 in the final year.

Q. So, Doctor, let me ask you this. The recommended max dose for -- again, for 90 days, that was hoovering around 100, right?

A. That's correct.

Q. So that would be about right here? (Indicating) Is that correct, Doctor?

A. That's exactly right, yes.

Q. And that's what the guidelines and the standard of care -- that's what that recommends, not exceeding that amount for more than 90 days?

A. Right. And that's -- just to be clear, that is the threshold at which a doctor who's practicing in primary care needs to make a referral to a pain medication specialist in order to be very cautious about any doses that are higher than the realm of 100 milligrams.

Q. So, Doctor, let me ask you this. Do you have an opinion about the amounts -- the amount of opioid pills

and doses that St. Louis University and Dr. Walden prescribed to Brian Koon for back pain?

A. Yes.

Q. What is that opinion?

A. My opinion is that Dr. Walden prescribed excessive and increasingly excessive doses to the point where I would characterize them as colossal and extraordinary doses. The kind of doses that -- to give a patient, exposed him to the very high risk of injury to himself or to other people in the event that he was driving a car or responsible for caring for another person. This is a level at which state licensure boards and the Drug Enforcement Agency --

MR. VENKER: Your Honor, could I renew my objection I made earlier in motion in limine to these topics about the DEA and other enforcement agencies?

THE COURT: The objection is noted. Your previous objection is noted and it's overruled.

BY MR. SIMON:

Q. Please continue, Doctor.

A. This is the pattern of utilization that the regulators such as the State licensure boards and the DEA are trying to protect patients from. It's a pattern of prescribing that exposes a patient to a very high risk of dying for backache.

So that's a -- what I said before, colossal and reckless and extraordinary doses.

Q. So, Doctor, have you been involved in any cases where -- where a physician's license was under review for prescribing too many -- too much opioid narcotics to a patient?

A. Yes, I have.

MR. VENKER: Object as to hearsay, Your Honor.

MR. SIMON: Asking if he's been involved in it, Your Honor, what he knows about it.

MR. VENKER: It's still hearsay, whatever he hears.

MR. SIMON: He's been involved in a review process, Judge.

THE COURT: Approach.

(The following proceedings were held at the bench.)

THE COURT: What was the question -- the question you asked was has he been involved --

MR. SIMON: He's been asked to review cases where a doctor's license was under review for overprescribing of opioids. So he's seen it firsthand. He's reviewed material, he knows the case, because he was a reviewer in the case. He's testified to that in his deposition, and that's what I'm asking him -- I'm not

asking him about hearsay, I'm asking about his own personal experience and being involved in cases where a doctor's license was under review for prescribing opioids.

MR. VENKER: I think we've raised this in our motion in limine, Your Honor, but this is really him talking about these other doctors, and whatever they are, this is totally irrelevant to what's going on here. There's no reason to even try to get into how much of a matchup there is. He's already given his opinions.

THE COURT: Hold on. Let's take a couple bites. As the question is asked, it's not hearsay, so it's overruled at hearsay. But your question -- your next objection is --

MR. VENKER: Relevance.

THE COURT: If it's relevant. All right. How is his viewing other doctors' behavior in those cases relevant to this?

MR. SIMON: Okay. We have a punitive damage claim.

THE COURT: Correct.

MR. SIMON: We are trying to show that the doctor's conduct, specifically with respect to the amount of medication he has prescribed over the period of time, rises to the level of being reckless in a conscious disregard for safety. This witness has experience,

firsthand experience, of doctors whose licenses were under review and their privileges to prescribe were revoked for prescribing less than what Dr. Walden has prescribed in this case. That's very clear evidence supporting the issue of punitive damages.

MR. VENKER: Judge, that's not evidence at all. We don't know what those standards were, we don't know what the prescribing was involved, and this jury is supposed to be deciding based on the evidence in this courtroom, not about some cases Dr. Genecin may have been involved in.

MR. SIMON: It's not Dr. Genecin. I mean -- I'm sorry. I thought you were talking about -- I apologize.

MR. VENKER: Dr. Genecin may have been involved in. It's so prejudicial it's clearly irrelevant. It has nothing to do with whether or not punitive damages should be considered in this case.

MR. SIMON: Judge, the other thing, too, is it goes to support his opinion in this case that these doses are too much, that these doses are excessive, you know, his experience in being involved in that is relevant to his credibility in terms of what he's saying.

MR. VENKER: You're also talking about administrative or criminal proceedings in these other situations. Dr. Genecin said he was involved in that, has

nothing to do with civil lawsuit, and the damages here we don't even know. You can say it's apples and oranges.

MR. SIMON: I'm not going into the specifics of the cases.

THE COURT: All right. Hold on. I'm a little lost. Okay. I -- I understand your need to support the punitive damages. I got that.

MR. SIMON: Yes, sir.

THE COURT: I don't understand how the line we're going down now aids the jury in making that determination. I don't understand how him seeing three other cases where a person did X, Y, Z, aids the jury in this case. That's where --

MR. SIMON: He's familiar with DEA review, he's familiar with DEA review of doctors for overprescribing of opioid narcotics. He has reviewed one or more of those cases. He is familiar with the amounts that those doctors prescribed, and the fact that their privileges were revoked, their privileges to prescribe opioid narcotics or narcotics --

THE COURT: Okay. So, I'm not telling you how to try your case, but everything you just said, I'm actually okay with. But you -- in other words, are you familiar with this behavior, are you familiar with this X, Y and Z, and does Dr. Walden's behavior -- in other

words -- all right. You said you've -- I'm trying not to do your case for you.

MR. SIMON: Appreciate the questions. Saves us a trip back up here.

THE COURT: I guess what I'm saying, kind of like what I said earlier, he can testify to the factors that lead to the determination that he should be punished punitively. And, so, if you want to -- if you want to have the witness state his familiarity with -- that there are types of behaviors that -- well --

MR. VENKER: Judge, if I may.

MR. SIMON: He did testify in his deposition. I mean he -- Paul asked him about it at his deposition.

MR. VENKER: It doesn't make it relevant, though.

MR. SIMON: It's not a surprise.

MR. VENKER: These other cases, whatever they are, Judge, we don't know any of the circumstances of those, and here is somebody -- we don't have any of the --

THE COURT: I'm in agreement with you. There is a -- there's a fine line between what both of you want. I don't think you should be talking about the details of the other cases. I don't -- I don't think -- I think he needs -- the way this needs -- in my opinion, the way this needs to be couched, when you are talking about punitive, is

what are the factors that he thinks support the punitive. And then as the witness -- ask the witness is this person -- in other words, if -- is X a factor in determining whether someone's behavior is X, did they exhibit that in this case, and how. I think that's appropriate.

But I don't think you can bring in those other cases, because I think -- I think -- while it is probative, I think the prejudicial nature of it and the confusion outweigh the probative value. But I'm not foreclosing this line of questioning. I think you just need to rephrase the way that you're doing it.

MR. SIMON: Without going into the details of the other cases?

THE COURT: Yeah, I don't think you can -- in other words, you can't say other people have gone to jail for this type of thing. But he can say these are the factors that I consider in terms of whether a person's behavior is X, Y, Z.

MR. VENKER: What does that have to do with these other cases, Judge?

THE COURT: That's what I'm saying, I'm not --

MR. SIMON: The way I'm thinking about this, and maybe I'm missing something, is the jury probably doesn't have any experience in terms of what's okay or not in terms of the amount of dose. That's an issue central to

the case. We have an expert who says that it's way high, it's colossal, you know, it's reckless.

THE COURT: Right.

MR. SIMON: They're going to have an expert coming in saying it's all perfect and it's fine and it's okay to do it and keep doing it. So we need to prove -- the plaintiff needs to prove that the conduct not only was negligent, but reckless, supporting a punitive damage claim. I think that evidence that other physicians have lost their privileges to prescribe medication because they gave amounts less than what Walden gave, I think it's clearly relevant to the punitive damage and reckless conduct in this case. That's how I think it's relevant. In terms of how I get to it, I need to get into --

MR. VENKER: Well I think there's a phrase called substantial similarity if you're going to even get into other events. So where is the substantial similarity of any of this?

THE COURT: Yeah, that's --

MR. VENKER: Even if you assumed it's relevant, I don't think it is, but we have no fact patterns here.

THE COURT: Yes. That's why I -- that's why I don't think you can -- you can get into -- I understand what you're trying to do. So I think it's -- I think the topic is relevant. In the sense that what are the factors

you consider whether someone's behavior is X, Y, Z. I don't think you can use those examples to get there.

MR. SIMON: Okay. I can ask him what factors he considers reaching the conclusion the doctor's conduct was reckless?

THE COURT: Right. But his answer can't be because I've been a witness on so and so, and I've seen so and so do so and so.

MR. SIMON: I can cut him off or he'll object, I guess.

THE COURT: Yeah, I can't put that cat in the bag once he goes down that road. So why don't we do this. Why don't we take a -- why don't we do a ten minute recess, I'll give you time to talk to the witness. Because I -- that -- I don't want to cut off the area, but I think that goes too far.

MR. SIMON: Okay.

THE COURT: I think you're allowed to get into the factors, but he can't base the factors on I was a party to a -- or testified, so and so went to jail because they did X, Y, Z. I think that's way too far.

MR. VENKER: So my objection is sustained?

THE COURT: Your objection is sustained, but he's not precluded from the topic. His witness can't get into specific areas, he can't talk about --

MR. SIMON: Of other cases?

THE COURT: Yeah, of other cases. He can talk about factors.

MR. VENKER: The same thing you said earlier on the record?

THE COURT: Right. Exactly.

MR. VENKER: Okay. All right.

THE COURT: Does that clear it up?

MR. SIMON: Yes, Your Honor.

MR. VENKER: I need to renew my objection again about any reference to the Drug Enforcement Agency because of the reasons we've stated in our motion in limine. But, again, I just think it's so prejudicial. I just want to renew my objection to that.

THE COURT: Yeah, your objection is noted.

MR. SIMON: I don't think we need to break, I'll move on and get it done.

MR. VENKER: So how is my objection ruled on?

THE COURT: It's sustained -- it's -- no, it's overruled.

MR. VENKER: As to the Drug Enforcement Agency references?

THE COURT: Yes.

MR. VENKER: All right. Thank you, Your Honor.

(Proceedings returned to open court.)

BY MR. SIMON:

Q. Doctor, have you ever seen these amounts prescribed for chronic low back pain?

A. No, never.

Q. Okay. Have you ever read about, heard about these types of amounts for chronic low back pain?

A. No.

Q. Doctor, what kind of side effects -- what kind of effects can doses of -- let's talk about 1500 milligrams a day. What kind of effects can that dose have on someone's brain?

A. Understanding that a patient who has that amount of drug in his system and is still breathing indicates that he has tolerance to the respiratory supression. However, that is a patient who has impaired thinking, impaired cognition, impaired memory, abnormal perception, abnormal interactions with other people, impact in terms of emotions and relating to family. It is a person who is likely to spend a significant part of his day in an inappropriately sedated fashion. This is a patient who falls asleep at the wheel, or this is a patient who falls asleep when he should be awake or becomes -- acts in a stoned or lethargic manner. This is a -- we develop tolerance to -- unfortunately, to the pain relieving benefit of the drug. We fortunately develop tolerance to

the respiratory supression. So if you go slowly enough, the patient will continue to breathe; and in some cases they won't, they'll die. But in some cases they will live. But we can never develop absolute tolerance to all of the effects that the drug has on cognition. It's called a narcotic because it induces a state called narcosis, which is a state of feeling no pain. It's a state of -- of sedation, of altered perception, impaired judgment, impaired thinking. And it's obviously very deleterious to a person.

Q. So, Doctor, do you have an opinion as to whether or not there was any legitimate medical purpose for prescribing these amounts of opioid narcotics to Brian Koon?

A. Yes.

Q. Okay. What is that opinion?

A. My opinion is that a patient with low back pain should never be treated with chronic opioid therapy by a primary care doctor, that these doses were astronomical and reckless and that there was no purpose to it of any benefit to the patient.

Q. Thank you, Doctor. Doctor, what is your understanding of Brian Koon's injuries? What, if any, injuries was Brian -- were caused by the doses -- the excessive doses of opioid narcotics?

A. Well, the most important injury was addiction to the opioid medication. And then he was found in rehab to be suffering from a relapse of his depression, major depression. He went through withdrawal in coming off of narcotics. An area that's possibly under -- under discussed and understood is the severe consternation and the risk to a patient that that imparts. So that was another element.

It had effects on his interactions with family, and social functioning that were also adverse, and which I read about in deposition testimony.

Q. Okay. And, Doctor, do you have an opinion as to whether or not St. Louis University and Dr. Walden did an appropriate risk assessment of Brian Koon before putting him on long-term opioid narcotics?

MR. VENKER: I objection, Your Honor, to the reference to St. Louis University in that question.

THE COURT: Overruled. He can answer.

A. I do have an opinion.

BY MR. SIMON:

Q. What is that opinion, Doctor?

A. That there was no assessment of the patient that met the standard of care with respect to using opioid treatments for back pain.

Q. Okay. And, Doctor, did that -- did the failure

to do an appropriate risk assessment fall below the standard of care?

A. It did.

Q. Did that failure to do an appropriate risk assessment cause or contribute to cause Brian Koon's injuries?

A. Yes.

Q. Do you have an opinion as to whether or not St. Louis University and Dr. Walden followed the appropriate standard of care by prescribing long-term opioid treatment to Brian Koon for his low back pain?

A. I do.

Q. And what is that opinion, Doctor?

A. That, again, they deviated from the standard of care.

Q. Did that failure to meet standard of care cause or contribute to cause Brian Koon's injuries?

A. Yes.

Q. Doctor, do you have an opinion as to whether or not Dr. Walden and St. Louis University fell below the appropriate standard of care in monitoring Brian Koon's use of opioid narcotics?

MR. VENKER: Objection, again, Your Honor, I'd like to renew my objection about St. Louis University and monitoring.

THE COURT: So noted. Overruled.

MR. VENKER: Thank you.

A. Yes, I have an opinion.

BY MR. SIMON:

Q. What is that opinion?

A. That they did not have any monitoring system in place to monitor Mr. Koon.

Q. Okay. And do you believe that fell below the standard of care?

A. Yes.

Q. Okay. And, Doctor, do you have an opinion as to whether or not that failure caused or contributed to cause injuries to Brian Koon?

A. Yes.

Q. Doctor, do you have an opinion as to whether or not St. Louis University and Dr. Walden fell below the standard of care in assessing Brian Koon for possible addiction during his use of opioid narcotics?

A. I do.

MR. VENKER: Object again, Your Honor, to the reference to St. Louis University and monitoring.

THE COURT: So noted. It will be a continuing objection to any use of St. Louis University.

MR. VENKER: Yes, Your Honor.

THE COURT: When it comes to monitoring.

MR. VENKER: Right. And that objection is overruled?

THE COURT: It's overruled.

MR. VENKER: Thank you, Your Honor.

BY MR. SIMON:

Q. What is that opinion, Doctor?

A. My opinion is that they did deviate from the standard of care in not having any monitoring system in place.

Q. Okay. And, Doctor, do you have an opinion as to whether or not that failure caused or contributed to cause Brian Koon's injuries?

A. Yes.

Q. What is that opinion?

A. Is that it did directly cause his injury.

Q. Doctor, do you have an opinion as to whether or not the amount of opioid narcotics Dr. Walden and St. Louis University prescribed to Brian Koon in 2008 reached the appropriate standard of care?

A. The amount in 2008?

Q. Yes, sir.

A. Yes, I do have an opinion.

Q. Okay. What is that opinion?

A. My opinion is that it was excessive and too long a period of time.

Q. Okay. And, Doctor, do you have an opinion as to whether or not the amount of opioid narcotics Dr. Walden and St. Louis University prescribed to Brian Koon in 2009 breached the appropriate standard of care?

A. Yes.

Q. What is that opinion?

A. That increasing the dose by four fold that it was a deviation from the standard of care in terms of dosing, which was far in excess of the safe limit for a primary care doctor treating back pain, and the duration was open-ended without any specific goals of therapy or end point defined.

Q. Do you have an opinion as to whether or not the amounts of opioid narcotics Dr. Walden and St. Louis University prescribed to Brian Koon in 2010 breached the appropriate standard of care?

A. Yes.

Q. What is that opinion?

A. My opinion is that the frequency of renewals of prescriptions and the amount of drug was ever increasing, that that was a reflection of a tolerance addiction, sensitization, and the amount reached astronomical proportions, although it continued to rise for another couple of years.

Q. Okay. Doctor, do you have an opinion as to

whether or not the amount of opioid narcotics Dr. Walden and St. Louis University prescribed to Brian Koon in 2011 and 2012 breached the appropriate standard of care?

A. Yes.

Q. What is that opinion?

A. My opinion is that these were -- I've characterized them as colossal doses of opioids, that that was a deviation from the standard of care that exposed Mr. Koon to the risk of addiction and the other complications that we've talked about.

Q. Doctor, do you have an opinion as to whether or not Dr. Walden and St. Louis University's breach of the standard of care in prescribing the amount of opioid narcotics to Brian Koon in 2008, 2009, 2010, 2012, caused or contributed to cause Brian Koon's injuries?

A. Yes.

Q. What is that opinion, Doctor?

A. That they contributed to his injuries.

Q. And, Doctor, do you have an opinion as to whether the amount of narcotics Dr. Walden and St. Louis University prescribed to Brian Koon from 2008 through 2012 constituted a conscious disregard for safety?

MR. VENKER: Object to this witness giving an ultimate opinion like that, Your Honor.

THE COURT: Rephrase.

BY MR. SIMON:

Q. Do you have an opinion as to whether or not the amounts -- do you have an opinion, Doctor, as to whether or not the amounts of opioid narcotics Dr. Walden and St. Louis University prescribed to Brian Koon from 2008 through 2012 supports a finding of conscious disregard for safety?

MR. VENKER: Same objection, Your Honor, still.

THE COURT: Overruled. He can answer that question.

A. Yes, I believe that very strongly supports that.

BY MR. SIMON:

Q. Okay. Doctor, do you have an opinion as to whether or not the amount of opioid narcotics prescribed by Dr. Walden and St. Louis University to Brian Koon from 2008 through 2012 supports a finding of reckless conduct on behalf of St. Louis University and Dr. Walden?

MR. VENKER: Same objection, Your Honor, about the -- the witness should not be allowed to give an ultimate opinion, ultimate fact.

THE COURT: Your objection is noted. Overruled.

MR. VENKER: And invades the province of the jury, of course.

THE COURT: Your objection is noted.

A. Could you repeat the question?

BY MR. SIMON:

Q. Yes, sir. Do you have an opinion as to whether or not the amount of opioid narcotics prescribed by St. Louis University and Dr. Walden to Brian Koon from 2008 through 2012 supports a finding of reckless conduct on behalf of St. Louis University and Dr. Walden?

A. I do, yes.

MR. VENKER: Same objection again, Your Honor, about invading the province of the jury.

THE COURT: You can answer.

BY MR. SIMON:

Q. What is that opinion, Doctor?

A. My opinion is that it does support that conclusion, yes.

Q. Doctor, we're almost at the end here. And what I want to do, Doctor -- you know, I want to cover just a couple things that the jury heard in opening statement from St. Louis University and Dr. Walden. And I want to ask you about it. Okay?

A. Yes.

Q. Let me ask you this, Doctor. I think the jury heard that it was okay to give these amounts to Brian Koon because he was trying to keep his job, to help him keep his job.

Do you agree with that, that's an appropriate

reason to give this amount of opioid narcotics?

MR. VENKER: Your Honor, I'm going to object to this. May we approach?

THE COURT: Yes.

(The following proceedings were held at the bench.)

MR. VENKER: I'm going to object to this for a couple of reasons. First of all, these are not any opinions Dr. Genecin could have possibly given in his deposition, because that was last year -- earlier this year. So I don't know what these opinions are. Also, the comment on an opening statement of another party, I don't -- that's totally inappropriate. I don't think there's any basis for that at all.

THE COURT: Are you claiming that these were admissions?

MR. SIMON: No, Judge, it's -- I'm trying not to call him back in rebuttal. These are issues that were raised by the defendant in this case in opening. And I would like to address these issues with this witness now so that we don't have to bring him back.

MR. VENKER: That was not evidence, Judge, that was opening statement.

MR. SIMON: I can rephrase it. He was here, he heard it.

THE COURT: Okay. Hold on. I get that you want to be -- yeah, I don't know how you get to be proactively --

MR. VENKER: Right. In rebuttal.

THE COURT: I get the logistics or challenge, but --

MR. SIMON: Can I ask it in a different way, then, without referring to opening?

THE COURT: Okay. No. Because -- the reason being is because, one, the opening is not evidence. So -- the jury has been told not to give it any weight. You --

MR. SIMON: Understood.

THE COURT: You're being proactive, you're assuming this is going to come in. But until it comes in, and how it comes in -- just because he wants it to come in, it could be objected to and actually never come in. So it's -- you're --

MR. SIMON: Anticipating before it happens?

THE COURT: You're anticipating before it happens.

MR. SIMON: Wait and do it on redirect?

THE COURT: I think that's a more appropriate time.

MR. SIMON: Fair enough.

MR. VENKER: My objection is sustained?

THE COURT: Yes.

MR. VENKER: Thank you, Your Honor.

(Proceedings returned to open court.)

MR. SIMON: Your Honor, subject to moving for admission of the exhibits, I have no further questions at this time.

THE COURT: All right. I think this is a good time for a break. We'll do cross-examination after lunch. I'll let you guys go early for lunch. Need to beat the lunch crowd. I'm going to give you -- it's 11:30. I'll give you an hour for lunch and ask that you be back at 12:40. Since you're getting ahead of the crowd, you won't spend all your time sitting in line, hopefully.

(Whereupon, Instruction 300.04.1 read to the Jury.)

THE COURT: We are in recess until 12:40.

(Whereupon, a short recess was taken.)

THE COURT: Please be seated. Counsel, if you are ready you may proceed with cross.

MR. VENKER: Thank you, Your Honor.

**CROSS-EXAMINATION**

BY MR. VENKER:

Q. Good afternoon, Dr. Genecin.

A. Good afternoon.

Q. I have some questions for you about some of your

testimony this morning, but I have some other questions first. You talked about being the director of Yale Health Center?

A. That's right.

Q. And that takes up about half of your time, doesn't it?

A. Yeah, just under half. I'm a little bit more clinical than administrative, but I do have an administrative job as well.

Q. Right. You see about -- what, about 18 to 20 hours a week in the outpatient clinic?

A. Of appointments, yes.

Q. Yeah. I think that's what you told me in your deposition. And you've had that arrangement since you began in that director position, and that was, what, 1989?

A. No, 1997 I became director.

Q. Okay.

A. Although it fluctuated for the first seven or eight years, it's been -- more or less stayed at about 20 hours per week -- 18 to 20 hours a week of outpatient appointments at Yale Health Center for the last few years.

Q. All right. So basically a half time practice of medicine?

A. Right. In addition to my outpatient practice, though, I also work in the Yale Hospital.

Q. On that rotation you told me about in your deposition?

A. I do. And I also work in the neighborhood food pantry and stuff like that as well.

Q. And the rotations you did in the hospital were, what, spread out over two months each year?

A. They are two months per year full time hospital work, yes.

Q. Okay. And you say your patient load is about a thousand patients in that outpatient clinic?

A. Yes.

Q. All right. And that's based on working there roughly half time, accurate?

A. That's right.

Q. Okay. Your position with Yale University itself, you said you are a clinical -- I don't want to say it incorrectly. Clinical adjunct professor?

A. Associate professor of medicine in the school of medicine.

Q. Okay. And that's not a tenure track position, is it?

A. That's correct.

Q. Okay. Are you actually paid for that role as opposed to being paid for being the director of --

A. No, I'm paid to be director of Yale Health, and

I work in -- at the hospital in teaching as part of my job. But I'm not paid to be a professor, I'm paid to be the director of the clinic.

Q. All right. Okay. And you've testified in other medical/legal cases, correct?

A. Yes.

Q. All right. And, like, for example, your daily charge for trial here is $7,000 a day; isn't that right?

A. Yes, for a trial per diem, for a 24 hour period, I do charge $7,000.

Q. All right. So you're here for two days. So that's $14,000?

A. Yes.

Q. All right. Okay. And then I guess travel expenses are also just paid? You don't get those, but you don't have to spend those yourself, correct?

A. That's right. The attorneys' office will make travel arrangements.

Q. Sure, I understand. And so you've testified mostly for plaintiffs. Isn't that right? About 80 to 90 percent?

A. Yes.

Q. And you've done twenty consultations on cases where you review the case and then actually where you give a deposition and then testify at trial. That's 277 or 280

occasions where you've been involved in medical/legal work, correct?

A. I haven't kept an actual count of the number of times, so I can't give an exact number. I would estimate that's the right ball park based on my average, yes.

Q. Okay. And, so, I just did some math, and what -- what comes out, in terms of your testifying in court and deposition, is that you have made, I think, somewhere around over a million dollars in these 20 years or so of testifying in medical/legal cases.

Does that sound right to you?

A. Yes.

Q. Okay. A million dollars. Okay. Thank you, sir. And you advertise your services?

A. No, I don't directly advertise. I have, in the past, but not currently, worked with a couple of agencies that assist attorneys in finding experts, and I believe that those companies advertise. But I personally do not advertise.

Q. Okay. But there are companies like MedQuest and something called TASA?

A. Those have been true in the last ten years. I'm not working with either of them currently.

Q. Okay. I see. But you had given your name to them to be -- to serve as an expert in medical/legal

matters, correct?

A. Yes.

Q. Okay. And I believe you've testified in one of your depositions that as of 2015 you've testified in trial about fifty times. Does that sound accurate to you?

A. I don't keep an exact count, but it's an proximate range.

Q. Okay. Now, when you -- in your work on this case, you were contacted in January of 2014, correct?

A. Yes.

Q. All right. And in your deposition you told me that you got the materials from Mr. Simon's office on January 30th, and that on January 31 you contacted him and said you had reached your opinions in the case about what the negligence was. Isn't that right?

A. I don't recall the exact dates, but, yes, I frequently will read a case when I get it, and talk with the attorney and give my opinions based on the information that I've had the chance to read up until that point.

Q. Okay. And what you told me in your deposition was that you had spent maybe one or two hours reviewing the file as of that point. Before you called Mr. Simon. Correct?

A. I think I did testify to that, yes.

Q. Okay. All right. And, so, the material you

were given was a pretty sizable set of medical records, wasn't it? Over several years for Mr. Koon's care?

A. Again, I don't recall exactly. I don't know whether I got the chart I ended up with all at once or whether I got it in stages. My impression, based on the limited amount of time, was that I did not have a huge chart to begin with and may have gotten additional materials subsequently.

Q. All right. Well do you remember what you got at first? Because if you didn't have the whole chart, but you still arrived at your opinion, how did that come about?

A. Well I have the chart of the patient's care in the years in question with the doctor in question. There was subsequent care that I've gotten records about since -- after Mr. Koon stopped seeing Dr. Walden. Lots of other documents, such as deposition testimony and various court documents that experts are sent subsequently. But the core material, which is the medical record, was available to me for the time frame that was relevant for the review of this case.

Q. Okay. But the fact remains that within a period of twenty-four hours or less of getting whatever part of the file you got, you gave Mr. Simon's office an opinion that you believed Dr. Walden acted below the standard of

care. Is that right?

A. I don't recall the exact time frame. I had the notes in front of me when I gave testimony for my deposition, I don't have my notes in front of me now. But, yes, I did give my opinion soon after. That would be my habit and my custom after reviewing a case.

Q. Well, let's look at your deposition then. I think -- let's see. I'll just hand you your deposition.

MR. VENKER: If that's okay?

MR. SIMON: Sure.

BY MR. VENKER:

Q. It's Page 8 in your deposition. If you look at my question on line 16, and then on down to line 20 is your answer. Why don't you just read it for the jury.

A. Yes, okay. And how many hours had you reviewed the case between receiving the file on January 30th and your phone call on January 31st, 2014?

My answer was I don't recall, but it couldn't -- it wouldn't have been more than an hour or two.

Q. Thank you, sir. And that's consistent -- you remember that now, having seen the transcript?

A. Well, I remembered that I testified to that, I don't have a recollection of how much -- of actually -- I don't have a recollection of January 2014.

Q. Okay. Dr. Genecin, you do believe that an

expert should be impartial, don't you?

A. Yes.

Q. And you believe an expert should be forthright and open in terms of presenting opinions and testimony to a trier of fact like a jury, don't you?

A. Of course.

Q. Okay. You believe an expert ought to be a champion for the truth?

A. That's right.

Q. Okay. And as an expert you wouldn't -- you wouldn't ignore information that would be helpful in arriving at what the truth is; isn't that true?

A. No, I have to weigh all the information that's available to me and try to determine whether it has an impact on -- or -- all of that adds up to formulating an opinion.

Q. Okay. Now, there is no set maximum daily dose for opioid medications, is there, Doctor? That is there is no guideline, no set, no regulation where it says never prescribe above X milligrams of opioids per day; isn't that true?

A. With respect to non-cancer pain, for primary care doctors and -- those are internal medicine doctors and family physicians, general practitioners, there are many guidelines. Many of them come from states, many of

them come from professional organizations, many come from the CDC. And they all set the maximum dose prior to referring a patient to a pain physician at or around 100 milligrams morphine equivalent dose. I've seen up to 120 milligrams, I've seen 90 milligrams, but a patient whose pain is not adequately controlled or a patient who's having side effects from their medications when they're reaching that level needs to go from the primary care doctor to the specialist.

Q. Okay. I'll just ask my question again. Is there any guideline that sets a maximum daily dose that no one should ever exceed in prescribing opioid medications, Doctor?

A. Not no one. I think that many doctors are acquainted with using opioids and may use them more aggressively. Certainly in terminal cases, palliative care, cancer care, hospice work, which I've also done, will use higher doses. But for a patient with low back pain in a primary care practice, approximately 100 milligrams is about the limit before the patient needs to be seen by a pain specialist.

Q. I'll try it again, Doctor. Let me turn it a little bit for you. So other than these guidelines that you're referring to that you say set a maximum, is there anything else? Like there's no Federal regulation that

sets any maximum daily dose for opioid dose; isn't that true?

A. Well, CDC is a Federal agency, it is not a -- an enforcement agency.

Q. Doctor --

A. But it does send out guidelines.

Q. Doctor, can I just ask -- the question was do you know of any Federal regulation that actually sets a daily maximum of milligrams of opioid pain medication a patient can receive on a daily basis? That was the question. So, do you know of one or not?

A. Are you saying is there a law that tells doctors what the limit is?

Q. I said --

A. No, there's no law.

Q. Okay. And the regulation -- and these guidelines you've talked about, you said -- you told us yourself your personal limit is somewhere, what, 100 milligrams?

A. 100, right.

Q. Right. And you told me in your deposition that you don't ever prescribe a patient more than 100 milligrams of opioid medication for pain, right?

A. We're talking about patients --

Q. Doctor -- Doctor -- I'm just --

A. Non-cancer patients, patients with low back pain, like Mr. Koon. We're not talking about sickle cell patients, patients with chronic pancreatitis, or metastatic disease or trauma. I have extensive experience caring for those patients and I've given substantially more narcotics to patients in that context.

Q. Let me try it again. Didn't you tell me in your deposition, Doctor, I don't ever treat patients with chronic low back pain with chronic opioids?

A. Yes.

Q. Okay. And didn't you then also tell me, though, that the exceptions -- that there are exceptions to that rule?

A. The exceptions are as I stated, yes.

Q. Okay. And so the patients who have those other conditions that you're talking about, cancer patients, sickle cell disease patients --

A. Yes.

Q. Are you suggesting that a doctor could put high doses of opioids -- prescribe high doses of opioids for those patients and they could be -- you described earlier, I think, somebody would be, what, a zombie, or functionally out of it, or a stoner? Is that what you're saying, that doctors who have those patients, they prescribe that level so those patients are basically

opioid intoxicated? You're not saying that, are you?

A. Not exactly.

Q. Okay.

A. The goal with --

Q. Let me ask you this, if I can. You don't treat those patients, right, because you refer them on to a pain management specialist, right?

A. Well, no, in the hospital I treat them all the time.

Q. With pain management?

A. Yes, I have many years of experience in managing patients as an inpatient setting with opioid analgesics; and outpatient setting, the patients with sickle cell anemia, or patient with a complex pain problem requiring higher than 100 milligrams of morphine equivalent dose that I would refer to a pain physician.

Q. Are you saying if you have a patient who's in the hospital you wouldn't involve a pain management physician?

A. No, generally not.

Q. Okay. And, so -- but the patients that you would deal with, once they got to 100 milligrams a day of morphine equivalent dosing, you would refer them on to a pain management specialist?

A. In office setting, yes, that's correct.

Q. Okay. Now, you're not a pain management expert yourself, right?

A. No, I'm an internal medicine physician, I think like Dr. Walden.

Q. Okay. And, so, for pain management -- for management -- physician handling a patient on opioid prescription medications, you would have to defer to that pain management physician, wouldn't you, because he or she is outside your specialty; is that right?

A. That's correct. And for other modalities of treatment for pain, for safe management of a patient on a high dose narcotic, I would defer to a pain management physician, and do so regularly.

Q. All right. And you also told me in your deposition that you work with pain management specialists with your -- certain patients, as you have referred to here, correct?

A. Yes, I do, from time to time.

Q. And I think in your deposition you told me you're working with a pain management specialist for a patient who has an implantable morphine pump. Do you remember telling me about that?

A. That's right, I do.

Q. And you describe that patient as having a chronic spine problem, true?

A. Yes.

Q. All right. And, so, in that situation you have found that that fits one of your exceptions, right?

A. No, that's a patient who takes a minute amount of morphine that's directly infused into the spinal canal. That patient is taking micrograms of morphine, it's very small, small fraction.

Q. Well -- but it's also being put right into the spinal canal, isn't it?

A. Yes. It's, in essence, topical therapy into the spine.

Q. So it's a whole different effect on the patient at that point versus somebody taking oral opioids, isn't it?

A. Yes. Absolutely no relationship to an oral opioid case.

Q. Really, for somebody to get a morphine pump, that's a pretty serious step in medical care, isn't it?

A. Right. And it's something that would need to be managed by a pain physician, they implant those pumps, they prescribe the medication for them and deal with the various issues that are involved in monitoring and so forth.

Q. And at that level where somebody has a morphine pump implanted, oftentimes -- or maybe it's the standard

of care to perform a psychiatric evaluation of that patient to make sure the pain they have is not pseudo pain; isn't that right? Or maybe you don't know that because that would be a pain management doctor.

A. I will state that although psychiatric illness and severe pain often coexist, I am not aware of any guideline requiring a psychiatric evaluation to rule out pseudo pain prior to implanting a device into the spinal canal. I would defer that question to a pain specialist.

Q. All right. Thanks, Doctor. There's no textbook on pain management that sets out the upper limit of long-term opioid analgesic dosing, is there?

A. I'm familiar with internal medicine literature, and I would defer to a pain specialist to talk about the advanced pain management, and including the patient's selection, monitoring therapy, assessing the safety of medication. That's out of the spectrum for a primary care doctor.

Q. Okay. So what you're saying is that there's no textbook that you know of, whether on pain management or even internal medicine, that sets out an upper limit of long-term opioid analgesic dosing. Am I right about that?

A. No. What I said was that I am familiar with internal medicine literature, and I would defer to a pain management doctor to cite pain management literature. In

internal medicine literature that I'm familiar with, the standard of care requires that an outpatient with low back pain not be treated with chronic opioid analgesics, or when the patient needs to be for some reason, like chronic opioid analgesics, that a primary care doctor refer that patient to a pain specialist when the dosing gets high.

Q. All right. Doctor, my question is, you don't know of any textbook, whether on pain management or internal medicine, that sets out what the upper limit of long-term opioid analgesic dosing is, do you? That's the question. Either you do or you don't.

A. No, I don't.

Q. All right. Thank you. And would you agree that the upper limit of narcotic dosing or opioid analgesic dosing is highly patient dependent? That is different patients can handle different levels?

A. Yes, that is true. And the same patient can handle increasing levels over time.

Q. All right. And, so --

A. That's tolerance.

Q. So, for example, what a patient may not be able to tolerate in the initiation of that opioid therapy they would easily tolerate later, assuming everything else is working for this patient down the line. So 5 milligrams might be too much in the beginning, but 20, 40 milligrams

could well be fine once they've developed tolerance, right?

A. Yes.

Q. Okay. And tolerance is a naturally expected physiologic phenomenon when somebody is taking opioid medication; isn't that true?

A. Yes, tolerance is a -- an expected phenomenon that benefit of -- meets the benefit, in terms of pain relief, will wear off at any given dose. That's one of the reasons why it's not that useful for long-term therapy of benign conditions such as low back pain.

Q. So the -- the different PDR labels that you were looking at with Mr. Simon, those are FDA approved pamphlets or information for those drugs, aren't they?

A. Those are the drug labeling information mandated by the Food and Drug Administration published in that -- used to be a book called the Physician's Desk Reference. I'm not sure if it's still available as a book because most doctors I know look at it online. But, yes, that's what it's called, PDR, or Physician's Desk Reference.

Q. And those pamphlets, those product information that you talked about this morning, those don't have any specific set limit -- daily limit for dosing, do they?

A. No.

Q. Okay. Do you treat any sickle cell disease

patients on a routine basis?

A. I treat sickle cell patients in the hospital all the time. I have treated sickle cell patients in outpatient clinic. I don't currently have a sickle cell patient in my outpatient practice. I do see them in the hospital.

Q. And those patients oftentimes utilize opioid medication -- pain medications, isn't that true?

A. Yes.

Q. As a matter of fact, opioid pain medication may be one of the few medications that actually can relieve their pain to the extent possible, right?

A. That's correct.

Q. Okay. And I think you told me in your deposition that when the dosing, as you described there as significant morphine equivalent dosing, that it's best to get somebody who's an expert in that assessment, meaning a pain management specialist. Didn't you tell me that?

A. I did.

Q. And, again, what that pain management specialist might do in terms of dose range you don't know, because that's somebody else's specialty and it's not yours, correct?

A. Well, I can state based on my experience, though, because I've taken care of many patients with end

of life care, cancer pain, trauma, sickle cell disease.

The doses in this case are extraordinary and exceed those that are commonly used for any of those chronic diseases.

Q. Did you ever examine Mr. Koon?

A. I'm sorry?

Q. Did you ever examine Mr. Koon?

A. No.

Q. Did you ever look him in the eye and try to help him figure out his pain and how he was going to handle it?

A. No, I -- no, I did not. I'm not his doctor.

Q. Okay. Have you had patients who have had intense intractable pain where you couldn't really find the source of the pain?

A. Yes.

Q. Okay. So that's certainly -- I mean, you don't think Mr. Koon was being somehow deceitful to Dr. Walden, do you --

A. No.

Q. -- in describing his pain as being intense?

A. No.

Q. His pain big enough to disturb his sleep?

A. No. I think there was no reason to -- to be concerned about whether he was telling the truth about pain.

Q. All right. Okay. I mean, you saw the records, didn't you? Again, not clear which records you reviewed, but did you see where Mr. Koon was in so much pain he had difficulty driving?

A. Yes.

Q. All right. And difficulty -- I just said difficulty sleeping. That's pretty much pain, isn't it, when you can't even sleep?

A. Yes.

Q. And he had pain not just in his low back, but didn't he have it elsewhere?

A. He did.

Q. He had it in his neck, didn't he?

A. In his neck and at different times going into his legs and arms as well.

Q. Yes. And he sought treatment for those things, didn't he, in addition to the opioid medication?

A. Yes, he did. He went to see a chiropractor, physical therapy. I think he went to pain medicine doctors at different times as well.

Q. Right. And, so, in terms of the different modalities, is -- I think the phrase is non-opioid modalities, or different methods of treatment, Mr. Koon did have other non-opioid modalities, didn't he? You say physical therapy. He actually saw pain management

specialists on more than a few occasions over time, correct?

A. He never had a systematic program of non-opioid medications and trials of medications in combination, including nonsteroidal anti-inflammatory, muscle relaxants, antiseizure medicines such as gabapentin or pregabalin, which are Lyrica and Neurontin. Tricyclic anti-depressants, which are beneficial for chronic pain. I never saw that he had trials of those medications, which are nonnarcotic approaches to pain, prior to considering narcotics.

What I saw was a prescription for an over-the-counter Ibuprofen and a muscle relaxant, and then a week later starting him on narcotic analgesic hydrocodone without trying any of those other medication modalities. That was how Dr. Walden prescribed them.

Q. So your impression of Mr. Koon is that basically he just had -- are you describing it as routine low back pain?

A. Well, his pain --

Q. I'm just asking you that question, Doctor. Do you consider that Mr. Koon had merely routine low back pain?

A. Well, I must preface my answer by stating that low back pain is one of the most frequent reasons why

patients come to see doctors. And I have no doubt that he had both back pain and discomfort, as he described.

However, I do not see indication in the medical record his pain was ever quantified where he was ever put on a ten-point scale and --

Q. Doctor, I'm going to interrupt you for a second, if I might.

A. It's impossible to --

Q. You've already had a chance to give your testimony on those issues. I just want to be efficient here, and I'm really asking you whether you are characterizing Mr. Koon as a patient who has really just routine low back pain. That's what I'm asking you. And so -- you can give me some information, but I would at least like a yes or no for starter.

A. There's insufficient information in the medical record of the start of treatment with opioids to judge the severity --

Q. Doctor --

A. -- because it was never quantified.

Q. Dr. Genecin, you're making me feel rude now. You really are.

MR. SIMON: Your Honor, could I object? I would at least respectfully request the witness be allowed to answer the question. He's cutting him off.

THE COURT: Doctor, what I need you to do is be very -- listen to the question carefully and formulate your answer in line with the question asked. You may proceed.

MR. VENKER: Thank you, Your Honor.

BY MR. VENKER:

Q. So, Doctor, the question is simply whether you are characterizing Mr. Koon as a patient who has, in your opinion, routine lower back pain?

A. I understand your question. I'm not sure it's a yes or no answer.

Q. Okay. In your deposition you told me that you would -- you would have seen him in your practice and you wouldn't have sent him to a pain management specialist; is that correct?

A. That's correct.

Q. And that's because you didn't think he needed to go above 100 milligrams a day for -- of opioids for appropriate pain relief. Is that -- I take it that's what you mean by that?

A. Well, I think that there are a lot of intervention for low back pain before opioids, and we don't start patients on chronic opioid therapy for low back pain. It's not effective for that condition, and the standard of care does not use -- does not include giving

chronic opioid therapy for low back pain.

Q. All right. Doctor, you have talked earlier about the CDC guidelines. Let's talk about those a little bit. And these are -- these guidelines that you and Mr. Simon talked about this morning. You remember those, don't you? Yes?

A. Yes.

Q. You're, of course, familiar with them, aren't you?

A. I am.

Q. These guidelines didn't exist in 2008 or 2012, did they?

A. No. Similar guidelines, though, did exist and the literature on which this is based was published and readily available --

Q. Doctor --

A. -- in those years.

MR. VENKER: Your Honor, I'm going to ask the answer after the word no be stricken as not responsive to my question.

THE COURT: All right. The jury will disregard everything after the answer of no. Doctor, please focus your answers on the questions asked.

BY MR. VENKER:

Q. Okay. These are guidelines, as you -- right?

Isn't that what they are? They're guidelines, right?

A. Yes.

Q. It says right there, as big as they could, guideline, right?

A. Correct.

Q. And a guideline -- in your opinion, what you're telling us, is that a guideline is mandatory?

A. No, no, the standard of care is mandatory.

Q. But you said these guidelines represent the standard of care, didn't you?

A. They reflect the standard of care.

Q. All right. Okay. Well, let's look at the heading.

MR. VENKER: Could you go to the text right above rational? Can you highlight that?

BY MR. VENKER:

Q. Can you see that, Doctor?

A. Yes.

Q. And it says -- stop right there -- "the recommendations in this guideline are voluntary rather than prescriptive standards." You see that, don't you?

A. Yes.

Q. All right. And so voluntary is the opposite of mandatory, isn't it?

A. Voluntary is, yes.

Q. Yes. Okay. So earlier when you told us that these were the standard of care, and the standard of care should be followed, right, that's mandatory, isn't it?

A. The standard of care is mandatory, that's right.

Q. But these guidelines, which your interpretation of what this Federal agency has done, you say it's the standard of care, but yet the agency itself describes them as voluntary, correct?

A. Yes.

Q. All right. And the next sentence says these guidelines -- basically says they are based on emerging evidence. Meaning evidence up to of 2016, right?

A. Correct.

Q. And you know this whole effort started somewhere around 2013, right?

A. Yes.

Q. Okay. So, again, after 2000. So it says they are based on emerging evidence including observational studies or randomized clinical trials with notable limitations. And notable limitations means that they're not really as good as the CDC would like, right? There's some limits on them? They're looking at them, but they wish they were maybe a little bigger or broader or had more patients, right?

A. That's correct.

Q. Okay. And then the last sentence says, "clinicians should consider the circumstances and unique needs of each patient when providing care."

You agree with that, of course, just generally, don't you?

A. I do.

Q. Okay. All right.

MR. VENKER: Mike, let's go to one of the exhibits from this morning.

BY MR. VENKER:

Q. So this other guideline that you talked about with Mr. Simon this morning -- I can give you a copy if it's easier. Is that better? I can't see that far.

A. Yes.

Q. So this says Agency Medical Directors -- and if you scroll down to the bottom of the page, if you can. Down at the very bottom there's a line. Do you see that?

A. Yes.

Q. And it says what, Doctor?

A. Washington -- published by Washington State Agency Medical Directors Group.

Q. Okay. And what is that? That's not the Federal government, is it?

A. No, it's actually an organization in the state of Washington that has published a series of very

influential guidelines --

Q. Right.

A. -- that are relied upon by many states and by many guideline forming organizations in order to try to guide safe treatment of opioid analgesics for patients who are being treated for benign disease.

Q. Right.

A. Non-cancer.

Q. Right. And, so, let's go back. You told us that basically no internal medicine doctor should be treating chronic back pain or chronic pain with long-term opioids, right?

A. For back pain, yes, that's correct. Long-term back pain of this sort without -- there are issues, obviously, they have had motor vehicle accident, trauma, that's a different question.

Q. Okay. So let's look at Page 2 of this document, this guideline from the state of Washington from nine years ago. And it says -- the first sentence, it says the guideline is part of a year-long educational pilot. Doesn't it?

A. Yes.

Q. Yeah. Okay. So, pilot, I mean, that's like a pilot program or something, isn't it? Something that's not been established yet. Isn't that your understanding

of that word?

A. What was pilot was the educational program, not the standard of care.

Q. Okay. Well -- so that's what this is about, though, is about a pilot educational program, correct?

A. Right. In 2007 there was an effort in the state of Washington to implement an educational program for doctors in the state of Washington.

Q. All right. For the State of Washington, correct. And this document actually talks about situations where there's treatment with opioids even at high doses. You're familiar with that, aren't you?

A. Yes.

Q. All right. Okay.

(There was a discussion held off the record.)

BY MR. VENKER:

Q. All right. So we're back to the CDC guidelines, the 2016 guidelines that just came out this year. The first sentence, what we're looking at now, says, "this guideline provides recommendations for the prescribing of opioid pain medication by primary care clinicians for chronic pain; i.e. pain conditions that typically last longer than three months or past the normal tissue healing -- normal tissue healing."

You see that, don't you, Doctor?

A. Yes.

Q. All right. So this guideline is really geared to the very treatment that you say internal medicine doctors should not be involved in, chronic pain longer than three months. Doesn't say -- it didn't qualify it, does it?

A. No, no, doctors are involved in it. The question is to use many modalities of treatment that are appropriate for the treatment of chronic pain. When a patient has been through the full inventory of possible modalities that a primary care doctor can very safely prescribe, nonnarcotic medications and other intervention, and then is needing more and more opioid analgesics and that's still not helping, then that's when you send them. But a primary care doctor treats chronic pain all the time.

Q. Okay. And, again, the CDC guidelines, by their own text, they say they are voluntary, correct?

A. Yes. They're --

Q. Okay. Thank you.

A. Yes.

Q. Thank you. Now, you earlier talked about the injuries that you believe Mr. Koon has had from this course of opioid medication. You've talked about addiction. You're not an addiction specialist, are you?

A. No, I'm a primary care internist.

Q. Okay. I mean, like Dr. Janet Cattrall, she's an addiction specialist at Yale, isn't she?

A. I don't know the name.

Q. You don't know the name? Okay. All right. So, let's talk about the potential for addiction and dependency from using opioids. Every patient has the potential for addiction, correct?

A. Some patients do to a very low degree, some patients to a very high degree.

Q. Okay. Because somebody is going to be addicted who has a predisposition to that status; is that right?

A. One of the factors that is involved in -- so it's -- risk for addiction is a predisposition to becoming addicted. That's partly family history and other factors such as psychiatric illness, tobacco use disorder. Some patients are very resistant to getting addicted to any substance.

Q. Okay. And so your opinion is based on really what you saw in the records for the course of treatment with Dr. Walden that ended on August 30th, 2012?

A. That's correct.

Q. You did not review any records after that; am I right about that?

A. No, I did subsequently. Of course I did.

Q. Okay. And what did you review after that, Doctor?

A. I reviewed the subsequent hospital and medical records involving his subsequent pain management, his detox, and psychiatric, you know, drug treatment admission. The records of surgeons and hospitalizations, and surgical intervention to treat his neck and his back problem. All of those records I've reviewed.

Q. Okay. Because when I took your deposition you hadn't reviewed all the records about all the different back surgeries Mr. Koon had after August of 2012, right?

A. I don't recall exactly at my deposition how much I had reviewed, but I have read all the records that I have been sent, and they do include those at this point. I may have received subsequent information.

Q. But you don't treat anyone who, by your definition, has become an addict, correct? You would refer that patient to someone else?

A. No, I treat patients who are addicts, but their addiction is treated by an addiction specialist. I will treat them for blood pressure, for diabetes control, and so forth. But the treatment of addiction is something that I would defer to an addiction specialist.

Q. Sure, that's what I meant. I appreciate you clearing it up. And, so, opioid -- opioid medications do

lead to tolerance, and there's -- there is also an expected degree of physical dependency with that tolerance, correct?

A. Yes.

Q. Those go hand-in-hand, don't they?

A. They do.

Q. All right. And the other dependency is something more -- I guess what's called psychological dependency, which is much more akin to addiction itself, right?

A. That's right.

Q. All right. And you described addiction -- let's see. In your deposition you said that addiction is a complicated problem that includes habitation, but it is a preoccupation of drug craving and an inability to do without a life, at the center of which is obtaining a supply and taking the medication. So craving is very important. You agree with that statement?

A. Yes.

Q. Okay. Doctor, is the highest daily dose of opioids you've ever given a patient on your own without consultation with a pain management specialist 100 milligrams a day?

A. Approximately 100 milligrams, yes.

Q. All right. And, so, any of your patients, of

your thousand patients that you see as outpatients, you've not given any of them above 100 milligrams of morphine equivalent of a daily dose?

A. That's correct. My policy is to refer patients for a pain management if I have tried all nonnarcotic approaches that I can think of, and what I think is a reasonable amount of opioid treatment. Those are -- out of those I refer to a specialist.

Q. Okay. I meant to ask you -- I'm not sure if I asked you. The CDC guidelines that we've been referring to, the 2016 guidelines, they don't have a daily maximum limit for opioid dosing, do they?

A. For non-cancer pain in an outpatient setting, 120 milligrams is the -- is the upper limit before they recommend that primary care physicians, internists, family physicians refer patients to a pain specialist.

Q. So there's no set limit, though, in this CDC document; am I right about that? Nothing that says never give a patient above 800 milligrams of morphine equivalent dose a day? There's nothing in here like that, is there?

A. No, they say 120 milligrams morphine equivalent doses, then primary care doctor whose patient is not doing well should then be going to a pain specialist.

Q. In this voluntary set of guidelines, right?

A. Yes.

Q. Patients with chronic pain are often depressed, aren't they, Doctor?

A. Yes. Chronic pain and depression often go hand-in-hand.

Q. All right. Whether they're on opioid medications or not, correct?

A. Yes. Patients with poorly controlled pain are particularly prone to depression. So doctors caring for patients with chronic uncontrolled pain need to also deal with the component of depression, because if you don't treat that, then the patient is not going to get much better.

Q. Okay. One of the patients that you, in your practice, that you found to be an exception to your own 100-milligram a day for morphine equivalent dosing was somebody you told me about in your deposition of a patient who had a lumbar spine fracture and had a lot of hardware and rods and things.

Do you remember telling me that?

A. Yes.

Q. All right. And did you manage that person's pain?

A. No, the pain medication was managed initially by the neurosurgeon, and then rehab center, and then subsequently by a pain management. I have not been the

person who's been prescribing the dose of opioid narcotic.

Q. Okay. I just ask --

A. The patient's on a combination of treatment, though, including gabapentin, including tricyclic anti-depressants, nonsteroidal anti-inflammatory, and relatively modest dose of narcotic analgesics.

Q. I just mention because this patient was in your deposition, you mentioned him as one of the exceptions to this 100-milligram a day dose. So you're assuming -- are you assuming he's getting more than 100 milligrams a day with the pain?

A. At times, yes. Yes, at times he did.

Q. You talked about Mr. Koon having a relapse of his depression. Is that based on the records at CenterPointe?

A. Yes. Also based on the -- his history of depression and the depression noted by Dr. Walden, then had recurrent depression, and that was diagnosed at CenterPointe.

Q. Okay.

MR. VENKER: I don't have anything further. Thanks, Doctor.

THE COURT: Any redirect?

MR. SIMON: Yes, Your Honor.

Mike, could you please put up Exhibit 170-4,

please?

MR. SIMON: Doctor, this is a letter dated July 25th, 2012.

MR. VENKER: Your Honor, may we approach?

THE COURT: You may.

(The following proceedings were held at the bench.)

THE COURT: All right.

MR. VENKER: I'm going to object to this as improper redirect. This letter is --

THE COURT: Okay. I'm not sure what you asked when you pulled up --

MR. VENKER: He's going to put up --

MR. SIMON: It's a letter that his expert wrote --

MR. VENKER: One of my experts.

MR. SIMON: -- to the FDA asking the FDA to change the label on opioid narcotics so that it should say you don't use it for more than 100 milligrams a day for 90 days. His expert wrote it back in 2012 to the FDA trying to get the label changed.

We just heard thirty minutes of cross-examination challenging this doctor, challenging his testimony that 100 milligram dose is accepted, 100 milligram dose is standard of care, 100 milligram dose is recognized. That's all we

heard for the first thirty minutes. This is his expert, taking the same position, and I'm allowed to redirect to address those issues.

MR. VENKER: Why would he get to redirect on a letter written by somebody else? My expert is coming to trial, he can cross him on the letter.

MR. SIMON: We're going to do that, Judge.

MR. VENKER: Sure. I expect that. But why does Dr. Genecin get to comment on a letter written by somebody else? This is just intended --

MR. SIMON: He's read his depo, he's read -- this was an exhibit.

MR. VENKER: Fine. Okay.

MR. SIMON: He's read it.

MR. VENKER: Okay.

MR. SIMON: Reliance materials. It's in his file. I was going to bring it up with him on direct and didn't until this issue came up challenging the 100 milligrams. It's fair game, Judge, it's his expert.

MR. VENKER: So somebody wrote a letter, I mean, it's my expert, he can cross him all he wants when gets here. What does it have to do with Dr. Genecin? This is just a platform for him to be critical of my expert before he gets here. I mean, I just think it's totally irrelevant to anything.

THE COURT: Okay. All right. Hold on. Let me make sure I'm tracking you. All right. Your expert talked about the 100 milligrams for no more than 90 days.

MR. SIMON: Yes, sir.

THE COURT: You cross-examined him on that topic. Okay. And why is it that you need to bring something outside of what your -- your witness is saying?

MR. SIMON: Because he's challenging my expert's testimony that it is a well-accepted standard throughout the medical profession. He's -- he's cross-examined him challenging his assertion and his opinion that the standard is 100, it's not safe to go beyond 100, you're not supposed to go beyond 100.

THE COURT: Okay. I get what he's doing. What I'm -- what I'm not tracking with is why that document is necessary. In other words, if you feel that you need to rehabilitate your client, what does that collateral source have to do with it? I don't get how -- I'm missing --

MR. SIMON: The jury could be left with the impression that -- he asked him there is no consensus, there is no standard, this came out in 2016, that's what he brought out about the CDC guideline. This is 2012, and, Judge, it's not only signed by Dr. Gunderson, it's signed by a whole group of physicians all over the country. Thirty-seven of them. This is a document that

was produced at a deposition, it was testified to in deposition, this is in evidence. A document in evidence and identified.

THE COURT: All right. But is it a document that he has --

MR. SIMON: He has this document, he's reviewed it.

THE COURT: No, no, in the -- I guess I'm confused. This is a document that your --

MR. VENKER: My expert Dr. Gunderson wrote in 2012.

MR. CRONIN: He agrees with plaintiff's expert.

MR. SIMON: He agrees with my expert. That's the whole point I'm trying to make. That's all I'm trying to do.

THE COURT: Stop. Because Renee is going to kill you. Okay.

MR. CRONIN: Also I shouldn't be talking, so I'm sorry.

THE COURT: Okay. Number one, I understand what you're trying to do. But I think it's improper. I think you can -- I'm going to allow you to rehabilitate your client with his testimony, but I don't -- I think it's improper to use that document -- when his -- when his expert gets up, you get to -- you get to -- you can

impeach him with his own document. I'm fine with that. But you're allowed to say you -- I'll allow you to get is your opinion supported by. But you don't get to bring in an actual document.

MR. SIMON: I can't bring it in?

THE COURT: You can't bring in a document. Or you can impeach his guy -- well, not impeach but cross-examine.

MR. VENKER: Cross-examine.

THE COURT: You can say you're familiar with Dr. Gunderson, you're aware of a letter where he wrote to the FDA. You can say --

MR. SIMON: Judge, can I --

MR. VENKER: He's commenting on another expert's opinion, Judge.

MR. SIMON: Judge, I'm pointing out that the defendants in this case are talking out both sides of their mouth. Hold on. The fact is that my expert's here now, and he may want to ask him to comment on this. This -- this -- the defendant in this case is challenging this expert's testimony about a limitation of 100 milligrams, and their own expert -- he's on the stand. I don't want to leave the jury with the impression, Judge, that -- he did his cross-examination. I don't want to leave the jury with the impression that -- you know, just with what he

cross-examined with.

THE COURT: The problem is, unless I missed it, during cross I didn't hear him ask the question are you the only one that holds this opinion. I think --

MR. VENKER: No, I didn't say that.

THE COURT: If he would have said you're out there on an island, this wouldn't be the discussion. I don't think he opened the door to say that he's out there on an island, and I think -- I'm not excluding the evidence. I don't think it's --

MR. SIMON: At this time?

THE COURT: I think it's premature.

MR. SIMON: Okay. All right.

MR. VENKER: Thank you, Your Honor.

(Proceedings returned to open court.)

MR. SIMON: No further questions, Your Honor.

THE COURT: May this witness be excused?

MR. SIMON: Yes, sir.

THE COURT: You're excused, but you're subject to recall, so don't discuss your testimony with any other witnesses till the trial is concluded.

(Whereupon, Instruction 300.04.1 read to the Jury.)

(Whereupon, a brief recess was taken.)

(The following proceedings were held in the presence of the

jury:)

THE COURT: All right. Mr. Simon, please call your next witness.

MR. SIMON: Your Honor, at this time the plaintiffs call Dr. Mary Fitzgibbons to the stand.

THE COURT: Doctor, my clerk's going to swear you in right here. If you'll raise your right hand.

***MARY FITZGIBBONS, PH.D.***,

having been duly sworn by the deputy clerk, testified:

THE COURT: Ma'am, if you'd have a seat up here. Be careful, there's a step. Make yourself comfortable. Adjust the microphone.

From time to time you may hear the attorneys say objection. If they do, if you'd pause and let me rule on the objection before you answer.

THE WITNESS: Fine.

THE COURT: All right. You may proceed.

MR. SIMON: Thank you, Your Honor.

BY MR. SIMON:

Q Doctor, please state your full name.

A Mary Fitzgibbons.

Q And what is your profession?

A I'm a psychologist, licensed psychologist.

Q Okay. How long have you been a licensed psychologist?

A Since 1984.

Q Okay. And, so Doctor, where's your office?

A At 270 and Olive, 12125 Woodcrest Executive Drive.

Q An what's the name of your practice?

A West County Psychological Associates.

Q Okay. And how long have you been involved with West County Psychological Associates?

A Since 1987.

Q Okay. And, so Doctor, I've asked you -- my office hired you in this case; correct?

A Yes, they did.

Q Okay. And what did we ask you to do?

A You asked me to meet with Mr. Koon and do an evaluation for him.

Q Okay. And have you done that?

A Yes, I did.

Q And, Doctor, will you agree that the opinions and the testimony that you give here today in court will be based upon a reasonable degree of psychological certainty?

A Yes.

Q Okay. And before we get into what you did and what your opinions and conclusions are, I want to give the jury a little more information about you and your

background and practice. Okay?

A Yes.

Q Can you start -- let's start out with your formal education. Can you tell us what your formal education is.

A Yes. I received my -- my master's and my doctorate at St. Louis University. My doctorate was in counseling, but I was at that point able to be licensed as a psychologist in the state of Missouri.

Q Okay. And can you describe and take us through your professional practice since that time.

A I worked for a short period of time for another organization and then in about 1987 started my own company. And it -- in general, it's a general practice so we see children, we see -- we see adults, we do marriage counseling. And we do assessments, psychological assessments. We do a number of things. And that's been that way. I've always had other therapists contract with me in the office. We function as a team. And right now there are probably about 15 therapists at West County.

Q Okay. And, Doctor, have you -- you've had experience in diagnosing mental conditions?

A Yes, I have. Extensively.

Q How many times have you done that?

A Numbers of times. For about 15 years I was a

supervise -- I did supervision with the therapists from Catholic Family Counseling. So all of their -- all the cases that went through insurance had to have -- had to have -- I supervised. So there were many in that situation.

But then in my own office I have done -- again, I've done supervision with all my psychologists -- most of my psychologists and the counselors in the office. I meet with all of my therapists at least every two weeks. And so in that regard, beyond all of my clients -- and I started out by doing -- seeing probably about 40 clients a week, which is really a lot. And now I have sort of weaned it down to about 30 clients a week. So over the years, when you think about the numbers of years, we're talking about a lot of people that -- a lot of diagnoses. And I would venture to say it probably gets into the thousands.

Q Okay. And so you've been involved in over a thousand -- or thousands of psychiatric evaluations?

A Psychological.

Q Psychological. Okay. So Doctor, you were provided with some materials to review in this case; correct?

A Yes, I was.

Q What were you provided?

A I was provided with the deposition from Brian Koon. I was provided with the deposition from Michelle Koon. Deposition from Dr. Gunderson. Reread my deposition. I saw the records from CenterPointe, reviewed the records -- the summaries from the records from CenterPointe. Saw records from Psych Care Consultants. Saw the records from SLUCare.

Q Okay. And, so Doctor, you mentioned Dr. Gunderson. Who is Dr. Gunderson?

A Dr. Gunderson, from my understanding, is the expert witness for the defense.

Q Okay. And you've been provided with Dr. Gunderson's deposition transcript.

A Yes, I was.

Q Okay. And, Doctor, the records -- you talked about records from CenterPointe. And what records were those?

A There are records of Brian Koon's stay in CenterPointe in 2012. So they had all the medical records, but preceding that they also had summaries of his -- summaries of the activities that he did during the stay.

Q Okay.

A And it also gave their psychological -- gave their diagnoses.

Q And were those records -- that's the facility where Brian did the detox and rehabilitation?

A That's right. Yes, that's right.

Q All right. And you said also SLU records. Were those -- did those include records of Dr. McKean?

A Yes, they did.

Q Okay. And who's Dr. McKean?

A Dr. McKean was a psychiatrist at SLUCare who Brian visited with.

Q Okay. And Psychiatric Consultants, you said you saw some of those records?

A I think it was Psych Care Consultants. Yes, that should be Dr. -- I guess it's Dr. Ryall's records.

Q Ryall's.

A And she was referred -- Brian was referred to Dr. Ryall from Dr. Ohlms from CenterPointe.

Q Okay. Now, Dr. Fitzgibbons, let me ask you this. Did you have Dr. McKean and Dr. Ryall's records at your deposition?

A I -- I had Dr. McKean's. Yes, I had -- yes, I did. Yes, I did.

Q Okay. And I don't know whether -- and the reason I'm asking is you were asked at your deposition whether you had those records or not. You've certainly reviewed them as of this time; correct?

A Yes. I had to think. I can't remember --

THE COURT: Hold on, ma'am.

MR. BARTH: Judge, can we approach for a minute.

(Counsel approached the bench and the following proceedings were held:)

MR. BARTH: Judge, the objection here is the expert has now been provided more materials than she had at deposition and is getting ready to offer new opinions that have not been given to any of us. She testified at deposition the only records she reviewed were -- the day before she reviewed three pages of CenterPointe records. Now she's going to talk about Dr. Gunderson's records, she's going to talk about Dr. Ryall and Dr. McKean. She did not even have at her deposition. This constitutes total surprise to the defendants. We've not been provided any notice that she's reviewed additional opinions.

MR. SIMON: I can address that, Judge. Number one, no new opinions. Number two, at the deposition they raked her over the coals because she didn't have records from these two facilities. I provided her the records. She's reviewed the records, and I was just going to ask her if it changed any of her opinions whatsoever, and she's going to say no. That's it.

THE COURT: Let's see where it goes. I agree with you, if it is new opinion, there is an issue. But if

there's nothing new, then we're okay. So I'm going to -- as of right now, I'm going to overrule your objection. If something becomes objectionable, raise the objection.

MR. BARTH: Thank you, Your Honor.

(The proceedings returned to open court.)

Q Dr. Fitzgibbons, do you recall that my office provided you with records of Dr. McKean and Dr. Ryall shortly after your deposition?

A Yes. I want to go back because I was thinking about that while you were up there.

Q And that's because the attorney from SLU asked you whether you reviewed those records, and shortly after the depo we gave them to you; correct?

A Yes. I did not have them prior to the depo.

Q And that didn't change any of your opinions in this case, did it?

A No, absolutely not.

Q Okay. Very good.

Okay. So other than reviewing the medical records and the depositions, did you -- what else did you do?

A I reread my depositions and reread my notes and -- and so I reviewed all the materials that I had.

Q Okay. Did you also meet with Brian?

A From the time -- I have not -- I have -- well,

did I meet with Brian at what point?

Q Any course in this -- in your involvement in this case.

A Oh, I met Brian initially, I believe, it was November the 11th. And I had seven visits with Brian. And the last one ended January 6th.

Q Okay. So you reviewed some medical records, you reviewed depositions of Brian and Michelle, and you also met with Brian on several occasions.

A Yes, I did.

Q Okay. And I think from looking at your notes, Doctor, it's about six or seven times. Does that sound about right?

A That's right.

Q Okay. All right. And you've got your file materials with you, or some of them; is that correct?

A Yes, I do.

Q Okay. When is the first time that you met with Brian?

A I met with him initially -- let me get my glasses. I met with him initially November the 11th, 2015.

Q Okay. And where would that have been?

A In my office.

Q Okay. And about how long did you meet with him?

A My visits are generally 45 minutes.

Q Okay. And what was the purpose of that first meeting?

A Your office had called and asked if I would see him. I knew that this would be a court case, but that's all I knew. So when Brian came in, he told me his story.

Q Okay.

A So I really didn't know any of what this was about until Brian came in.

Q Okay. And, so Doctor, let me ask you this. Can you tell the members of the jury what, if any, information Brian provided to you during that first meeting.

A During the first meeting we talked about his -- that he had been seeing Dr. Walden. He thought he began seeing him in 2000, 2001. He said he saw him on a regular visit -- on a regular basis in terms of getting a checkup. And he had had -- he had had cancer when he was 21 and he was going in to see Dr. Walden just to review his -- review the situation in terms of his -- to determine whether he had any lumps. But he said it was just regular stuff that he saw him for.

And so that's -- that was the initial thing. He then went on to say that -- he started talking about the fact that -- I want to just explain, Brian's -- when Brian is speaking, he comes across very, very -- again, very

effusively. He talks, you know, I want to say in large amounts. So when I look at my notes, they're not exactly the notes I like to take only because he's giving me so much information. So sometimes it doesn't go in order. But he's so -- you know, he's -- he's very forth -- you know, forthright in telling you what his story is.

He said his back started flaring up and that he went to Acute Care after he had an adjustment from the chiropractor. He began -- he said he was seeing Dr. Walden. In that first -- when he said his back started acting up, he was on -- somebody gave him Vicodin, low amount of Vicodin. However, he saw Dr. Walden after that. He didn't know exactly what the date was.

The first pain medication Dr. Walden gave him was hydrocodone. And initially it was a low amount. He went back to Acute Care after another pain episode and they gave him OxyContin because the pain was greater. He went to a follow-up visit with Dr. Walden. At that point they added OxyContin to the hydrocodone.

He -- he said he was on the maximum amount of these medicines by 2012. He developed a tolerance. The initial amounts were sufficient just for a time and then there would be a need to increase them because the pain would increase. Brian would call -- call Dr. Walden on the phone for more medicine and Dr. Walden would fill the

prescription.

He said he had a fusion surgery and was operated on front and back on the fourth and fifth lumbar. He was off of work for about a -- he was off of work for about eleven months. He then returned to work doing light duty. However, the work eventually refused him.

So these notes are -- they jump around. And I think in some ways I could even tell the story a little bit better if I could do it in some chronological order. But essentially this is what was happening on the first visit.

His primary care physician was Dr. Walden. Ten years. He said he had a great relationship and trusted him. However, when he was having back problems -- he had back problems. He had -- what happened was that he said that 14 years before this he was carrying some kind of a suit bag on his shoulder. He said that -- that he collapsed with that. He then went to Dr. Frank Mistretta, a chiropractor. He saw Mistretta for a number of years.

Eventually again he goes back to talking about how Dr. Walden was his doctor. He liked Dr. Walden at the time. And then he talks a little bit about his -- his Hodgkin's lymphoma.

Q Okay. And does that -- does that pretty much conclude what was discussed during the first visit,

Doctor?

A Yes, it does.

Q And that would take us to the next visit; right?

A Yes.

Q And when was that?

A The next visit is November 21st, 2015.

Q Okay. And what information did Brian give you during that visit?

A He started talking about all of the doctors that he had been seeing. And then he talked about Dr. Badar who was his primary doctor who preceded Dr. -- I think it's Javaid who examined him when he went to CenterPointe. He went to see Dr. Badar before going into treatment at CenterPointe.

He --

MR. BARTH: Judge, I'm going to object on the grounds of what Dr. Badar said to Brian. I think she's reading a record. It would be hearsay.

MR. SIMON: Your Honor, it's a medical history that she took from Brian that she's using to formulate her opinions and diagnosis in this case.

THE COURT: I'm going to overrule. That's a proper exception to the hearsay. You may answer.

Q (By Mr. Simon) Go ahead, Doctor.

A I'm sorry. Going on, he talks about seeing a

doctor Patel who was a urologist who had seen him over a year for prostate. And Dr. Patel referred Brian to Cathy Naughton who is a fertility specialist. He was not -- not able to make enough testosterone, he says, because of the opiates. They had wanted children, they were trying to have children. He talked a little bit about Michelle, his wife.

And then he talks about Dr. Berry, a pain management doctor who was seeing him for his steroid injections in his back prior to his operation. It's Dr. Berry who calls him the fact that he was probably taking too much medication.

MR. BARTH: Objection, Your Honor. Again I'm going to move for hearsay. And improper bolstering of testimony from the plaintiff.

MR. SIMON: Your Honor, it's a history she took from Brian.

MR. BARTH: But she's not saying -- she doesn't provide any care or treatment to him so what's the exception.

MR. SIMON: She's giving opinions based upon the -- as a licensed psychologist, Your Honor. She's giving opinions based upon the history and the information that has been provided to her.

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

But we're going to tighten it up.

MR. SIMON: Okay.

Q (By Mr. Simon) So Doctor, we're on the second visit, 11/21/15?

A Yes.

Q Okay. And why don't we go through and -- let me put it this way. Can you sort of provide the significant aspects of information that he told you on a given day?

A Let's -- yes.

Q I'm putting a little pressure on you.

A He sees -- he's talked about Dr. Berry and how Dr. Berry was really sort of shocked by the amount of medication that he was on. And he was shocked that -- Dr. Berry was surprised that the DEA hadn't noticed how much pain meds were being prescribed.

Now I'm telling you, these are his words. This is exactly what he's telling me, and I'm writing it down. None of these are my opinions or my words.

He said it was unfortunate that Brian had slipped through the cracks. Dr. Berry would not give Brian medication. He would -- he only gave him injections.

Michelle, his wife, wanted -- wanted Brian to go into a treatment center. But they couldn't find one because no one would take him based on the amount and

kinds of medications that he was on. Michelle called Dr. Walden a number of times because she was concerned about the medication he was taking. That comes across over and over again that Michelle -- Michelle was very concerned and was trying to make contact with Dr. Walden.

They were looking for a psychiatrist to prescribe Suboxone which would help him if he detoxed for all -- which would help him in terms of detoxing for these medications. He asked Dr. Walden a number of times if he could go into treatment. Dr. Walden did not refer him for rehabilitation. He just kept delaying it.

The psychiatrist in this case was -- I've got down in my notes it was Dr. McKean. He and Michelle went to see Dr. McKean. Dr. McKean then called Dr. Berry, and they were trying to make contact. Again, apparently from these notes, saying that they were trying to contact Dr. Walden. And Michelle wanted to ask -- Michelle called Dr. Walden and asked for the meds to be decreased.

Now, during this time, Brian says he doesn't remember much of this. He was addicted, not realizing how serious the situation was. He said that he never went outside of -- outside to get this medication from Dr. Walden because the medication was always available through Dr. Walden.

What then happened was Michelle was apparently

filling -- getting these prescriptions filled through the pharmacist. And Keller Apothecary told her that --

MR. BARTH: Again, Your Honor, I'm going to move to object on the basis of hearsay.

MR. SIMON: We can skip over that part, I think, Your Honor.

THE COURT: Sustained. Move on.

Q (By Mr. Simon) Okay. And why don't you -- the conversations with the pharmacy, we can skip those.

A All right.

Q But please continue.

A All right. Brian was ashamed that he was addicted but felt as though he had no control over it. This comes across over and over again. That he is in great shame over this addiction. He talks about the fact then how miserable life was at home, especially for Michelle, because they even put the meds -- they put his meds in a lock box and then he would go crazy and start searching for the medications.

They -- Brian and Michelle went to see Dr. Melanie McKean again, the psychiatrist at SLU. And then he talks again about talking to Dr. Berry. She called Dr. Walden and told him take Brian off two pain killers, the oxycodone and the hydrocodone, and leave him

on the OxyContin, but they would increase that dosage. They wanted him off it, but he couldn't control the pain and addiction.

Then he tells me at that point that after he saw Dr. McKean he was so despondent and he had a pistol and he put it in his mouth and decided that he actually couldn't do that to both Michelle and to his daughter Emily. And so he doesn't mention another suicide attempt, but he said that he could not go through with that.

Q Okay. And, Doctor, that was all on the second visit; right?

A That's right.

Q November 21st, 2015?

A That's right.

Q Okay. And when did you see him next?

A I saw him November 28th.

Q Okay. And it looks like on this visit you got into a little more detail about his background and childhood and so forth; correct?

A Yes.

Q Okay. And what did Brian -- what information did Brian provide to you at that point?

A At that point I told him he was -- we go back and we started talking about his childhood. He was born in -- he was adopted in Pennsylvania. I believe they

moved to New York. But then when he was about six, he came to -- they came to -- in sixth grade they came to St. Louis. He had a brother who was also adopted. His brother had some physical problems. Brian thinks that he was somewhat depressed because of the adoption.

When he was 14, he went to see a Dr. Corday because he had cut himself. And they hospitalized him for 28 days at Mercy. St. John's Mercy. He said that it was sort of a respite for him to be able to go into the hospital for that month. He described himself as being withdrawn. At that point he was going to Parkway North -- Parkway North High School. He said in terms of drug usage he was smoking marijuana but didn't -- didn't use other drugs.

He left Parkway North because he said -- because of truancy. He was obviously not going to school. His parents enrolled him at Logos, and at that point Logos -- I think at that point was taking children who -- who had had difficult time in a regular school. He stayed at Logos, I think, less than a year. And then he left Logos without -- without a high school diploma. Eventually got a GED. When he was at Logos, he cut again. And again, it was only one time. And in those days you could hospitalize for that for 28 days. And again he saw it as sort of a respite.

Brian said that Dr. Corday had told him that his therapeutic issue was abandonment issues. Fears of abandonment. Which would make some sense. Probably because of the adoptive situation. He talked about his relationship with his mother and his father and his -- he did not have a strong -- it didn't sound as though he had a strong relationship with his father. He said he was much closer to his mother.

He, at this point during adolescence, wants to know who his mother is, but he never pursued that.

Q That would be his biological parents?

A Yes, I'm sorry. Yes, his biological mother.

Q Okay.

A He said again the move to St. Louis was very difficult in the sixth grade. He didn't get along, his grades were poor, his father -- his father would take the school side.

His brother died when he was -- his brother died when his brother was 33 in his sleep. They didn't know the cause.

And then he talks about his cancer when he's 21. And he was obviously a very -- described himself as a very upset, angry, quote, unquote, pissed off kid. But Brian says that when he had cancer at 21, when he went through the cancer treatment -- and he said it was Hodgkin's

lymphoma -- he said everything changed. And at that point what happened was he began to really realize that life could be good. And he had stage 4 cancer.

He comes out of that. And he said his whole attitude had changed. And it was remarkable that he said that, you know, that prior to that there had been some -- you know, there had been -- obviously he had been depressed at times. But at this point now, at this point he is -- I think the cancer was in 1993. He felt much better about himself. Everything changed. Physically and emotionally. He says he had a second chance in life. He said life was good then.

He had radical radiation with the cancer treatment. He was -- and he talks about other kinds of -- the physical issues, losing -- he lost 270 -- he went from 270 pounds to 160 pounds. He doesn't remember -- he said he doesn't remember a lot from that point. He said he is in remission now, he doesn't have any issues with the cancer.

He -- then he goes on to talk again about the drugs. He said he feels as though the drugs left a greater scar on him. He said even though he may have had -- I think they gave him Percocet with the cancer. He didn't become -- there was no sense of being addicted at that point. The cancer gave him a second chance in life.

He said he felt that he was happy to be alive. He claims that he didn't feel the depression after the cancer. He did have some anxiety about whether the cancer could return. He went every three months for the first year or two to determine -- to determine his health. And he obviously has stayed fine.

And that was the end of that.

Q Doctor, it sounds like each visit you sort of concentrated on a different stage of his life?

A Yes. What happens when clients come in, I generally let them take the lead in terms of where they want to go. And I may have an idea of what I want to ask, and I will eventually get there. But generally the client takes the lead.

And as I said, Brian speaks very, very quickly and there's a lot coming. And there were times I'd even have to say to him, I need to get this down, you know, we need to go a little slower here. So there was just -- you know, it's almost like a stream of consciousness with him.

Q Okay. So the next time you saw him, it looks like it was November 30th of 2015?

A That's right.

Q Okay. And, so let's see, that's about a month later? I'm sorry --

A No.

Q Two days later. Okay.

A Yeah. And --

Q All right. We were --

A I'm sorry, go ahead.

Q I'm cutting you off. I'm sorry.

A I wasn't saying anything.

Q All right. So what was discussed and what information did he provide on that next visit on November 30th?

A He talked about the fact that in the years 2008, 2012, when he was on the pain -- on the opioids, he doesn't remember -- he doesn't remember much. In fact, that's his great -- that's his great concern. He says his memories come from Michelle primarily during those four years. And so -- and what lease saying to me about those years is Michelle has told him, and he said he can't recall details.

He talks about his daughter Emily's baptism. He doesn't remember the baptism. His father was a pastor at Ladue Chapel and he baptized Emily. He doesn't remember -- he doesn't remember that either. He said -- in fact, he says this over and over again, that if only he could get those years back. He felt that he lost those years, they were precious to him. Emily apparently must have been born in 2009.

Q I think so, yes.

A Yes. And, so yes, he started taking the opioids in 2008. And so those early years for Emily, he lost those years. And it was a great, great loss, as he says it. And he's really emotional as he's talking. And obviously it's very evident that this is really important to him.

In treatment -- in treatment after a week of sobriety -- so he goes to treatment at CenterPointe. And the first time he sees his wife and doctor after he's been in treatment for about a week, he says that he was a wreck. He was terrified. He was scared to death. He had no sense of how to have a relationship with them. And so what happens was he said he was always medicated when he was with them, especially with his daughter. He said Michelle hadn't seen him sober for a long time. He didn't know how to act. He didn't know if they would really want him.

He said -- he talks about the fact that Emily was apparently running. She's a three-year-old. And he said he never remembers her running. So -- can I digress and talk about Michelle's deposition?

Q Okay. Did you -- let me ask you a question.

A Yes, sir.

Q Did you gain any information from Michelle's

deposition to assist you?

A Yes.

Q Okay. And what information would that have been?

A You know, Michelle -- I was really shocked to see -- and not only because -- when I do therapy with couples a lot of times, you're going to get one story from one person, another story from another person. I was really surprised to see how Michelle's --

MR. BARTH: Your Honor, I would object to improper bolstering. She has not seen Michelle. She's just commenting on a deposition that she read.

MR. SIMON: She used those depositions again --

THE COURT: Approach.

(Counsel approached the bench and the following proceedings were held:)

MR. BARTH: We had started the objection that she is now moving on to just reading her notes and just commenting upon Michelle through deposition testimony, which is improper bolstering of a witness. She's made it clear she has not seen Michelle. And now she's going to read her deposition and comment upon it and how it applies to Brian. It's completely improper. It's bolstering. And it's the relevance here, I don't know what the relevance is.

MR. CRONIN: Judge, this was the subject of a motion in limine. A psychologist has to determine the accuracy of what is reported to them in order to formulate their diagnosis. And that is what she has done. The accuracy and consistency of what Brian said to her and what he said in his depo and what Michelle said in her depo so she can determine whether she trusts what Brian is saying to her to reach a diagnosis.

MR. BARTH: If she saw Michelle -- we can't give her a legal document and make that the basis for credibility. If she saw Michelle in person for her diagnosis and treatment, I might go along with that. But she's never seen Michelle. Now she's going to comment upon her credibility from the deposition.

MR. CRONIN: The deposition was under oath, Your Honor. I don't know that it's being suggested that Michelle lied under oath.

THE COURT: Hold on. What is the relevance of her commenting on a deposition that she read? How does that help the jury? She's available; right? She's getting ready to testify.

MR. CRONIN: She is going to, Judge. Because she is going to be cross-examined and all of her opinions are based only on trusting that what Brian is saying to her is accurate. That's going to be suggested that that's

not reliable. And she's seeing the same thing every time -- she's saying the same thing every time she sees him and in his depo and what his wife said in her depo. So she can trust that the stories are accurate to formulate her diagnosis.

THE COURT: Okay. So here's what I'm going to -- I'm going to sustain in regards to bolstering. However, you can -- I will allow you to comment regarding -- is Mr. Koon -- is Mr. Koon consistent with --

MR. SIMON: Got it. That would be a better way to do it anyway.

THE COURT: Right now she's giving too much weight.

(The proceedings returned to open court.)

Q (By Mr. Simon) So Doctor, let me ask it this way. You met with Brian for several sessions, and that's what we're going through now; right?

A Yes.

Q And you never met with Michelle; right?

A No, I didn't.

Q You never met with them both together?

A No, I didn't.

Q But you were given the deposition transcript of testimony that Michelle gave under oath in this case; correct?

A Yes, I did.

Q And those were questions that the attorneys for SLU had asked her; correct?

A Yes.

Q Extensive; right?

A Yes.

Q Okay. And based on your review of that deposition, was what Brian was telling you consistent with what was in the deposition or not?

A It was absolutely consistent.

Q Okay. Very good. So let's -- rather than get into the depo, because Michelle's going to be testifying, we'll go ahead and let's finish with what Brian told you. Okay?

A All right.

Q We're back on November 30th of 2015?

A That's right.

Q Okay. And I'm sorry, we -- do you know where we were at?

A We were talking about -- about the fact that Brian hadn't seen -- couldn't remember Emily running. And again, Brian's -- most of Brian's -- most of Brian's discussion with me is about this loss. This loss of what he experienced. Loss of not being able to see his child grow up, realizing he didn't really -- he didn't know this

child. This child really didn't know him either.

He wanted to be off the drugs but felt that he didn't have any control over the medication. Again he goes back to talking about Dr. Walden. Dr. Walden -- he told Dr. Walden that he didn't have any control and he was upset because Dr. Walden didn't do anything about it. He would have wanted Dr. Walden at least to attempt to put him in rehab or if he could have weaned the medicine down. Even when they talked about weaning him, Dr. Walden didn't follow through with that.

Again, he goes back to Dr. Melanie McKean. And he says that both Brian -- he and Michelle both saw Dr. McKean. Again, she's a psychiatrist. Brian told her his story and pled with her that he wanted to get off the medicine. He said he didn't know how to get off the opiates. The psychiatrist, Dr. McKean, talked to Dr. Walden. And this is what Michelle told Brian.

Dr. Berry also advised the psychiatrist to talk to Dr. Walden about getting Dr. Walden off the medicine. So it seems like Dr. Brian -- I'm sorry -- Dr. Berry and Dr. McKean were talking together. And again in talking with Brian and wanting to talk to Dr. Walden about the -- about the excess of medications.

Again, he talks about the medications he was on. And, again, I said this earlier, he repeats that -- that

Dr. McKean wanted -- made the recommendation that they take him off the oxycodone and the hydrocodone and just increase the OxyContin. Michelle had already called Dr. Walden complaining about the amount of meds he was taking. Dr. Walden's response was that he was going to give her -- give him two weeks medication instead of four weeks. Michelle was upset with that. She wanted him to cut the medications down.

His marriage was falling apart. They hadn't slept together -- he and Michelle had not slept together in six years. The drugs killed his sexual drive. He said he was losing any connection with her. And then at some point he really felt they lost connection. He talked about the fact that, you know, he was -- had disappointed her so badly. But yet after four years of being on these medications, he felt as though he didn't know how to connect back with her again. And that's a problem. They had a connection prior to this, but after that he doesn't know how to connect.

Brian was in intensive therapy again in CenterPointe after -- and then he went into outpatient after that. Dr. Ohlms was seeing him. At that point then he started going to NA meetings and AA meetings. He wasn't home that much. What happens is he says he gets out of CenterPointe and at that point now he's going to

outpatient at CenterPointe and then he's going -- in the evenings he's going to NA meetings and AA meetings.

So here when he gets out of rehab, what happens is that he doesn't go back and connect again. Doesn't know how to connect. And so he finds -- at some point he says one of these -- either in these notes or -- he says that -- he said it was safer to be in rehab. And that makes a lot of sense. And so being at home was really -- was really difficult for him.

He had to do whatever he could do to stay off the drugs so he went to the meetings to take care of himself. But what he didn't realize was he was hurting his marriage by being gone all the time. For him it was a conflict situation. He knew he needed the meetings. He knew he needed something to keep him off the drugs. He knew he wanted desperately to get back with his wife. And, yet, you know, and yet he was in great conflict. He doesn't feel the connection to Michelle. They hadn't slept in the same bed for four years. They were cordial to each other.

Q And when did you see him next, Doctor?

A Then I saw him December 30th, 2015.

Q All right. And what was discussed on that day -- at that time?

A Well, looking at my notes, I'm assuming what I

may have asked was just give me the issues that you see, because he talks about five different things. The issues that he sees are that Walden turned him into an opiate addict. He will be an addict -- his fear is that he will be an addict until he dies. His marriage is in trouble. He is really affected by his fatherhood with his daughter.

What he says is that everything was resolving around the meds. Everything they did even as a family was resolved around when he could take his meds, if he's going to have the meds with him. So he said it almost became -- it was absolutely extensive about the meds. That certainly got in the way of his relationship with his wife, and certainly with his daughter.

The thing is that he mentions at one point his daughter said how much she loved him, and even though he says he loves her, he was absolutely so emotionally fearful of getting close with her because he was afraid if he got too close with her that he would again -- excuse the expression -- screw it up. That was how he saw it. He was really frightened that he was going to hurt them by being close to them. So he had a tremendous fear of getting close to them after he got out of rehab.

Then he talks about the fact that he had four surgeries from 2012 to 2015. We talked about what he was -- what medications he was taking presently. And at

that point after the -- after all the surgeries were over, he was taking Tramadol.

He had not been seeing anyone -- I asked him about if he was getting, you know, getting help from anyone. And especially in terms of his -- the addiction. He said he had not been seeing anyone regularly after CenterPointe and aftercare except for AA and NA. But he hasn't been going -- hadn't been going to them regularly. When I asked him why he hadn't been going to them, he said -- apparently he was on the Tramadol and felt like -- he said he didn't want to go to a meeting under the influence of an opiate. Even though he was not on -- he wasn't on the oxycodone or hydrocodone or OxyContin.

He said that he had lost trust in people. He couldn't trust himself or his own actions. And that was another thing. I think when he talks about this issue of trust, it's a very big issue for him. The fact that he can't trust himself, how can he expect others to trust him. And that certainly being an opiate addict or, you know -- what he says is that he knows that he never will be able to trust himself and he knows others won't be able to trust him. He's destroyed the trust, and he certainly has destroyed the trust he had with Michelle.

He talks about the fact that one of the reasons certainly is because of who he was during those four

years, but the fact that, you know, that he would -- they would -- they would hide the medicines and he would be aware that's what was going on and then he would be frantic. Frantic in order to get ahold of them.

He talks about the fact that this trust issue that once he started seeing Dr. -- he went to CenterPointe and then saw Dr. Ryall after that. They would ask him for a urine specimen, making sure that he wasn't on any other -- any other medications except for the Suboxone. And he said that -- two things. One is that he realized that nobody's going to trust his word anymore. He knew that urine -- taking that urine specimen was critical because nobody was going to trust him.

But the other thing that bothers him too is that Walden never -- Dr. Walden never asked him for a urine sample. And he said obviously they had to do it because they were looking to make sure that he was -- taking the appropriate medications. He said both Dr. Ohlms and Dr. Ryall would have him again give a urine sample after each new script. And again he talked about his word not being trusted. You have nothing without trust. Those are his words.

Every time he has an operation, he feels conflicted in some ways about getting the drugs, but then dreading that he'll have to go through this again. This

is his words. He said his life is a train wreck in progress. It was nothing like it was before 2008.

Q So Doctor, the next time you saw him was December 19th, and that really wasn't an information session; right?

A That's right.

Q What did you do then at that visit on December 19th?

A Again, repeating about what I said about the words were coming so fast, I wasn't sure of my own notes, knowing that I -- you know, that I was going to eventually have to go into a deposition. So what I did was I just said to Brian that I would like to sit down with him and go over my notes to make sure that what I had was accurate.

Q And that's the time that you spent with him on December 19th?

A That's correct.

Q And then the last time you saw him was January 6th of 2016; right?

A Right.

Q Okay. And, generally, what was the purpose of that visit?

A I was going into that deposition for him the following day and it was obvious -- and even though I had

seen Brian six times before that, I still had not come up with -- I had not talked with him about a diagnosis.

What I generally do in these kinds of cases is sit down with what they call the Diagnostic and Statistical Manual, and that's where all the diagnoses are listed for therapists, psychologists, psychiatrists -- well, psychologists and psychiatrists to give a diagnosis. And in this -- they call it the DSM. And in the new DSM-5, as they have been in the previous ones, they will give all the criteria for a particular diagnosis. The client or the patient has to fulfill those criteria in order to be diagnosed.

So what I did was I sat down with Brian that day, took the DSM-5 out and said we need to go through this to determine to make sure that he fulfills the requirements for what I considered at that point was the diagnosis that I was coming up with. So we sat down and we went through the diagnoses for major depressive disorder, we went through the diagnoses for opioid use disorder, and then we went through the diagnoses for opioid withdrawal.

Q Okay. And, Doctor, the DSM is what you used to go through to come to these diagnoses?

A Yes.

Q Okay. And you've done that -- this wasn't the

first time you did that; right?

A It was the first time with him that I had.

Q But you've done that many, many times in the past?

A That's what -- that's what everyone does. You need to use the -- you need to use their coding to diagnose. And for the most part, most of it is for insurance purposes. But also to determine -- you know, to really determine what kind of a diagnosis you have.

Q Okay. And, Doctor, you mentioned three diagnoses. One was opioid withdrawal; right?

A That's right.

Q Okay. And opioid use disorder was another?

A That's right.

Q Okay. And major depressive disorder?

A That's right.

Q Did you reach all of those diagnoses with respect to Brian Koon?

A Yes.

Q Okay. And what I'd like to do is just have you go through briefly, Doctor, and which ones -- let's talk about opioid withdrawal first. Is that okay?

A We can.

Q Okay. What I'd like to do is have you take the jury through what -- what is that? What -- how did you

diagnose it and what is that condition?

A Well, I looked at that because if he was an opioid use -- you know, if he was -- we had diagnosed him as opioid use disorder. And looking at the opioid withdrawal, essentially what that talks about is it discusses the symptoms that he would have under a withdrawal process. And so he has to have a presence of at least -- I believe here there are nine symptoms.

And of those nine, what happens is that they -- they -- you can diagnose him with either mild -- oh, no, I'm sorry. What happens is that you can only -- you can only diagnose this if he has a moderate or a severe opioid use disorder. You can't do it if it's a mild.

Well, when I looked at the criteria, Brian was positive for all but one. And so he had -- he had eight of the symptomology. Would you want me to just run through them?

Q Can you just tell us generally what is the condition. What is -- I guess maybe the symptoms would be the best description.

A I can talk about the symptoms. In a case where someone is withdrawing from a pain medication such as opioids, what happens is you're looking at the symptomology that they are experiencing soon after they're off the medications. And so it -- and so what they do is

they give the diagnostic criteria. And under -- there are Sections A, B, C -- A, B, C and D.

And under A they talk about the presence of either a cessation or reduction in opioid use that has been heavy and prolonged. So withdrawal means that he had stopped using it. And then -- and, of course, that was positive.

And the administration of opioid antagonist after a period of opioid use, which was his Suboxone. So that was -- he also -- he also was positive for that one.

So then you have to have three or more of the following, developing within minutes to several days once he gets off the medication. So the nine -- the nine symptoms are a dysphoric mood, sad. Nausea, vomiting. Muscle aches. Lacrimation or rhinorrhea. In other words, a lot of crying, his nose running. Pupilary dilation. Sweating. Piloerection. Again, he says he was sweating a lot. He was not positive for diarrhea because he said the medications had made him constipated so that was never the issue for him. But he was positive for yawning, fever and insomnia.

Then they go -- so then it just says C is the signs or symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning. And they're not attributed to

another medical condition. So he certainly seemed to fulfill the requirements at the time he went into withdrawal for opioid withdrawal.

Q Okay. And were you able to classify it as moderate? Severe?

A I was -- considering he had eight out of the nine, I would say it would be severe.

Q Okay. Again, is that a condition that exists currently?

A No.

Q Okay. That's --

A That was when he -- that's when he got off the -- and that was -- that was after he had one of the operations. I think it was after his second operation. Or third operation. Third operation.

Q Okay. And, so Doctor, the second diagnoses was opioid use disorder?

A Yes.

Q Is that right?

A Yes.

Q What is that?

A Again, it is -- here. The -- I'm sorry.

Okay. With the opioid use disorder, essentially what happens is that it includes signs and symptoms that reflect compulsive prolonged administration of opioid

substances that are used for no legitimate medical purposes. And so it's taking a good amount of opioids that are not necessarily used -- they're not necessarily used for medical purposes. But it's an excessive amount. And even if it were for medical purposes, apparently the DSM is saying it would be an excessive amount.

And, so again, with that, they give a number of criteria in order to determine whether he fulfills the requirements for this. So again, under A, it says a problematic pattern of opioid use leading to clinically significant impairment or distress. And this says you only need two of the following occurring within a 12-month period. You need only two. So any -- there are ten. And he fulfills the requirements for all ten.

Opioids are often taken in larger amounts or over a longer period than was intended. There is a consistent desire or an unsuccessful effort to cut down or control opioid use. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid or recover from its effects. This craving or strong desire or urge to use opioids.

There's recurrent opioid use resulting in a failure to fulfill major role obligations at work, school or home. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or

exacerbated by the effects of the opioids. Important social, occupational or recreational activities are given up or reduced because of opioid use. And he talked about the fact that they weren't going out. They were doing nothing by the time he was -- he had gotten to this point.

Recurrent opioid use in situations in which it is physically hazardous. He talked about driving the car while -- while being on that medication. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

And then tolerance as defined by either of the following. A need for markedly increased amounts of opioids to achieve intoxication or desired affect. And a markedly diminished effect with controlled use of the same amount. That was all -- he was positive for all of that. And so withdrawal as manifested by either the following: Characteristic opioid withdrawal syndrome or opioids are taken to relieve or avoid withdrawal symptoms.

So he does -- he does answer positive for everything on the opioid use disorder.

Q Doctor, let me ask you this. Did I hear you say out of the list you only need two --

A Yes.

Q -- to be diagnosed with opioid use disorder?

A Yes.

Q Two out of the ten; correct?

A Yes.

Q And you reached the conclusion that Brian has ten out of ten; is that right?

A He has ten out of ten. So what the DSM goes on to say is that it's specified as severe if there's a presence of six or more symptoms.

Q So you classified his as severe?

A That's right.

Q Okay. And then is that similar to addiction? Is that what we're talking about?

A That's -- yes.

Q And, Doctor, is that a condition or a disorder that Brian currently has?

A Yes. Yes.

Q Okay. And, Doctor, let me ask you this: What, if any -- have you reached a prognosis for Brian as far as the opioid use disorder?

A I would be hesitant about saying that. What the DSM will tell us is that the longer the use, the more intense the use, the harder it's going to be for him to be able to recover from this.

I'm especially not to going to say, but I really wouldn't talk about that in terms of prognosis because I

don't do drug -- I don't do any drug work. In my office, I have other people -- in fact, I had talked to Brian about seeing another therapist in my office if they were going to continue -- if he was going to continue to come in. I -- so I would be very hesitant to say that -- that there's a prognosis for him in that regard. On the other hand, given what the DSM is saying, it certainly doesn't seem as though it's going to be very easy.

Q Okay. And, Doctor, the last -- the last diagnosis was what?

A Major depressive disorder.

Q Okay. Well, let me back up for a second. You don't treat drug abuse patients?

A No. No, I never have.

Q Okay. And if -- are you still able to make a diagnosis?

A Yes, I can.

Q In other words, how are you able to make these diagnoses if you don't regularly treat drug patients?

A Because I'm using the DSM. I can -- I can make the diagnosis. Anyone can make the diagnosis if -- you know, if it's obvious that those symptoms are there.

In meeting with Brian, we went over that. I have to determine whether -- whether the information he's giving to me is accurate. It certainly seemed accurate.

In fact, it goes along with the stories he's telling me. So in some ways a lot of those -- a lot of those symptomology I could have just crossed off -- I could have just checked off the list, rather, because he had already told me that these things were the things that were happening.

So yes, I can make the diagnosis. It doesn't necessarily mean that I'm going to treat.

Q Okay. And, Doctor, let's -- then the final diagnoses was major depressive disorder; correct?

A That's right.

Q Okay. And can you tell us what is that and how did you make that diagnosis?

A So it is -- it's -- major depressive disorder, of all the depressive disorders, it's probably the most -- one of the most serious. And generally what happens is -- I'll generally look at major depressive disorder when I see somebody who's really not functioning. They don't go to work, they can't get out of bed. And so it was obvious that given all the issues that Brian was dealing with, he would really -- he would really qualify for major depressive disorder.

So obviously it's a situation where people are depressed for at least a two-week period of time. And the depression is more than -- it's more than maybe what -- a

very common sort of depression is called dysthymia. They now call it persistent depressive disorder. Many of us have dysthymia. It's chronic, it's long-term. However, you know, it doesn't interfere with the way we live. With major depressive disorder, there is a -- there really is a -- it has an impact on our functioning.

So in order to qualify for major depressive disorder, you have to have five or more of the following present during the same two-week period. And -- and what it talks about is there is a depressed mood and there's a loss of interest or pleasure. So the first is depressed mood most the day nearly every day as indicated by -- either by subjective reports, his report. In other words, he feels sad, empty or hopeless. Or observations made by others. And yes.

The next one, markedly diminished interest or pleasure in all or almost all activities most of the day nearly every day. And, again, either by subjective account or observation. So it doesn't just have to be what others say. It can certainly come -- be coming from how he perceives the situation.

Significant weight loss when not dieting or weight gain. Or decrease or increase in appetite nearly every day. He had talked about this weight loss, and so for that reason I probably am going to say yes. I had

wondered about that. But, quite honestly, there are only a couple of these that he doesn't qualify for.

Insomnia or hypersomnia every day. He had hypersomnia. Psychomotor agitation or retardation every day. In other words, he's very restless and his body's moving a lot. And he said no, that wasn't -- he didn't have that symptom.

Fatigue or loss of energy nearly every day. Yes, he does.

Feelings of worthlessness, excessive or inappropriate guilt, which may be delusional, nearly every day. And not -- but it's not merely self-reproach or guilt about being sick. And he does have that sense of worthlessness. In fact, that's what I'm really very concerned about with him.

Diminished ability to think or concentrate or being indecisive. And he says yes, absolutely. He had a very difficult time sometimes making decisions.

The ninth one is interesting. It's a recurrent thought of death. Not just your dying. Recurrent suicidal ideation means without a specific plan or a suicide attempt or specific plan for committing suicide. As I told you earlier, he talked briefly about the one day that he had the pistol and he put it in his mouth and then he took it out.

Now, I asked him whether he was suicidal at this point, and he said no. However, I'm going to tell you that I've done a lot of therapy over the years, and I -- I would be very concerned about Brian's state of -- his mental state. At least as of when I saw him in January. I don't know where he is today. But as of January, I was really concerned. Somebody who may really commit suicide is not necessarily going to tell the therapist that that's what they're thinking of doing.

The fear is that Brian is the -- probably the appropriate age, and the fact that he's a male -- male -- men are generally more likely to complete suicide, and I think it's a pretty well-known fact. And women will talk about it, women will attempt, but men will carry it through. So while I did put recurrent, I'm going to say yes because of the issue around the pistol.

The symptoms -- all of these symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning. So for that reason, he says it is -- there were nine -- nine symptoms, and he has to have -- well, he has to have five or more. And out of the nine, I would have said he has eight.

Q And, Doctor, have you reached all of those diagnoses to a reasonable degree of psychological

certainty?

A Yes.

Q Okay. And, so Doctor, you not only met with Brian seven times, seven sessions, but you read his deposition; right?

A Yes.

Q And you read -- you read his medical records; correct? Some of his medical records.

A I'm sorry, I read what?

Q You read some of his medical records?

A Yes.

Q Okay. Was Brian consistent in his reporting to you and what he reported to others?

A Yes. That's the other thing that was really very surprising. When I looked at SLUCare, Dr. McKean had given him the exact same diagnosis. Major depressive disorder.

MR. BARTH: Your Honor, I object to speculation, lack of foundation. I don't know that she can testify what the state of mind was in 2012 when she saw him in 2015.

MR. SIMON: I'll withdraw the question, Your Honor.

Q (By Mr. Simon) Doctor, let me ask you this. You did read Dr. Gunderson's deposition;

correct?

A Yes.

Q Okay. And Dr. -- who is Dr. Gunderson?

A As I said earlier, Dr. Gunderson is the witness for the defense.

Q Okay. And is what Dr. Gunderson says consistent with the diagnoses that you've reached?

A Yes. I saw nothing, in fact, in that deposition that said he disagreed with what I said. He apparently had read my deposition. And he said that Brian had opioid use disorder and major depression. And the only other thing he said was that some of the issues needed to be explored more, and I agreed with him. If we'd have continued to do therapy, we would have done that.

Q So basically you reached the same diagnoses as the expert for St. Louis University?

A That's right.

MR. SIMON: No further questions, Your Honor.

THE COURT: Cross.

MR. BARTH: Yes, Your Honor.

**CROSS-EXAMINATION**

BY MR. BARTH:

Q Good afternoon, Doctor.

A Good afternoon.

Q Hi. My name's Michael Barth. We met shortly

before your testimony today.

You are not a medical doctor; is that correct?

A That's correct.

Q You're not a psychiatrist?

A No.

Q You can't prescribe any medications?

A That's right.

Q Can you see patients in hospitals?

A If I have a client who goes to the hospital, yes, I can do that with permission.

Q Do you have privileges to see them?

A No, I don't. Psychologists don't have privileges in hospitals in Missouri.

Q And you are not an addiction or substance abuse physician?

A That's right.

Q There's actually somebody in your office that is?

A Yes.

Q And that's Dr. Bryan Duckham?

A That's right.

Q And he has not seen Brian?

A I'm sorry. He's not what?

Q He has not seen Mr. Koon?

A No. No, but he was willing to see him. We had

already talked about that.

Q Okay. We'll talk about that.

You have a masters in counseling education; is that correct?

A That's right.

Q And a Ph.D. in counseling education?

A That's right.

Q You do not have a Ph.D. in psychology.

A No. Because in --

Q Just a yes or to a no.

A That's right.

Q Okay. And today if you would have graduated with the same degree, could you have even sat for the licensure exam?

A No, because the law has changed.

Q The law has changed.

You've been with West County Psychological Associates since 1987?

A I think that was when I started.

Q Okay. And the focus of your practice has been with school districts, senior care and marriage and divorce?

A It's been over a myriad of things. And so families, individuals, couples, yes.

Q Okay. And you have no publications on the

issues we're discussing here today? Addictions and substance abuse.

A No.

Q You've never been a paid faculty member on any of the topics we're discussing here today?

A You know, I can't -- a paid faculty member on what?

Q On any of the topics we're talking about today.

A I've done a lot of grad school training, but not specifically on these topics.

Q And just to be clear, this is the first and only time you've ever testified on the topic of addiction and substance abuse in court?

A Yes.

Q Or by deposition.

A Have I had depositions in regard -- I don't remember -- I've done a number of depositions, but I don't remember that substance abuse would have been the focus.

Q Okay. Doctor, would you agree that there's some hereditary component to addiction?

A I think so.

Q And do you agree that an expert should review all the pertinent information and data before reaching a conclusion?

A Yes.

Q And do you believe that experts should not make diagnoses outside their area of expertise?

A I believe I have the capability of making that diagnosis because I'm making it out of the DSM and following -- following their procedures. Yes, I have. I can.

Q Well, let me ask again. Do you believe an expert should be able to make diagnoses outside the area of their expertise? Yes or no.

A Given the appropriate information, yes, I think they can.

Q I want to talk a little bit about your legal work.

A Uh-huh.

Q You've been doing this type of work since the 1980s?

A Yes.

Q Is that about 30 years?

A Probably.

Q And you first started doing work for the law firm of Gray & Ritter?

A That's right.

Q Okay. And is that the firm that Mr. Simon started out at?

A That's correct.

Q Okay. And do you still do work for the law firm of Gray & Ritter?

A I have until very recently. The last case went on for about six years. And Mr. Graham told me that there may still be more to come, but as of -- we haven't done anything in the last year on that.

Q Sure. Are those two firms, Gray & Ritter and the Simon Law Firm, the two firms you primarily do all your work for?

A Yes.

Q Those are both plaintiffs' law firms?

A Yes.

Q You don't do any work for defense firms?

A No.

Q And you started doing the work for Gray & Ritter because your first husband was friends with Bob Ritter? Went to law school together?

A Yes. Yeah, we've known him since law school.

Q So you've known Mr. Ritter on a social basis for quite some time?

A Yes.

Q And in the last 15 years, you do about two to four cases a year for the Simon Law Firm?

A Approximately a couple cases a year I probably have going.

Q So that's somewhere between 30 and 60 cases?

A Oh, I don't know if I have that many. No, I wouldn't say -- I think over the years, I've seen -- they haven't been consistent over 30 years. I'd say probably I've done ten, 15 cases.

Q My question was in the last 15 years, you've done approximately two to four cases per year?

A It would be hard to say. Probably about ten. I really haven't counted.

Q And what are your charges for being here today?

A Two hundred -- $300 on the -- for the -- $300 an hour for the -- either deposition or trial. And 200 for reading.

Q Okay. And when you're in the office seeing a client, what's your normal charge?

A My normal fee, which is 100 -- right now it's 135.

Q Okay. And when you prepare to give a deposition, what's your hourly fee?

A Two hundred an hour.

Q And then it goes up to $300 an hour when you actually give the deposition?

A That's right.

Q And how many hours do you have in this case, Dr. Fitzgibbons?

A In this case?

Q Yes.

A From the beginning? Preparing for the deposition also?

Q Correct.

A I -- honestly, I don't know. I'd have to go back and -- I'd really have to check with my secretary. I don't know.

Q I want to talk a little bit more about the work you did do in this case. Who hired you?

A I believe I got a call from Simon -- from John Simon's office asking if we would see -- if I would see Brian.

Q That's what I want to make clear. You were not sought out by Mr. Koon for treatment?

A I was sought out by the -- the law firm called.

Q So you were retained by the law firm?

A Yes.

Q So who is your client? The law firm or Mr. Koon?

A I assume Mr. Koon is my client. They referred him, I saw Mr. Koon. I had no contact with the law firm until the deposition.

Q But your bills are paid by the law firm?

A My bills are paid by the law firm.

Q Okay. And just so I'm clear, you have not provided any therapy to Mr. Koon?

A Not really, no. Really those seven -- those seven sessions were primarily just getting the information. In general, what I do with most of these cases, I do see -- I do see them for therapy. Because a lot of the cases go on for a year or two years before we ever get to the deposition.

In this case, that wasn't the case. And when I -- when looking at the situation with him, I was going to feel much more comfortable -- that's why I already talked with Dr. Duckham about seeing him if this were going on through our office.

Q And you've not provided any services to Michelle Koon?

A No.

Q Never seen her in a professional context?

A No, I've never seen her until today.

Q So when you assessed Mr. Koon in the office, you're not providing therapy; correct? I want to make sure I've got that right.

A At this point I wouldn't call that therapy. It was really more of an assessment.

Q And then you were reaching a mental health diagnosis?

A That's right.

Q Okay. So then you would make a mental health diagnosis but not provide any treatment?

A In this case, that's correct.

Q And you saw him last on January 6th of 2016?

A Yes.

Q You made three mental health diagnoses; correct?

A That's correct.

Q And provided zero treatment in the five-month time frame?

MR. CRONIN: Your Honor, can we approach?

THE COURT: Yes.

(Counsel approached the bench and the following proceedings were held:)

MR. CRONIN: We specifically asked the defendants' firm if Mary could see our patient -- our client again so that she wouldn't be cross-examined that she hasn't seen him since the depo. They refused to let her do that. I would like the jury instructed that the defense firm would not let Mary see him again since the depo because they just made it sound like she has no interest in seeing him, there's nothing wrong with him.

THE COURT: So what you're saying is on the redirect you're going to get into that?

MR. SIMON: Sure. That sounds good.

THE COURT: Hold on.

MR. MAHON: I was the one involved in this exchange before trial. I think what happened is in literally the week before trial, Mr. Cronin called and said hey, we're thinking about having Ms. Fitzgibbons see Brian Koon again. If we do that, would you guys want to take her deposition and learn any updated opinions and see what all she's done. And I said, well, yeah, I think we'd have to do that. We're not going to not protect our client and just come into trial and be surprised by additional work that was done. And so then the plaintiff's firm made the strategic decision to not do that so as to not lose the trial date. That's not us refusing to let them not do something.

MR. SIMON: Can I make a suggestion to clear this all up. Assuming they're willing to drop it and not pursue it further, we will withdraw our objection and not bring it up on redirect.

MR. BARTH: The only thing I want to make clear is that he's not going to see Dr. Duckham.

THE COURT: I think you've explored it far enough.

(The proceedings returned to open court.)

Q (By Mr. Barth) Dr. Fitzgibbons, when were you first contacted in this case?

A Well, if I saw him November the 11th, obviously prior to that. But I honestly don't know because my secretary takes those appointments. She makes the appointments for me.

Q And you knew this was going to be a quick turnaround?

A No, I didn't know that.

Q You didn't know that you were going to have a deposition scheduled quickly after seeing Mr. Koon?

A I don't think I knew that when I -- on November 11th. I don't think I knew that.

Q Okay. But I believe you told us at your deposition this was the shortest turnaround you've ever done --

A Yes.

Q -- on a legal case?

A Yes.

Q And, in all fairness, your typical process is to see somebody for a year or so?

A A year, two years sometimes.

Q And then you provide the deposition?

A That's right.

Q When you were initially hired back in November of 2015, you were not provided any depositions or medical records?

A Not initially. No, I didn't see the medical records.

Q And the only records you saw were the day before your deposition? The CenterPointe records -- CenterPointe Hospital?

A That's right, yes.

Q And those were --

A And I quickly -- I personally didn't get a chance to read them.

Q And you were doing some reading. Were you reading your notes?

A Today?

Q Yes.

A For the most part, yes.

Q Okay. And what do -- what do you call those?

A What do I call them?

Q Correct. Are they treatment notes? Case notes?

A Oh, they're my case notes.

Q Case notes. And just so I understand, when you're going through and creating those notes, you're taking down what Mr. Koon is telling you, and then you're telling us that today.

A That's right.

Q Okay. And that's pretty much how the six sessions went where you would sit down and take down

information, handwritten?

A That's right.

Q And then you would turn around and have those notes typed up.

A Yes.

Q And then you would send them to the law firm.

A When they asked for them, yes.

Q Okay. There's an entry that you were asked about, I want to talk a little bit more.

Mike, can you put up G-5, page 25. Can you blow that up for us.

Dr. Fitzgibbons, can you tell us what we're looking at right now.

A Yes.

Q What is it?

A What is that?

Q Yes.

A Essentially it was that particular day, that's what I -- that was -- those are my notes. It was that I reviewed the case notes with Brian because -- again, I've explained that he talks so quickly, there was so much that I wanted to make sure that they were accurate.

Q So you reviewed your interview notes with Mr. Koon before you sent them to the law firm?

A I went over them. I don't know that I read

them -- I think I went over them just making sure that if I had any questions, whether I -- whether this is exactly what he was saying to me. I just didn't -- I didn't want -- I didn't want to be inaccurate.

Q Is that a little unusual in your practice?

A Yeah, because I generally don't have to do that.

Q Generally, therapists don't share their notes with their clients?

A I don't know that it was a matter of sharing it with him. I just wanted to make sure that what I had down was accurate. Because there were so many -- there were so many events and they were never in chronological order. So just for me to keep them straight in my own head, I had to -- in fact, I had to -- I even had to list them chronologically for myself.

Q Were any changes made to those notes?

A No. No, not essentially. I don't think so because I don't notice that -- I didn't do much with that. I don't see that I rewrote over them. Those were the original notes. My handwritten notes were the original notes.

Q Do you know if any changes were made to the notes?

A No, I don't think they did.

Q And you had these six meetings with Mr. Koon

that Mr. Simon went over, with the last one being January 6th of 2016?

A That's correct.

Q And I'm not going to rehash all those. And that last note of January 6th, 2016, is that when you reached your medical -- psychiatric -- psychological diagnosis in this case?

A That's right.

Q Okay. Do you know when you were disclosed as an expert witness in this case?

A Do I know what?

Q Do you know when the plaintiffs disclosed you as an expert witness in this case?

A No, I don't.

Q I can show you the document, but if I represent to you that it was November 30th, 2015, would you have any reason to disagree with that?

A No.

Q Is it normal for you to be disclosed as an expert witness before you've even reached a diagnosis?

A I would assume so because I'm being brought in as the expert witness. So I know that -- I know that when they're hiring me to do this and I see that client, chances are -- and it's always turned out that way -- I see the client, I come in as the expert witness, and I go

to the deposition.

Q But just so we're clear, you reached your diagnosis in January of 2016?

A That's right. After those -- after those visits.

Q Okay. Did you provide Mr. Koon with any testing?

A With any what?

Q Any testing.

A No.

Q So no personality testing?

A No.

Q No MMPI, the Minnesota Multiphasic Personality Inventory?

A No. If we would have done that -- and I didn't -- first of all, I didn't see the need to do that. You know, we do that. We do a lot of psychological evaluations in our office. I don't do them. Again, I have other -- I have other psychologists who do that. But I didn't see the need to do that.

Q And then when you made the diagnosis -- I just want to understand a little bit more. You take out the DSM manual?

A Uh-huh.

Q And I know you were reading from it there today.

Do you actually show it to Mr. Koon and go down the factors?

A I don't show -- I have it in my hand, and I'm saying all right, I need to go through this with you. You need to just tell me which of these -- which of these is accurate for you.

Q And he knows he's being seen in connection with litigation?

A Yes. I -- in fact, I mentioned this in my deposition that I do this with all the clients. And let me give you an example. I think in one of these visits, very briefly I took out the -- I took out the diagnosis for posttraumatic stress, and he -- and it was evident he wasn't giving me anything that said it would have been posttraumatic stress. I find people are pretty honest about just saying yes, no so --

Q And, Doctor, are you a member of the American Psychological Association?

A Yes, I am.

Q And I take it that you're aware of their ethical principles on psychologists and code of conduct?

A Yes, I assume.

Q More specifically the 2010 version.

A I don't know if I've seen that.

Q But as a member of the American Psychological

Association, you're bound by their ethical guidelines?

A Yes, I am.

Q I want to ask you a couple of things about that. Principle D, entitled Justice. Psychologists exercise reasonable judgment to take precautions to ensure their potential biases, the boundaries of their competence, the limitations of their expertise do not lead to or condone unjust practices.

Do you agree with that statement?

A Yes.

Q And Principle C is entitled Integrity. Psychologists seek to promote accuracy, honesty and truthfulness in the science, teaching and practice of psychology.

Would you agree with that statement?

A Yes, I do.

Q And the last one under the ethical standard two entitled Competence and Boundaries of Competence. Do you agree that psychologists provide services, teach and conduct research with populations within the areas only within the boundaries of their competence, based upon their education, training, supervised experience, consultation, study or professional experience?

A Yes.

Q Basically practice in the area of your

expertise?

A Yes.

Q And you don't have any clients that are currently treating for substance abuse?

A I will never treat them, no.

Q That's all I have. Thank you, ma'am.

THE COURT: Any redirect?

MR. SIMON: Very brief, Your Honor.

**REDIRECT EXAMINATION**

BY MR. SIMON:

Q Doctor, my office provided you with Brian's records; right?

A Yes.

Q And you've reviewed those; right?

A Yes.

Q We provided you with depositions and you've reviewed those; correct?

A Correct.

Q You met with Brian seven times; correct?

A Correct.

Q And you reached your diagnosis; correct?

A Yes.

Q And St. Louis University hired an expert and that expert reached the same diagnosis about Brian in this case; is that correct?

A Yes.

Q Thank you.

THE COURT: All right. Any recross?

MR. BARTH: No, Your Honor.

THE COURT: All right. May this witness be excused?

MR. SIMON: Yes, Your Honor.

THE COURT: All right. Doctor, you're excused but you're subject to being recalled so please don't discuss your testimony with any other witnesses until the trial is over. Thank you, Doctor.

(The witness was excused.)

MR. CRONIN: Short break, Judge? I don't remember when we took our last one.

THE COURT: All right. So let's do this. While you bring your next witness, we'll stand and we'll do the hokey pokey.

MR. CRONIN: Michelle Koon will be our witness.

THE COURT: All right. While we wait for the next witness, why don't we stand and get the blood flowing a little bit.

Call your next witness.

MR. CRONIN: Your Honor, plaintiffs would call Plaintiff Michelle Koon to the stand.

***MICHELLE KOON***,

having been duly sworn by the deputy clerk, testified:

**DIRECT EXAMINATION**

THE COURT: All right. Ma'am, have a seat right here. Make yourself comfortable. Adjust the seat. Speak in the microphone.

Same instructions I gave everybody. If you hear them say objection, I need you -- if you hear them say objection, if you'll pause and let me rule on it before you answer.

THE WITNESS: Yes, sir.

THE COURT: If at any time this gets too much and you need to take a break, you bring it to my attention. Okay?

THE WITNESS: Okay.

THE COURT: You may inquire.

BY MR. CRONIN:

Q Would you please tell the jury your name.

A Michelle Koon.

Q Michelle, you're going to have to talk up a little bit.

A I'm sorry. It's Michelle Koon.

Q Are you a little bit nervous, Michelle?

A Yes, sir.

Q Would you describe yourself as a pretty

emotional person?

A Yes, sir.

Q We're going to start out kind of easy so we can kind of slip into it. Okay?

How old are you?

A I'm 35.

Q Where were you born, Michelle?

A St. Louis.

Q You've lived in the St. Louis area your whole life?

A Yes, sir.

Q What's your highest level of school?

A I have an associate's degree in applied science.

Q Okay. And specifically for a certain type of work?

A Massage therapy.

Q And what do you do for a living, Michelle?

A I'm a massage therapist.

Q Okay. Where at?

A Massage Envy.

Q Michelle, are you married?

A Yes, sir.

Q What's your husband's name?

A Brian Koon.

Q Have you had any marriages before Brian?

A No, sir.

Q Michelle, are you and Brian currently living together?

A No, sir.

Q For how long has that been?

A Since this past January.

Q Okay. You and Brian are still married though?

A Yes, sir.

Q Have you initiated any legal separation?

A No, sir.

Q All right. Where are you living, Michelle?

A I have a house in the city.

Q Who lives there with you?

A Me and my daughter.

Q Your daughter's name is?

A Emily Koon.

Q Michelle, you met -- am I right that you met Brian when you were a little bit younger? In your teenage years?

A Yes, sir.

Q Was there then a pretty big gap where you didn't see each other for a while?

A Yes, sir.

Q How did you come across each other again?

A We ran into each other again through a mutual

friend.

Q When was that?

A In 2005.

Q Tell me about from that time you ran into each other again, how your relationship developed.

A In the beginning Brian was -- he was one of the sweetest, soft-spoken men I have ever met.

Q Well, how did you -- did you just start talking? I want to know kind of how it developed. Take me through the stages.

A At first we would just see each other at my friend's house. And then it took several months for him to finally get my number. And we slowly started talking after that. And I fell in love with him.

Q Did it get pretty serious, I guess, then?

A Yes.

Q When did the two of you -- how long after you guys started dating did Brian wait to ask you to marry him?

A Less than six months.

Q When did you get married?

A In 2006.

Q Before 2008, Michelle, can you tell the jury what Brian was like. Personality wise.

A He was very soft-spoken, he was very sweet. He

treated me like a princess. He made me feel like I was --

Q Take your time, Michelle.

A -- the only person in the world that mattered.

Q What kinds of things did you like to do together?

A We would go to my family's country house, go swimming, go fishing, go out on the boat. We'd stay up all night just talking, watching movies, eating pizza.

Q Michelle, you mentioned that you and Brian have a child together named Emily?

A Yes, sir.

Q Okay. How old is Emily?

A She's six.

Q Do you and Brian -- either of you have any children before Emily?

A No, sir.

Q Okay. When was Emily born again?

A July of 2009.

Q Okay. So fair to say you would have found out that you were pregnant sometime in the fall or late 2008?

A Yes, sir.

Q Were you both excited?

A Very much so.

Q By the time that Emily was born in June -- July of 2009, Michelle, was there something going on with Brian

that was a little bit different than before?

A Yes, sir.

Q Was that about a year and a half after he'd begun being prescribed opioids?

A Yes, sir.

Q Were you -- were you aware that Dr. Walden was Brian's primary care doctor?

A Yes, sir.

Q Before 2008, did Brian sometimes have acute back -- his back would go out?

A Yes, sir.

Q Okay. And would he get some chiropractic treatment or a short case of pain treatment to clear it up?

A Yes, sir.

Q All right. Now, Michelle, in early 2008, did Brian have some back pain that began to be more regular?

A Yes, sir.

Q All right. Were you -- were you made aware when Dr. Walden first started Brian on opiates?

A Yes, sir.

Q Now, Michelle, prior to that point, in the beginning of 2008, are you aware of Brian ever having any kind of pill, drug, or any kind of substance abuse problem?

A No, sir.

Q Did you ever go to doctor visits with Brian?

A Yes, I did.

Q Why, Michelle?

A Because when he was 21 and went to the doctor and found out he had cancer, he was by himself. And I didn't want him to feel like he was in anything alone.

MR. CRONIN: Mike, can you pull up Exhibit 1. I didn't give you any notice. Page 124.

UNIDENTIFIED SPEAKER: 24 or 124?

MR. CRONIN: 124. Can you blow up the date.

Q (By Mr. Cronin) Michelle, you see that says July 8th, 2008?

A Yes, sir.

Q Okay. And, Mike, can you blow up the message here.

Michelle, this is one of Brian's medical records with Dr. Walden. And in the message it says: Did increase hydrocodone dose, then tried to decrease dose and then felt very bad, shaky, nose running, sweating, weak, yawning. Then took the med and felt better, within an hour. Needs help.

Do you see that?

A Yes, sir.

Q Okay. Are you aware this is a message from

Brian Koon to his doctor in July of 2008?

A Yes, sir.

Q Were you aware of that incident around that time period?

A Yeah. That incident happened on our way back from the country house.

Q Okay. And Brian is reporting some symptoms after trying to decrease his dose and reports to his doctor the symptoms and that they went away after he took his pain pills again. Is that what you get from that record?

A Yes, sir.

Q Mike, can you pull up -- well, can you zone back out. Can you highlight that part.

You see there it says refill authorized, Michelle, on that date?

A Yes, sir.

Q Mike, can you pull up Exhibit 1, page 125.

Michelle, what's the date? You see that says July 11th, 2008, Michelle?

A Yes, sir.

Q You see where the note says pharmacy called about the refills?

A Yes, sir.

Q Do you see where the message says took too much

medicine?

A Yes, sir.

Q Do you see where it says okay to refill?

A Yes, sir.

Q This is in July of 2008?

A Yes, sir.

Q Okay. Mike, can you pull up Exhibit 1, page 195. Can you blow up, show us the date.

Michelle, you see this is a record from Dr. Ohlms' office from August of 2008?

A Yes, sir.

Q Okay. And, Mike, can you zone back out. I think it's here.

So it says: Doing better with back. Receiving injection therapy at St. Luke's with Dr. Ann Christopher. Taking Vicodin six times per day with plans to wean back in one week. Desires to return to work full duties. Bee sting, something, otherwise well.

Okay. Michelle, do you remember Brian discussing with you in August of 2008 a desire to wean back?

A Yes, sir.

Q You can take it down, Mike.

Did Dr. Walden do that?

A No, sir.

Q Did he ever try to do it up until August of 2012?

A No, sir.

Q Eventually was Brian on three different types of opioids at once?

A Yes, sir.

Q Do you know what types?

A It was OxyContin, oxycodone and hydrocodone.

Q Did Brian's dose of opioids chronically get increased over the next four years?

A Yes, sir.

Q And were you aware of that because you knew what medications he was on?

A Yes, sir.

Q How often was the dose getting upped of those three different opioids?

A Very regularly.

Q Michelle, did you ever get involved in trying to manage Brian's pain meds?

A Yes, sir.

Q Why?

A Because it was taking over our lives.

Q Did you want to try to get involved to try to get some control over it?

A Yes, sir.

Q And what would happen?

A He would find them and take them, explain to me that he needed them.

Q How often was Brian running out of his pills, Michelle?

A Every month.

Q And what would you say to Brian?

A In the beginning I would bring up the fact that there was a problem, and he would just explain to me that his doctor told him that he needed them if he wanted to work.

Q Michelle, did you ever call Dr. Walden's office?

A Yes, sir.

Q And tell them that he went through his pills already?

A Yes, sir.

Q Did you do that regularly?

A Almost every month.

Q When you would call Dr. Walden's office to talk about the pills, did you usually even get to speak with the doctor himself?

A No, sir.

Q And what would happen? Who would you talk to?

A I would talk to the secretaries.

Q Did you tell them that Brian went through his

pills too fast?

A Yes, sir.

Q Okay. And then what would be the next thing that would happen?

A They would call back later that day and tell me that there was --

MR. MAHON: Your Honor, I object to this. It's hearsay from unidentified secretaries apparently in the office who are not here to testify.

THE COURT: Your response.

MR. CRONIN: Judge, this is for the effect that it had on Michelle.

THE COURT: I'm going to sustain it. Rephrase it.

MR. CRONIN: Okay.

Q (By Mr. Cronin) Michelle, what kind of response would you get back after you would tell Dr. Walden's office that Brian went through his pills early, and how did it affect you?

MR. MAHON: Same objection, Your Honor. It's seeking the response.

THE COURT: Overruled. She can answer.

THE WITNESS: I would get a call back later that day saying that there was a prescription ready. And I knew that I would have to go another month dealing with

the same thing.

Q (By Mr. Cronin) Michelle, if you had concerns, why would you call for Brian for refills or increases or go pick up prescriptions for him?

A Because not only did I have a sick husband at home, but by the time he'd be out of his medicine, he'd be going through withdrawals, I also had a little girl at home who I was trying to protect. And when he had his medicine, he was one man. But --

Q Michelle, were you doing what you thought you needed to do to keep the home as safe as possible?

A Yes, sir.

MR. MAHON: Your Honor, I'm going to object as leading.

THE COURT: Sustained.

Q (By Mr. Cronin) Michelle, did you ever take any of Brian's opioid pills?

A No, sir.

Q Was there a time when you had an aunt that stole some of his pills?

A Yes, sir.

Q Did that only happen one time?

A Yes, sir.

Q Were there any other times where anyone else got or took any of Brian's pills?

A No, sir.

Q How would Brian react to people taking his pills?

A He would have been furious.

Q Michelle, when you would call Dr. Walden's office for an early refill or about another dose, would you be asked to have Brian come in for an office visit?

A No, sir.

Q Did you usually just go in and pick up a new one early?

A Yes, sir.

Q Without an office visit with Brian?

A Correct.

Q And would they sometimes be for increased doses?

A Yes, sir.

Q Without Dr. Walden talking to you or Brian or having any office visit with him at all?

A Yes, sir.

Q Do you recall Dr. Walden sometimes giving Brian morphine to fill in the gaps between prescriptions when they couldn't be refilled early?

A Yes, sir.

MR. CRONIN: Mike, can you pull up Exhibit 1, page 549, please.

UNIDENTIFIED SPEAKER: I didn't hear what page.

MR. CRONIN: 549. Whatever the date is on there. Okay. This is -- well, let's go a little bit further down.

Q (By Mr. Cronin) Michelle, you see this is a record dated April 2nd, 2012, and it says requesting referral to pain management?

A Yes, sir.

Q Did you call Dr. Walden's office requesting the referral to pain management?

A Yes, sir.

Q Why?

A Because I had already got -- I had called one of my friends who also has back problems and got the name of her doctor. And I talked to Brian about going to see the doctor, and he said no. And he refused to go because it wasn't somebody that his doctor had referred him to.

Q Did you make that call on your own accord, Michelle?

A Yes, sir.

Q Is a referral to pain management something that Dr. Walden did or something that you called and asked for?

A I did.

Q Did you -- was that Dr. Berry then?

A Yes, sir.

Q In spring 2012. Did you go to Brian's visits,

any of them, to Dr. Berry?

A Yes, sir.

Q Okay. Did you go to the first one?

A Yes, sir.

Q What happened there, Michelle, and what -- what effect did that have on you in realizing whether there was an issue?

A At that appointment, it was brought to my attention -- and it was the first time --

MR. MAHON: Judge, I'm just going to object. This is calling for hearsay statements. May we approach?

THE COURT: You may.

(Counsel approached the bench and the following proceedings were held:)

MR. MAHON: I think now we're about to get into the statements purportedly made by a healthcare provider, a non-testifying one. This was a subject of a motion in limine which was granted to keep out hearsay statements from non-testifying healthcare providers. I think this may also get into comments about the DEA or surprise by the DEA investigation or lack thereof.

It's highly prejudicial. It's hearsay. But even if it had any probative value or could overcome a hearsay burden, hurdle, it would be the breadth of this outweighs any probative value.

THE COURT: What are you anticipating she's going to say?

MR. CRONIN: Your Honor, it's the same thing Dr. Fitzgibbons just said. Dr. Berry told them he couldn't believe the amount of medication he was on, Brian slipped through the cracks, he could not believe the DEA had not been notified. That's what she already testified to.

It is not hearsay because it is not being offered for the truth of the matter asserted. It is being offered because it scared Michelle and Brian to death. It made them realize something needed to be done. And Dr. Walden's free to be subpoenaed by the defendants.

THE COURT: All right.

MR. CRONIN: Dr. Berry.

MR. MAHON: I completely disagree. I think the problem is this is a statement from a healthcare provider, a physician. This is a medical malpractice case. So they are trying to use the state reports from Dr. Berry, which they're not in the medical records. They are trying to use them as proof of the matter asserted. If they wanted Dr. Berry to testify to this, they should have called him. That is exactly the purpose of this. This is somebody who has a medical degree in a medical malpractice case. It would potentially carry great weight and be highly

prejudicial.

THE COURT: Here's what I'm thinking. I'm going to -- I'm thinking about allowing you to elicit this testimony. But then I'm going to give a -- I'm going to instruct the jury that it's not for the truth of the matter asserted, it's rather for the effect those statements had on -- that the jury should consider the statements by Dr. Berry not for the truth of those statements, but to whether the effect that those had on the witness.

MR. CRONIN: Understood.

MR. MAHON: Yeah, yeah. And I appreciate that, Judge, but I think it's too prejudicial to even be brought in for that purpose or with that kind of limiting instruction. But I just want to make sure that -- my objection is to keep it out altogether. Is that being overruled?

THE COURT: Yes. That objection is being overruled. One, because it did come in through the doctor. But I do think -- so I do think it's probative as to what the person did next. Not as to the truth of it. I think it's probative -- I think it is prejudicial, but it doesn't trump the probative value. But I think the way I'm curing it reduces any of the -- blunts any of the prejudicial nature of it. But regardless of whether I do

the statement or not, I think it doesn't rise to being overly prejudicial. So I'm going to deny your motion, knowing that I'm going to give the -- what I think is a curative admonition.

MR. CRONIN: Would you like me to pause afterwards, Judge, for you to do that?

THE COURT: Yes.

MR. MAHON: Can my objection be running, continuing for any exchange?

THE COURT: Any comment about Dr. Berry, I'll note that the Court will say for the record that that will be a continuing objection.

MR. MAHON: Thank you.

(The proceedings returned to open court.)

Q (By Mr. Cronin) Michelle, what happened when you went to Dr. Berry's office and what effect did it have on you?

A When we got to Dr. Berry's office, they started inputting his medication into the computer system. And they kept having to go back and correct over and over the amount of medication Brian was on because they didn't believe that the numbers that we had on paper were true.

Q Did Dr. Berry say anything to you and Brian about the medications, and what effect did that have on you?

A He said that it was unfortunate that Brian slipped through the cracks and somehow the DA -- the DEA managed to miss that one. And for the first time Brian recognized that there was a problem.

Q Michelle, did that scare you?

A It terrified me.

Q Did that make you think that you needed to urgently start getting help with this?

MR. MAHON: Your Honor, I just object to the leading nature.

THE COURT: Sustained to the leading. Is this a good time for me to --

MR. CRONIN: Yes, Judge.

THE COURT: Ladies and gentlemen of the jury, I'm going to instruct you that the statements that the witness has attributed to Dr. Berry are not to be considered for you as for whether the statements are truthful or not, but rather as to the effect that they had on the witness after hearing those statements.

All right. You may proceed.

Q (By Mr. Cronin) Michelle, did Dr. Berry get involved in Brian's medication treatment?

A No, sir.

Q What did Dr. Berry do with Brian?

A He gave Brian spinal injections.

Q Did he talk to you and Brian about seeking a treatment facility potentially?

A Yes, sir.

Q And did he talk to the two of you about exploring the idea of seeing a psychologist or a psychiatrist?

A Yes, sir.

Q Okay. Mike, can you pull up Exhibit 1, SLUCare, page 556. And if we can go to, I think, that part.

Michelle, this is a record -- a SLUCare record from April 30th, 2012. Did you call Dr. Walden's office interested in discussing the first steps to weaning your husband off the medication and asked Dr. Walden to call you back?

A Yes, sir.

Q Mike, can you scroll out and go to the one right above it.

Michelle, did you not get a call back for two weeks?

A Correct.

Q You can take that down, Mike.

Michelle, did you realize that five days after that 5/16 conversation Brian was written the same three prescriptions for the same three types of opioids, for the same number of pills and same dose that had previously

been done?

A Yes, sir.

Q Can you pull up, Mike, SLUCare 574. Exhibit 1, 574.

Michelle, let me ask you, in May, did you and Brian go to Dr. Walden's office for a visit after you had seen Dr. Berry?

A Yes, sir.

Q Okay. And this is a record from May 24th, 2012. You probably don't remember the day. Does that sound like it's probably the right neighborhood?

A Yes, sir.

Q Can you go down -- well, let me ask you this, Michelle. Were you at that visit?

A I believe so.

Q What happened at that visit? What was Brian telling his doctor?

A If that's the appointment that I'm thinking of, that's the time when Brian sat there in tears asking his doctor to get him off the medication.

Q Did Brian tell his doctor that the pills were running his life?

A Yes, sir.

Q Do you see that in the medical record?

A Yes, sir.

Q Okay. Then do you see where it says tolerating medication well? Continues to experience pain without change in pattern. Continues on narcotic analgesics without change from previous visit. Denies noncompliance, no new adverse effects.

Isn't that what Brian was telling his doctor, they were running his life and he couldn't be compliant?

A Yes, sir.

Q And the record says denies noncompliance. Does that seem a little self-serving to you, Michelle?

A Yes, sir.

Q Did you ever get a call from Dr. Walden about a pharmacy?

A Yes, sir.

Q Okay. Were you told by a pharmacy and Dr. Walden that a pharmacy would not fill one of Brian's prescriptions?

MR. MAHON: Your Honor, I object. Hearsay.

THE COURT: Counsel, approach.

(Counsel approached the bench and the following proceedings were held:)

THE COURT: Did you say hearsay?

MR. CRONIN: I'll rephrase the question, Judge.

THE COURT: Rephrase. All right.

MR. MAHON: Yeah. I think now he's going to get

into statements from a pharmacist to her that will apparently be for the effect on them. But I don't think so. I think it's really for the truth of the matter asserted about what unidentified pharmacists that are not here to testify had to say. So I think it's rank hearsay.

MR. CRONIN: Judge, it's pretty much the same thing as Dr. Berry. They told her that when they were giving them to him, they felt he was a terminal patient. They found out he wasn't, and they wouldn't fill the prescription anymore.

But if he wants, I won't ask what they said to her. I'll ask if there was a pharmacy that refused to fill one of Brian's prescriptions and Dr. Walden just sent her to another one.

THE COURT: That's a better one. I'll allow that.

MR. MAHON: I still object. Is that being overruled?

THE COURT: Yes.

MR. MAHON: Okay.

(The proceedings returned to open court.)

Q (By Mr. Cronin) Michelle, was there a time when a pharmacy, that you were made aware of, refused to fill one of Brian's prescriptions?

A Yes, sir.

Q And did you speak with Dr. Walden about that?
A Yes, sir.
Q Did he write -- just write you a new prescription to go to another pharmacy?
A Yes, sir.
Q We talked about Dr. Berry discussing a psychiatrist with you and Brian. Do you remember that?
A Yes, sir.
Q Did you then find a psychiatrist?
A Yes, sir.
Q Who was that?
A That was Dr. McKean.
Q Did you set up the appointment?
A Yes, sir.
Q Again, was that something Dr. Walden recommended or did Dr. Berry recommend it and then you found the psychiatrist?
A Dr. Berry recommended it and I found the psychiatrist through my doctor.
Q And was that a -- was that a SLU psychiatrist?
A Yes, sir.
Q Did you go to any of those visits?
A I went to one of them.
Q Okay. Was it your understanding that Dr. McKean was going to try to collaborate with Dr. Walden and

Dr. Berry about the medications?

A Yes, that was my understanding.

Q Michelle, we're going to get to kind of the tough part now. Okay? What changes did you observe in Brian from 2008 on?

A I don't remember exactly when he started the medicine in 2008, but by the time I had my daughter in July of 2009 he was no longer the man that I had married. He was no longer the man I had chosen to be the father of my children. He had lost all -- all of his joy for life.

Q Were the two of you growing apart, Michelle?

A Yes, sir.

Q What was -- to you and what you observed, what was Brian's focus, rather -- well, what was Brian's focus?

A Brian's sole focus was getting his medicine, taking his medicine. Asking Dr. Walden for a new refill. And that was pretty much it.

Q Michelle, did it seem to you that these pills were stripping away what made Brian Brian?

MR. MAHON: Your Honor, I object. Leading.

THE COURT: Sustained. Rephrase.

Q (By Mr. Cronin) From the time Brian began on opioids in 2008 through 2012, were there personality changes that you observed?

A Yes, sir.

Q Tell us about them.

A There was no more laughter. There was no more communication. When I would talk to him, I was just -- just a shell of a person.

Q Did Brian want to increasingly over that time period go out and do things with you?

MR. MAHON: Your Honor, I think it's leading again.

THE COURT: Sustained. Rephrase.

Q (By Mr. Cronin) Michelle, what happened with you and Brian's social life?

A It became nonexistent.

Q Were you and Brian ever intimate any longer?

A No, sir.

Q And, Michelle, Brian had some erectile dysfunction issues before 2008; is that correct?

A Yes.

Q Was he prescribed Cialis by Dr. Walden?

A I believe so.

Q Were the two of you able to have intercourse when he would be prescribed those medications during the times he had the problems?

A I'm sorry. What was the date you said? I'm sorry.

Q How did the intimacy change from before 2008,

Michelle, to after 2008?

A We had attempted twice after we had my daughter in 2009. Both times were unsuccessful. The Cialis was never even opened.

Q Michelle, were you -- did Brian seem like he was constantly zoned out?

MR. MAHON: It's leading again.

THE COURT: Sustained. Rephrase.

Q (By Mr. Cronin) What kind of state did Brian seem like he was in?

A It's hard to describe. He was there, but he wasn't.

Q Is that true during the time he was in the hospital when Emily was born?

A Yes, sir.

Q Michelle, what was your life like during those four years?

A My life was turned completely upside-down. All over a medication. It went from once feeling like a princess to living in a house with a stranger.

Q Michelle, what kind of an emotional effect did this have on you? As a woman.

A It destroyed me.

Q Michelle, were you ever scared for Brian's health or safety?

A Very much so.

Q Do you have any examples you can share with the jury?

A We were on our way back from his parent's house one time. He said he was fine to drive. He fell asleep at the wheel with me and my daughter in the car. Several nights I would wake up to find him sleeping on the front porch with a lit cigarette in his mouth. Every night I'd reach over to make sure he was still breathing. Because, I mean, it was only a matter of time before I woke up and I wasn't going to have him anymore.

Q Did you ever find him doing anything odd?

A Yes, I did.

Q What?

A He was in the bathroom trying to flush my books down the toilet in the middle of the night.

Q Michelle, what was Brian's relationship with Emily like? During these four years. Or during the three years, because she was born in 2009.

A They didn't have one.

Q Was he involved in raising her or being part of her life?

A No, sir.

Q How did that make you feel?

A Like I had failed my daughter.

Q Michelle, what happened that led to seeking help? And I don't -- I'm not asking anything Brian told you later. I want to say what you are aware of at the time that led to seeking help.

A His medication got denied at a pharmacy. I called Dr. Walden's office to find out what to do. It was a Friday afternoon, it was too late to go pick up the medicine. So Brian started going through the withdrawals. He had already been out for a couple days. So Dr. Walden's office wrote a new prescription. I couldn't get up there to get it filled. So the next day his withdrawals got even worse.

I called my grandmother and my aunt to come over and sit with my daughter. They took her to the backyard while I snuck him out the front door. I took him to St. Mary's with a bucket in his lap. And I already knew that they wouldn't keep him because I had already done all the research, but I needed a safe place for him to be while I figured out what to do. That day I needed -- I knew I needed to find somebody to help me save my husband.

Q Did you try to find somewhere else to bring him?

A Yes.

Q How did you find CenterPointe?

A I had actually got the name of CenterPointe through one of the pharmacists at Schnucks.

Q Who took Brian to CenterPointe?
A I did.
Q Tell me what that car ride was like.
A It was horrible.
Q What happened?
A He was in a lot of pain. He was -- at that moment he was a person I did not recognize at all. Some of the sounds that he was making from the pain are sounds I wouldn't want anybody to hear. He was so frustrated by the time we got there, I can't tell you how many times he punched the inside of the car door.
Q Michelle, at this time were you aware of the gun incident?
A No.
Q Is that something you found out later?
A Yes, sir.
Q Michelle, did you ever visit Brian at CenterPointe?
A Yes, sir.
Q How many times?
A Two times.
Q Tell me about the first one.
A The first time I went to see him he was still in detox. When I walked in and seen him, he looked like a little old man that was dying. He was so skinny. His

face was sunken in. He was shaking. It was scary. We didn't have anything to talk about.

Q Did you talk to him?

A Not really. I mean --

Q Do you know Brian doesn't remember that? I'll ask Brian.

Judge, I'll withdraw the question.

Michelle, did you go see Brian a second time?

A Yes, sir.

Q Was that a significant day in your life? The date?

A Yes, sir.

Q What was the date?

A It was September 16th.

Q Why do you remember that it was that date?

A Because that was my six-year wedding anniversary.

Q Did you bring anybody with you?

A I had my daughter with me.

Q Michelle, what happened that day?

A We were sitting outside just like the rest of the families that were there. Emily took off running across the grass field. Brian looked at me, and the look on his face, you couldn't tell if it was fear or excitement. You couldn't read it. And he goes, she can

run? That was the first time he had ever seen our kid through clear eyes.

Q How did Brian react to that? In your observation. What did you observe?

A You can almost see his anxiety level rise. He had to hold back tears.

Q Did he have to end the visit?

A Yes. He politely asked us to leave.

Q Michelle, how about your relationship with Brian since he got out of CenterPointe? Has it rebounded?

A No, sir.

Q Have you been able to find the place you were at before 2008?

A No, sir.

Q Michelle, why did you move out earlier this year?

A Because I had spent years holding on to a man and a relationship that was no longer there. I'm sorry, Brian.

Q Michelle, if someone suggested to you that the amount of opioids Brian was being prescribed was fine and didn't cause any damage to your family, how would that make you feel?

A They're mistaken.

Q I don't have any further questions.

THE COURT: Okay. Any cross-examination?

MR. MAHON: Yes, Your Honor.

**CROSS-EXAMINATION**

BY MR. MAHON:

Q Ms. Koon, I've got a few questions for you. Are you okay?

A Yes, sir.

Q We heard a little bit about your husband when he was younger in his early 20s, how he had suffered from Hodgkin's lymphoma cancer; is that right?

A Yes, sir.

Q I think you alluded to it before, but Mr. Koon had some experience in the course of the cancer treatment with some opioid pain medication then, around that time. Isn't that true?

A Yes, sir.

Q And so in 2008, this time frame we're talking about where Dr. Walden was prescribing some pain medication, that was not Mr. Koon's first experience with those types of medications, was it?

A Correct.

Q And I think you had told us just a little bit ago that you're not aware -- before that 2008 time frame, you're not aware of your husband ever having any issues with substance abuse of any kind.

A Correct.

Q As we've heard a lot here, Mr. Koon has suffered from back pain for a number of years; right?

A Yes, sir.

Q Okay. And I think your recollection from when we talked before in deposition was sometime probably around 2006 or 2007 is when you can first recall hearing him complain about back pain on an ongoing basis. Does that sound about right?

A Yes, sir.

Q We've heard about some of the different treatment that Mr. Koon went through for the back pain, and I wanted to run through some of those with you. He went to a chiropractor named Dr. Mistretta. Isn't that true?

A Yes, sir.

Q And there was a pain management doctor named Dr. Christopher that actually provided some epidural injections into the spine. Do you recall that?

A Yes, sir.

Q And Mr. Koon went through some physical therapy too?

A Yes, sir.

Q And there were a couple of different times when your husband went to surgeons to actually evaluate his

back and try to see if there was a surgical option that might be appropriate for him. Do you recall that?

A Yes, sir.

Q And I think one surgeon involved in this was somebody at SLU named Dr. Place. Does that name ring a bell to you?

A Yes, sir.

Q And then after Dr. Place, there was a second surgeon involved named Dr. Heim who, I believe, is over out at St. Luke's. Is that your understanding?

A Yes, sir.

Q I think we've heard that Brian first went to Dr. Walden to be his primary care doctor sometime around 2001. Wouldn't that be maybe around four years before the two of you started dating?

A Yes, sir.

Q So you wouldn't have been around with Brian on a regular basis to know what his interaction with Dr. Walden was during that time frame, would you?

A No.

Q And by the time you were married in 2006, didn't Mr. Koon tell you that -- a little bit about his doctor, Dr. Walden, and that Dr. Walden was someone he had a lot of respect for?

A Yes, sir.

Q Didn't Mr. Koon in that same general time frame -- at one point, didn't he even recommend that maybe you should consider switching doctors so you could become a patient of Dr. Walden's as well?

A Yes, sir.

Q I think you've told us how you had a few occasions to actually meet Dr. Walden when you would go with Brian. That's your memory that you would go with him to some of these visits and actually hear Dr. Walden. Is that true?

A Yes, sir.

Q And when you met Dr. Walden, you liked him too, didn't you?

A Correct.

Q I think, in your words, you found that he had a good bedside manner. True?

A Yes, sir.

Q I think also in your words that he was somebody that -- you said Dr. Walden seemed like he was straight to the point about whatever issues were addressed.

A Yes, sir.

Q And SLU, we know, is an academic institution, there's a school of medicine there, and we know Dr. Walden is a professor of medicine there. You noticed at times that there would be students there working with

Dr. Walden.

A Yes, sir.

Q Okay. And based on your interaction with them there, he seemed to be someone who was working well with these students that he was teaching.

A Yes, sir.

Q I think you have a recollection -- I think it's a little bit vague, but you have a recollection of one visit where you remember being there with your husband, with Dr. Walden, where there was a discussion about risks and benefits of opioid treatment. Isn't that true?

A Yes, sir.

Q And you're not quite sure exactly what time frame that was.

A No, sir.

Q And you can't really recall the specifics as to what was said by one person or the other; right?

A No. Just a little bit.

Q Okay. But what you can recall is that there was a discussion about risks and benefits of opioids; right?

A Yes, sir.

Q And I think what you can also recall about that is that -- let me back up. You can't quite recall exactly how you felt about it at the time, but I think you were clear that Mr. Koon had agreed that whenever this meeting

was that the benefits for him of using opioids outweighed the risks. Isn't that true?

THE COURT: Was there an answer?

THE WITNESS: Not yet.

THE COURT: Okay. Sorry.

THE WITNESS: He believed -- he believed it to be true.

Q (By Mr. Mahon) I wanted to ask you a few questions about your husband's job. We've heard a little bit about that. I think we'll hear more in the case that he had the position and still has the position as a mechanical maintenance worker for the Parks Department in the City of St. Louis. Is that true?

A Yes, sir.

Q And from what you know about your husband and about the type of work he did, this is a job that's pretty physically demanding, isn't it?

A Yes, sir.

Q It was hard on his body in terms of the physical labor that it required. True?

A Yes, sir.

Q And I think, if I recall correctly, you've told us that you're a massage therapist with Massage Envy. But when your daughter was born, you stopped working at that

point; right?

A Yes.

Q Okay. And so at least from the time frame that your daughter was born up until, I think, just very recently -- and maybe you've gone back to work the end of last year. True?

A Yes, sir.

Q But at least from the point in time from after your daughter was born up until, you know, just the end of last year, Mr. Koon would have been the sole source of income for your family; right?

A Yes, sir.

Q And so during this 2008 to 2012 time frame we've been talking about where your husband was a patient of Dr. Walden's, you would not have been working during that time frame. True?

A I worked for a little bit, not long.

Q Okay. What do you mean by a little bit?

A Maybe from 2008 till 2012, there was a few months in there that I did work.

Q Okay. But outside of those few months, your family was dependent upon Brian's income to sustain itself; right?

A Yes, sir.

Q And so particularly with a young child coming

into the family, that was pretty important that Mr. Koon continue to work to be able to support the family financially, wasn't it?

A Yes, sir.

Q And with this back pain that was affecting your husband, you and he had some conversations, didn't you, about, you know, maybe there's a possibility that he could quit that job because it was physically demanding and maybe he could find something that was a little bit easier on his body?

A Yes. I recommended that, sir.

Q And I think during the course of those types of discussions, at one point you considered maybe you could go back to work full-time as a possibility?

A Yes, sir.

Q And I think you even maybe had a conversation with somebody at work just to see -- to discuss that idea a little bit; right?

A Yes, sir.

Q And -- but ultimately you didn't end up going back to work full-time because the pain medication helped your husband to be able to perform at work; right?

MR. CRONIN: Objection, Your Honor. Calls for speculation.

THE COURT: Sustained. Rephrase.

Q (By Mr. Mahon) I think -- we've mentioned a little bit here, but you and I have talked about this case before, haven't we? You gave a deposition in the case?

A Yes, sir.

Q Okay. And your attorney was there at the deposition?

A Yes, sir.

Q And I was there, and there was a court reporter who took everything down so we could read what was said; right?

A Yes, sir.

Q And that was a deposition under oath; right?

A Yes, sir.

MR. CRONIN: Your Honor, a question has to be posed to my client and an answer given before she can be impeached and cross-examined with her testimony. It's improper cross-examination.

MR. MAHON: I'm not trying to impeach her. I'm just trying to show her her deposition testimony to refresh her memory about it.

THE COURT: All right. If you're going to refresh, you may refresh.

MR. MAHON: Thank you. May I approach the witness, Your Honor?

THE COURT: You may.

Q (By Mr. Mahon) And, if I could, I just wanted to direct you to page 86 of the deposition. And specifically it's lines 2 through 7. If you could take a look and read that and let me know.

A Yes, sir.

Q Okay. And so does that refresh your recollection about the consideration you had for going back to work at some point in time during that 2008 to 2012 time frame and whether you would need to do that?

A Yes, sir.

Q Okay. And what did you say as far as why you didn't go back to work during that time frame?

A Because he was working.

Q Right. And -- well, let's look here. It's page 86. It's lines 2 through 7. And you can just follow with me.

The question is: And do you know how far those discussions ever went. Did you ever inquire about going back to work?

And was the answer: I spoke to my employer about coming back and that was as far as I made it on that end. And then with the medication he was able to work.

A Yes, sir.

Q Did I read that correctly?

A Yes, sir.

Q And, in fact, your husband was able to keep his job, wasn't he, and work as a mechanical maintenance worker for the City of St. Louis, the position he still holds today?

A Yes, sir.

Q I think the jury will hear from some of his co-workers in this case at a different point in time, but you're aware, aren't you, that he had certain performance ratings that were -- that his superiors would fill out for him to evaluate how he was doing in a particular year?

A Yes, sir.

Q And you're aware during that 2008 to 2012 time frame he had overall ratings of successful?

A I never seen his ratings. I'm sorry.

Q You weren't aware of that?

A Huh-uh.

Q I think we'll hear some testimony on this as well, but you're aware that Mr. Koon received a raise at his job in 2010, weren't you?

A Yes.

MR. CRONIN: Objection, Your Honor. Can we approach?

THE COURT: Yes.

(Counsel approached the bench and the following

proceedings were held:)

MR. CRONIN: Your Honor, I object to the foundation of this question. The supervisor specifically testified that it was not a merit raise. It was a cost of living increase. He didn't receive another merit raise until 2013 after he got off of the opioids. That's the testimony. And now it's been suggested that he got a merit raise.

MR. MAHON: First of all, I don't think that I said the word merit.

MR. CRONIN: It's implied, Judge. I'm sorry, John.

MR. MAHON: I don't think I said that word, but in any event, I also think Mr. Cronin has the facts wrong and it will come out in the testimony. But in 2010 -- there were cost of living raises, but not that year. The one I'm thinking about in 2010 had to do with him taking an OSHA course and getting a raise related to that.

THE COURT: Okay.

MR. MAHON: So it's neither here nor there. This is his wife. She has knowledge to know.

MR. CRONIN: Judge, I think these gentlemen -- his supervisor -- she has no idea.

THE COURT: Here's what I'm going to allow. You can talk about if there was a raise, whatever that OSHA

thing. You can talk about 2010 as being narrowed to that. And then everybody else can testify --

MR. MAHON: I just want to see if she was aware of it.

THE COURT: But you need to add the 2010.

MR. CRONIN: That it was for an OSHA class.

THE COURT: Put it in context. I just want you to put it in context. She may be aware, she may not be aware. There needs to be some context to that question. It will be clear when it comes from the other people, but the jurors need context for that question.

MR. MAHON: Okay.

(The proceedings returned to open court.)

Q (By Mr. Mahon) Okay. Mrs. Koon, you were aware in 2010 that your husband received a raise through the City in connection with him taking an OSHA safety course, weren't you?

A Yes, sir.

Q Okay. And I think you mentioned earlier that Mr. Koon has told you that he's had some issues remembering events during this 2008 to 2012 time frame; right?

A Yes, sir.

Q Okay. Were you aware that his parents gave depositions in this case? Sworn testimony?

A Yes, sir.

Q Were you aware that they testified under oath --

MR. CRONIN: Your Honor, objection. Mr. Mahon is now asking my client to testify on other testimony in the case. It's improper, there's no foundation for it. She hasn't reviewed the depositions.

THE COURT: Approach.

(Counsel approached the bench and the following proceedings were held:)

THE COURT: What's the actual question?

MR. MAHON: The question is going to be, if I can get it out, is whether or not she was aware that Mr. Koon's parents denied any knowledge of memory issues in their sworn testimony at deposition, whether she was aware of that or not. I'm not really going to take it really any further than that. I want to know also if she was aware of that.

MR. CRONIN: Judge, can we ask the witness what she remembers and she was aware of. Rather than saying what we think some other testimony is so that we can get it in now, and then asking if she's aware what their sworn testimony was.

THE COURT: I --

MR. CRONIN: It's completely improper.

THE COURT: Help me out with how the answer to

that question helps the jury do anything.

MR. MAHON: Well, I think what this shows --

THE COURT: Because here's my problem with it. Who's being untruthful? The parents giving the sworn testimony or the wife giving the --

MR. MAHON: I'm not using it for the truth of the matter asserted. I'm trying to show there are apparently a couple different ideas or understandings about --

THE COURT: You can't do it this way. Because it's basically saying are you lying or are the parents lying. If it's not coming in for the truth, what's it coming in for? That there's inconsistent testimony? Inconsistent testimony is which one of these are the truth.

MR. MAHON: Well, I wasn't going to take it that far.

THE COURT: The problem is I think it's an easy inference for the jury to make. It's improper. So stay away from the parents -- with the parents. You can ask her what she knows, but she can't comment on whether they gave testimony under oath or whether they're being truthful or whether she was being truthful.

MR. MAHON: All right. That's fine.

MR. CRONIN: Thank you, Judge.

(The proceedings returned to open court.)

Q (By Mr. Mahon) Let me just ask this. Mr. Koon's parents, they're people that Mr. Koon has been close with for a number of years, aren't they?

A Yes, sir.

Q And how about your father and your brother, were you aware that they gave depositions in the case?

A Yes, sir.

Q And are those people that Mr. Koon has known for a number of years, even back to before 2008?

A They did not know him before -- well, yes, they knew him before the meds, yes. I'm sorry.

Q The two of you started dating in 2005 so maybe around that time they would have started to know him?

A Yes.

Q Okay. I wanted to ask you a couple of followup questions about your -- I think you had told us it's your memory that there was some occasion where you found your husband on the porch, that he had been smoking a cigarette and fell asleep. That was your memory; right?

A Yes, sir.

Q And this was at nighttime; right?

A Yes, sir.

Q And so I guess if I'm understanding you correctly, Mr. Koon would have gotten up out of bed and

walked out to the front porch and that's where you found him.

A Yes. He would also do it during the day though, sir.

Q And he would make it out to the front porch and have a cigarette, and then when you noticed him your memory is that he was asleep out there?

A He'd be slumped over in the chair. Or with his head against the wall. Yes, he'd be sleeping on the porch with a lit cigarette.

Q Any of these instances where you had -- your memory being that you found your husband on the porch asleep while smoking, you can't say that you ever told Dr. Walden about any of those incidents, can you?

A Not about sleeping on the porch, no, sir.

Q And also about your memory of this incident with Mr. Koon trying to flush some books down the toilet. Do you remember that testimony?

A Yes, sir.

Q Just to be clear, you didn't actually see him do this, did you?

A No. I seen my books after the fact. And he did tell Dr. Walden himself that that was happening. Because that was more than one occasion.

Q Okay. You didn't -- you can't say you actually

ever told Dr. Walden about this book incident, have you?

A Me personally, no.

Q And I wanted to ask you, too, about this other incident where it's your memory that there was one occasion when you were driving and your husband had fallen asleep at the wheel.

A Yes, sir.

Q Okay. You can't really say when this happened, can you?

A It was shortly before I made the request for him to see the pain management doctor.

Q So sometime in 2012?

A Yes, sir.

Q And -- but there was no accident involved in this incident, was there?

A No, sir.

Q Nobody was injured?

A No, sir. It was close, but no one was injured.

Q There was no police report filled out related to this incident, was there?

A No, sir.

Q Okay. And Mr. Koon drove the rest of the way home, didn't he?

A Against my better judgment, yes.

Q And this -- this incident where your memory

about your husband falling asleep at the wheel, you can't say you ever told Dr. Walden about that incident, can you?

A I do not recall.

Q You told us also a bit about your memory of checking on your husband periodically in the evening to make sure that he was still breathing. Do you remember that?

A Yes, sir.

Q Okay. But you never noticed, not even one time, that him having what appeared to be difficulty breathing or actually stopping breathing. True?

A There was times when it would be shallow. And then other times where I would be woken up with the sound of him --

Q Could you turn to page 48 of your deposition, please. And I specifically wanted to go to line 20 through 25.

And the question is: Okay. You said that you would check on him sometimes at night to see if he was still breathing. And did you ever notice that he appeared to have any difficulty breathing or that he had ever stopped breathing?

Answer: Not that I know of, sir.

A Correct.

Q Did I read that correctly?

A Yes, sir.

Q And we've heard a little bit about at some point in time you decided to get involved in your husband's medication; is that right?

A Yes, sir.

Q Okay. And you did so because your husband was taking more than you thought that he should have; right?

A Yes, sir.

Q Now, when he was doing that, didn't he tell you that it was because he was in pain and the medicine was not stopping or controlling all of the pain? Isn't that what he said?

A Yes, sir.

Q And you cannot say that you ever told Dr. Walden that you felt the need to step in and try to help with Brian's medications, can you?

A I can't recall if he was made aware of it or not.

Q I just want to be clear. My question is a little bit different. Not whether Dr. Walden may have been aware of it from someone else. I just wanted to know about you personally. You can't say that you ever told Dr. Walden yourself that you felt the need to step in and help monitor his medications?

A I know I told his secretaries. I don't know if

I ever said it to him or not.

Q And these secretaries that you're referencing, you can't recall anything about them in terms of their names, can you?

A No.

Q And, in fact, I think we've seen some of it, but you're the one, not your husband, on some occasions that would be the one to call in to Dr. Walden's office to request a refill or a higher dose. Isn't that right?

A Yes, sir.

Q Mike, if we can put up -- sorry, I didn't give you a heads up on this one. Defendants' Exhibit A, SLUCare records. Or even if you're in Plaintiffs' Exhibit 1, I think it's page 353. And if you could blow that up, Mike. Okay. Right there. On this February 23, 2009. Right in the very middle, Mike.

Where it says wife asking for OxyContin, ten milligrams, two tabs, BID. Stated they spoke with M.D. regarding increase. Please print complete history and sign. Thanks.

You don't have any reason to dispute that you called into the office on that date, do you?

A No, sir.

Q And -- that's good. You would call in from time to time and ask for refills or an increase in the

medications. You did this despite being concerned about how your husband was taking the medication because you preferred how he was with the medications than to how he was when he didn't have them. True?

A I wouldn't put it in them words, sir.

Q Could you turn to page 75 of the deposition, please. I'll move on then.

Okay. We heard a little bit about an incident that you recall where there was a relative, I think, who got access to some of Brian's medications; right?

A Yes, sir.

Q And, Mike, if you could pull up Exhibit A, page 500. I think it's that one right at the bottom there. In the middle towards the bottom. And this is from November 30th, 2011.

Patient's wife is calling, states he has been having increased neck pain and states he has been taking extra meds. Wife also states that a relative has been in their house and has took several oxycodone and now he doesn't have enough med to last. Patient's wife states patient wants to talk to provider.

Does that sound like the incident you were referring to?

A Yes, sir.

Q And just to be clear, this was a truthful

statement that some relative had, in fact, gotten into the medication?

A Yes, sir.

Q It wasn't some story that was made up in an effort to get more medication, was it?

A No, sir.

Q Okay. We had talked a little bit earlier, you had mentioned that there was a time when you had called in to try to request a referral for pain management; is that right?

A Yes, sir.

Q And that ended up being Dr. Berry, the pain management physician; right?

A Yes, sir.

Q Okay. Mike, could you pull up SLUCare, still Exhibit A, page 549. And kind of right in the middle. Yeah, blow up that area right there.

This is from April 2nd, 2012. And actually I wanted to look at -- I think it kind of runs backwards in time. First, April 2nd, 2012, 10:20 a.m. There's a telephone encounter. It says requesting referral to pain management. Do you see that?

A Yes, sir.

Q And then if you go up, that same day, April 2nd, 2012, 2:41 p.m., an order is placed in EPIC. That's just

a few hours later on the same day, isn't it?

A Yes, sir.

Q And, Mike, could you go to page 552, please. And just blow up that area at the top, please.

So this is also part of the records from Dr. Walden's office from that same day, April 2nd, 2012. And I wanted to focus on the note at the bottom. It says: Please note, the Back Pain Center does not initiate, take over/maintain or discontinue narcotic therapy.

Did I read that correctly, ma'am?

A Yes, sir.

Q And this note -- the date on this note is April 2nd, 2012, the same day that the call came in to request the referral; right?

A Yes, sir.

Q Okay. And I think I heard you testify before -- I may not have gotten it down correctly, but I wanted to figure out about the referral to Dr. McKean, the psychiatrist. And I thought you had said that you had found Dr. McKean on your own? Is that what you were saying?

A I got Dr. McKean's name from my doctor.

Q Okay. And you don't believe that Dr. Berry referred your husband to Dr. McKean?

A I don't believe so, sir.

Q Mike, could you pull up Defendants' Exhibit K. It's page 16. It's at the very bottom that I wanted to try to draw attention to. Thanks.

At the very bottom of this record -- actually, maybe we should just go back to the top so I can even identify what date we're dealing with here. Thanks, Mike.

So this is from June 8th, 2012, up at the top. And there's a series of information there, but I wanted to focus back on the bottom. And it says he will be set up for epidural injection, still at the number two part. And then number three, referral for counseling, Dr. Melanie McKean. Do you see that?

A I see it, yes, sir.

Q You made a couple of statements about being at the office with your husband at Dr. Berry's office. Do you remember that?

A Yes, sir.

Q Okay. And you mentioned something about the DEA, I thought; right?

A Yes, sir.

Q You've never seen any documentation of that, have you?

A No, sir.

Q Okay. You also mentioned something about a pharmacy refusing to fill a prescription.

A Yes.

Q I thought I heard that.

A Yes, sir.

Q You don't know when that was, do you?

A It was shortly before I put him in CenterPointe Hospital.

Q So around August or September 2012 time frame?

A Yes, sir.

Q And you've never seen any documentation of that, have you? Of a pharmacist -- pharmacy refusing to fill a script, have you?

A No. But they called me personally, as well as calling him.

Q Okay. But my question is just about documentation. You've not seen that written down anywhere, have you?

A No, sir.

Q Okay. And you had mentioned a little bit about the weaning plan that was developed between Dr. Walden, Dr. Berry and Dr. McKean. Do you remember that?

A Yes, sir.

Q Okay. And you were actively engaged in that; right?

A Yes, sir.

Q If we could go to Exhibit A, page 663, Mike. If

you could highlight -- well, first, let's just blow up the top part.

This is from a SLUCare record, August 16, 2012. And specifically there's some -- some text in there. And I wanted to focus on -- I guess after the first sentence there.

It says: He states small decreases in OxyIR, and there's some dosing information, has been tolerable. He has noticed some increase in pain, but continues eager and motivated by continued weaning. In addition, he states steroid injections by Dr. Berry have been helpful.

Do you recall, was your husband interested and motivated to complete the weaning process that had been developed by these physicians?

A At that point in time, I'm not sure.

Q At any point in time was he interested and motivated to try the weaning plan?

A Yes, sir.

Q And we've heard some mention about -- and we've heard a couple of phrases about it. I think you had said before, some episode where your husband had a pistol. Do you remember that?

A Yes, sir.

Q And just to be clear, this was not something that you ever saw, was it?

A No, sir.

Q But it's something that Brian had shared with you after the fact?

A Yes, sir.

Q And it's your understanding that this event with the pistol was something that took place the same day that you took your husband to St. Mary's Hospital?

A That's what I originally thought, but I'm not sure when that actually happened.

Q Did Brian -- that's what he initially told you, though, that that happened on the same day that he went to St. Mary's?

A On our way to CenterPointe, he made the comment that he should have went ahead and pulled the trigger. So I just assumed that it was that day.

Q But as you sit here now, you're not sure when that occurred?

A No, I'm not.

Q And so I think your testimony was that you understand that in the early 2000s your husband had some issues with erectile dysfunction, was taking medications for that; right?

A I heard something about it later on.

Q So we've heard some talk about this, but it's my understanding that there were four different surgeries

that your husband went through after CenterPointe up until 2015; right?

A Yes, sir.

Q And weren't two of them here in the neck?

A Yes.

Q And then two of them were down in the lower back area?

A Yes, sir.

Q And the physicians that were involved in that treatment prescribed your husband opioids for periods of time after he was recovered from those surgeries, didn't they?

A Yes, sir.

Q And, in fact, your husband still continues to take one type of an opioid called Tramadol. Is that true?

A Yes, sir.

Q I know when we spoke at your deposition there was a discussion about marriage counseling and that being something that you were interested in and that you thought maybe you might do sometime after the deposition's completed. Do you remember that?

A Yes, sir.

Q Is that something that you and your husband have ever done?

A No, sir.

Q Do you have any plans to attempt that maybe after the lawsuit's over?

A As of right now, I'm not sure.

Q And you and your husband have never gotten together with Mary Fitzgibbons. We've heard some testimony from her that she does marriage counseling. Have you ever gotten together with her about that?

A He asked me to. Right now I'm just trying to find myself again after all this.

Q So I take it you've not actually sat down with Mary Fitzgibbons.

A No, sir.

Q Now, Mrs. Koon, I'm just about wrapping up, but has Mr. Koon ever at any point admitted in your presence that he feels he bears any responsibility for any of the circumstances that led him to seeking rehab treatment at CenterPointe?

A Sorry. Can you repeat?

Q I'm sorry. My question --

A Can you repeat?

Q My question to you is has your husband at any point admitted in your presence that he feels he bears any responsibility for any of the circumstances that led him to seeking rehab treatment at CenterPointe?

A He has apologized to me so many times for

allowing this to happen to our lives.

Q I'm sorry?

A He has apologized to me on several occasions for allowing this to let it -- allowing this to take over our lives.

Q I don't think I have any more questions.

THE COURT: Redirect.

MR. CRONIN: Two minutes, Judge.

Mike, can you pull up Exhibit 1, 85. Can you go to the box.

**REDIRECT EXAMINATION**

BY MR. CRONIN:

Q Do you see that, Michelle? This is from Dr. Walden's and SLU's records. It's dated July 6th, 2012. It says: Pharmacist called, concerned about patient getting large amounts of pain med, getting it frequently. Wife told pharmacist that she has to hide his meds and that he found them and took all them. Pharmacist states she cannot fill script written on July 2nd, 2012, because it is too soon. Pharmacist is wanting to know what to do with the script that was just written. Does provider want pharmacy to return script to patient. Wife states patient has an appointment with psych to start getting him off med. Please advise.

Did I read that right?

A Yes, sir.

Q So that would be documentation of a pharmacist refusing to fill Brian's prescriptions; right?

A Yes, sir.

THE COURT: Hold on. Is there an objection?

MR. MAHON: It's leading, Your Honor.

MR. CRONIN: It's redirect, Judge.

THE COURT: You still need to tighten it up.

MR. CRONIN: Sure.

Q (By Mr. Cronin) Michelle, does this look like it's documentation of a pharmacist refusing to fill Brian's prescriptions?

MR. MAHON: I think it still is leading. I think it's lack of foundation and self-serving, Your Honor.

THE COURT: Overruled.

MR. MAHON: I think she said she has no knowledge.

THE COURT: Overruled. But let's not stay on this.

MR. CRONIN: Sure.

Q (By Mr. Cronin) Michelle, these are Dr. Walden's records. Have you ever read that from his records before?

A No, I have not.

Q Okay. Mike, can you pull up Exhibit 75-1, Photo 2.

Michelle, is this a picture of you and Brian before 2008?

A Yes, sir.

Q Mike, can you pull up a picture of Exhibit 75-2 -- 75-2, Photo 2.

Is this a picture of Brian after 2008?

A Yes, sir.

Q Can you pull up Photo 8.

Is that also a picture of Brian during 2008 to 2012? A photo with Emily?

A Yes, sir.

Q Did Brian look like that a lot?

A Yes. I had to remove her from his arms right after that picture was taken.

MR. CRONIN: I don't have any more questions, Your Honor.

THE COURT: Any recross?

MR. MAHON: No, Your Honor.

THE COURT: All right. Thank you, ma'am. You may step down.

(The witness was excused.)

THE COURT: All right. Before 5:00. We're going to adjourn for the day. We'll start back up -- let

me talk to the attorneys real quick.

(There was an off-the-record discussion held at the bench.)

THE COURT: All right. Ladies and gentlemen of the jury, I'm going to bring you back again tomorrow morning at 8:30. Was there coffee for you guys? And doughnuts? Good healthy doughnuts. I don't know that they're healthy, but they're doughnuts.

All right. The Court again reminds you of what you were told at the first recess. Until you retire to consider your verdict you must not discuss this case among yourselves or with others or permit anyone to discuss it in your hearing. You should not form or express any opinion about this case until it's finally given to you to decide. Please don't do any research or investigation on your own. And don't communicate with others about the case by any means.

We'll be in recess until 8:30 tomorrow morning.

(The jury was dismissed at 4:50 p.m. until 8:30 a.m., Thursday, June 23, 2016.)

(The following proceedings were held out of the presence of the jury:)

THE COURT: We're on the record to dispose of some objections regarding some of the depositions. We're outside the hearing of the jury. All right.

MR. MAHON: That's right, Judge. This is off of the third deposition objections and counter-designations of the defendants. It was filed on June 17, 2016. The first witness that has been designated by the plaintiffs is Adrian DiBisceglie. And we raised this issue at some of the motions in limine. But I think the substance of Dr. DiBisceglie's testimony concerns the physicians compensation plan and bonus structure for Dr. Walden's compensation. We think all that should stay out so we object to this deposition in its entirety. There's not particular objections to rule on. Really we don't think any of that should come in. It's prejudicial.

THE COURT: All right. My previous ruling is still in effect. I'm going to deny the -- overrule the objection to the testimony from Dr. DiBisceglie.

MR. CRONIN: Then you have individual ones; right?

MR. VENKER: Counter-designations. You might not have seen yet.

MR. CRONIN: Yeah, I've got them. I don't have objections to them.

MR. VENKER: That's it with Dr. DiBisceglie's objections.

MR. MAHON: Then there's Dr. Tate's.

MR. CRONIN: Were there any individual

objections to Dr. DiBisceglie?

MR. MAHON: No.

MR. CRONIN: All right. So that one's done.

And there are individual objections to Tate?

MR. MAHON: Yes.

THE COURT: Did we talk about Tate?

MR. VENKER: I don't know, Judge. It's what he testified about money that SLU received on these clinical trials for opiates -- well, it was other things too, but opiates.

MR. CRONIN: And, Judge, I believe your ruling was we are limited to clinical trials with pharmaceutical companies that manufacture the opioids Brian was on.

THE COURT: Who make the drugs is what I said.

MR. CRONIN: And Paul has objected to some of them. And some of them, I acknowledge, we should withdraw. Everyone but Abbott and Purdue.

MR. VENKER: I think Abbott may have made Vicodin originally, but I believe also generically. So whose drug it was that Mr. Koon got.

MR. CRONIN: Judge, Abbott made Vicodin. Brian was on Vicodin. And Dr. Genecin said he believes Abbott made Vicodin. So I believe that one's tied in, but the other -- there's three others that we're willing to take out.

THE COURT: All right. So it sounds like you can link Abbott --

MR. CRONIN: Abbott and Purdue.

THE COURT: Abbott and Purdue. All the rest are excluded.

MR. VENKER: The other category of information here is the consulting agreements. We're just renewing our objection to that. This is information that consulting agreements -- Dr. Walden wasn't identified as having any of them so we object on those grounds.

THE COURT: Did I rule on that one?

MR. SIMON: Judge, here's what happened. There was a court order ordering SLU to provide information about consulting agreements their doctors have with specific pharmaceutical companies. We took that deposition with a special master, and I believe they admitted in that deposition on the record that that information was not provided. Okay?

So I've got a real issue with this because, you know, there was a court order requiring them to provide the information. And now based on your pretrial ruling, it sounds like we're not going to be able to get this in because we didn't insist that they abide by the Court's order and provide us with specific information about the consulting agreement.

So what we have -- I would like to get in generally that St. Louis University doctors have consulting agreements with pharmaceutical companies, have had them, continue to have them, and -- and that's really what I want to get in. That's -- the testimony's already in the can in the depo.

But, again, their argument is there's no tie to specific pharma companies who sell these types of drugs. I didn't get what we were supposed to get. We were supposed to get a deposition from somebody to provide that information, Paul.

MR. VENKER: No, I understand. But here's the thing. A pharma said there's no central repository for this. My point is, Judge, there's no consulting agreement period with Dr. Walden. But I'm saying whether we had these consulting agreements or not, I think the same objection --

MR. SIMON: Dr. Walden is not the only defendant. They've got 450 internal doctors at SLUCare.

MR. VENKER: I know.

THE COURT: So your objection is to --

MR. VENKER: Relevancy.

THE COURT: -- relevancy of consulting agreements.

MR. VENKER: Yes, sir.

THE COURT: One, I think it's relevant to the other defendant, SLU. It may not be particular as to Dr. Walden, but there's another defendant. And I think it is relevant in weighing the probative versus prejudicial value. I think it is probative of the -- of the Defendant SLU. And I think that outweighs the prejudicial nature so I'm going to allow that line of --

MR. VENKER: So the objection is overruled?

THE COURT: Yes, sir.

MR. VENKER: All right. Thank you, Your Honor.

THE COURT: Are we done?

MR. CRONIN: We can do other ones if you want.

THE COURT: Why don't we knock them out. There's two more depositions. One is Dan Skillman. Another one is Chris Bublis, B-U-B-L-I-S.

(There was a discussion held off the record.)

THE COURT: Go ahead. Skillman first.

MR. MAHON: With Skillman first. Plaintiffs' objections to mine and then mine to his. There's not that many.

MR. CRONIN: We can do yours first if you like.

MR. MAHON: Okay. My defendants' objections to plaintiffs' counter-designations for Dan Skillman. The first part is page 85, lines 2 through 8.

THE COURT: Lines 2 through 8.

MR. MAHON: Okay. So yeah. There's a question here about basically after 2012 -- 2013-2014 and 2014-2015. The question though is those are the years after Brian got off the opioids. Did you know that? So I object to the form. I think it's misstates the evidence. That Brian has continued to take opioids in one form or another up until the present time. So this question of him implies that Brian stopped taking opioids after 2012 and never took them ever again.

THE COURT: So is Skillman coming in?

MR. CRONIN: No. It's a video.

MR. MAHON: And, Tim, I think you maybe even corrected --

MR. CRONIN: I think I cleaned it up in the next question, Judge. So I'll agree to withdraw lines 2 through 4. John, is that okay? Because I think I cleaned it up then starting with line 9.

MR. MAHON: Oh, yeah, yeah. Just withdraw that.

THE COURT: Okay.

MR. CRONIN: I think we worked it out. Is that right?

MR. MAHON: Yeah. And the next one is still on page 85, but it's lines 17 to 24. And so what's going on here, the context of this is that Mr. Cronin had gone through and was trying to show that there was a dip in

performance on the performance reviews, how they were scored. And so, you know, I think that's fair to go through all that stuff.

But he says here now from looking at his performance reviews, it kind of seems like something might have been going on in Brian's life from 2008 to 2012 that caused his work performance to slip, doesn't it? So I object to it. I think it calls for speculation, it is argumentative. I think even the answer shows the speculative nature, is it possible.

MR. CRONIN: Judge, it's cross-examination after extensive direct examination asking Mr. Skillman many, many questions to imply that he was --

THE COURT: All right. I'm going to overrule the objection, and the jury can give it its appropriate weight.

MR. MAHON: Okay. And then this is related, but page 85, line 25 to 86, line 4. He then says is that what -- after he asked the first question, he then says is that what it appears like to you. So really I have the same -- same question and lack of foundation.

THE COURT: I'm going to overrule. I think if there is any confusion, I think it bodes well for the defense rather than the plaintiffs. And so I'll overrule that.

MR. MAHON: All right. The last one of this witness is page 86, line 22 to 87, line 2. It's still kind of in the same line of questioning. He says -- or actually it's a little bit different. He goes through and mentions some things that happened to Brian on the job, like some on-the-job injuries. And that's fine, they go through that. But then their question is the kind of thing someone might do if they're impaired; right? And so I think it's argumentative, I think it's speculative. There's no foundation for it. He said I don't know, but I just don't even think that question should be asked.

MR. CRONIN: Sounds like you liked my question. I'll let you make a decision.

THE COURT: That one's sustained.

MR. CRONIN: That's what I thought.

MR. MAHON: That's the last defendants' objection to plaintiffs' counter-designations for Skillman.

MR. CRONIN: I think we had a couple objections.

MR. MAHON: Yeah, you did.

MR. CRONIN: 43:11 to 49:23. This is a big chunk.

THE COURT: 43:11 until where? 49?

MR. CRONIN: To 49:23. So this is going through, I believe, performance ratings after Brian was no

longer treating with Dr. Walden, getting prescribed prescriptions by him. So my objection, Judge, is to relevance, it is confusing. These are all after Brian's care with Dr. Walden ended.

MR. MAHON: My response is that's exactly right, it is after the care ended. But this goes to show that Mr. Koon continued to be employed and continued to get successful performance ratings at his job. This goes to -- you know, part of the damages here is his relationships socially, with people at work and with his family. And this tends to show that he's been able to keep the job, his relationships with the people at work are intact, he's received raises. And so this really goes not to liability issues but really to damages because I think the testimony is that their lives are in shambles. And this, I think, goes to show that he's at least kept it together at work.

MR. CRONIN: Judge, we're not making a lost wage claim in this case. It's not disputed that he's continued at his job.

MR. MAHON: It goes to relationships. One final thing, it also shows no -- that he hasn't relapsed and lost his job. He's gone back to the throws of addiction.

THE COURT: Okay. So there's two arguments here. You're arguing the -- all right. I guess here's my

ruling. These -- there's a certain line, for example -- and I'm not sure when I look back at page 289. But look at page 43, line 15.

You look back at page 289, looking at these factors, did Mr. Koon receive raises for each of these in 2013. Yes.

All right. Here's -- and so if I like certain parts and don't like certain parts -- this is a video?

MR. MAHON: Yes.

MR. CRONIN: Yes, Judge. You can rule that some stay in, some stay out. It's your call. I object to the six straight pages because it is going through his written performance ratings for those six pages.

THE COURT: All right. Your argument is this is not a lost wages case. I agree that it is not. But you're saying that the person was damaged through the doctor's actions. Your argument is he's not been damaged by the actions and here's evidence that he's not been damaged because he was able to do these particular social -- or these type of functions on his job.

MR. MAHON: Right. You're basically just verifying what's in the records.

THE COURT: Has there been any records?

MR. MAHON: There will be. It's business records. This witness -- Tim said they won't challenge

the authenticity of it.

MR. CRONIN: We will not.

THE COURT: All right. Here's what I'll do. I'm not going to exclude it. I think it does not go towards lost wages. And that's never been the argument of the plaintiffs. But it does go to his functionality post an alleged injury that is physical and cognitive.

And so whatever amount of weight the jury's going to give to his ability to be happy in customer service, they'll give it the appropriate weight. I don't think it should be excluded. I think there's been testimony that people can function at a high rate when they're on the drugs. I think there's been evidence from both sides conflicting this. I'm not going to exclude it for that reason. So that will be -- that exclusion will be overruled.

MR. CRONIN: Judge, the next one is a small designation. Page 49, line 18 to 23. So Judge, this is after pages of questioning going through the ratings for each factor individually and pointing out what they are. And then there's a summary would it be accurate to say that through these Mr. Koon was rated at either successful, highly successful on each of the performance factors there.

Judge, my objection is to form and foundation.

Each one was gone through and it's clear that almost all of them are successful, not highly successful. I don't know why we need to summarize them when each one was gone through.

MR. MAHON: All I have to say is I think Mr. Cronin had the opportunity and did cross-examine the witness where he went through and tried to ask questions to clarify any issues that he had. It's an accurate statement that each of the factors were either designated as successful or highly successful. It didn't say in the question which one was more or how many times for this or how many that. It's an accurate statement.

THE COURT: All right. The objection is misleading, I'm going to overrule that objection. I think it is "or" and not "and". Being that format, it's appropriate.

MR. CRONIN: Judge, my final one is 14 pages. It is page 55, line 24 through 69. And it discusses worker's compensation claims and unrelated medical issues. So anything in there is subject to a motion in limine where if -- the fact that there was a comp claim made or defendant has received it. Some of it in there may not say comp claims, but I think it's all under that.

How about this? How about you and I see where it's comp claims and we'll figure it out.

THE COURT: Why don't we wait on that one.

MR. MAHON: I think the Court said yeah, we agreed we're not to talk about the comp claim, but we could talk about doctors. So maybe we can work that out.

All right. Bublis, the last guy. I just have two objections from defendants to the plaintiffs' counter-designations for Chris Bublis. And I think they're both related. It's a hearsay issue.

It's page 50, line -- line 15 -- it should be 50 to 25, but there's a typo on the objections. It says 50 to 15, but it's 15 to 25. And then it actually goes onto page 51, line 1 to 12. And what this concerns is there's a gentleman named Lowell Lake, who is Mr. Koon's supervisor. He's deceased.

And so I'm making a hearsay objection here because I think Mr. Cronin is asking Mr. Bublis about information he learned or a conversation with Mr. Lake. So that's really what it's about. It's a hearsay objection. And I think it's about what was Mr. Lake aware of and what did Mr. Lake say about Brian driving at work. That's the general topic.

THE COURT: So what's your objection?

MR. MAHON: It's hearsay because Mr. Lake obviously cannot testify and won't be coming to testify so there's no way to cross-examine him. I think Mr. Bublis can talk about, you know, what he knew or what he

observed. But what he's really being asked to do here is to say what Mr. Lake told him. That's my concern.

MR. CRONIN: Judge, first, in opening statement counsel told the jury that plaintiff's supervisors had no idea that anything was going on, that there was any kind of pain pill problem. This is direct evidence that that was a false statement.

Secondly, Mr. Lake was Brian's foreman, his direct supervisor. Chris Bublis is Mr. Lake's supervisor. And in his job duties he's saying he knows that an employee under him was aware of his employee's pain pill problem.

THE COURT: The person that's talking was Mr. Lake's --

MR. CRONIN: Mr. Lake's supervisor.

THE COURT: So Mr. Lake is not the supervisor.

MR. CRONIN: Mr. Lake is Brian's supervisor. He's dead.

THE COURT: Right. But the person who's talking, Mr. Lake worked for him.

MR. CRONIN: Yes.

THE COURT: I think that is an appropriate employee -- supervisor/employee relationship, and he can testify as to what his -- an employee knew or didn't know. If it had been the other way around, then I would agree that it would be excluded.

I think it is -- it is hearsay, but it -- I don't think it's for the truth of the matter. It's more for the way a person would act in a supervisory role. So it would be subsequent actions based on information so it's not the truth of the matter asserted, but how did the person treat the person after having absorbed that information. So I'll deny those.

Are those the two?

MR. MAHON: Yes.

MR. CRONIN: I think there's one on 51, 12.

MR. MAHON: That's the same.

THE COURT: I think that's appropriate. I'll overrule that.

MR. CRONIN: John, were those yours? I don't remember if I had any.

Okay. So this one's a 14-page one, but I'll summarize. Mr. -- with Mr. Skillman. Let me try to --

THE COURT: Are we on Skillman or --

MR. CRONIN: Here's how the hierarchy goes. Skillman, supervisor. What's his title? It goes Skillman, Bublis, Lake, Brian. So we already went through Skillman's testimony. He was gone through all the performance ratings. Then the same thing was done for Mr. Bublis. They're already hearing it with Mr. Skillman. It's 14 pages of the same thing. It's cumulative.

THE COURT: Is there anything that Bublis is going to give that differs from Skillman? Skillman is at the top of the food chain and Bublis is below; right?

MR. CRONIN: For those 14 pages, I don't think so.

MR. MAHON: I think it is different. The records we're using for both witnesses are the same, but both of these witnesses signed these performance reviews in different capacities. One is -- Bublis at one point in time was a direct supervisor after Mr. Lake passed. And then before that he was kind of the second level above. And then Skillman signed these all as the top guy in the department. But I didn't go through all the same information. I didn't repeat the definitions and the terms and all that because the idea was Skillman would testify first.

But the key thing is here I think the plaintiffs are arguing that part of the cross with Skillman was, well, you didn't really directly observe Mr. Koon, did you. Well, Bublis did. He observed him on a weekly basis. So he's got a different perspective.

THE COURT: Is there anything in Bublis's where he says he observed him on a weekly basis?

MR. CRONIN: Yes. And that's a different designation.

THE COURT: I'm okay with Bublis talking about what his role was in the review. I'm okay with Bublis -- there's a part in there that talks about yeah, they signed it. In other words, if they're talking about records and there's a signature, the jury should understand what that person's role was in the signature, and the inference is he signed off on -- if he signed off on it, he agrees with it.

If there's anything that adds to what Skillman said or differs from Skillman, I'll entertain those. But if it's just you agree that he's a four out of five on customer service and it's the same thing that Skillman says, that is cumulative. Especially the format that it's coming in. If this was live testimony, I wouldn't think so, but -- I know depositions are allowed to come in. But if it's just another restatement of the evaluation, it's cumulative.

If you've got something unique or there's an different flavor on a particular one, I'll entertain the particular flavor. And it doesn't -- I understand that they're not going to say the identical same. But if they're going over the same 2012 evaluation that says customer service was highly successful or whatever, job skills he was successful, to me that's cumulative.

MR. MAHON: Well, Judge, I mean this is a critical part of the case. Their claim from their expert

is that Mr. Koon was rendered a zombie by these medications. And these are two co-workers -- it's just two of them, it's not six of them -- in different capacities that have different connections with Mr. Koon in terms of how often they're observing him. And they're talking about how he's performing at work. So yes, the records that we're walking through with them are the same, but they have really different knowledge levels about how he performs. They have different roles. I really don't think it's cumulative. It's a pretty critical part of the case.

THE COURT: What part do you -- what parts are the matching parts?

MR. CRONIN: Judge, I think to save the Court time, let me take some time to try to figure out the particular matching parts.

THE COURT: Yeah. If there's a particular part -- I mean, I get that -- I don't want to preclude you from the entire thing, but I would prefer that we not duplicate -- if these guys have to watch two videos of people saying the exact same thing, you're going to kill them. Not that I'm a jury specialist, but I can imagine 14 pages of both people -- 14 pages of video, I don't know how long that comes out on an actual video. I'm thinking it ain't gonna be short. If it's the same thing --

MR. MAHON: The plaintiffs have both plaintiffs who testify and Dr. Fitzgibbons who basically just repeated what was told to her so --

THE COURT: Yeah, that wasn't the most exciting. Don't get me wrong. In excitement points, that was on a low end scale of excitement. However, they weren't identical.

So I can say I'm not going to tell you how to try your case. But if we can find some stuff that's not the same that still allows you to, I would rather focus on that. If there needs to be some duplication, I understand that, but I would prefer not to have two identical videos, if we can manage it.

MR. MAHON: I did short circuit it by -- you know, I used Skillman to set all the background and to say, well, what does successful mean and what do these different factors mean. And then with Bublis, I just simply had him say did he get successful or not, you know, in this or that. I did move it along so it's a lot quicker.

THE COURT: All right. I'll entertain. See if you can take some meat off the bones.

MR. MAHON: Thanks, Judge.

THE COURT: Does that wrap it up?

MR. MAHON: That wraps it up.

(Court adjourned at 5:25 p.m. until 8:30 a.m., Thursday, June 23, 2016.)

Thursday, June 23, 2016

THE COURT: Please be seated. Good morning, welcome back. All right.

Mr. Simon, you may proceed.

MR. SIMON: Your Honor, at this time the plaintiffs would present the videotaped deposition of Dr. Henry Walden, and this deposition was taken on July 24th, 2015.

THE COURT: All right.

(The following proceedings were held at the bench.)

THE COURT: Just a procedural issue. Since I've never done this before, I'm not sure, does she need to take anything down?

MR. SIMON: No, no, we'll just -- we have it all ready.

MR. VENKER: We'll submit it as an exhibit.

THE COURT: Just wanted to make sure.

(Proceedings returned to open court.)

THE COURT: You may proceed.

MR. SIMON: Thank you, Your Honor.

(Whereupon, the videotaped deposition of Dr. Walden was played to the jury.)

MR. SIMON: Your Honor, that concludes the deposition.

THE COURT: All right. We'll take a short fifteen minute recess.

(Whereupon, Instruction 300.04.1 read to the Jury.)

(Whereupon, a short recess was taken.)

THE COURT: Please be seated.

MR. VENKER: Your Honor, may we approach?

THE COURT: Yes.

(The following proceedings were held at the bench.)

MR. VENKER: Your Honor, we thought we'd handle some of these objections before the witness gets on the stand, if that's appropriate. Just to renew objections on issues that we've already objected to with our motions in limine, such as the opioid epidemic. I suspect --

THE COURT: Hold on. What's the name of the witness?

MR. VENKER: This is Dr. Robert Heaney. St. Louis University.

THE COURT: All right. So these are previous objections to comments that Dr. Heaney made?

MR. VENKER: I anticipate --

THE COURT: Okay. Just for the record, just so

the record knows what we're talking about.

MR. VENKER: Yeah. Dr. Heaney was designated as a corporate designee for SLU, and he was asked about the issue of -- the monitoring issue here that Mr. Simon has raised. I'm expecting him to be asked about the opioid epidemic, and I want to renew our objection to that. And also any references to, like, the DEA, or any Federal authorities.

We want to renew our objections to those topics. And I can object to the questioning. I thought it might be more efficient to do it this way. I thought it would be more efficient to do it this way. But I know we have --

MR. MAHON: And just about the monitoring aspect about part of the -- aspect of the objection is that we don't think plaintiffs have had sufficient expert testimony to support the claim directly against SLU for some sort of monitoring issue. I think the only testimony from plaintiffs' expert was about monitoring that he believes Dr. Walden failed to perform.

MR. SIMON: Specifically -- in response to that, I asked Dr. Genecin specifically if Dr. Walden and St. Louis University had an obligation to monitor the amount of opioid narcotics prescribed to their patients, including Brian Koon. At that point I believe Paul stood up and objected to St. Louis University, Your Honor

overruled it. We have testimony from our expert that both had the duty --

THE COURT: All right. The record will reflect that you have renewed your objection. It remains overruled. If there's anything outside of that, feel free to object. Or if you think -- you're not prohibited to any further objections, but the record will reflect the continuing objection as being noted.

MR. VENKER: Okay. And overruled?

THE COURT: And overruled.

MR. VENKER: Thank you, Your Honor.

(Proceedings returned to open court.)

THE COURT: All right. You may call your next witness.

MR. SIMON: Your Honor, at this time the plaintiffs would call Dr. Robert Heaney to the stand.

***DR. ROBERT HEANEY***,

having been duly sworn by the deputy clerk, testified:

**DIRECT EXAMINATION.**

THE COURT: You may inquire.

BY MR. SIMON:

Q. Good morning, Doctor.

A. Good morning, Mr. Simon.

Q. Doctor, you are employed by St. Louis University; is that correct?

A. That's correct.

Q. And your current position is chief executive officer of St. Louis University Care or SLUCare, correct?

A. I am the chief executive officer of SLUCare, correct.

Q. Okay. You're the top person there?

A. I'm the chief executive officer for the physician practice of St. Louis University SLUCare, correct.

Q. Okay. So, in other words, everybody there ultimately reports upward, and you're the top person, correct?

A. I am the chief executive officer of the practice.

Q. All right. And so, Doctor, you also are the assistant vice-president for medical affairs for the medical center, correct?

A. That is correct.

Q. Okay. And not only that, you're an internal medicine doctor, correct?

A. Correct.

Q. And, Doctor, you were chosen by St. Louis University to be their representative or spokesperson for this case; is that correct?

A. That is also correct.

Q. Okay. So, in other words, we were interested in information having to do with issues in the case, and St. Louis University chose you as their representative to come to a deposition and provide us with that information; is that correct?

A. Correct.

Q. Okay. So, Doctor -- now, St. Louis University owns and operates SLUCare, correct?

A. That is correct.

Q. You're an employee of the University, right?

A. Yes.

Q. Okay. And St. Louis University employs about how many physicians?

A. About four hundred and fifty.

Q. Okay. And about how many are internal medicine doctors like you and Dr. Walden?

A. There are about a hundred and sixty individuals.

Q. Okay. So, Doctor, Brian Koon was a patient of St. Louis University, correct?

A. It's my understanding.

Q. Okay. And St. Louis University accepted Brian Koon as its patient, right?

A. Yes.

Q. And St. Louis University provided treatment to Brian Koon for a period of time, including from the

beginning of 2008 until August of 2012. Is that your understanding?

A. That's my understanding.

Q. And, Doctor, St. Louis University prescribed narcotic opioids to Brian Koon, correct?

A. Dr. Walden prescribed those medications to his patient. He is a part of our practice, yes.

Q. Okay. Dr. Walden is an employee of St. Louis University, correct?

A. Correct.

Q. He works for SLUCare, correct?

A. He's a licensed independent provider that provided those -- wrote those prescriptions for this patient, yes.

Q. Okay. My point is both Dr. Walden -- Brian Koon was Dr. Walden's patient, and also St. Louis University's patient, correct?

A. Correct.

Q. Dr. Walden prescribed opioid narcotics and St. Louis University prescribed opioid narcotics to Brian Koon, correct?

A. Dr. Walden wrote those prescriptions, and he's a -- he is a part of SLUCare, that is correct.

Q. Okay. Part of his employment -- he was in the course and scope of his employment at St. Louis University

at the time?

A. That is correct.

Q. Okay. And, Doctor, those prescriptions included OxyContin, oxycodone and hydrocodone, correct?

A. That is my understanding.

Q. So, Doctor --

MR. SIMON: May I approach, Your Honor?

THE COURT: You may.

BY MR. SIMON:

Q. Doctor, I'm handing you an exhibit that's been marked 50-23. Do you recognize that, Doctor?

A. No. This is the first time I've seen this.

Q. Okay. Well, let me -- let's take a little closer look at it. It says this is a publication from the Missouri Hospital Association. Correct?

A. Yes.

Q. Are you familiar with the Missouri Hospital Association?

A. I am.

Q. Is St. Louis University Medical Center a member of the Missouri Hospital Association?

A. St. Louis University Hospital is a member of the Missouri Hospital Association. SSM Health St. Louis owns and operates that hospital, and -- but SLUCare and the University is not a member of the Missouri Hospital

Association.

Q. But you're assistant vice-president for medical affairs for the medical center, correct?

A. The medical center for the University. That includes school of nursing, allied health, medical school, and other educational and research enterprises. But I'm not an assistant vice-president for St. Louis University Hospital.

Q. Okay. Well, Doctor, let me ask you this. And this has been marked as Exhibit 50-23. And this is an article, it looks like, from November of 2015. Correct?

A. It says effective November 2015, correct.

Q. And it says, "opioid use in Missouri, strategy for reduce, misuse and abuse."

Have I read that correctly?

A. Yes.

Q. And the very first paragraph, under background, says, "the fastest growing drug problem across the U.S. and Missouri is the misuse and abuse of opioid pain relievers. Throughout the last two decades the rise in prescriptions, use and abuse of prescription-based opioids, has increased at an alarming rate."

Do you agree with that, Doctor?

MR. VENKER: Your Honor, may we approach?

THE COURT: You may.

(The following proceedings were held at the bench.)

MR. VENKER: I object, Your Honor, to Dr. Heaney being examined, or maybe even cross-examined, over this plaintiffs' own Exhibit 50-23. It's some kind of publication. I don't believe it's really medical literature. It looks like it's an internal publication for the Missouri Hospital Association, of which he's already testified that he is not a part, nor is SLU a part, nor SLUCare a part.

So I think there's really no foundation for him to be bound in any way to this, and so I object for those reasons.

MR. SIMON: It's not been published to the jury, I'm not looking for submission, I'm looking to discuss it with the doctor to ascertain whether he agrees with the statements.

MR. VENKER: I still -- also, Judge, this is in 2015, November 2015, it's after the care involved.

MR. SIMON: Well, I'm going to follow up on that, Your Honor, and ask him if St. Louis University was aware of these issues back in 2008 through 2012. And I think that's certainly relevant both ways; if they knew about it, it's relevant and if they had no idea about opioid abuse in Missouri during that time period, that's

also relevant.

MR. VENKER: Well, Judge --

THE COURT: Hold on. Let me make sure I know what objections we're dealing with. It sounds like you're making a foundation objection.

MR. VENKER: Yes, Your Honor.

THE COURT: As a first objection.

MR. VENKER: Yes.

THE COURT: What's your response to the foundation objection?

MR. SIMON: He's familiar with the publication and he's familiar with the organization, and it's a publication from that organization.

THE COURT: All right. On the grounds of foundation I'm going to overrule. Your next one is relevance?

MR. VENKER: Relevancy, because November --

MR. SIMON: I just said, Your Honor, that -- you know, it's the same thing having to do with our -- our motion -- the defendants' motion on the opioid epidemic. This is particularly relevant because it has to do with Missouri, including the national epidemic. This is a Missouri publication, it's a Missouri Hospital Association, and as I said, I'm not moving at this point to admit the exhibit but to question this witness, who's

the CEO of SLUCare, to determine whether or not this information was known by SLU during the 2008 to 2012 time period.

THE COURT: But -- when you say you're not moving to admit it, but then you read it, that is the equivalent of publishing it to the jury. That's the -- it has the same --

MR. VENKER: Right.

THE COURT: -- effect as --

MR. CRONIN: I filed a trial brief about how to appropriately use medical literature and, Your Honor, I'm doing it in the exact way they said we had to do it.

MR. MAHON: There has to be some evidence to establish a foundation --

MR. SIMON: I did that. That's been overruled.

MR. MAHON: -- that it's generally accepted in the medical community or that it's authoritative. No witness has said that about this publication. Dr. Heaney said he's never even seen this before.

THE COURT: All right.

MR. VENKER: To cross-examine him essentially on this article from an organization he's not a member of, Judge, is -- that's what the foundation objection is all about. You've overruled our objection to the area of opioid epidemic. But to, you know, tell the jury I've got

this article from the Missouri Hospital Association, and do you agree with this, that's --

MR. SIMON: Judge, I'll cross-examine him on it and put up any issues that they have with it. He recognizes the organization, he recognizes that it is a publication from the organization. I mean, the foundation was overruled. The issue we're dealing with now is relevance, and I can't imagine information or material that's more relevant to the issue in the case than a Missouri publication talking about the very central issue of the case.

THE COURT: Okay. I'm going to overrule on relevant. It is relevant. I've already ruled on the foundation. I'm not changing my ruling on the foundation.

All right. So what I'm not privy to is do you guys -- you guys have agreed that this is the way that you guys are --

MR. SIMON: That's what they said in their trial brief, Judge, that we would read from it and ask the witness if they agreed with the statement or not. If the witness agrees, it becomes evidence in the case. But I'm not publishing the exhibit.

MR. VENKER: That's not the way we talked about it, Judge, in our briefing.

MR. MAHON: I know you've overruled it on

foundation, but our briefing says it has to be -- before you cross-examine any witness using medical literature, you have to establish a foundation, which means evidence that's generally accepted or authoritative. Generally accepted in the community or authoritative. Either the witness himself has to establish that, or through some other witness.

This witness has not done that, cannot do it, because he's never seen it before, and no other witness has done that. So that's what we say in our trial brief. Only after that hurdle has been met, then the proper procedure is to read exact verbatim from it and ask the witness if he agrees with it. That's the proper procedure.

MR. CRONIN: Respectfully, that is not what their trial brief said. Their trial brief said if we want to do it with our expect, he has to established the authenticity. If you are cross-examining the other side's expert -- which we endorsed their corporate rep as an expert -- then you do not have to ask them if it's authoritative. The reason being they're never going to agree that it is. We filed a response saying --

THE COURT: Okay. All right.

MR. VENKER: Here's the thing, Judge, this was about medical literature. This is just a publication from the Missouri Hospital Association. This is not, you know,

medical literature on medical issues in this case, such as addiction, dependency.

THE COURT: All right.

MR. VENKER: This is just an article.

THE COURT: Number one, I agree that it's an article, but we are talking about a medical hospital in Missouri. So, whether he wants to acknowledge that he knows about it, this -- to me, this is within the scope of what a CEO in any medical hospital in Missouri should --

MR. SIMON: Certainly should know about it.

THE COURT: To what degree, he can tell about. But it is -- and from what -- it appears to be a legitimate organization. This is -- so, I'm going to overrule on foundation. And I've already overruled on --

MR. SIMON: Relevancy.

THE COURT: -- relevancy. You'll have an opportunity to cross, and the jury will give it its proper.

MR. SIMON: Thank you, Your Honor.

(Proceedings returned to open court.)

BY MR. SIMON:

Q. So, Doctor, back to the document, under background. And this is a Missouri publication, correct?

A. Correct.

Q. Okay. And, by the way, you're familiar with the

Missouri Hospital Association, right?

A. Correct.

Q. And this is their publication, correct?

A. I believe so.

Q. Okay. And, Doctor, it says the fastest -- you've got a copy in front of you, correct?

A. I do.

Q. It says, "the fast growing drug problem across the U.S. and in Missouri is the misuse and abuse of opioid-based pain relievers."

Do you agree with that?

A. That is what the article says, yes.

Q. Okay. Do you agree with it?

A. I think the abuse and misuse of opioids is a fast growing problem, and we were aware of that, yes.

Q. Okay. And by we you're talking about St. Louis University, correct?

A. Correct.

Q. And SLUCare, correct?

A. Correct.

Q. Okay. And SLUCare was aware of this information and this problem years ago, correct?

A. We regularly monitor reports from the Missouri Hospital Association and the State Department of Public Health, and, so, yes, these have been becoming -- come to

our attention, yeah.

Q. Okay. And so, Doctor, St. Louis University was aware of this problem with opioid abuse of opioid prescription medication during the 2008 to 2012 time period; would you agree with that, sir?

A. I would have to doublecheck on the time period. What I can say is, from this article, it has to do mostly with emergency department visits. And I do know that our emergency department physicians working at St. Louis University Hospital regularly track this, and from our part of the practice we were not seeing this as a problem coming to the attention on the ambulatory practice for SLUCare.

Q. Okay. And, Doctor, my question is, this information -- are you telling me that SLU was not privy to this information, St. Louis University?

A. That's not what I said, sir. I think we were aware that there was an increase in use and misuse and abuse of opioids during that time period, yes.

Q. Okay. And, Doctor, you would agree that there's a major, serious problem with prescription opioid narcotics. Would you agree with that, sir?

A. I think there's a problem with opioid narcotics misuse and abuse, yes.

Q. Okay. And that problem has gone on for at least

two decades, correct?

A. I couldn't speculate as to the time period. But it has gone on for quite a while, yes.

Q. And it's been escalating, correct, Doctor?

A. It has been increasing.

Q. Okay. And the same document says, "across the U.S. consumption of opioid analgesics increased by 300 percent between 1999 and 2010."

Is that correct?

A. That's what the article says, yes.

Q. Okay. And then it says, "this rate of use was parallel by chronic nonmedical use of opioids resulting in death. Since 2002, deaths from prescription drugs have surpassed those of cocaine and heroin combined."

Have I read that correctly?

A. You have.

Q. The rate of overdose deaths increased by nineteen percent per year from 2000 to 2006.

Have I read that correctly?

A. Yes.

MR. SIMON: May I approach, Your Honor?

THE COURT: You may.

BY MR. SIMON:

Q. Doctor, I'm handing you another exhibit that's been marked as 50-16. And this is from the New England

Journal of Medicine. Is that correct, Doctor?

A. Yes, sir.

Q. Okay. You recognize that publication, correct?

A. I do.

Q. Okay. And that's a very well respected, well recognized medical publication, correct?

A. Indeed.

Q. Okay. And the title of this is A Flood Of Opioids, A Rising Tide of Deaths. Correct?

A. That is the title.

Q. And what was the publication date -- or what's the date on this document?

A. November 18th, 2010.

Q. Okay.

MR. VENKER: Your Honor, may we approach?

THE COURT: You may.

(The following proceedings were held at the bench.)

MR. MAHON: Judge, I think we have to make the same objection again to the use of this medical article. Lack of foundation. I'm citing to the Barker versus Schisler, 329 S.W.3d 726, from the Southern District, 2011, Page 731. "In order to use written material to cross-examine an expert, the propounding party must establish that said material is generally accepted and

regarded as authoritative within the profession. The witness' mere familiarity with the text is not sufficient."

Basically it's just the point we made earlier, that the proper foundation has not been laid to this. That's what the objection is.

THE COURT: Can I see that?

MR. MAHON: That's got some markings, sorry.

THE COURT: That's okay.

(There was a discussion held off the record.)

THE COURT: So your objection is that while you agree he's familiar with it, that there's been nothing that establishes that it's authoritative --

MR. VENKER: Correct, Your Honor.

THE COURT: -- within the profession?

MR. VENKER: Correct.

MR. MAHON: Correct.

THE COURT: All right. Reading this case, it says, "the propounding party must establish that said written material is authoritative through his own expert, outside the hearing of the jury, or during cross-examination of the opposing expert."

MR. VENKER: This is basically an adverse party, an adverse witness to them, Your Honor.

MR. CRONIN: Your Honor, there is another case

cited in their trial brief, which they told us they agreed how we could do this, and now we're hearing we can't do it the way that we're doing it. And to admit it as evidence, we have to establish authoritativeness. There's another case that says that you can read statements from it to the opposing party, or their expert, and ask if they agree without establishing authoritativeness. It's in their trial brief. I don't have those cases with me, because they filed something saying they agreed that we could do it.

THE COURT: Because the next line says, "once this prerequisite is met, counsel may cross-examine the opposing expert by framing a proposition in the exact language of the text or treatise and asking the witness whether he or she agrees with it."

MR. VENKER: That's what they're trying to do, sure.

THE COURT: So you're saying there's something that says you don't have to have one?

MR. CRONIN: We don't have to establish authoritativeness to read statements from medical literature and ask if they --

MR. SIMON: Judge, I think he's already testified to that. Also I asked him if it was a well-recognized, highly respected -- I mean, I think he's

ready said enough to establish -- even if we have to comply with that requirement, I think he's already given it to us. This is the New England Journal of Medicine, Your Honor.

MR. MAHON: We did cite to Grippe versus Momtazee, 780 S.W.2d 551 (1986), out of the Eastern District, where we cited to that in our trial brief, and it says, "a prerequisite to the use of scientific texts and treatises in the examination of an expert witness is evidence that they are authoritative." And in this Grippe case it involves something from the New England Journal of Medicine. So I think it's the very same text that we are talking about.

MR. VENKER: Very same article.

MR. MAHON: Very same article. Sorry.

MR. VENKER: It's all right.

MR. SIMON: Your Honor, if I could --

THE COURT: Hold on.

MR. SIMON: I apologize.

THE COURT: All right. How do you know that this is from the new England -- this is from the New England Journal of Medicine?

MR. MAHON: Right there. New England Journal of Medicine.

THE COURT: All right. So, prior to being

handed this I would have a different opinion on it. My little knowledge of the general medicine would have given it a higher prestige than 99.9 percent of the articles. But this case says that it is not authoritative and it's merely expressing opinions and those types of things.

So, while I do think it is a -- any internal medicine doctor would be aware of the New England Journal of Medicine, based on this it doesn't rise to the level -- unless you --

MR. CRONIN: It's in response to their trial brief, Judge. The understanding of what the trial brief says -- we got here for pretrial, and we were told we agree with that. Now we're in the middle of doing it and we're being told they don't --

THE COURT: All right. Help me out with number two. Because number two it specifically says you don't have to establish -- and that plaintiffs agree that these are --

MR. MAHON: I guess we have to look at the Gridley versus Johnson case.

THE COURT: That's what this is right here. Gridley versus --

MR. CRONIN: That's my response to theirs -- here's that --

MR. MAHON: That's Gridley.

THE COURT: That's Gridley right there. That's the one --

MR. MAHON: Yeah, so, I think, Page 481 -- yes, so this case, Grippe versus Momtazee, says you need to have authoritativeness first.

THE COURT: Look at the last line. It says --

MR. VENKER: The cite to Gridley says you have to be authoritative.

THE COURT: Right. And then this says despite -- this says we don't have to do it. If I'm reading it right.

MR. VENKER: Okay. So, the -- so Grippe versus Momtazee cites the Gridley, the case we're talking about the plaintiffs have in their briefs. Here's what the Appellate Court here says.

THE COURT: I agree, the Appellate Court says -- I'm in agreement.

MR. VENKER: Right.

THE COURT: It appears that you guys have worked out an agreement that says you don't have to do that.

MR. VENKER: No, I didn't. My understanding was that they agreed with what we said in our trial brief. That's what I understood.

THE COURT: What does your trial brief say?

MR. VENKER: They're quoting Gridley versus

Johnson, the opposite proposition.

MR. CRONIN: I just went straight to the cross-examine section.

THE COURT: Okay. These two reconcile.

MR. VENKER: No, they don't. I think it's just their response. I thought -- what I understood was they agreed with our brief. I haven't read this plaintiff's response. This doesn't say it's a consent form or anything, it just says plaintiff's response.

MR. SIMON: Judge, I can help us here. I will go ahead and lay a foundation, and if I don't lay an appropriate foundation with this witness, I'll move on.

THE COURT: Okay.

MR. SIMON: Okay? We'll save everybody some time.

(Proceedings returned to open court.)

THE COURT: All right, you may proceed.

MR. SIMON: Thank you.

BY MR. SIMON:

Q. Doctor, you've got in front you the article from the New England Journal of Medicine; is that correct?

A. Yes, I do.

Q. It's marked as 50-16; is that right?

A. Correct.

Q. And you're certainly familiar with the New

England Journal of Medicine, correct?

A. Yes.

Q. Is it a very well known, well respected medical journal?

A. Yes.

Q. Is it, you know, read, reviewed, relied on by physicians across the United States?

A. Yes.

Q. Okay. And you certainly consider it to be authoritative on medical issues for physicians across the United States?

A. It's one of the top medical journals.

Q. Okay. Doctor, back to the content. This is -- the title is A Flood Of Opioids, A Rising Tide Of Deaths. Correct?

A. That is the title.

Q. It looks like it was published November 15th of 2010, right?

A. I have November 18th.

Q. I'm sorry. November 18th. Thank you. And it says, "according to the Centers for Disease Control and Prevention, deaths from unintentional drug overdoses in the United States have been rising steeply since the early 1990s and are the second leading cause of accidental deaths, with 27,658 such deaths reported in 2007."

Correct?

A. Correct.

Q. "That increase has been propelled by a rising number of overdoses of opioids, synthetic versions of opium, which caused 11,499 of the deaths in 2007, more than heroin and cocaine combined."

Is that correct?

A. Correct.

Q. "Visits to emergency departments for opioid abuse more then doubled in 2004 and 2008, and admissions to substance abuse treatment programs increased by 400 percent between 1998 and 2008, with prescription pain killers being the second most prevalent type of abused drug after marijuana."

Have I read that correctly?

A. Yes, you have.

Q. And this is not new information in 2016, is it, Doctor?

A. No, it is not.

Q. Okay. St. Louis University and SLUCare and Dr. Walden and you have known about this problem, this epidemic, for some time now, correct?

A. We would have known about the increasing problem with opioids, yes.

Q. Okay.

MR. SIMON: And, Mike, if you could please -- one more --

BY MR. SIMON:

Q. You're certainly familiar with the CDC, right, Doctor?

A. Yes, I am.

Q. And I don't think we need to put this up. You know that the CDC has a publication listing the same types of statistics, correct?

A. Yes.

Q. Okay. And, in particular, Doctor, I'm reading from a document that the jury has already seen, it's Exhibit 50-6, and a couple things I want to cover with you. On Page 4 -- and this is from the CDC guideline for prescription opioids for chronic pain. And it says, "the Drug Abuse Warning Network estimated that more than 400 in 20,000 emergency department visits were related to the misuse or abuse of narcotic pain relievers in 2011."

Do you agree with that, Doctor?

A. I don't know which issue you're quoting from. Is that the Mortality or Mortality Weekly? I haven't seen it, so --

Q. Okay. Let's pop it up real quickly. 50-6, Page 4. Okay. And next column on the --

MR. SIMON: Go up, I think, Mike. To the left.

Uh-huh.

BY MR. SIMON:

Q. Okay. And right down there it says the drug -- let me see. Excuse me. Okay. You see it here, Doctor? This is a document from the CDC, and you see where it says, "the Drug Abuse Warning Network estimated that more than 420,000 emergency department visits were related to the misuse or abuse of narcotic pain relievers in 2011, the most recent year for which data are available."

Have I read that correctly?

A. You have read it correctly. I don't know when that was published.

Q. It was published in of 2016, Doctor.

A. Thank you.

Q. Okay. Any reason to dispute that information from the CDC, Doctor?

A. Would not be a matter of dispute, no.

Q. Okay. And, so, Doctor, we're talking about 420 -- and the problem has increased or escalated since 2011, correct?

A. From the information that you provided here, as you can -- and as made available in 2016, on the basis of 2011 information, it seems clear that the problem is increasing, yes.

Q. Okay. And, so, Doctor, to put the problem in

perspective, what we're talking about -- assuming the numbers from 2011 didn't go up, we're talking about 1,153. 1,153 emergency room visits per day for opioid narcotic pain prescription.

A. Misuse or abuse.

Q. Okay. And we're going to talk about that, Doctor. The New England Journal of Medicine said that it's -- the number of deaths is over 11,600 or so a year, correct? In the year that they're quoting. Right?

A. 11,499 is the number I see here, but --

Q. Okay. So 11,500. So, Doctor, again, we're talking about 1,153 emergency room visits a day, and 31 people dying every day, seven days a week, thirty days a month, 365 days a year, from prescription opioid narcotics.

A. Any death due to a medication is tragic, and the problem with these medications is they're powerful and subject to misuse and abuse by patients, or to being misdirected or misappropriated. I agree with you, this is a problem.

Q. Okay. And, Doctor, all prescriptions -- all of these prescriptions that we're talking about need to be written by a physician?

A. Correct.

Q. In other words, every one of these deaths, these

31 deaths that we see every day, those individuals got those opioid narcotics -- they were written through a prescription, correct?

A. Not necessarily for them. Many of those deaths are due to misuse or misappropriation or mal-direction, which is one of the reasons why the State tracking programs would be useful to prevent deaths, because it would help prevent misuse or misdirection.

The -- again, these are powerful medications that can be very helpful for people with disabling and debilitating pain, and any death for any of these folks is tragic. This is a problem.

Q. It doesn't start or happen without a prescription, correct, Doctor?

A. That is correct. And those prescriptions are provided for patients that have a medical indication for them.

Q. And the doctor is the one with the prescription pad, correct? The doctor writes the prescription?

A. We actually don't use pads anymore. But the doctor does write the prescription, yeah.

Q. Okay. Doctor -- and the jury has -- has heard all of this already, and I'm not going to go into it in detail, but these things are highly addictive, correct?

A. The medications you quickly develop tolerance

to, and they have a high propensity for addiction. This is a known problem. And so we monitor all of our patients when we prescribe these medications, yes.

Q. Okay. They can lead to psychological dependence, physical dependence, mental impairment, physical impairment, respiratory depression and death, correct, Doctor?

A. Those are the listed complications and side effects. And, again, you're balancing the benefit of trying to live with terrible debilitating pain on the one hand versus accepting some of these effects, and the trick is to make sure that you find the right dose that maintains patient's functional capacity so that they can live a life that's not dominated by pain.

But, again, this is a problem. No -- no death, for whatever reason, is anything other than tragic.

Q. Okay. And, Doctor, these risks, including death and impairment, depression, dependence, addiction, those are all things that St. Louis University knew way before 2008, correct?

A. Yes, sir.

Q. Doctor, do you agree that a doctor should serve the highest interest of his or her patient?

A. I do.

Q. Do you agree that doctors are not allowed to

needlessly endanger their patients?

A. I do.

Q. And do you think not following those rules violates the standard of care for a physician?

A. Which rules are you talking about, sir?

Q. The ones I just asked you about, Doctor.

A. You mean the highest care and --

Q. Yes, sir.

A. That would be inappropriate for a physician, correct.

Q. Okay. Same with putting their patients needlessly in danger. That violates the standard of care, correct, Doctor?

A. Putting any patient needlessly at risk would be a wrong thing to do.

Q. Okay. And, Doctor, do you agree, does St. Louis University agree, that opioids should not be used if safer alternatives are available?

A. We agree.

Q. Does St. Louis University agree that when prescribing opioids the lowest possible effective dose should always be used?

A. Generally, yes.

Q. Does St. Louis University agree that opioids should be used for the shortest time necessary?

A. Yes.

Q. Does St. Louis University agree that a physician must continuously evaluate the safety and effectiveness of the opioid therapy?

A. We expect that for all medications we prescribe, so, yes, for opioids, absolutely.

Q. Okay. Does St. Louis University agree that the amount of narcotics given to a patient must be monitored?

A. We agree that the therapy should be monitored by the prescribing physician.

Q. Okay. Doctor, should St. Louis University monitor the amount of narcotic opioids that is prescribed to its patients?

A. Not to this point, because it had not risen to an area in our practice where we were seeing attributable suffering from or death from our patients in our ambulatory practice. So we monitored adverse events, and our providers' credentials and privileges, we took in patient comments and complaints, and had numerous mechanisms for doing those, and we worked with our affiliated teaching hospitals to take a look at patient outcomes under the inpatient and outpatient setting.

And in our practice we were not seeing a reason at that time to monitor opioids specifically any differently than we might monitor other arthritic

medications, or we might monitor heart medications.

So during the time period in question we were not monitoring opioid analgesics as a practice.

Q. Okay. Doctor, do you believe the amount of opioid narcotics given to a patient should be continuously monitored?

A. By the prescribing physician, yes.

Q. Do you agree, does St. Louis University agree, that the patient must be continuously monitored for signs of abuse, misuse or addiction?

A. By the doctor who's working with the patient. It's in the doctor-patient relationship, yes.

Q. Okay. And if a doctor believes his or her patient is addicted, do you agree that the doctor should help that patient get off the medication?

A. Actually, there are some circumstances in which a patient is tolerant and habituated to the medications where actually it's the best care for them to continue to use those medications rather than to suffer and be debilitated by pain.

So the addiction, per se, really has to be judged in light of what's in the best interest of the patient. Which I already indicated is what we expect our treating physicians to focus on.

Q. Doctor, what about a back strain?

A. What about a back strain?

Q. What about a back strain? If a patient is addicted to opioid narcotics, and they're taking them for a back strain, you think it's okay to keep the patient on opioid narcotics?

MR. VENKER: Just object to the vagueness of the question, Your Honor.

A. I really couldn't --

THE COURT: Hold on, Doctor. Rephrase. Tighten it up a little bit.

BY MR. SIMON:

Q. Doctor, we just watched Dr. Walden's deposition, and he said that his diagnosis was back strain, muscular strain, for Mr. -- have you read Dr. Walden's deposition in this case?

A. No, I have not.

Q. Okay. Well, I'll ask you, Doctor, to assume that -- that Dr. Walden, in his deposition, diagnosed back strain or sprain. Musculoskeletal strain.

MR. VENKER: Your Honor, I'm just going to object to asking this witness about another witness' testimony. I don't think that's proper. I object on those grounds.

THE COURT: Overruled.

MR. SIMON: I'll rephrase, Your Honor.

THE COURT: Rephrase.

BY MR. SIMON:

Q. Do you believe that a patient who is fully addicted to opioid narcotics should help be weaned from the medication, Doctor?

A. It depends on whether or not there is alternative or better therapies to help them manage their pain.

Q. Okay. Do you agree that a doctor must never continue opioids just because the patient is addicted?

MR. VENKER: Object to the vagueness.

THE COURT: Rephrase.

BY MR. SIMON:

Q. Do you agree, Doctor, that a -- a Doctor must never continue opioids solely because the patient has become addicted to them?

A. You know, honestly I think that's out of the scope of my practice, that -- you're asking questions that would be more appropriately directed to a pain management physician. So, I -- I can't -- I can neither agree nor disagree.

What I can agree on is that the treating physicians should always try to find the least amount of medication that will work to help the patient maintain good functional capacity with debilitating pain.

Q. And, Doctor, what about when a patient is addicted? When a patient has become addicted to prescription opioid narcotics, given to the patient by their doctor. When the patient is addicted, do you think it's proper for the physician to abandon the patient after they become addicted?

A. No. I think the doctor-patient relationship is such that the treating physician should try to help a patient that wants to get off of these medications to work with the right care provider or the right team to be able to accomplish that. Sometimes patients can get off, sometimes they can get on lower doses.

But, again, it really does come down to the doctor and the patient working together.

Q. Okay. Doctor, are you familiar with the CDC guidelines for dosage amounts?

A. I don't have a working knowledge of them right now, no.

Q. Okay.

MR. SIMON: Let's go, please, to Exhibit 50-6, Mike. Page 18.

MR. VENKER: Your Honor, may we approach?

THE COURT: Yep.

(The following proceedings were held at the bench.)

MR. VENKER: I just want to make an objection. I don't think my earlier objections dealt with guidelines per se. We've made that objection throughout. I just want to make sure I preserve that objection now. Because I think John talked to Dr. Heaney in terms of CDC general statistics, that was in that document, but not guidelines per se.

So I just want to object -- renew or objection to guidelines being brought into evidence. These CDC guidelines, as we know, are from of 2016, so they are irrelevant. They're also guidelines. They're not the standard of care.

So, again, I also want to incorporate all the earlier objections we've made on that issue in this case, Judge.

THE COURT: Your response?

MR. SIMON: Judge, it's already been ruled on multiple times. The guidelines are relevant for all of the reasons we discussed earlier on the record.

THE COURT: All right. Your objection is overruled, but it's noted as a continuing objection.

MR. VENKER: Thank you, Your Honor.

(Proceedings returned to open court.)

MR. SIMON: Okay, Mike, if we could, let's go to 50-6, Page 18.

BY MR. SIMON:

Q. Okay. And, Doctor, I will tell you that this is from the Center for Disease Control, CDC, guidelines for prescribing --

MR. VENKER: Do you have a copy for the witness that he could actually look at?

MR. SIMON: Sure. May I approach, Your Honor?

THE COURT: You may.

MR. SIMON: Here you go, Doctor. Page 18, Doctor. Mike, if you could go down to number five. Paragraph five.

BY MR. SIMON:

Q. Okay, Doctor, you see -- can you see paragraph five on the screen?

A. It doesn't match up. It doesn't match up to my Page 18 in this document.

Q. Is it Exhibit 50-6, Doctor?

A. It says Plaintiffs' Exhibit 50-6, and I am on Page 18, but I am not seeing what you --

THE COURT: Try Page 16.

BY MR. SIMON:

Q. I'm sorry, Page 16. You know what, I think the bottom right-hand side -- there's a Bates stamp number and a page number on the document. Do you see where it says -- it says 16 on the article, but it's Page 18 on the

Bates stamp number. Do you see it on the bottom?

A. I do have box 1, CDC recommendations.

Q. You found it?

A. Yes, sir.

MR. SIMON: Let's blow it up, please, Mike.

BY MR. SIMON:

Q. When opioids are started, clinicians should prescribe lowest effective dosage. You agree with that, right?

A. I think that's a good recommendation.

Q. Clinicians should use caution when prescribing opioids in any dosage, should carefully assess evidence of individual benefits and risks when increasing dosage to equal to or greater than 50 morphine milligram equivalents.

Do you agree with that?

A. I think that's the recommendation as of March of 2016, if I get the date on this right. I think that there's good -- I have no reason to call into question this CDC's recommendation.

Q. Okay. Was that a good idea back five years ago, Doctor?

A. I wouldn't be able to have an opinion on that. It was not the CDC's recommendation five years ago.

Q. Okay. Doctor, let me ask you this. You're an

internal medicine physician, correct?

A. I am, sir.

Q. Were you seeing patients five years ago?

A. Yes, I was.

Q. Were you treating patients with back pain?

A. Yes, I was.

Q. Were you prescribing opioid narcotics?

A. Yes, I was.

Q. Were you an employee of St. Louis University?

A. Yes.

Q. Okay. And did you concern yourself with how much dosage you were giving your patients of opioid narcotics?

A. Yes, I did.

Q. Okay. And let's say back in 2008. 2008, Doctor, would this statement be accurate back in 2008?

A. Again, what do you mean by accurate? I mean, is it -- should it be 45 morphine equivalents, should it be 55? I mean, the Center for Disease Control --

Q. Let's break it down.

A. -- is giving some guidelines.

Q. Let's break it down. I'll make it a little easier for you.

A. Oh, thank you.

Q. It says, "clinicians should use caution when

prescribing opioids in any dosage."

Is that a good idea today?

A. Yes.

Q. Was it a good idea back in 2008?

A. Yes.

Q. Okay. "Should carefully assess evidence of individual benefits and risks when increasing dosage to more than 50 morphine equivalent doses."

Is that a good idea today?

A. If -- yes.

Q. Was that a good idea back in 2008?

A. I don't know what the threshold might have been for morphine equivalent. What I will be happy to agree with you on is as you're increasing these doses you should absolutely be monitoring them, yes.

Q. Doctor, was that a good idea, that statement, back in 2008?

A. What do you mean by good idea?

Q. Good medical practice, Doctor.

A. You know, you can always look back and see if it was good now, and you could say it would have been good then. I don't know that we had the information at that point in time to set a particular threshold, that a particular morphine equivalent.

Q. Well, Doctor, what was your threshold back in

2007?

A. I'm not sure that anybody -- that I was aware of any particular threshold in 2007. So I can't testify to that.

Q. Okay. And let's go further, Doctor. It says, "and should avoid increasing dosage to more than 90 morphine equivalent doses per day, or carefully justify a decision to titrate dosage to greater than 90."

Have I read that correctly?

A. You have.

Q. Do you agree with that statement?

A. I agree that's the CDC's recommendations as of 2016.

Q. Is that safe medical practice, in your opinion? Does that constitute safe medical practice?

A. I think that's a good recommendation.

Q. Okay. Was that a good recommendation back in 2008?

A. I -- again, increasing doses and careful monitoring should be a part of any physician's practice when they're prescribing these medications.

Q. Okay. Let's go to 50-4, please. Okay. And, Doctor, this is a document the jury has already seen, and the reason I'm putting it up is you see the date on the bottom there, Doctor? Let's blow it up, please, there on

the bottom. It says March of 2007.

A. Thank you.

Q. And, Doctor, by the way, you were designated by St. Louis University to discuss these very issues with us in this case. Correct?

A. Yes, sir.

Q. You were -- you are here to provide us with information known by St. Louis University on those issues, correct?

A. Correct.

Q. Okay. And, so, let me ask you this. Are you telling us today that back in 2008 St. Louis University was not aware of any dosage guidelines for opioid narcotics?

A. No, I'm -- you asked me about my practice, and now you're asking about St. Louis University. So, emergency room physicians, obviously, and other physicians that treat pain I'm sure would have been aware of this. Concerns did not come -- rise to the level of practice administration or policy or procedure, or University policy or procedure, because we were not seeing that level of problem in our ambulatory practice during that period of time.

So, you know, I -- I don't think that the University, for instance, would be aware of -- at a

corporate level, about precisely what the right dose of a high blood pressure medication would be.

So if you're asking at a university or practice level whether or not we were aware of these particular guidelines, I would have to say that generally aware that this was an issue, but it had not risen to a level of concern that would have prompted us to put programs into place that would have added additional monitors.

Q. And you're comparing this to blood pressure medication, Doctor? Is that what you're doing?

A. Stroke medication, heart medication. I'm comparing it to any medications. Arthritic medications, which have their own risks.

Q. Doctor, we are in the middle of a blood pressure medication epidemic, overprescribing blood pressure medication?

MR. VENKER: Your Honor, I'm going to object to that question as argumentative.

THE COURT: Sustained. Move on.

BY MR. SIMON:

Q. Doctor, are -- are 30 people a day dying from overuse of blood pressure medication?

MR. VENKER: I'm going to object again as argumentative.

THE COURT: I'm going to overrule that one. You

can answer that question.

A. There are a lot of people that are dying daily from complications of hypertension, if it's mistreated or medications are abused. And some patients, I don't know how many, do die from hypertensive medications.

BY MR. SIMON:

Q. Doctor --

A. Again, any death from a medication misuse or abuse is tragic. The -- so -- please, I'm not trying to minimize in any way, shape or form that opioid medications are a problem, and I'm not trying to make a false comparison one way or the other.

Q. Fair enough. Doctor, these are guidelines from 2011.

MR. SIMON: Mike, please, if you could go to Page 003 of the document.

BY MR. SIMON:

Q. And, Doctor, that would be Page 3 on both counts. Page 3 of the document, and the Bates stamp number is 3.

MR. SIMON: Right-hand side, please. If you could, Mike, blow it up.

BY MR. SIMON:

Q. Okay. And, Doctor, these are inter-agency guidelines on opioid dosing for chronic non-cancer pain.

And it says, "in general the total daily dose of opioid should not exceed 120 milligrams of oral morphine equivalents."

Have I read that correctly?

A. Yes, you have.

Q. Was St. Louis University aware of this information in 2008?

A. Not to my knowledge. This is a state of Washington, and I don't believe there were any similar recommendations for Missouri at that time.

Q. Fair enough, Doctor. Next statement says, "rarely and only after pain management consultation should the total daily dose of opioid be increased above 120 milligrams oral morphine equivalents.

Have I read that correctly?

A. Yes.

Q. Was St. Louis University aware of that information in 2008?

A. At a corporate level, no.

Q. The next statement says, "safety and effectiveness of opioid therapy for chronic non-cancer pain should be routinely evaluated by the prescriber."

Was St. Louis University aware of that information in 2008?

A. At a corporate level, I've already said, I don't

think we were aware of this report. And I have already indicated that we agree with that statement. So --

Q. Doctor, the next statement says, "assessing the effectiveness of opioid treatment should entail tracking and documenting both functional improvement and pain relief."

Have I read that right?

A. Yes, you have.

Q. Did St. Louis University -- were they aware of that information back in 2008?

A. I think my answer is the same.

Q. Okay. The next statement in this document says, "a specialty consultation may be considered at any time if there is evidence of frequent adverse effects or lack of response to an opioid trial."

Have I read that correctly?

A. You have.

Q. Was St. Louis University aware of that information in 2008?

A. I don't think we were aware at the corporate level of this report. I do think that is good practice.

Q. Doctor, let's turn to Exhibit 36, please. Have you seen this document before, Doctor?

A. Not to my knowledge.

Q. Okay. This -- this is the -- well, let me ask

you this, Doctor.

MR. VENKER: Could I just make an objection to lack of foundation, Your Honor?

MR. SIMON: It's already been --

MR. VENKER: No, I mean this witness to be asked about it. He's already said he's never seen it before. So I'm objecting.

MR. SIMON: I'll explain it to him, Your Honor.

THE COURT: Explain.

MR. SIMON: Okay.

BY MR. SIMON:

Q. Doctor, are you aware of the amount of opioid narcotics Dr. Walden prescribed to Brian Koon?

A. No.

Q. Has anybody ever provided you with that information?

A. Not specifically, no.

Q. Okay. Doctor, were you aware -- were you aware that Dr. Walden had Brian Koon on more than 1500 morphine equivalent milligrams a day for over a year?

A. No.

Q. Are you okay with that amount? Do you believe that amount is excessive, or are you okay with it?

A. It's an unusually high dose.

Q. Okay. Doctor, do you believe 1,000 morphine --

morphine equivalent -- a dose of 1,000 -- we're talking about morphine equivalent doses. Do you believe 1,000 is an excessive daily dose?

A. I think it's an unusual dose.

Q. Okay. And, Doctor, my question is, do you believe 1,000 morphine equivalent -- milligrams, morphine equivalent dose, is excessive?

A. Depends on the patient and how the patient's pain is, what is necessary to control the pain, and how the patient is tolerating that, and whether or not they're maintaining their functional capacity.

So while it would be unusual, I'm sure there are some patients that would require a dose in that range. Again, from a corporate point of view, I don't have any information about that, so --

Q. Okay. And, Doctor, what about from a medical doctor internist specialist point of view. Do you believe -- do you believe 1,000 morphine equivalent dose is an excessive amount?

MR. VENKER: I'm just going to object to the vagueness again, Your Honor.

THE COURT: Overruled. You may answer.

A. That's an unusual dose.

BY MR. SIMON:

Q. Okay. 1,000 milligrams morphine equivalent

dose, you say that's unusual, correct?

A. Yes.

Q. Doctor, have you ever given that amount, 1,000?

A. No, I have not.

Q. Do you know any other physicians who have ever given a morphine equivalent dose to a non-cancer patient of 1,000 or more?

A. I don't know specifically. I'm sure there are physicians that -- pain management physicians that have used those doses. But I don't know any specifics.

Q. You've never seen it happen, correct?

A. Again, are you asking a corporate, or in my personal practice?

Q. Either way.

A. I have not seen that in my personal practice.

Q. Okay. So you've never seen it at all, ever, 1,000 milligrams a day; is that correct?

A. None of my patients have needed that for controlled pain in maintaining their ability to get on with their life. Yeah.

Q. Okay. And, Doctor, let me ask you this. Would you agree that 1,000 milligrams a day is an excessive dose?

MR. VENKER: Object as asked and answered, Your Honor.

THE COURT: Sustained.

BY MR. SIMON:

Q. Do you remember what you told me in your deposition, Doctor, when I first asked you that very first?

A. I think I talked about what, in different patient populations, a mean might be for control of pain, and a dose in that range would be probably about two standard deviations above that mean. If I remember the deposition correctly.

Q. Okay. And, Doctor, do you remember in the deposition me asking you do you feel 1,000 milligrams of morphine equivalent dose is an excessive amount on average over the course of a year? Do you remember me asking you that question?

A. Not specifically, but I'm sure you did.

Q. Okay. Do you remember giving this answer.

MR. SIMON: Go ahead, Mike, Page 46, line five.

MR. VENKER: Your Honor, I'm going to object to the deposition transcript being put up on the screen. Your Honor, may we approach?

MR. SIMON: I don't need to put it on the screen, Your Honor.

THE COURT: Okay.

MR. VENKER: What page and line number?

MR. SIMON: Page 46, lines five through six.

BY MR. SIMON:

Q. Doctor, do you remember me asking this question, and you giving this answer?

Question: Okay, and assuming -- Doctor, do you feel 1,000 milligrams of morphine equivalent dose is an excessive amount on average over the course of a year?

Answer: I would like to take a quick time-out at this point in time, if I may.

Do you remember telling me that in the deposition?

A. I remember asking for the time-out. If that's when it was in the deposition, I'm sure that's correct.

Q. You didn't know how much -- how much opioid narcotics Dr. Walden prescribed to Brian Koon, did you, at the time I took your deposition?

MR. VENKER: Your Honor, may we approach?

A. I don't know now.

MR. VENKER: Your Honor --

THE COURT: Hold on. Approach.

(The following proceedings were held at the bench.)

MR. VENKER: Your Honor, this was the corporate designee deposition of Dr. Heaney. I objected at that point to this whole line of questioning, about Dr.

Heaney's personal practice, because he was not noticed up as a person, he was noticed up as personal designee of SLU. I objected to anything about personal practice.

MR. SIMON: The objection was overruled. We had a special master, Judge Bresnahan, the objection was overruled. Goes to the weight. He answered by saying I need a time-out, I need to take a break.

MR. VENKER: So what.

MR. SIMON: Then they took a break. A twenty-eight minute break. And we came back with three minutes of running objections, and then I couldn't get the man to answer the question.

I think it's cross-examination, he's a defendant in this case, represents St. Louis University, I'm entitled to bring this out.

THE COURT: All right. I'll give you some room, but let's not be on it all day.

MR. SIMON: Yes, sir.

(Proceedings returned to open court.)

BY MR. SIMON:

Q. Doctor, at the time you gave a deposition in this case -- which would have been on May 31st this year, of 2016, correct?

A. I trust your report, yeah.

Q. Okay. And you didn't know how much medication

Dr. Walden had prescribed to Brian Koon at that point, correct?

A. That is correct.

Q. And I asked you if 1,000 milligrams was excessive. Do you remember that?

A. It's in the deposition, yes.

Q. Okay. And your answer was you wanted to take a break out of the deposition, correct?

A. No, I asked to take a break at that point. That wasn't an answer.

Q. Okay. You took a twenty-eight minute break; is that right?

MR. VENKER: Objection, Your Honor, it's argumentative.

MR. SIMON: I'll move on, Your Honor.

BY MR. SIMON:

Q. Okay. Doctor, do you have -- as a physician, as an internal medicine doctor, do you have any problem or concern with Dr. Walden prescribing 1500 milligrams a day for an entire year to Brian Koon?

A. For medication doses in that range, I expect Dr. Walden to monitor his patient very closely and to keep track of any signs or symptoms of adverse effects and, yeah, the concern goes up with the increasing doses. So, yes.

Q. Okay. Would you personally have a problem with that, Doctor?

MR. VENKER: Asked and answered, Your Honor. Object.

MR. SIMON: Your Honor, I think he said he would leave it to Dr. Walden to monitor the patient. I'm asking him what he thinks about it.

MR. VENKER: Well, I'm just going to object to the phrasing would you have a problem. That is really -- I think that's argumentative.

THE COURT: Sustained. Rephrase.

BY MR. SIMON:

Q. Would that be negligent, Doctor?

A. No.

Q. Would it breach the standard of care?

A. No. It depends on the care of the patient.

Q. Okay.

MR. SIMON: Mike, if you would, please, let's go back to Exhibit 50-6, and Page 4. Let's go down to the -- what's underlined in red, please, Mike.

BY MR. SIMON:

Q. Page 4, Doctor. Okay. Doctor, this is the CDC guideline, and it says, "for example, a recent study of patients aged 15 to 64 years receiving opioids for chronic non-cancer pain, and followed for up to 13 years, revealed

that one in 550 patients died from opioid-related overdose at a median of 2.6 years from their first opioid prescription."

Was St. Louis University aware of this -- was St. Louis University or their physicians aware of this information?

A. At a corporate level, I would say no.

Q. Was St. Louis University's physicians aware of this information?

A. Some of them may have been familiar with this. Those that specialized in pain or pain management, yes.

Q. Okay. It goes on to state that -- "and one in 32 patients who escalated to opioid dosages greater than 200 morphine milligram equivalents died from opioid-related overdose."

Have I read that correctly?

A. Yes, I see it.

Q. Okay. And, Doctor, was this information known by St. Louis University or its physicians?

A. Again, at a corporate level -- this is coming from a document published in of 2016 -- I don't know that we were aware of that at that time.

Q. Okay. When did St. Louis University become aware of it?

MR. VENKER: Aware of what, Your Honor? I'm

just going to object to vagueness.

BY MR. SIMON:

Q. This information, this study, where one in 32 patients who get more than 200 milligrams a day die.

MR. VENKER: Your Honor, this is a footnote in this guideline we're talking about. I think it's unfair to ask this witness that question.

THE COURT: Overruled. He can answer if he knows. Or rephrase.

BY MR. SIMON:

Q. Go ahead, Doctor.

A. At the moment I don't know whether or not we have any working group that has this information as part of our planning for the practice.

Q. So, Doctor, let me get this straight. St. Louis University has four hundred fifty physicians, correct?

A. We do not have pain management service in the SLUCare physician group, no.

Q. You have four hundred fifty physicians, correct?

A. About that.

Q. A hundred and sixty involved in internal medicine, right?

A. Right.

Q. And those hundred and sixty, I take it, prescribe opioid narcotics, right?

A. Not all of them.

Q. Okay. Do some of them? Most of them?

A. Some.

Q. Okay. How many?

A. I don't have that information.

Q. Half of them?

A. Probably a majority.

Q. Okay. The majority of the physicians, of a hundred and sixty internal medicine doctors, the majority prescribe opioid narcotics to their patient?

MR. VENKER: Your Honor, I object to the relevance of any of this line of questioning of what --

MR. SIMON: Cross-examination, Your Honor.

MR. VENKER: -- these physicians are doing now as opposed to the relevant time frame for the care, Your Honor, I object.

MR. SIMON: Your Honor, I'm laying a foundation for it so I can ask him if he was aware of this earlier.

THE COURT: Overruled. You may proceed.

BY MR. SIMON:

Q. Okay. So, Doctor, not to belabor this, St. Louis University is in the -- in the business of practicing medicine, correct?

A. Yes, sir.

Q. Hundreds of doctors doing so, right?

A. Correct.

Q. And they're prescribing -- some of them are prescribing opioid narcotics, correct?

A. Correct.

Q. And there's a study that we're looking at right now from the CDC saying that patients who get more than 200 a day, one in 32 die from overdose.

Is that what you're reading up here, Doctor?

A. That's what I'm reading.

Q. And my question is, did St. Louis University or its doctors know about that? And if, so when.

A. I'm sure some physicians in SLUCare were aware of that. I don't know when. And what I can tell you is that this information, as of today, has not yet risen to the point where we would have changed any of our practices or monitoring regarding safe use of these agents. We have and continue to rely on the doctor-patient relationship and our licensed independent providers to monitor their patients.

Thirty -- again, not to minimize any death, 31 of those patients out of the one in 32 apparently did okay and needed those medications.

Again, any death is tragic. And I have already indicated that corporately and individually we are aware that the higher the doses of these medications that are

used, the greater the potential problem, and the more we have to monitor the patients.

Q. And, Doctor, you see where it says the study of patients was receiving opioids for chronic non-cancer pain. Correct? These weren't patients dying of cancer, correct?

A. I read that.

Q. Okay. All right. And, so, Doctor, let me ask you this. When were you personally aware of this study?

A. Now.

Q. Okay. Based on -- based on what you know now, Doctor -- based on what you know now, do you feel that giving Brian Koon 1500 milligrams a day is excessive?

MR. VENKER: Your Honor, I'm just going to object to the relevance of this, again it is well outside the care time period of 2008 to 2012. Object on those grounds.

THE COURT: Your response?

MR. SIMON: Doctor, I was asking -- Your Honor, I'm asking the question -- Mr. Koon was treated from '08 to '12. The question assumes the time period.

THE COURT: Yeah. With that narrowing factor, you may answer.

BY MR. SIMON:

Q. Doctor?

A. We relied on Dr. Walden to take good care of Mr. Koon, and he was monitoring the doses and the medications that he was giving him, his response to those in terms of pain control and his ability to get on with his life.

So, I have already indicated that those are unusual doses, and we relied on Dr. Walden to do this carefully.

MR. SIMON: Put up 170-4, please.

MR. VENKER: Your Honor, may we approach? Take that down, Mike, please.

THE COURT: You may.

(The following proceedings were held at the bench.)

MR. VENKER: Your Honor, it looks like Mr. Simon plans to try to ask Dr. Heaney about the July 2012 letter that's referred to as the PROP letter. Which one of our experts, Dr. Gunderson, is a signatory on. We argued this the other day -- yesterday, I guess -- when he tried to use it then with his expert, Dr. Genecin.

I'll make the same objections now to the attempt to use it here. Dr. Heaney is not a party of this letter, he wasn't an author, he wasn't involved in it, he knows nothing about it, as far as I know, and to ask -- to allow Mr. Simon to cross-examine him on this letter would really

be quite unfair. He's going to have Dr. Gunderson here, he can cross-examine him. He's coming tomorrow to testify. He will be here tonight, but in court tomorrow to testify.

So I think it's inappropriate and objectionable to allow him to question Dr. Heaney on this -- on this letter, which has been identified by John before he started this line of questioning.

THE COURT: Didn't I already rule on this?

MR. SIMON: That was me not being able to use this letter with my own expert. With Dr. Genecin. I believe it was redirect. It was redirect. And it was an issue in terms of procedurally how I was using it. And the issue, I believe, Judge, was it was improper to use this on redirect. But it was proper to use this on cross-examination of their experts and their witnesses.

This is simply -- this is a letter from the Physicians for Responsible Opioid Prescribing. It is dated July 25th, 2012. And this letter undermines what this witness has just testified to about opioid dose amounts. Specifically it recommends, you know, the labels be changed on these medications to limit the dosage to 100 milligrams of morphine a day, and for duration of 90 days.

The other thing is that this letter is back in 2012, and this witness has already testified he's not aware of information or any guidelines that existed during that

time period. It certainly -- there's no question about the foundation or authenticity, they wrote it. Their expert signed the letter. He's a signatory to the letter. They're going to see it, it's coming in.

This guy -- I don't want to bring him back. I would like to use this letter to cross-examine him about the opinions and issues that he just told us about dosage guidelines. It's clearly relevant and it's their document.

MR. VENKER: Judge, we can bring in ten different letters from ten different people and start cross-examining witnesses about it. What's the point? This witness knows nothing about this letter. He has nothing to do with it. You're basically going to be asking what the intent of the letter writer is. How is Dr. Heaney going to know that? So this is some letter from some team --

THE COURT: How are you going to use this letter --

MR. SIMON: I'm going to --

THE COURT: -- with this witness?

MR. SIMON: I'm going to say it's -- are you aware of -- have you seen the Physicians for Responsible Opioid Prescribing, it's dated, it's the same thing I would do with an article, Judge, except I don't need to lay foundation, because their expert wrote. It is the

same principle. You don't need foundation. We don't need authenticity. I'm going to say that there's a group, Physicians for Responsible Opioid Prescribing, and they wrote a letter in 2012 to the FDA trying to get label changes on opioid narcotics to limit dosages to 100 milligrams a day for 90 days, and this was back in 2012, and it goes to cross-examine this witness on his statements that there's no dosage guidelines.

THE COURT: Okay. So your issue that you're attacking is whether there are dosage guidelines in 200 -- at the time --

MR. VENKER: This is a letter asking for labeling issue, Your Honor, this is not even asking for guidelines.

MR. SIMON: Even more general than that. We're having a dispute in this case about what dosage is proper. We're saying it should be 100. This guy is saying it can be 1500 for back strain or back pain. I can -- I'd like to cross-examine him with a document from the Physicians for Responsible Opioid Prescribing saying that it should be limited to 100 for 90 days. It's as simple as that.

THE COURT: So, wait. Is your argument do you agree or disagree?

MR. SIMON: Yes, I'll ask him if he agrees or disagrees.

THE COURT: So you're asking him does he agree or disagree --

MR. SIMON: We --

THE COURT: -- that the opioids ought to be at a certain level?

MR. SIMON: Yes, sir.

THE COURT: Isn't what he's been doing with every --

MR. SIMON: That's my point. I've been doing the same thing with everything.

MR. VENKER: This is a letter -- this is a letter, Judge, written by somebody else. Why would we ask this witness to try to figure out what these people who wrote this letter intended. What they want to do, Judge --

MR. SIMON: Judge, I'm not going there.

MR. VENKER: Dr. Gunderson will be here tomorrow. This is going to lead --

MR. SIMON: This isn't just Dr. Gunderson.

THE COURT: Let me make sure I understand. Everything else we've seen so far has been guidelines, have been --

MR. SIMON: Same thing, right.

MR. VENKER: This is a letter.

THE COURT: Hold on. Hold on. That's what I'm

trying to get to. How is this the same? Because this doesn't appear to be the same.

MR. SIMON: Well, because this is even more -- more relevant because it's from a group of physicians, and it's called Physicians for Responsible Opioid Prescribing. It even -- it is even more narrowly focused to physicians who know about this issue.

THE COURT: Okay. I get what this is. But how does this relate to this?

MR. VENKER: Right.

MR. SIMON: Because he has said that -- he's given -- he's flat out said that 1500 milligrams a day is fine. And when I presented him with the 2016 he suggested and inferred there were no guidelines, there was no consensus back in 2012, this is 2016 and it just came about. That's the impression he left with the jury.

I want to use this specifically to show there was consensus back in 2012 that it should have been limited to 100 milligrams a day for 90 days. Judge, this is cross-examination on the central issue of the case, and it's a document from the defendant.

MR. VENKER: Judge, this is one letter of somebody -- some group of people who think something. That's not showing consensus. What's the foundation for this to show consensus?

MR. SIMON: I don't need a foundation, Your Honor, this is what your expert --

MR. VENKER: Well, you can talk to my expert about it.

MR. SIMON: Judge, this is cross-examination. It's no different than the guidelines that we used, and --

THE COURT: I think it is different than the guidelines. I don't understand -- I don't get -- in my mind, I'm not lumping them in the same category. I do -- I do recognize that it was produced by the expert. My issue is not foundation. My issue is -- I guess would be relevance to this.

MR. SIMON: I won't use this document. I'll just ask him questions.

MR. VENKER: No. I object to this, Your Honor.

MR. SIMON: I'll withdraw it, Your Honor.

THE COURT: Okay.

(Proceedings returned to open court.)

BY MR. SIMON:

Q. Doctor, does St. Louis University have any policies or procedures for prescribing of controlled substances?

A. Yes, we do.

Q. Okay.

MR. VENKER: Your Honor -- thank you.

MR. SIMON: Let me get the right one, Doctor. And may I approach, Your Honor?

THE COURT: You may.

BY MR. SIMON:

Q. Doctor, I'm handing you what we've marked as Exhibit 40-1. And you've seen that document before, correct, Doctor?

A. Yes, I have.

Q. Matter of fact, we took your deposition and we asked for all policies and procedures that St. Louis University had about prescribing controlled substances, and this is what we got, right?

A. Correct.

Q. Okay. A single page, correct?

A. Correct.

Q. From what date, Doctor? 1998?

A. October of 1998.

Q. Okay.

MR. SIMON: And, Mike, can we please put up Exhibit 40-1?

BY MR. SIMON:

Q. Okay. And, Doctor, just so everybody is clear, other than this single page document from 1998, the Department of Internal Medicine has absolutely no policies and procedures relating to the prescribing of opioid

narcotics. This is it?

MR. VENKER: Object to the argumentative character of that question.

THE COURT: Overruled. It's cross.

A. This is the SLUCare policy regarding the prescribing of controlled substances and has to do with making certain that our providers and provider teams are compliant with their licensure requirements and all regulatory requirements.

BY MR. SIMON:

Q. Okay. So, Doctor, does this document have any policies and procedures about the prescribing of opioid narcotics?

A. It -- the procedure is as described. It specifies what needs to be on the prescriptions, and that a record will be maintained, and when using paper medical records what must be retained; and when using electronic medical records what must be maintained.

Q. Okay. Does it contain any information about prescribing opioid narcotics to patients with chronic back pain?

A. It does not.

Q. Does it have any information about the need to establish treatment goals before starting patients on opioid narcotics?

A. It is not called out here, no.

Q. Okay. Does it have any information about assessing of patients before getting them on opioid narcotics?

A. No, it does not in this policy.

Q. Okay. Does it have any information about monitoring or assessing patients after they're on opioid narcotics?

A. Not in this policy.

Q. Does it have any information about a -- the weighing of the risks and benefits of prescribing opioid narcotics?

A. Not in this policy.

Q. Does it have any information about assessing the patient for dependency or addiction while they're on narcotics.

A. No.

Q. Does it have any information about monitoring the patient's opioid narcotic treatment?

A. It does refer to who will write and the timing of prescriptions, so that's, I think, inherent in that, yes.

Q. Okay. So, Doctor, as far as policies and procedures about prescribing opioid narcotics, this is it from 1998, a single piece of paper for St. Louis

University and it's four hundred fifty physicians, correct?

A. We are, as I think I also indicated in the deposition --

MR. VENKER: Your Honor, may we approach?

THE COURT: Yes.

(The following proceedings were held at the bench.)

MR. VENKER: This witness isn't a lawyer, Your Honor, so he's not thinking of the -- there was another policy and procedure that was produced that post-dates this care.

MR. SIMON: I'll rephrase the question, make sure he doesn't answer --

THE COURT: Okay.

MR. SIMON: There's a document they didn't want to come in, we agreed with it.

THE COURT: Okay.

(Proceedings returned to open court.)

BY MR. SIMON:

Q. So, let me ask you this. Let's look up --

MR. SIMON: Put that back up there, please, Mike.

BY MR. SIMON:

Q. Okay. And let's go to the --

MR. SIMON: You can blow up the top third of it, I guess. Okay.

BY MR. SIMON:

Q. And it says SLUCare policy and procedure, there's the effective date, October of '98, right?

A. Correct.

Q. This one page, correct?

A. Correct.

Q. Okay. And, Doctor, it says -- it says review dates. That would be the dates that this policy is reviewed and updated by St. Louis University, correct?

A. Correct.

Q. So what were the dates that this policy has been updated and reviewed since 1998?

A. This policy has not been updated since 1998.

Q. No reviews, no updates?

A. None to my knowledge.

Q. Okay. And then let's scroll down to see -- because I want everybody to know the full extent of it.

MR. SIMON: Go ahead, Mike, let's go to purpose, subject.

BY MR. SIMON:

Q. Subject, prescribing of controlled substances. Correct?

A. Correct.

Q. Purpose, to ensure that the prescribing of controlled substances complies with the applicable state and Federal regulations. Correct?

A. Correct.

Q. Okay. It says policy. It is the policy of SLUCare to appropriately document the prescribing of controlled substances. Correct?

A. Correct.

Q. So, let me ask you this. If -- if Dr. Walden prescribed narcotics and didn't document them, he wouldn't be complying with this, right?

A. That is correct.

Q. Is morphine a narcotic?

A. Morphine is a narcotic.

Q. Is morphine a controlled substance?

A. Yes, it is.

Q. So if Dr. Walden prescribed morphine, we should be able to look in his records, right, and find out where and when he prescribed it, right?

A. Yes.

Q. Okay. Procedure. It says, "prescriptions for controlled substances must be dated and signed on the day issued. The prescription must include the following information; name, address of patient including street, city, zip code, legible name, address, and DEA

registration number of the practitioner, signature, name and quantity of drug prescribed, and directions for use."

Have I read that correctly?

A. Yes, you have.

Q. And it says, "practitioners who prescribe Schedule II controlled substances must maintain a record of all such prescriptions in the patient's medical record."

That's just what we were talking about, right?

A. Correct.

Q. Okay. All Schedule II prescription information must be highlighted in some manner so as to be readily retrievable. Correct?

A. Yes.

Q. Okay. Number four, proper medical report. When using paper prescription forms, the original prescription will be given to patient to take to the pharmacist. Correct?

A. Yes.

Q. Okay. It says, "a second copy of the prescription will be maintained in the patient's medical record on a red bordered monitoring sheet or otherwise highlighted." Correct?

A. Mounting sheet.

Q. All right. Fair enough. Then number five,

electronic medical record, when ordering Schedule II prescriptions electronically, the prescription is entered electronically and printed for the physician's signature. The signed prescription form is then given to the patient to take to the pharmacist or mailed to the patient.

Have I read that correctly?

A. You have.

Q. Okay. And this is the extent of St. Louis University's policies and procedures for narcotic prescriptions; is that correct, sir?

A. During this period of time, yes.

Q. Okay. And let me ask you this, Doctor. What department is Dr. Walden in? Internal medicine?

A. Correct.

Q. Okay. And you've got a hundred and sixty doctors in internal medicine, correct?

A. Correct.

Q. Okay. As of today for internal medicine, today, are there any new policies and procedures about prescribing narcotics for the entire internal medicine department other than this?

A. No.

Q. Doctor, is it true that St. Louis University does not monitor narcotic prescriptions solely on the basis of quantity or dose of the medication?

A. That is true.

Q. Is it true that there was never any monitoring done by St. Louis University of the quantity of the narcotics being prescribed to Mr. Koon by Dr. Walden?

A. None to my knowledge. Because it wouldn't have risen to his department chair's review, because there were no identified problems, concerns or adverse outcomes that would have prompted his department chair to review those records.

Q. Okay. And, Doctor, St. Louis University has financial arrangements or relationships with pharmaceutical companies, correct?

A. We do have working relationships with pharmaceutical companies.

MR. VENKER: Your Honor, may we approach?

THE COURT: You may.

(The following proceedings were held at the bench.)

MR. VENKER: We've raised this before. We tried to ask this witness this question. I'm just going to object about the pharmaceutical clinical trials and all the financial aspects of that, and their relationship between St. Louis University -- or SLUCare, I should say, and the pharmaceutical companies. We've raised this before many times. I just want to incorporate my

objections to make them again.

THE COURT: Okay. And before you go, how are we doing on time?

MR. SIMON: I've got about five minutes, I'm done.

THE COURT: Okay. Your objection is noted and it's renewed and it remains overruled.

MR. VENKER: Thank you, Your Honor.

(Proceedings returned to open court.)

BY MR. SIMON:

Q. Okay. Doctor, those relationships with pharmaceutical companies include clinical trials, correct?

A. Yes.

Q. Research funding, correct?

A. Yes.

Q. Providing sample medications, correct?

A. Yes.

Q. Providing materials about the products, the drugs and medications, correct?

A. Correct.

Q. Visits by Pharma representatives, correct?

A. Correct.

Q. Sponsoring national regional meetings at various medical organizations, correct?

A. Those are relationships with those regional

meetings or national corporations are not with St. Louis University.

Q. Okay. And also consulting agreements with the individual physicians, correct?

A. Some physicians have consulting arrangements, yes.

Q. So, in other words, some doctors, physicians at St. Louis University, have consulting agreements with pharmaceutical companies, correct?

A. Yes. They're national experts in their field, and their expertise and knowledge is sought out by the companies when they're trying to design trials.

Q. And they're paid, correct?

A. Their expenses are recovered. They do receive compensation for this, yes.

Q. Okay. Doctor, let me ask you about clinical trials. St. Louis University has -- has participated in clinical trials with pharmaceutical companies, correct?

A. Correct.

Q. And St. Louis University has participated in clinical trials with pharmaceutical companies that make opioid narcotics, correct?

A. I don't have any certain knowledge about that. But I believe you deposed Dr. Tate who probably provided you with that information.

Q. Okay. And the jury will hear the testimony from Dr. Tate. But is it generally your understanding that Purdue Pharma makes OxyContin, correct?

A. I believe that's correct.

Q. Okay. And St. Louis University has participated in several clinical trials with Purdue Pharma. Is that you understanding, Doctor?

A. I don't know the answer to that.

Q. Fair enough. Doctor, has St. Louis University changed any of its policies or procedures as a result of this case?

A. No.

MR. VENKER: Object to the relevancy of that, Your Honor.

THE COURT: All right. He's already answered, so it's moot.

BY MR. SIMON:

Q. Okay. So, Doctor, are physicians at St. Louis University allowed to prescribe narcotics over the phone?

A. There are some Schedules where opioid analgesics would be able to be prescribed, or other controlled substances, yes.

Q. Okay. And what about oxycodone, OxyContin, can those be prescribed over the phone, Doctor?

A. I don't believe so, no.

Q. Okay. And is that a policy of St. Louis University?

A. Actually, it's a requirement of their license and DEA number and Missouri BNDD. We require them to comply.

Q. Okay. So it's -- not only is it a policy of St. Louis University, what you're telling me is it's the law, correct?

A. We expect our providers to practice within the scope of their license, and also in their Missouri BNDD number and DEA, yes.

Q. Okay. Doctor, hang on one second.

MR. SIMON: Mike, could you please put up what we've mark as Exhibit 40-5?

BY MR. SIMON:

Q. And, Doctor, this is a letter from SLUCare, correct?

A. It has the SLUCare letterhead on it. I can't read it from here.

Q. Okay. We'll blow it up for you, Doctor.

MR. SIMON: Could you please blow up the top half, Mike?

BY MR. SIMON:

Q. And it's a letter registered and U.S. mailed dated July 28th, 2014, to Mr. Brian Koon, correct?

A. That's what I'm reading, yes.

Q. Okay.

MR. SIMON: Let's scroll down, please, Mike.

BY MR. SIMON:

Q. It says, "dear Mr. Brian Koon. Please be advised that effective Wednesday, July 2nd, 2014, the physicians of St. Louis University will no longer continue to treat you. You should, as soon as possible, establish medical care for your health issues from other -- from another physician. Should you need medical attention for an emergency before you establish care with another physician, you should proceed to the nearest emergency room."

Have I read that correctly, Doctor?

A. Yes, you have.

Q. The second sentence says, "we have been notified that you have filed a lawsuit against St. Louis University. Our ability to provide care for you is impeded by this action."

Have I read that correctly, Doctor?

A. You have.

MR. SIMON: No further questions, Your Honor.

THE COURT: Any cross?

MR. VENKER: I just have a few, Your Honor.

## CROSS-EXAMINATION

BY MR. VENKER:

Q. Dr. Heaney, do you still have that CDC document up there with you?

A. Exhibit 50-6?

Q. Yes, sir. You were asked, I think, about one of the pages here that involved reference to footnote 25. Do you remember that text? Let me see if I can find it real quick here. That's all right.

Anyway, the CDC guidelines, as you say, those are put out in 2016, aren't they?

A. That's March 18 of 2016.

Q. Right. Okay. And I want to make sure that there's not confusion. Earlier on Mr. Simon was asking you about the hospital and St. Louis University. In this time period we're talking about, in 2008 to 2012, St. Louis University didn't own the St. Louis University Hospital itself, did it?

A. It did not.

Q. Wasn't it owned by Tenet?

A. It was owned by Tenet Healthcare Corporation.

Q. All right. Okay. And Tenet, at that time, was a for-profit hospital, correct?

A. Correct.

Q. All right. But St. Louis University is

not-for-profit?

A. That is correct.

Q. All right. And -- St. Louis University is basically an educational institution, isn't it, Doctor?

A. We are a university, we exist to provide the next generation of healthcare providers, the nurses, physical therapists, physicians, and to do that we have to be engaged in research, and, of course, we want our healthcare trainees to learn about providing the best care that they can, so we are engaged in the clinical practice of medicine.

Q. Okay.

MR. VENKER: I don't have any further questions. Thank you.

MR. SIMON: May we approach, Your Honor?

THE COURT: You may.

(The following proceedings were held at the bench.)

MR. SIMON: Your Honor, Mr. -- Mr. Venker told this jury St. Louis University was nonprofit, suggesting that, you know, maybe they shouldn't be -- he's interjected the issue of insurance into the case, is what I'm saying. He suggested --

THE COURT: Time out. Time out.

MR. CRONIN: We moved to bifurcate the trial,

Judge, keep out all finances. They just opened the door.

THE COURT: Take a deep breath. Okay. If you want to go -- either one of you want to explain what a nonprofit is. A nonprofit is not interjecting insurance. A nonprofit is how you --

MR. SIMON: Okay. I understand.

THE COURT: -- spend your money. It's not the same.

MR. SIMON: I understand, Judge. I'll withdraw.

(Whereupon, proceedings returned to open court.)

MR. SIMON: No questions.

THE COURT: Okay. All right. May this witness be excused?

MR. SIMON: Yes, Your Honor.

MR. VENKER: Yes, Your Honor.

THE COURT: It's basically 12:30. We're going to give you an hour and five for lunch. We're going to rock and roll after lunch. So I need everybody back here at 1:30. My goal is get you out of here today by 5:00. I'm going to try to honor that. But we need to put in a good solid afternoon to make that happen.

(Whereupon, Instruction 300.04.1 read to the Jury.)

(Whereupon, a lunch recess was taken.)

(The following proceedings were had in open

court, out of the presence of the jury:)

MR. CRONIN: Judge, we have something we would like to put on the record, and then we have an objection to take up also.

THE COURT: All right. Let's do the record first. We're on the record outside the hearing of the jury.

MR. CRONIN: Judge, it has come to our attention that there have been negative comments made about John and I from the SLU representative in the courtroom that were audible for the jury to hear.

Yesterday there was a comment that Plaintiffs' lawyers are a special breed and they're just up there trying to twist the truth.

Today -- and, Judge, these are not things I heard; these are things I'm being told by people in the gallery. Today Mr. Simon was called a bottom feeder while he was examining Dr. Heaney. And this claim is from SLU's representative in the courtroom; and I'm being told it was loud enough, Connie Golden, for the jury to hear.

Judge, we debated what we want to ask the Court to do; but we want this on the record, and we would like the Court to admonish her not to make any comments in the future.

MR. SIMON: At a minimum.

MR. CRONIN: At a minimum.

MR. SIMON: And we're still reserving what we're asking the Court to do.

THE COURT: Any thoughts?

MR. CRONIN: Judge, to be clear, we do not think this is something counsel had anything to do with or knew about.

MR. SIMON: Absolutely.

MR. CRONIN: Absolutely not.

MR. VENKER: I was -- we got the information from Tim that Ms. Golden had said something. We did ask Ms. Golden about it. She said she said it under her breath. She didn't intend for anyone to hear it. She didn't think anyone heard it.

She was emotional at the time, I guess, due to John Simon's, however you want to describe, the effectiveness of his examination of Dr. Heaney, who Connie Golden knows and feels protective towards.

And so, my understanding is that the comment was made maybe at a whisper's level. I think there may have been someone in the gallery, maybe someone from the Simon firm, at the end of the pew where Ms. Golden was sitting and they heard it. I don't know how they reported it, but that's my understanding of what it was.

I don't see that there's any basis to think that

the jury heard. I'm confident she didn't intend for them to hear or anything. My understanding from her is she didn't think anybody heard her, and she didn't intend for them to.

So that's my preliminary response on this.

THE COURT: All right. Bring Ms. Golden up.

MR. VENKER: Yes, sir.

THE COURT: All right. Let the record reflect that I'm speaking with one of SLU's representatives, Ms. Golden. All right, ma'am.

MS. GOLDEN: Yes, sir.

THE COURT: All right. I know these lawsuits can be very emotional.

MS. GOLDEN: Very, very.

THE COURT: All right. And there's a lot at stake. But I got to ask if -- I'm not the thought police. But if you're going to say anything, you have to make sure --

MS. GOLDEN: I know.

THE COURT: You have to keep -- I prefer you not say anything, but that you keep your thoughts to yourself because it could jeopardize --

MS. GOLDEN: I understand.

THE COURT: -- the entire proceeding. And you can imagine the amount of time and energy that is spent on this.

MS. GOLDEN: That's part of it too, yeah.

THE COURT: So I'm going to allow you to remain in the courtroom.

MS. GOLDEN: I apologize. I apologize.

THE COURT: Okay. But we can't have anymore of that.

MS. GOLDEN: Don't worry. Don't worry. It was just emotional for me.

In my capacity at St. Louis University, my doctors, I'm real protective of them, and that's just what it was, especially Dr. Heaney, and I apologize.

THE COURT: All right. But no more of that?

MS. GOLDEN: Yes, sir.

THE COURT: Thank you.

(At this time Ms. Golden stepped down.)

THE COURT: I think there was something to do with the --

MR. MAHON: Back to our favorite topic of depositions. It's not much.

THE COURT: All right. Let's talk about our new favorite case topic ever.

MR. CRONIN: Judge, it's just this section of Michael Burke, Junior's deposition where he is being asked --

MR. MAHON: 19, 4 to 20, line 15.

MR. CRONIN: This is Michelle Koon's brother. We're going to read his deposition.

THE COURT: All right.

MR. CRONIN: He's asked a lot of questions to him about what he observed in Brian. The only portion we're objecting to, double hearsay and prejudicial it seems, he's talking about Brian conveying things that his supervisors have said to him at work. And the prejudicial part is family medical leave, stuff like that.

I think Brian is going to be here to be questioned about any issues of discipline with work. Two of Brian supervisors have given depos that are going to be played, and this is, I think, misleading because I don't think it's accurate. I think it's prejudicial. Some of it is irrelevant, and it's double hearsay.

THE COURT: Okay.

MR. MAHON: It's not hearsay. If you look at what the questions are, this is asking Michelle Koon's brother if Brian ever talked to him about job performance issues he was experiencing due to back pain; and so he's relaying what he learned from Brian.

And it goes on further, page 19 and 20, did Brian ever tell you about any specifics of job duties that he had that he couldn't do or had to change the way he did it because of back pain.

I think he's simply relaying what Mr. Koon, the Plaintiff, had told him about the effect the back pain was having on job performance duties. I don't think it's hearsay at all. I think it's directly relevant to the issues in the case.

MR. CRONIN: We're also not making a lost wage claim, Judge.

THE COURT: All right. Michael Burke is Ms. Koon's brother?

MR. MAHON: That's right.

MR. CRONIN: Yes.

MR. MAHON: A friend to Mr. Koon.

MR. CRONIN: That's accurate.

THE COURT: All right. Tim?

MR. CRONIN: Yeah, I'm sorry, Judge.

THE COURT: You listed about five objections.

MR. CRONIN: I did. One, Judge, I think some of it is multiple levels of hearsay. While one level may be cured by it being something the Plaintiff said that I believe they may be saying is against interest, I think the level of something supervisors said to him is not cured.

I think the things that are irrelevant and prejudicial matters that --

THE COURT: Let's deal with hearsay first.

You're saying it's hearsay because it is --

MR. CRONIN: That his supervisor said that they were going to discipline him.

THE COURT: His supervisors said to him that he was going to be disciplined. I don't get -- in my opinion, it doesn't rise to the level of double hearsay. It is hearsay, and if it is -- you stated that -- is that your exception, that it's a statement against interest?

MR. MAHON: It's a statement of a party from Mr. Koon.

MR. CRONIN: It has to be a statement against interest, Judge. I guess I was too forthright in saying what I thought their exception was.

THE COURT: Because I agree with you. I mean, he's there. He's your, I guess, witness, then it would be a statement against -- all right. So I'm going to overrule on hearsay.

You said it was irrelevant --

MR. CRONIN: We're not making a lost wages claim.

THE COURT: -- and lack of foundation, if I'm going by your scribble on the side.

MR. CRONIN: So lack of foundation of Michael Burke, Jr. being able to know what's going on with Brian's work at all, he's speculating.

But my real issue is there are some prejudicial things in the answer that aren't relevant at all, discipline for abusing family medical leave. I don't think there's anything in his work records. And frankly, I don't think that's something that the defendants have tried to pursue in the case. I don't think there's any other evidence of it. I think he's just wrong about it, and it's potentially incredibly prejudicial.

Maybe we can just excise portions of the answer.

THE COURT: All right. What's your response to the prejudicial?

MR. MAHON: Well, I think one of the issues in the case that's been talked about a lot is that Mr. Koon was having difficulty performing at work because of the back pain, and it shows the motivation to continue with -- continuing with opioid therapy and so these pressures of providing an income for his family and being able to perform at work and show up at work and not miss too much time from work are a big issue in the case.

I don't know that it's prejudicial; it's just the facts of the case.

THE COURT: All right. Any prejudice I think would be outweighed by its probative value. So I think it is -- I understand your perceived prejudice, but it is an issue of the case, and it is probative. So I think it's

relevant in that fact. And while it is prejudicial, I don't think it outweighs the probative value.

I think there's a foundation for it because it's -- this guy -- he said not only there's a relation but also a friendship relation, so I'm going to overrule the exclusion of page 19, 4 to page 20, 5.

MR. CRONIN: Understood, Judge. Thank you.

MR. MAHON: Can we re-visit the Bublis issue?

MR. CRONIN: Can we do that later?

MR. MAHON: We can do it later. The only issue, I understand Tim's got stuff to work on tonight so we don't have much time tonight, and it's something we're going to play tomorrow. As long as we take it up sometime today.

THE COURT: We'll take it up today.

MR. MAHON: Okay.

THE COURT: All right. Both sides ready?

MR. SIMON: Yes, Judge.

MR. VENKER: Yes.

THE COURT: All right.

o0o

(The proceedings returned to open court.)

THE COURT: All right. Welcome back from lunch. Plaintiffs, call your next witness.

MR. CRONIN: Your Honor, at this time Plaintiffs

would like to present and read in the deposition testimony of Brian's father, W.C. Koon, Junior.

THE COURT: You may proceed.

MR. CRONIN: Your Honor, playing the part of Mr. Koon is a law clerk from our office, Patrick.

THE COURT: Is this something the court reporter is going to take down?

MR. CRONIN: I believe normally -- we can give you an exhibit if you like, whatever she would prefer.

THE COURT: Why don't we go ahead and take it down? Are you just going to read it?

MR. CRONIN: Yeah.

THE COURT: You may proceed.

MR. CRONIN: We can do an exhibit if she would like to take a break, whatever the Court's preference is.

THE COURT: How long is it?

MR. CRONIN: It's always longer than you think. I would say 25 minutes.

THE COURT: Okay. You don't have to take it down. We'll just used the exhibit. Save those magic fingers.

All right. You may proceed.

(At this time portions of the deposition of W.C. Koon, Jr. were read to the jury.)

MR. CRONIN: Judge, that completes that

deposition.

THE COURT: All right. Thank you, sir.

All right. Plaintiffs, your next witness?

MR. CRONIN: Judge, at this time Plaintiffs would play the videotaped deposition of Dr. Raymond Tate, a SLU corporate representative.

MR. VENKER: Judge, can we approach before that?

THE COURT: You may.

(Counsel approached the bench, and the following proceedings were had, out of the hearing of the jury:)

MR. VENKER: Your Honor, we're just going to renew and want to preserve our objections to this subject matter of Dr. Tate's testimony. He is a St. Louis University employee who is a Vice President of Research, so he knows about the clinical trials that SLU was involved in.

THE COURT: Okay.

MR. VENKER: So we want to renew our objection to that whole topic, so really to the entire deposition, if you will, of Mr. Tate in terms of the topic itself. And I think we have worked out the objections as of yesterday that are going to be played.

MR. CRONIN: Individually.

MR. VENKER: I think the deposition has been basically modified, the transcript has.

THE COURT: Other than that, are there any other issues with Dr. Tate?

MR. MAHON: No.

THE COURT: All right. Your objections are noted, and they're overruled.

MR. VENKER: Okay, thank you.

(The proceedings returned to open court.)

THE COURT: All right. You may proceed with the video deposition of Dr. Tate.

(At this time the video deposition of Dr. Raymond Tate was played for the jury.)

MR. CRONIN: Your Honor, that concludes that deposition.

THE COURT: All right.

MR. CRONIN: Judge, we have, I promise, our last deposition of the day; and it will be read, not played, by video. And it is Michael Burke, Junior, Michelle Koon's brother. And we have another law clerk from our office that will be helping us out.

THE COURT: All right. You may proceed.

(At this time portions of the deposition of Michael Burke, Jr. were read to the jury.)

MR. CRONIN: That concludes that deposition, your Honor.

THE COURT: Thank you, sir.

MR. CRONIN: Judge, at this time Plaintiffs would call Brian Koon to the stand.

THE COURT: While we're waiting for Mr. Koon, we can stand and get the blood flowing.

Come on up, Mr. Koon. All right, Mr. Koon. Maureen is going to swear you in.

***BRIAN KOON***,

having been duly sworn by the deputy clerk, testified:

**DIRECT EXAMINATION**

THE COURT: All right. Have a seat, Mr. Koon.

All right. Same instructions I've given everybody else. If you hear somebody say objection, pause and let me rule on it before you answer.

THE WITNESS: Yes, sir.

THE COURT: All right. You may inquire.

BY MR. CRONIN:

Q Please state your name.

A Brian Koon.

Q Are you a little nervous, Brian?

A Yes.

Q We'll get through it. How old are you?

A Forty-four years old.

Q Where did you grow up?

A I was born in Pennsylvania, Pittsburgh.

Q You're going to have to talk up a little bit.

A I was born in Pennsylvania in Pittsburgh. I lived there for about four years and moved to Ithaca, New York with my family where we stayed until I was about 12 years old and then moved here to St. Louis.

Q How long have you lived in the St. Louis area?

A Oh, I've lived in the city for, well, since I -- I've lived in St. Louis since I was 12.

Q Where do you currently live, Brian?

A I live in south city.

Q With anybody?

A By myself.

Q Are you married?

A Yes.

Q What's your wife's name?

A Michelle.

Q Do you have any children, Brian?

A I have a daughter.

Q What's her name?

A Emily.

Q How old is Emily?

A She's six.

Q And your mother and father also live in the area?

A Yes.

Q That was your father's deposition that was just

read?

A Yes, it was.

Q Had you ever heard that testimony before?

A No.

Q How did that make you feel?

A Not too good.

Q What did your mom and dad do for a living growing up, Brian?

A My father's a minister. My mother was a schoolteacher.

Q Are you adopted, Brian?

A Yes, I am.

Q And was your brother -- you had a brother. Was he also adopted?

A Yes, he was adopted as well.

Q Brian, did you ever have any struggles dealing with that growing up in your teenage years?

A Yes, I had difficulties with that.

Q Can you tell me a little bit about it?

A As a teenager, especially after moving here from New York when I was 12 years old, I had a very hard time adjusting to life here. By the time I was in high school, I was rather depressed. I hadn't made very many friends.

I had abandonment issues from being adopted. I ended up being in the hospital a few times as a child

through my teenage years due to depression, and I had seen doctors for counseling for that.

Q Brian, did you work through those issues and put them behind you as you got a little older into your twenties?

A Yes, I did.

Q Brian, did you have a pretty major life event happen to you in your lower twenties?

A When I was 21, in the spring of '93, I was diagnosed with Hodgkin's disease.

Q Was that scary?

A Extremely.

Q What kind of treatment did you go through?

A I had radical radiation therapy.

Q What stage was your cancer, Brian?

A I had Stage 4 Hodgkin's, which is above and below your diaphragm. I had cancer from the middle of my face down to my waist.

Q Brian, did you beat that cancer?

A I did.

Q How long did it take?

A I had three or four months of radiation treatment daily. Monday through Friday I'd go down and have my treatment; and it was difficult, but I made it through it. It took sometime, but life got good. I had a

second chance.

Q What kind of feeling was that, Brian, to battle through and beat Stage 4 cancer at such a young age?

A It was an amazing feeling. I had a second chance at life, a new start. I saw things a lot differently. Everything was brighter, you know. You just stopped and smelled the roses and appreciated everything that you didn't before.

Q Brian, what did you do as you moved forward with your life after that?

A I went to college.

Q Where?

A I went to Ranken Technical College. I got a degree, an associate's degree, in the science of technology. I got a degree in heating and cooling.

Q Did you get a job when you got out?

A Yes, I did. I started work for the City of St. Louis Parks Division, Facility Services. I was a mechanical maintenance worker. I started two weeks after I graduated school.

Q Did you feel lucky to get a job right out of school?

A It was a good feeling, yes.

Q Brian, have you stayed there working in the City of St. Louis Parks Department for the past 18 years?

A That is correct.

Q Do you work in that job currently?

A Yes, I do.

Q Brian, are you making any kind of lost wages or inability to work claim in this case?

A No, I am not.

Q And while we're on the subject, are you making any kind of claim for reimbursement of any kind of medical expenses of any kind?

A No, I am not.

Q Brian, are we here to talk about the treatment you received from SLU and Dr. Walden from 2008 to 2012 and the resulting effect on you and your family's life?

A Yes, I am.

Q Why else are you here, Brian?

A I am here to hopefully prevent this from happening to another --

MR. VENKER: Your Honor --

A -- person and another family.

MR. VENKER: I'm sorry, may we approach, your Honor?

THE COURT: Yes.

(Counsel approached the bench, and the following proceedings were had, out of the hearing of the jury:)

MR. VENKER: I'm just going to object, your

Honor. This is a self-serving statement. It's not anything to do with any of the evidence in this case, so I just object to it. I think it -- and also just an improper, you know, personal appeal to the jury, emotional appeal.

So I ask that it be stricken and the jury advised to disregard it.

MR. CRONIN: Your Honor, I don't know what he means by a self-serving statement. Brian's entire testimony, I imagine, could be considered self-serving because he's doing it in support of his case.

We have a punitive damages claim, and the purpose of the punitive damages claim is to deter similar conduct. And that is one of the reasons Brian is here; that's one of the reasons he wants to be here.

THE COURT: I get that, but you got to --

MR. CRONIN: It was just one question and answer, Judge, and I'm moving on.

THE COURT: Okay. Let's move on.

MR. VENKER: So the objection is overruled?

THE COURT: All right, no. The first question he asked is not objectionable. It's my understanding, you actually objected before he finished the answer.

MR. VENKER: He answered really non-responsively. That's my other objection to that.

THE COURT: I believe, one, we cut the answer off before, so I don't think the jury heard an answer. You objected right before you told him to stop. So I think the objection was timely.

I'm going to sustain the objection. Counsel has agreed to move on. I don't think there was anything to strike because it was cut off before he answered.

MR. CRONIN: Judge, I would like for him to be able to answer the question.

MR. VENKER: I think he did answer it.

MR. CRONIN: I don't.

MR. VENKER: I'd like it stricken then if he answered it.

THE COURT: All right. If he did answer it, I'm going to strike it. If he didn't answer it -- all right. So here's what I'm going to rule.

If you guys think he answered the question and it's an objectionable issue, I'm going to assume that he answered the question.

MR. VENKER: I'm concerned he got enough out as I was objecting that the jury could hear. That's why I want them to be instructed to disregard.

THE COURT: The jury knows exactly why he's here. He doesn't need to say the magic words.

MR. CRONIN: I've got you.

THE COURT: We're going to move on. I'm going to tell the jury to disregard the question and answer.

MR. CRONIN: Judge, can I say one thing? If the jury is told in closing argument that Brian is only here for money, I'd like the opportunity to recall my client at that time.

THE COURT: I think it's been laid out pretty clear that this is a punitive to everybody.

Okay. Let's keep going. I'll take care of it.

(The proceedings returned to open court.)

THE COURT: Ladies and gentlemen, I have sustained the objection; therefore, you're going to disregard the previous question and the answer.

You may proceed.

Q (By Mr. Cronin:) Brian, do you have memory issues with what happened during that 2008 to 2012 time frame?

MR. VENKER: I object as leading, your Honor.

THE COURT: Overruled. I'll allow it.

A Yes, I do.

Q (By Mr. Cronin:) Why is that?

A From the medication.

MR. VENKER: Your Honor, I object to this being a medical conclusion now. I object to that and ask it be stricken.

THE COURT: Rephrase.

Q (By Mr. Cronin:) Brian, did you have any memory issues before 2008?

A No.

Q Do you have difficulty remembering things from 2008 to 2012?

A Yes.

Q Are you better able to remember things after 2012?

A Yes.

Q Brian, will you do your best to tell the jury what you can remember to anything you're asked during that time frame?

A Yes.

Q When did you first meet Michelle, Brian?

A I met Michelle, I guess, I was in -- the first time was when I was in my young twenties.

Q Then did you not see each other for -- was there kind of a gap for some years?

A Yes, there was a long gap.

Q How did you meet again?

A Through a mutual friend.

Q What happened between the two of you from that point? Well, when was that, by the way?

A Around 2005.

Q And what happened between the two of you after that?

A We started talkin'. It took a while, but I got her phone number, and we started talking. And we started dating shortly thereafter, and I fell very much in love with her.

Q When did you get married?

A September 16th, 2006.

Q Was that a happy day in your life?

A Absolutely.

Q Brian, what kinds of things did you and Michelle like to do together in your free time?

A We talked. We'd go down to the lake. We'd go for walks. We'd go fishing, swimming. We'd actually go to a shooting range together and enjoyed doing that as well.

Q When did you find out Michelle was pregnant with Emily?

A It was the fall of 2008.

Q Were the two of you excited?

A Extremely.

Q When was she born?

A She was born July 26th, 2009.

Q Do you remember much of her birth?

A No, I don't.

Q When did you first start seeing Dr. Walden as your primary care physician?

A In 2001.

Q Did you like -- did you like Dr. Walden as your primary care physician?

A I was extremely pleased with Dr. Walden.

Q Did you ever have back flareups where you'd throw your back out and go to Dr. Walden to get treatment for it?

A On occasion.

Q And would you sometimes -- what other kinds of treatment would you get whenever that would happen?

A I saw a chiropractor, Frank Mistretta.

Q Before 2008 would your back pain, with some treatment like chiropractic care or pain pills from Dr. Walden, would it resolve?

A Yes, it would subside.

Q Brian, did you ever go to Dr. Walden between 2001 and 2008 and tell him you were feeling depressed or having some anxiety or things like that?

A On occasion, yes.

Q Was it -- were they things as severe as what you had experienced when you were younger?

A No.

Q How about what you experienced in 2012 or

afterwards?

A Nothing like this at all.

Q Mike, can you pull up Exhibit one, page 107? These are SLU care records.

Let me ask you this, Brian. Did you start to get some back pain again in early 2008?

A Yes, I did.

Q Okay. And can you blow up the history of present illness, Mike? And Brian, this says, he states he threw his back off toweling off after a shower. Is that what happened?

A Yes.

Q Were you having some pain in your mid-back and lower back?

A Yes.

Q And what did you -- before you went to Dr. Walden, what did you do about it? Don't concern yourself with the medical record.

Before you went to Dr. Walden, what did you do about it?

A I saw my chiropractor.

Q Did that help with the lower-back pain?

A Yes.

Q Were you still having some mid-back pain issues?

A Yes.

Q Then did you go to Dr. Walden?

A Yes.

Q Okay. And if we can go out, Mike -- well, Brian let me ask you before.

What did Dr. Walden -- did Dr. Walden prescribe you something?

A Yes.

Q What?

A It was some muscle relaxers, some Advil, just over-the-counter.

Q Did he order some x-rays?

A Yes, he did.

Q Is it your recollection they came back normal?

A Yes.

Q Can we pull up page 110?

Brian, this is a note from Dr. Walden's office eight days later, February 29th, 2008.

Brian, do you recall telling Dr. Walden, back is still giving patient discomfort. Advil not helping on some days?

A That sounds correct, yes.

Q Who did you talk to? Did you talk to Dr. Walden, or did you talk to somebody else in his office?

A I believe I talked to a nurse.

Q And did someone other than Dr. Walden call you back and tell you that you'd been prescribed Vicodin?

A I believe so.

Q Did you ask for Vicodin or just say the dose of Advil sometimes wasn't enough?

A I said that the dose of Advil was not enough.

Q So did Dr. Walden place you on opioids without seeing you or talking to you that day?

A Yes.

Q Did he discuss any risks or benefits with you?

A No.

Q After about a month, Brian, were you prescribed Vicodin again?

A Yes.

Q For more refills?

A Yes.

Q Was that without an office visit?

MR. VENKER: Your Honor, I object to the leading nature of these questions.

THE COURT: I'll sustain. Tighten it up.

Q (By Mr. Cronin:) Brian, the first several times that you got prescriptions for opioids with refills from Dr. Walden, were there office visits?

A No.

Q Were any risks or benefits about these

medications discussed with you during the beginning of the opioid treatment you were placed on?

A No.

Q Do you know when the first time that was discussed with you was?

A I do not recall, no.

Q Would you be surprised to learn the first time it's in the records is June of 2009?

MR. VENKER: Your Honor, I object as leading and argumentative.

MR. CRONIN: I'll withdraw the question, Judge.

Q (By Mr. Cronin:) Brian, was it after you were placed on opioids that your back pain started to get worse?

A Yes.

MR. VENKER: Your Honor, I object again to the leading questions.

MR. CRONIN: Judge, my questions do not assume the answer and by definition are not leading questions.

MR. VENKER: I still make my objection as being leading, your Honor.

THE COURT: Overruled.

MR. CRONIN: Mike, can you pull up page 113?

Q (By Mr. Cronin:) Brian, according to this record you told Dr. Walden on a visit on 4-1, uses

two to three Vicodin after work is completed and that helps him. He's otherwise doing quite well.

Do you recall reporting that to your doctor?

A No, I don't. I don't recall it.

Q How about this? Early on were you sometimes taking two to three Vicodin at a time despite what your prescription was?

A Yes.

Q Do you dispute what's in the medical records?

A Not at all, no.

Q Do you recall Dr. Walden discussing with you at that visit that your pain could be due to a possible herniated disc?

A I don't recall that.

Q How about this, Brian? Was an MRI ordered?

A Yes.

Q Do you recall calling in to get the MRI results?

A That would sound correct, that I would have called for that.

Q What do you recall the MRI results being?

A Negative.

Q Do you recall them being mild arthritis in the lower back?

A Yes.

Q Can we go to Exhibit 1, page 116, Mike?

MR. VENKER: I'm sorry, what was the page again?

MR. CRONIN: 116.

Q (By Mr. Cronin:) Brian, according to this record on April 16th, 2008, this is a message, "Wants results of MRI. Having to take more than prescribed dose of pain meds. They do work. He just has to take more."

Brian, were you telling your doctor that you were taking more than the prescribed amount of pain medicine?

A Yes, I was.

Q And is this less than two months after you had been prescribed the pain meds by your physician?

MR. VENKER: Your Honor, I object to the leading character of these questions.

THE COURT: Tighten them up.

MR. CRONIN: Okay, Judge.

Q (By Mr. Cronin:) Brian, do you see on this visit your Vicodin dose was increased from 5 milligrams up to 7.5 milligrams?

A Yes, I do.

Q And increased the number of pills to 90 with three refills. Is that your recollection of how your dose escalated?

A Yes.

Q Can we go to page 118, Mike?

Brian, did you know the pharmacy called Dr. Walden to make sure he was aware of what he had just done?

A I was not aware of that, no.

Q Do you see in your medical records with your doctor where it says, "Okay" and Dr. Walden's signature?

A Yes, I see that.

Q Brian, at about this time, did Dr. Walden refer you to go see an orthopedic surgeon?

A Yes, Dr. Place.

Q And what generally happened at your visit to see the orthopedic surgeon?

A He said that there was nothing surgically that could be done and referred me to therapy, physical therapy.

Q Okay. And so is it Dr. Place that referred you to physical therapy?

A Yes.

Q Did Dr. Walden refer you to physical therapy at that time?

A No, it was Dr. Place.

Q Where did you go?

A It was in a strip mall by my house in Hampton Village. I can't remember the name of the actual company,

but it was right down the street in a strip mall.

Q Did you do the physical therapy?

A Yes, I did.

Q Did it help at all?

A It helped somewhat.

Q Were you ever prescribed physical therapy again over the next few years by your primary care physician?

A No.

Q Did you also go see a neurosurgeon to get a second opinion about whether you needed surgery?

A Yes, I did.

Q And who was that?

A That was a Dr. Heim at St. Luke's Brain and Spine Institute.

Q And did he convey to you that you needed to have surgery at that time?

A He said surgery was not an option at that time. He referred me for injections.

Q Did he refer you to a pain management doctor?

A Yes.

Q And was that Dr. Christopher?

A Yes, I believe Chris Christy or Chris Christopher, something.

Q Again, Brian, is it Dr. Heim that referred you to the pain management doctor, or was it Dr. Walden?

A It was Dr. Heim.

Q Brian, as we start to move forward, 2008 and past, for the next four years did your dose of opioids continue increasing?

A Yes, it did.

Q Did that happen over and over again?

A Yes, it did.

Q Were you placed on multiple different types of opioids at once?

A Yes, I was.

Q Did you have trouble keeping track of what you were supposed to be taking and when?

A I did.

Q Can you tell me about that?

A It's a lot of pills to take. It's a lot to keep track of. And when you're on that much medication, things get, get blurry, get fuzzy, and you take an amount and you know, sometimes I would forget how much I took. It became confusing after a while.

Q Brian, did you have trouble controlling yourself with the pills?

MR. VENKER: Your Honor, I'm just going to object as leading.

THE COURT: Sustained. Rephrase.

Q (By Mr. Cronin:) Brian, did you have any

control issues with the pills?

A Yes, I did.

Q Tell me about that.

A It was difficult for me to just take what was prescribed to me. I would take the prescribed amount, and it would start wearing off so I'd take a little more. Sometimes I would forget how much I had taken. And so you just say, okay, well I'll have a couple more.

It got to the point that I would continually take the medicine. I would not have control over it. We tried locking it up in a lockbox. I figured out how to open the box. My wife would hide the medicine from me.

I'd go through the house, sometimes neatly, so she wouldn't know if I had found it. And sometimes I'd wait a day or two and say, you know, I found this, you need to find another spot for it. It wasn't fair to my wife.

Q Well, let me ask you this, Brian. I think you answered my question. Are you disputing that you would ask your doctor for more pills?

A No.

Q Are you disputing that you would sometimes ask your doctor for higher doses?

A Not at all.

Q Are you disputing that you wanted treatment for

your back pain to keep working?

A That's why I was taking the medicine, yes.

Q Did you trust your doctor as to what your treatment should be?

A Yes, I did.

Q Mike, can you pull up Exhibit 1, page 124?

This is a note from July 8th, 2008. Brian, it says, "Message, did increase hydrocodone dose then tried to decrease dose and then felt very bad, shaking, nose running, sweating, weak, yawning and moody. Then took the meds and felt better within an hour. Needs help."

Is that something you reported to Dr. Walden's office on that day?

A It was.

Q Do you remember that?

A Not clearly. What I do remember is the feeling bad. We were coming back from the lake, my wife and I, Michelle, and I could not stop yawning. It was just -- you know how you yawn once or twice, but it was just continuing over the ride home. It would not stop.

And you know, I was sweaty; I was shaky. I did not feel good. And I took another pill, and 45 minutes or so later, that went away and I felt okay. And I'm like, well, that's not right. So --

Q Brian, did Dr. Walden call you back?

A No.

Q Were you asked to come in for an office visit?

A No.

Q Did Dr. Walden just authorize another refill?

A Yes.

Q Brian, had you ever had any kind of addiction or substance abuse problems before this?

A No.

Q How about smoking?

A Yes, I -- yes, I've smoked since I was a teenager and have not been able to successfully quit.

Q Mike, can you pull up Exhibit 1, page 195? Can you show us the date, please?

Brian, this is a record from August 19th, 2008.

And then can we go out?

Brian, do you recall contacting your physician's office and telling them that you were doing better with back. Receiving injection therapy at St. Luke's with Dr. Ann Christopher. Taking Vicodin six times per day with plans to wean back in one week.

A I don't remember that clearly; but if that's what it says, I believe that.

Q Do you recall having a desire at any time in 2008 to want to wean back on your pills?

A Yes, I did.

Q Did your physician wean you back on the pills?

A No.

Q Can you go to page 208, Mike?

This is a record from November 6 -- well, I don't think that's it. Where's the date at, Mike? Encounter date, November 25th, 2008. Scroll out.

Brian, three months after that, did your Vicodin dose get doubled?

MR. VENKER: Object as leading, your Honor.

THE COURT: Sustained.

MR. CRONIN: Judge, these questions do not assume the answer.

THE COURT: Just tighten them up a little bit.

Q (By Mr. Cronin:) How about this, Brian? Do you know the exact dose you were on from the period 2008 to 2012?

A No, I do not.

Q Should we look at the pharmacy records for those?

A That would be a good idea, yeah.

Q Brian, did you get then placed on OxyContin in early 2009, in addition to the Vicodin?

A I believe so, yes.

Q Were you taken off the Vicodin when you got put on OxyContin?

A No.

Q Brian, from 2009 to the middle of 2012 were doses regularly doubled?

A Yes.

Q Were three different types of opioids regularly increased?

MR. VENKER: Your Honor, I'm just going to object. Well, may we approach?

(Counsel approached the bench, and the following proceedings were had, out of the hearing of the jury:)

MR. CRONIN: This is instructive --

MR. VENKER: Your Honor --

THE COURT: Everybody take a deep breath.

Number one, some of your questions are leading, not all of them are leading. So he has a right to object. Some of them don't suggest the answer; some of them do. And so, I am not going to obstruct you from directing your client. I understand sometimes it is necessary, so I'm weighing the times when I think it's necessary.

But I'll give you an example. When you said, was your medicine doubled, that was a leading question. The answer was in it, everything. So sometimes you're leading, and sometimes you're not.

MR. CRONIN: Sure.

THE COURT: And so the burden is on you to --

MR. CRONIN: Understood, Judge.

THE COURT: I'll call the balls and strikes as I see them, but not every one of them have been leading so let's take it as it comes.

MR. VENKER: I'll try to refrain. I'm not trying to be obstructive. But he said he doesn't remember what the doses were, and you said should we refer to the pharmacy records; and then you said did they double.

MR. CRONIN: Judge, these are all undisputed facts. I don't know why objections are being made.

MR. VENKER: Because I don't know what the witness is going to say. It sounds like you're saying to him here's the information.

THE COURT: I'm keeping the totality of the situation. Some of them are leading, but they make sense. But the ones that jump out at me, I'm going to rule accordingly.

MR. VENKER: All right.

MR. CRONIN: All right.

(The proceedings returned to open court.)

Q (By Mr. Cronin:) Brian, did you ever go through your pills too quickly?

A Yes.

Q How often?

A Regularly.

Q Did you hide that information from your doctor?

A No, I did not.

Q Was your doctor always advised when you ran out of your pills?

A Yes.

Q Did Dr. Walden write you new prescriptions early ever?

A Yes.

Q How often?

A Regularly. Every month. I had to get a written prescription. And I had to call the office and say, I am out of my medication. And then I'd get a call back saying that the prescription was written and I could come pick it up.

Q Brian, were new prescriptions written early for you or ever with higher doses without office visits?

A Yes.

Q How often?

A Fairly regularly.

Q Do you recall any conversations with Dr. Walden where he set forth any kind of plan, like when the opioid treatment would stop or how high the doses would go?

A No, I do not.

Q Brian, did you have back pain?

A Yes, I did.

Q Did you want treatment that would allow you to continue working?

A Yes.

Q What were your conversations with your physician about in that regard?

A I'd go in and talk to him. And originally it was, I need to keep working. I had a wife, a young daughter, and it was important to me to be able to work. I was concerned that I would not be able to stay in my position if I could not do the workload, and that's why I was taking the pain medicine.

Q Brian, did your physician, Dr. Walden, tell you what treatment he thought was best?

A Yes.

Q What was that?

A It was to start off with the Vicodin and continue on. It was through the management of the pain medications.

Q Brian, what began to affect your job more, the pain or the pills?

A The pills affected me more, down the road.

Q Go ahead. I'm sorry.

A You know, at first the pills did not affect me more than my back pain did. But as time went on, I was not able to do my work due to the medication more than the

back pain.

Q Who was your foreman?

A Lowell Lake.

Q Did you tell him that you were taking pain medication?

A Yes, I did.

Q How was the pain medication affecting your ability to do your job?

A I couldn't use equipment or operate equipment that I used to be able to use. I couldn't drive myself anymore. I had somebody drive me. A coworker would be with me, and he would be with me and he would drive to and from the job sites.

After a while, I ended up doing paperwork for my boss. I did his dailies, requisitions. He kept me around in the office. He carried me for a good year and a half, two years. He made sure that I wasn't going to be out somewhere where I would get hurt physically.

Strength-wise, I didn't have the strength I used to. It was difficult, but, you know, my boss carried me to the end of it.

Q Brian, what were your -- have you ever seen your performance reviews from work?

A Yes, I have.

Q What were they like before 2008?

A Outstanding, highly successful.

Q Did your performance reviews begin to go down in 2008?

A Yes, they did.

Q Can you pull up page 260 of Exhibit 1, Mike? This is an encounter date of June 8, 2009.

Brian, this says, "Brian Koon is a 37-year-old male. Complains of shortness of breath last PM one time; awakened from sleep; was gasping and complaining of chest pain. Unsure how long attack lasted but over a period of two to three hours was feeling better."

Brian, do you remember this visit?

A Not particularly I don't.

Q Okay.

A I remember waking up in the evening one night and not being able to get a breath of air. That I remember. I don't remember the visit that came of that, no.

Q Do you see the bottom where it says, "Patient is adopted. Still with some pain now."?

A Yes, I do.

Q Well, how about this? Did you tell me you don't specifically remember the visit?

A Yes.

Q Okay. You can pull it down, Mike.

Brian, is this around the time your daughter was born, middle of 2009?

A Yes, my daughter was born in July of 2009.

Q By this point, Brian, looking back, what kind of effect were these pills having on your life?

A Looking back at it, you know, I can't -- 2009, I can't remember my daughter's birth. You know? The birth of my child. My memories come from my wife, my family. I mean, this is the birth of my only child. I can't remember it.

So, you know, what kind of effect does that have? I heard my wife tell me for the first time in court yesterday that I wasn't the man that she married. It's a pretty terrible effect that it's having on my life.

Q Brian, did you ever get morphine from your physician to fill in gaps when it wasn't time for a new prescription yet?

A Yes.

Q Do you know how many times that happened?

A I believe once.

Q So you remember it happening only once?

A That is correct.

Q Brian, what happened with your intimacy with your wife during these years?

A There was none.

Q What was happening with your personal relationship with your wife looking back?

A We became roommates more than a husband and wife, looking back at it. During that time, I assumed everything was fine. Looking back at it, nothing was okay. We became roommates.

I guess I'd go to work and come home and, you know, I thought I was doing my part by doing that. That's -- I'd go to work, come home, sit on the couch. I mean, I didn't do much of anything during those years.

Q What was your relationship with your daughter like for the first few years of her life?

A I don't recall.

Q How does that make you feel now?

A Ashamed. Like I abandoned my daughter. I was there.

Q Do you remember her baptism?

A No, I do not.

Q Do you remember her first steps?

A No.

Q Her first words?

A No.

Q Brian, what was your focus as we move forward in these 2008 to 2012 years?

A My focus was my medication. It -- that was it

for me. It ran my life. It told me when to eat, when to sleep. It was all that mattered. Everything revolved around taking my pills. Everything revolved around it.

It's a terrible thing to have absolutely no control, no control over it. It ran me. It was more important than my wife, than my daughter. It was more important than me.

Q Brian, did you have any constipation problems during this period you were on opioids?

A Yes, I did.

Q Tell me about that.

A I could not go to the bathroom without the use of laxatives, stool softeners, liquid glycerin enemas. I at times would -- you'll have to excuse me. I would have to reach around and -- I'd have to put my fingers in my rectum and pull my stool out it was so compacted. It was hard as a rock. You could not pass it.

And after taking, you know, a bunch of laxatives, the top part would start pushing, and you know, it would have to come out. And if you let it go to long, which was frequent because you don't focus on going to the bathroom, it would occur, and I would have to reach and pull stool out of myself.

Q Brian, did you end up seeing a Dr. Berry sometime in 2012?

A Yes, I did.

Q Did you know how that came about?

A Dr. Berry, I believe my wife had initiated something of finding a pain management doctor for me is what I believe.

Q Brian, what happened when you went to see Dr. Berry?

A When I went to see Dr. Berry, I -- I was -- I woke up for the first time. I was told that in no uncertain terms that I was --

MR. VENKER: Your Honor, may we approach?

THE COURT: You may.

(Counsel approached the bench, and the following proceedings were had, out of the hearing of the jury:)

MR. VENKER: It seemed clear to come up because we're going to get back into this fairly significant area of Dr. Berry's supposed statements to this man and his wife about the DEA supposedly having missed Mr. Koon somehow.

The testimony has already been discussed at pretty good length. So I just want to renew my objection at this time to that as hearsay and every other reason we talked about it being prejudicial, irrelevant. And so I just want to renew those objections now.

MR. CRONIN: I'll clean up the question to make

clear I'm asking for the purpose of what effect it had on him.

THE COURT: So the objection remains overruled, but it sounds like counsel is going to tighten it up.

MR. CRONIN: I will.

MR. VENKER: So for this line of questioning my objection is good?

THE COURT: Yes.

MR. VENKER: Thank you.

(The proceedings returned to open court.)

Q (By Mr. Cronin:) Brian, what did Dr. Berry say to you about the pain medications and what kind of effect did it have on you?

A I was told I was taking too much pain medication, it was an extremely large amount, and that I should find a way to get off of it. He told me he would not take over my pain management as far as my medication went.

Q Brian, was that the first time that you really realized how bad of a problem the pills had become for you?

A Yes.

MR. VENKER: Object as leading, your Honor.

THE COURT: Sustained. Jury will disregard the question and the answer. Ask another question.

MR. CRONIN: Sure.

Q (By Mr. Cronin:) Brian, did Dr. Berry's statements to you have any effect on you as to whether there was a problem?

A Yes, they did.

Q Tell me about that.

A I was going to see a pain management doctor. For that doctor to tell me that he would not take over my treatment because I was on too much medicine, way too much medicine, that woke me up for the first time. It was difficult to hear.

It was frustrating that the doctor would not take over the management of my medication. He did, however, offer to still do spinal injections of steroids. So that was my wake up call.

Q Brian, do you have any recollection of an office visit with Dr. Walden around this time frame?

A Yes.

Q Tell me about that.

A I went in to talk to Dr. Walden, and I told him about the conversation I had with Dr. Berry and that I was on too much medication, that I wanted to get off the medication and that it was running my life.

I don't know how much clearer I could have been. I was in tears. I was a grown man crying to my doctor

that I trusted to come off my medication.

Q Brian, were you asking for help?

A Absolutely.

Q What did your doctor do?

A Nothing.

Q How did that make you feel?

A Pretty hopeless.

Q Brian, did something happen towards late summer, early September that made you go seek more extensive help?

A Yes.

Q What?

A I got pretty down. I couldn't keep control of my medication. I felt everything slipping away from me, and I was looking for an easy way out. And I was in my room, and I picked up the .38 we have. And I put it in my mouth and said, you know, this has got to go; I'm done.

And the only thing that kept from that was I had a wife and daughter in my front room, you know. I can't have my wife and kid come in and find me like that. I mean, that -- that would be beyond an abomination. That is the point that something had to give.

Q Brian, did you stop seeing Dr. Walden completely?

A Yes.

Q Did your wife take you to a facility called

Centerpoint?

A Yes, she did.

Q Did you go through any withdrawals when you went off the opioids?

A Yes.

Q What were those like?

A Extreme nausea, sweating, chills, muscle cramps that felt like the muscles are pullin' off your bones. Just lyin' there in the bed, my winter coat and covered up, not knowing what to do. It feels like the muscles are comin' off my legs, and all I could do is I remember layin' there and sayin' the Lord's Prayer over and over and over and praying for it to stop.

Q Brian, was rehab difficult for you?

A Extremely.

Q Why?

A I had to face myself for the first time in four years. I remember coming out of detox, and they put me in the chemical dependency unit. And I remember going in to the bathroom. I had a room with my own bathroom, shower. It was nice. I remember looking in the mirror and not seeing who was there. I didn't recognize myself. I looked not like me. I looked like an old man in that mirror. I did not know who was there anymore.

Q Brian, were there two different stages of

rehabilitation treatment?

A Yes.

Q What were they?

A When I first got there, I was put in a locked unit that was detox.

Q How long was that?

A I believe maybe three to four days.

Q And what stage was after that?

A The chemical dependency unit, the rehab.

Q Okay. Was that an outpatient, or it was just not --

A That was inpatient.

Q Okay. How long was that?

A That was two and a half, three weeks.

Q What kind of treatment did you undergo?

A I underwent treatment for addiction to opiates.

Q What kind of treatment? Was it group therapy?

A Group therapy, individual therapy. I was placed on Suboxone to control my withdrawals, my cravings. I was placed on all different new kinds of medicines. I was placed on Suboxone was the main thing for the withdrawals.

The treatment was group therapy, individual therapy with doctors, some -- just mostly group therapy focusing on different aspects of addiction. It was a busy schedule. You went from 8:00 a.m. all the way up until

seven, 8:00 at night. You had AA or NA meetings in the evenings. It was an intense look into one's self.

Q Brian, did you ever fill out mood surveys at Centerpoint?

A Every morning.

Q Mike, can you pull up Exhibit 10, page 162? Can you blow up this part?

Brian, is this your handwriting?

A Yes.

Q And you see it's dated September 16th, 2012?

A Yes, I see that.

Q Do you see you wrote, "To have a positive visit with my wife and little girl"?

A Yes.

Q What happened in that visit, Brian?

You can take it down, Mike.

A That was the first time I had seen my wife and my daughter since coming to treatment. It was my sixth wedding anniversary. I was beyond nervous to see them. When they -- when they came up, it, it was almost unbearable to see them.

I had not seen my daughter with clear eyes in my entire life since she had been born. I had not -- she was just beautiful. And my wife, comin' to see me in rehab on your sixth anniversary. It was tough. I -- excuse me.

Q What happened with Emily?

A We went outside. We sat down on the grass, and Emily got up and started running. It was a beautiful sight. I didn't know my daughter could run. And I said that to my wife; and she said, Brian, Emily has been running for over a year now.

Q Did you not know that your daughter could run or talk?

A No, I didn't. And at that point I politely asked my wife if she could take Emily and if they could leave, because I could not --

Q Brian, from Centerpoint to today, do you ever wonder whether you should have done something differently?

A Every day. Every day I wonder.

Q Brian, did you keep a diary in the hospital as part of your medical treatment?

A Yes.

MR. CRONIN: Permission to approach, Judge?

THE COURT: You may.

Q (By Mr. Cronin:) Does this look like it?

A Yes.

Q Why did you keep the diary?

A We kept a diary because we had classes that we went to. We were given a lot of information, and you needed to be able to write it down so you could review it

and so you could digest it in the evening on your free time.

Q Can you tell me what the first entry in the diary says?

A Why I came to Centerpoint.

Q What's the answer?

A To get my life back.

Q I just have one other entry I want to ask you about, Brian. Did you keep this diary when you were in classes during your twelve-step program?

A Yes.

Q What's step one?

A We admit that we are powerless over whatever you're addicted to.

Q Brian, what was the purpose that you were in Centerpoint and going through your twelve-step program for?

A It was to overcome my addiction to opioids.

Q Do you see this entry where it says, "Step one, blame others, no. I am an addict. It's my fault."

A Yes, I see that.

Q Is that your handwriting?

A Yes, it is.

Q What were the circumstances in which you wrote that?

A That was taken down off a white board where the instructor would write down notes for everybody to take. It was a general thing that everybody wrote down.

Q Brian, were you at Centerpoint to try to get better?

A Yes, I was.

Q Were you there to try to figure out if somebody else caused this?

A No.

Q Brian, do you remember having to fill out some questions as part of your treatment for step one of your twelve-step program?

A Yes.

Q And was that -- were you asked to do that as part of your treatment by your providers?

A Yes, I was.

Q And step one, question two says, "How has use of alcohol or drugs affected the way you really feel about yourself. Give at least three examples."

And Brian --

MR. VENKER: Is this a different exhibit?

MR. CRONIN: This was Exhibit B-1 to his deposition. I don't think we have it on our list, but it was -- sorry, and the other one was B-2.

MR. VENKER: I got that one.

Q (By Mr. Cronin:) Brian, can you tell me what you wrote for those three examples?

A I feel that I have become useless at work being unable to perform my duties as I should. I had become utterly disgusted with myself as a man. I feel -- I felt at a total loss. I have not slept with my wife in two and a half years being physically unable to. I felt like I was going crazy, unable to control myself. I was beyond angry, in complete despair being unable to control the amount of pills I was taking.

Q Brian, have you had any back surgeries since you got out of Centerpoint?

A Yes, I have.

Q How many?

A Four.

Q What were they?

A I had the first one was in November of 2012 right after I got out of Centerpoint. I had the fusion of my neck, my cervical. It was C5 to C6, I believe. My disc was ruptured so they removed my disk and put a plate in the front of my neck holding my vertebrae together.

The second one I had was I believe the summer of 2013. I had my -- a discectomy, I believe, is the terminology. I had a disc repaired in my lower back. And that was L4, L5, inbetween there.

And the next surgery was again of my lower back. And that would have been in April of 2014. The disc blew out completely. I ended up having a lumbar fusion. They removed my disk. They took bone out of my hip to replace the disk, and they put screws and rods in the back and went through my front and placed the plate in the front.

The last surgery I had was spring of last year. I had some arthritis removed out of my neck, and that was at C6, C7 in the back and some bone removed from my spine in that area. And that was the last surgery I've had.

Q Brian, were you prescribed any opioid pain medication following your surgeries?

A Yes, I was.

Q What kinds of doses after back surgeries?

A Mild doses of hydrocodone, some Percocet.

Q Were you placed on close to the doses you had been on in 2012 before going to Centerpoint?

A Nowhere near, no.

Q Did you ever -- did you have an issue at any point after any of your surgeries with those medications?

A The first two surgeries, I did not. I was still taking Suboxone. After the third surgery, I had issues. I did not have the Suboxone anymore, and I ended up going through some withdrawals when I came off the medication. It was -- it was tough but, you know, I got through it.

And the last surgery I had, I ended up having issues coming off the medication from my neck surgery, and I talked to my doctor who was aware. And let me make sure that you know that all my surgeons for all my surgeries are aware that I'm opioid addict. That was one of the first things I told them.

Q Brian, are you taking any pain medication now?

A Yes, I take Tramadol.

Q Okay. Do you have an understanding as to whether Tramadol is different than the types you were taking before?

A Yes. My understanding is that Tramadol is a pseudo narcotic. It effects the pain receptors in my brain the same way as, you know, an opioid would, but I do not have any narcotic effect from that and I am able to take that as prescribed.

Q What kind of dose are you on?

A I take a 50-milligram tab every four hours as needed.

Q Did you know that 50 milligrams of Tramadol is 30 MED?

A I do now, yes.

Q Brian, have you been on Tramadol for about a year now?

A That is correct.

Q Okay. About the same dose?

A Yes.

Q Brian, did your relationship with Michelle get any better after you got out?

A It seemed to at first. There was -- yeah, I mean, in the sense that I could talk to her with a clear head. You know, I would remember what I was talking about. But in the sense of being able to get close again, it -- I lost -- I love my wife dearly. But I am not in love with her anymore. I have lost that connection that we have. And it is -- I am beyond ashamed of this. I haven't been a husband to my wife in any sense. I haven't emotionally been able to be there for her. Physically I'm -- there's been nothing. I can't tell you the last time I kissed Michelle.

Q Brian, when you got out of rehab, were you scared to get close to anyone?

A I was scared to get close to my wife, my daughter.

Q Why?

A For fear of screwing it up again. For fear of being an utter disappointment. For fear of being a failure as a husband, as a father.

Q Has your relationship with Emily recently started to get a little bit better?

A Yes, with Emily, it has.

Q Tell me about that.

A My daughter visits with me on the weekends. I have her for the weekends. And it's been good for me to have her. I've been able to start building a relationship with my daughter which has been wonderful.

I had to learn how to give my daughter a bath in the beginning and learn how to wash her hair, and that to me was one of the most fulfilling moments that I could have with my daughter. I didn't have it when she was younger, but -- my daughter loves me. And there's no doubt in my mind she loves her dad. And for that, I am forever grateful for that. That has kept me -- that has kept me going. That has kept me steady.

Q Brian, as you pointed out, did you hear Michelle's testimony yesterday?

A Yes, I did.

Q Was that really the first time you heard Michelle talk about how all of this affected her?

A That is the first time.

Q Was that difficult for you?

A Extremely.

Q Do you feel you needed to hear it?

A I absolutely needed to hear it. I can understand why my wife has left me, and I do not -- I do

not blame her.

Q Brian, those are all the questions I have for you.

THE COURT: All right. Cross?

MR. VENKER: Should we take a break, your Honor?

THE COURT: All right. Let's take a ten-minute break.

The Court again reminds you what you were told at the first recess of this trial. Please do not discuss this case with anyone. Don't form or express any opinion. Don't do any research. Don't communicate with anyone about it. It will be a short bathroom break. Ten minutes.

(At this time a recess was taken.)

o0o

(The proceedings returned to open court.)

THE COURT: All right. Please be seated.

You may inquire.

MR. VENKER: Thank you, your Honor.

**CROSS-EXAMINATION**

BY MR. VENKER:

Q Good afternoon, Mr. Koon.

A Good afternoon.

Q You know, I'm going to move this up a little bit.

I've got some questions for you, Mr. Koon.

Let's do some generalities, background. You talked about having depression as a teen; is that right?

A That's correct.

Q And you were hospitalized for about 28 days or so?

A That would be correct.

Q All right. And then when you had Hodgkin's, treatment for your Hodgkin's disease in the early 1990s, you had radiation therapy, correct?

A Correct.

Q And that has resulted in certain medical condition or health consequences for you since then, hasn't it?

A It has caused me to lose my teeth, yes.

Q Any other conditions?

A My thyroid.

Q Anything else?

A Nothing has been substantiated beyond that.

Q All right. And after the -- during the time you had that treatment you had opiate pain medications during that time period, didn't you?

A Briefly, yes.

Q And the physician at that time explained to you the risks of that medication?

A Yes.

Q Including dependency and possible addiction?
A Yes.
Q And you had no history of addiction from that episode, correct?
A Correct.
Q Any difficulty getting off of those medications?
A No.
Q You have a kidney condition that prevents you from taking the nonsteroidal anti-inflammatory drugs; is that right?
A That's correct.
Q So things like, what, Ibuprofen?
A Any kinds of NSAID.
Q Nonsteroidals?
A Yes.
Q Because they could possibly further injure your kidneys, right?
MR. CRONIN: Your Honor, vague as to time frame. These are subsequent as to 2012.
THE COURT: I'll allow you to fix it on Redirect. It's Cross.
Q (By Mr. Venker:) Let's talk about, I realize it's a little sensitive, but it's something we need to talk about. The erectile dysfunction.
You were given medication for that by Dr. Walden

as early as the -- in the early 2000s; isn't that right?

A That is correct.

Q And was that on more than one occasion?

A I don't recall specifically.

Q Do you recall it was in the 2002 time frame?

A I don't recall what time frame it was in.

Q All right, sure.

Mike, can you put up this is Exhibit A, the SLUCare records? SLUCare page 34. Right down here, Mike.

All right. So this is records from SLUCare, Dr. Walden's records. It says erectile dysfunction, correct?

A Yes.

Q Okay. So let's go back, Mike, and show the whole -- the date on this. Can you blow that up so we can see that? Okay.

So this is in October of 2002, right?

A That is correct.

Q Okay. And do you remember whether after 2002 you continued to get medication for that condition, sir?

A I think maybe once or twice more.

Q Okay. And was that because it wasn't helping or you didn't need it over that time period?

A Because of what?

Q Was it actually not helping you, or was it

helping you?

A It helped somewhat, yeah.

Q Somewhat, okay.

You talked -- you talked about some of your interactions with some of the physicians, so I wanted to ask you about some of that.

You told us on Direct Examination that you talked about having control issues with the pills, and it was difficult for you to take just what you needed and you wanted to take more. Can you tell us when that started for you, Mr. Koon?

A Not with absolute certainty, I can't give you an exact date when that started. That is not that clear to me.

Q Okay. Do you have any memory at all of having conversations with Dr. Walden where you and he discussed the risks and the benefits of you deciding whether you'd go on opioid medications for your pain?

A I believe I remember conversations sometime early on.

Q Okay. And in that conversation with Dr. Walden, do you remember him telling you, you know, you can become dependent on these medications; they can be beneficial, but they also can be dangerous. Do you remember anything like that?

A He said it can lead to dependency, I believe, yes.

Q Okay. And so did he tell you anything about what that would feel like or what you should do if you felt like you were becoming dependent?

A No, he did not.

Q And when you had office visits with him, do you remember him asking you about how you were doing on the medication, how you were feeling, do you remember him asking you those questions?

A Not particularly, no.

Q All right. And so the first office visit you had with him in 2008 after getting a prescription, do you remember him talking with you then about the potential for dependency and addiction for the medications?

A He talked about the risks and benefits and decided that the benefits outweighed the risks at that point.

Q Now, when you say he decided, this was your decision as well, wasn't it, Mr. Koon?

A I was following my doctor's guidance.

Q Okay. Well, in the end, the patient has to make the final decision on whether they're willing to accept the risks of any treatment or procedure, don't you agree with that?

A Dr. Walden had been my doctor since 2001. I trusted him. I trusted his judgment. So I went with his suggestion.

Q Okay. But in the end, it had to be your decision as the patient to decide whether you would accept the risks involved. Do you agree with that?

A In the end, sure, I did have to say, okay, Dr. Walden, I agree with your recommendation.

Q Okay. And you mentioned as early as July of 2008. So you had just been on these medications for, what, since late February of 2008? And in July of 2008 Mr. Cronin and you discussed this event where you were coming back from the lake, driving back from the lake house that your wife's family had. Do you remember talking about that?

A Yes, I do.

Q Okay. And you talked about having symptoms of yawning, shaking, sweating. Do you remember telling us about that?

A Yes, I do.

Q I think what I wrote down is you took a pill and within four to five minutes you felt better. Do you remember saying that?

A I said around 45 minutes.

Q Okay, 45 minutes.

And then you said, what I wrote down is, you were saying to yourself that you didn't think that was right. Is that what you said to yourself, this isn't right to have this happen?

A That sounds correct, yes.

Q So at that point you didn't call Dr. Walden, did you, and say, Dr. Walden, I'm not feeling good on these medications. This isn't right. I don't feel good. You didn't call him and tell him that, did you?

A I called him and left a message saying that I was not feeling well.

Q Right. Okay. Did you say you thought these drugs were not right for you? That's what I'm asking.

A Directly, those words, no, I did not say that.

Q Okay. All right. And I take it that as of this July 2008 time frame, you don't remember what dose you were on, that daily dose at that point, do you?

A In July of 2008?

Q Yes, sir. I know it's a long time ago.

A I don't recall the daily dose at that point, no, sir.

Q Okay. All right. So in early 2009 you talked about being prescribed OxyContin. Do you remember that?

A Yes.

Q That was a different doctor than Dr. Walden, but

someone else in the SLUCare physician's group?

A Originally, yes.

Q Okay, right. That's what I meant. At that visit where that was prescribed for you. That's all, all right?

A Okay.

Q All right. You mentioned you had issues with constipation. You never talked to Dr. Walden about that, did you?

A Yes, I did.

Q And when was that, sir?

A That was early on when I was becoming constipated.

Q Okay. Did he give you advice on what to do?

A He said that there were over-the-counter laxatives to be used.

Q All right.

A And that was about the end of the discussion on that.

Q Okay. And so did you use those?

A Yes.

Q And did they work?

A No.

Q Did you tell Dr. Walden they didn't work?

A No.

Q Okay.

A I was embarrassed.

Q Well, you talked about constipation with him the first time. Why would it be embarrassing to call him another time?

A I talked about him with constipation the first time. I didn't talk about having to stick my fingers in my rectum and pull out hardened stool. That's a little embarrassing.

Q I realize it's a delicate topic, sir, but you're telling us about it now. Are you saying you chose not to tell Dr. Walden about it?

A At the time, yes.

Q What year was that; do you recall?

A When I first had the hardened stool?

Q Yes, sir. Was it 2008?

A I honestly don't recall what year that first occurred.

Q All right. You told us also that -- earlier I think you were saying that under -- in answering one of Mr. Cronin's questions that from 2008 to 2012, for that whole four-year period or four-plus-year period, your focus was on your pills and they ran your life. Am I saying that back to you correctly?

A Can you repeat that once more, sir?

Q Sure. In my notes it says that earlier you told us in response to a question that for this period of time of 2008 all the way through into 2012, that your pills was your sole focus and that, I think I wrote down, that it ran my life?

A In the beginning? No. Three-quarters of the way through, yes.

Q All right. And so three-quarters of the way through would be, what, sometime in 2011?

A No. I mean, three-quarters of that time. Somewhere between the end of 2008, somewhere in 2009, early, mid-2009.

Q So early 2009, that's when it started for you when you say the pills began running your life?

A Yes, that it began to become my sole focus.

Q All right. And so during that time you were still in this pretty severe pain you were having; isn't that true?

A I was in pain. I had back pain, yes.

Q And you didn't have just back pain. You had neck pain as well, didn't you?

A I did.

Q And sometimes it would go down into your arms and hands?

A In my left arm and hand.

Q And into your legs as well?

A Occasionally it would go into my legs.

Q You told us on Direct Examination as well that when you talked to Dr. Berry, that this was the first time that anybody, any doctor had told you that you were taking too many medications and that you had to do -- I'm not sure if you said you had -- or that he told you you had to do something about it, but you decided you needed to do something about it, correct?

A That I decided that I needed to do something about it?

Q Yes, sir.

A Yes.

Q Okay. And so at that point then you then saw Dr. Walden and you told us about that conversation. But after that visit with Dr. Walden where you say you pled with him in tears to help you get off medication, is that what the plea was about?

A The plea was I wanted to be off the medicine.

Q Right. And so you basically said then Dr. Walden said nothing. He did nothing to help you do that, right?

A That is correct.

Q All right. So was there a reason -- I mean, your wife you say had gotten Dr. Berry involved; and she

actually was saying she involved Dr. McKean later in your care. Was there a reason, if that's what Dr. Walden said to you at this meeting you had with him in May of 2012, that if he wasn't going to help you, did you think about seeking another doctor, if that's what happened?

A Other doctors would not take over my regime of medicine to get off it because I was on too much.

Q Okay. When you talked to Dr. McKean in the summer of 2012, she didn't say she wouldn't help you, did she?

A Dr. McKean couldn't prescribe my medicine. Dr. McKean was sought out because, from my understanding of what was going on, we were looking for somebody that could prescribe Suboxone. Now, this is what I remember from my wife telling me. This is not my direct memory.

Now, that's why we went to see McKean originally. Not every psychiatrist can prescribe Suboxone. So we told her what was going on.

Q Okay.

A And she came up with the idea to -- I believe this is correct -- liaise between Dr. Berry, to get advice from a pain management specialist --

Q Right.

A -- to tell Dr. Walden how to get me off the drugs.

Q Okay. And that happened, didn't it, that conversation? Those conversations took place, didn't they?

A I believe so, yes.

Q Because then Dr. Walden wrote the orders for you to start tapering down off the medications; isn't that true?

A That is true.

Q All right.

A But I was unable to taper down off the medication and had told him so.

Q Okay.

A I told him I was unable to taper, that I had no control, and that I wanted to be put into rehab.

Q You're saying you told him this when, sir?

A In that first visit I had with him.

Q And you're saying you told Dr. Walden this, but he refused?

A His response to me was, well, let's wait and see what Dr. Berry has to say. And I had told him that Dr. Berry did not want to have a thing to do with the medicine side of my treatment.

Q Okay. And so you say Dr. Berry told you he wouldn't deal with it, but did you go seek any other physician after Dr. Walden? I mean, I know you're saying

supposedly doctors wouldn't help you; but Dr. Berry said that as a pain management specialist, but did you seek anyone else. That's what I'm asking you. If this was said to you, did you seek anyone else out?

A I went into rehabilitation after that.

Q That was in September?

A Yes. In September I went into rehab.

Q I mean, before that though, sir. Did you do it in May or June?

A I'm not aware if I did or not.

Q Let's talk about your work with the City Parks Department, all right?

A Yes.

Q So you told us earlier you've worked there since 1998?

A Yes.

Q And your position was and still is mechanical maintenance worker, correct?

A That is correct.

Q And so as a part of that job -- Mike, can you put up DDD, COSTL if you need that, 334 to 336 of this exhibit? Let's just go down to the bottom here.

Okay. So this is basically your job. Maintains equipment and systems for heating, ventilating, air-conditioning and plumbing. Performs preventive

maintenance to equipment. Checks operation, lubricates moving parts, changes belts and filters. Pours and finishes concrete. Installation of a lot of equipment there, air handlers, compressors.

Those are the kinds of things you did and still do for the City Parks Department?

A Yes, except I do not do air-conditioning. I don't work with refrigerant, and I don't pour or finish concrete.

Q Let's go on to the second page of that, Mike, at the top. Let's do this a couple lines up here.

It says, "May occasionally weld, braze and cut metal using electric and gas welding and cutting equipment to fabricate, maintain and repair metal objects on city equipment, pipes, structures, et cetera."

You did that too, I guess?

A No. We have welders in the carpentry division that do the welding.

Q So you weren't involved in that. All right.

The job you had with -- you can take that down. The job that you had with the city is physically demanding, isn't it?

A At times, yes, it is.

Q And it was important to you, and you told Dr. Walden it was important to you, to keep working at

this job, correct?

A Absolutely it was.

Q And the pain you had affected your ability to perform that job, didn't it?

A It did.

Q I think you told us in your deposition that certainly at times you were struggling to maintain the workload and that was why you decided to take the pain medications, the opioids, right?

A Correct.

Q Let's talk about when the pain medications helped you. Let's put up Exhibit A, SLUCare page 113.

So this is in April. Let's go down to -- here it is you're talking about your pain. "He now notes low back pain which radiates into both legs, right greater than left. No associated weakness. It is worse at the end of the day after working his job. It is somewhat better with relaxation and analgesics."

Did I read that correctly?

A Yes, you did.

Q Then it says here, "He uses two to three Vicodin after work is complete and that helps him. Otherwise he is doing well. He has no other complaints or concern."

Do you have any reason to doubt that that's what you told Dr. Walden then, do you?

A No.

Q All right. Let's go to page 116, Mike.

Okay. This is from April 16th, 2008. Just saying again, "Having to take more meds than prescribed dose of pain meds. They do work. He just has to take more."

That sounds like what you told -- you don't have any reason to doubt you told Dr. Walden that, do you?

A No.

Q Let's go to page 82. This is Exhibit C, sorry. Exhibit C-1, Mike. It's SLU Hospital, 82. No. How about -- 82 is what I'm looking for, Mike. It's the top box there.

Okay. Here it is. "The patient states this back pain has been a problem since October 2007." Is that when the back pain really started to become severe, Mr. Koon?

A I believe it started getting worse, yes.

Q This is your May 19th, 2008 office visit with Dr. Place, the orthopedic surgeon.

A Okay.

Q But that also says, "But this has gotten significantly worse in the last few months. He states that it has gotten to the point where he has to be on light duty at work. His job requires him to lift as well

as crouch into tight spaces. He says that activity makes this pain worse. Rest and medication seem to make it better."

Do you have any reason to doubt that's what you told Dr. Place in May of 2008, sir?

A No.

Q They note here too that it says, you told them when you get out of your truck you have significant stiffness in your lumbar spine. That was a true statement when you told Dr. Place that, wasn't it?

A Yes.

Q And it also says that you were able to walk one to two blocks before noticing the pain and you have to sit down. You told Dr. Place that as well?

A Yes.

Q Okay. Let's go, Mike, back to Exhibit A, SLUCare, 228.

So this is an office visit at SLUCare where you saw Dr. Brinker. And here it talks about you having a history of chronic back pain and you had some cortisone injections. You had insomnia then. Was the insomnia due to having the back pain wouldn't let you sleep?

A When is this from, sir?

Q This is from February 10th of 2009. Do you see it there, sir? This is when you talked to Dr. Brinker at

SLUCare. Are you with me?

A Yeah, I'm with you, absolutely.

Q I didn't want to rush you.

A No, I'm fine.

Q It says, "Patient is still currently working where he performs occasional heavy lifting and bending in odd positions. He is unable to reduce workload 2/2 to economics." Due to economics? "Patient has been continuing on Lortab, but they seem to be less effective."

So the Lortab wasn't working?

A As well, yes.

Q Okay, all right. So by this office visit in February of 2009, Mr. Koon, are you saying by this time you were losing control of your ability to decide how many pills to take?

A My memory is not clear with that, sir. I said at some point in 2009. I'm not saying at this exact given point. I don't exactly remember what day that started.

Q Okay. Well, other than the visit you had with Dr. Walden where you told us that you were crying with him to -- pleading with him to get you off the medications, you didn't ever tell him before that time that the medications were running your life, did you?

A I had told him before that I have had issues with the medication, yes.

Q So when was that, sir?

A Sir, I can't tell you exactly when. I do not remember exactly when.

Q It's kind of important for you to remember when that was, Mr. Koon.

MR. CRONIN: Is that a question? That doesn't sound like a question. That sounds like closing argument.

THE COURT: Overruled. You may continue your Cross.

MR. VENKER: Thank you.

Q (By Mr. Venker:) So you just don't have any memory of that, sir?

A I have a memory of it but not the time.

Q Okay. Let's look at, Mike, Exhibit A SLUCare, 240, 241.

So this is an office visit with Dr. Walden. There's the date, February 17th, 2009. So this is just a week after you saw Dr. Brinker and he prescribed the oxycodone for you. Let's go down to see what information is in here.

So it says, "Continues to have" -- so this is what you would have been telling Dr. Walden then, a week later after you got these oxycodone pills prescribed by Dr. Brinker. "Continues to have pain throughout back. Scheduled to have injection therapy through pain

management in the near future."

So the injection therapy is something that you had from time to time, correct?

A That is correct.

Q All right. But I think in your deposition you told us that the injection therapy wasn't as effective for you as the opioid medications, correct?

A That is correct.

Q All right. And you also told us in your deposition that from a cost standpoint, the injections were much more expensive than the opioid medication, right?

A Yes, I did.

Q All right. And so, anyway, this goes on to say, "Tolerating the oxycodone well. No adverse effects." That's what you told Dr. Walden at that time on February 17th of 2009, no adverse effects from the oxycodone, correct?

A If that's what the record states.

Q Okay. It says you're continuing to work and you're saying that you have pain in cervical spine with radiation to your left arm, right?

A That would be correct.

Q Let's look at the second page, Mike. Let's try this.

Okay. So it says, "Since his last visit" -- again, this is still the same visit, so the last visit would have been February 10, 2009. "Since his last visit he has been on OxyContin 20 milligrams BID which has helped his pain but has not eliminated and wears off quicker than he likes."

It says you're going to follow up at the spine clinic and get steroid injections for your lower back in the lumbosacral area, however, you still noted you have pain in your mid, lower thoracic cervical region in the back that is not being addressed in the spine clinic due to his followup being seen by NP is a nurse practitioner.

Again, does that sound like something you would have reported to Dr. Walden?

A I don't remember that specifically, but if that's what in the record.

Q No reason to doubt it?

A Yes.

Q Let's go in to 2011, Mike. Let's look at exhibit A, SLUCare 411. It's kind of hard for me to see it.

Okay. Main concern -- denies any known -- okay. Let's go down, smoking, degenerative -- let's go down. What more is down there? Is there a second page to this? Take us back to the first one, Mike, sorry.

MR. MAHON: 411, Mike.

MR. VENKER: I'm sorry, Mike. Did I say 413? I meant 411. Let's look at history.

Q (By Mr. Venker:) Okay. Let's go on to the next one, Mike. Let's do -- let's go to SLUCare 458. That's in August of 2011.

Up here it says, "History of present illness, doing okay, still with back discomfort. No worse than usual. Tolerating medication well."

Again, the kind of thing you don't dispute that you reported that to Dr. Walden in August of 2011, do you, sir?

A No, I do not dispute a that.

Q Dr. Walden was also talking to you about other things, your hypothyroidism, smoking, hyperlipidemia. So it wasn't just the back pain; he was treating you for these other things as well, right?

A Yes, he was my physician.

Q All right. Okay. Let's go down to assessment and plan. I don't see it there. Okay.

(At this time there was a discussion between counsel.)

Q Okay, sorry, assessment and plan.

And so assessment and plan includes, "Back pain. Continue narcotic analgesics. Had long discussion

concerning tolerance and dependency."

Again, you have no reason to dispute that's in the records in August of 2011, do you, Mr. Koon?

A No.

Q And I guess you don't remember any of the questions Dr. Walden would have asked you during that discussion, do you?

A No.

Q All right. And are you saying that by this time in August of 2011 you were to the point where you could no longer control yourself in terms of how many pills you were taking?

A I had a difficult time controlling my medication, yes.

Q Okay. So by this time in August of 2011, that's what I'm asking.

A Yes.

Q Okay. And how far back before August of 2011 do you think you started having difficulty controlling your ability to take only the pills you needed?

A I don't remember an exact date, sir.

Q Well, Mike, let's go back to August 20th again. Exhibit A, SLUCare 291. Let's see. Is there another page to this one? Oh, wait. Go back. I'm sorry. Yeah, do it here.

Okay. So this one in August 20th, 2009, "Continues to note back pain which compromises his activity and lifestyle."

Again, no reason to doubt you told Dr. Walden that, correct?

A That would be correct.

Q "Gets some relief" -- some relief -- "with OxyContin and Vicodin but believes OxyContin is not as potent as it once was."

Do you remember telling him that?

A That's in the record, that's fine.

Q Okay. So it goes on to say, "Tolerates them well." So that's what you would have told Dr. Walden. And then it says, "No other concerns." And then it says, "Recent baby in family and enjoys her."

So that would be what you were telling Dr. Walden, right, about your daughter Emily?

A That would be correct.

Q Okay. And this says, "Denies medication noncompliance." And that would have been what you told Dr. Walden at that time, wouldn't it?

A That would be correct.

Q Let's go, Mike, to Defendant's Exhibit M, Norton 17.

Okay. So this is an office visit that you had

on August 19th of 2011 with Dr. Norton, and he was a chiropractor you saw?

A He was the chiropractor I saw, yes.

Q And so you told him that there has been improvement for sure, when talking to him about the adjustments he was doing to you, correct?

A That would be correct.

Q And you said, "It use to be when I got home after work, I was done for the day. Now I'm able to do more things." Is that what it says?

A That is what it reads, yes.

Q And so, do you remember what the adjustment was that Dr. Norton did for you, the adjustments that he was doing that produced that result that you felt better when you got home after work?

A I believe I was getting neck and back adjustments.

Q Anything more than that, I mean, from him?

A I don't believe so.

Q Okay. And at this point in time in August of 2011, would you say that that's when you, again, did not have control over whether you were taking the right amount of pain pills that Dr. Walden prescribed you?

A That would be correct.

Q Okay. Mike, let's put up Exhibit DDD 244, COSTL

244.

All right. So, Mr. Koon, this is a document out of your file at work, right? It's the performance review for 2008, the year 2008. And if we look at the bottom, it really would be signed in 2009. That's the normal cycle for that, the year-end review, so to speak?

A That would be for the year before, yeah.

Q I'm sorry?

A That would be signed, as the review is 2008, you said?

Q Well, this says 2008. And at the bottom, if we look back, this is signed in 2009, looking back on 2008, correct?

A I believe so.

Q And so this is when you were working then in the year 2008, correct? So it talks about your rating. The HS, that means highly satisfactory?

A Highly successful.

Q Highly successful, thank you for clarification.

So the rating here says, "Mr. Koon demonstrated excellent workmanship with new technology when replacing Cherokee Center's domestic hot water system."

A I was part of a group that did that.

Q Okay. But you got this commendation yourself, right?

A Yes.

Q And then on quality -- so that was productivity. On quality, again, highly successful rating. It says, "Brian consistently shows perfectionistic tenacity in any assigned task."

Now, was this -- during any of this time period were you having difficulty with these medications, these pain medications we're talking about?

A July of 2008?

Q Well, this review -- Mike, let's take a bigger overview and look at the -- we have to look at 251 to find the actual signature, DDD 251.

So this is the signature sheet for that?

MR. CRONIN: Judge, I object. The other document is an addendum to previous documents. This is a new performance review for a new year. This is misleading the witness.

THE COURT: Attorneys, approach.

(Counsel approached the bench, and the following proceedings were had, out of the hearing of the jury:)

THE COURT: How about this? Since it's eight minutes to five, why don't we just start the performance review part of the Cross tomorrow and --

MR. VENKER: And I'll tighten it up.

THE COURT: And make sure you're on the right

year.

(The proceedings returned to open court.)

THE COURT: All right. Ladies and gentlemen, we're going to recess for the day. Our plan is not to keep you long on Friday past five. All right? So I told you I'd give you an idea of what's going to go. The goal is not to keep you past five. That doesn't mean we might not go a little bit past, but we're not going to do a protracted day on Friday. There's no intent to do that. So if we do run long, that's on me. Based on what I'm hearing and how we're rolling, we're not going to go long on Friday.

The plan is to wrap it up hopefully on Monday and have the case to you to decide on Monday. That's the plan as we are going today. If it changes, I'll keep you posted, but I wanted to give you an outline of where we're going. All right?

That being said, as I told you before, do not discuss this case until it's given to you to decide. Don't discuss this case with anyone else. Do not form any opinion about the case or do any research or investigation, and do not communicate about the case with anyone.

We are in recess until tomorrow morning. 8:30, same time.

(At this time the jury was excused, and the

following proceedings were had, out of the presence of the jury:)

THE COURT: We're on the record outside the hearing of the jury to discuss some issues with the Bublis deposition. Page 21?

MR. MAHON: Starts on page 20, Judge. This is the deposition of Chris Bublis, and I think the area in question objected to by the Plaintiffs is 20, line 8 to 34 line 13. And I had another chance last night to look through it.

THE COURT: Twenty, line 8, all the way to 34, line 14?

MR. MAHON: Line 13.

THE COURT: All right.

MR. MAHON: And I think the objection is that it's cumulative of what Mr. Skillman had to say in his deposition.

THE COURT: Okay.

MR. MAHON: And I looked through it last night and this morning to see if there's a way to, you know, if it's cumulative and a way to take out anything that's truly cumulative; and I don't think there's any workable way to do that.

I was reading through it on page 20, I specifically cut out stuff that I went over with

Mr. Skillman. I can I do a shorthand version and don't go over the definitions of the different terms that we're going through because I already went through that with Mr. Skillman, and that's kind of what we talk about on page 20 to 21 --

MR. CRONIN: I'm going to cut you off.

MR. MAHON: Yeah.

MR. CRONIN: Neither I nor do I expect the Court wants to go through line by-line this testimony. If they don't think it's cumulative, I'll withdraw my objection and let the jury -- if they're frustrated with hearing the same thing twice, I'll be happy to make --

THE COURT: All right. So the objection is withdrawn.

MR. MAHON: I appreciate it, thanks.

THE COURT: That's a wrap.

(Court was adjourned until 8:30 a.m., June 24, 2016.

FRIDAY, JUNE 24, 2016

THE COURT: Please be seated. Welcome back, ladies and gentlemen. Good morning. All right. Mr. Koon, I will remind you that you are still under oath.

Counsel, you may proceed.

MR. VENKER: Thank you, Your Honor.

BY MR. VENKER:

Q. Good morning, Mr. Koon.

A. Good morning.

MR. VENKER: Mike, would you put up Plaintiffs' Exhibit 75-2, 13 and 15. Let's do 13 first.

BY MR. VENKER:

Q. Okay. So, Mr. Koon, this is a picture of who, sir?

A. That's a picture of myself, my wife, my daughter, and my mother.

Q. All right. This is identified below as being taken in this time frame of 2008 to 2012, correct?

A. Yes.

Q. Okay. Looks like it's taken, what, maybe at a Thanksgiving dinner, maybe?

A. Maybe. I'm not sure.

Q. Okay. And, so, how old is your daughter in that picture, do you think?

A. I don't know.

Q. Okay. And who is standing behind you?

A. That is my mother.

Q. All right.

MR. VENKER: Let's look at number 15, Mike.

BY MR. VENKER:

Q. And this picture, Mr. Koon, shows you and your

wife, correct?

A. Yes.

Q. And you're pushing a stroller, aren't you?

A. Yes.

Q. And is your daughter in that stroller? Or was she, I should say?

A. Yes.

Q. Okay. And do you remember -- this looks like it's in the summer some time?

A. I'm not sure.

Q. Okay. I assume your daughter was pretty young, so it would have been in, what, the 2009 time frame? After she was born, obviously, in July?

A. After she was born.

Q. In July, right? Of 2009?

A. I'm not sure.

Q. You're not sure of what, sir?

A. The date.

Q. Of when your daughter was born?

A. Oh, my daughter was born, yes.

Q. In July of 2009. That's all I'm asking.

A. Yes, I'm sorry. I misunderstood you.

Q. That's fine. Okay.

MR. VENKER: Thanks, Mike.

BY MR. VENKER:

Q. Now, yesterday -- I don't know that we'll -- I don't mean to belabor it, but it sounds like it's accurate to say that whatever charting there is in Dr. Walden's charting, you don't have any reason to dispute that, do you, sir?

A. I believe that's what he wrote.

Q. Okay. All right. And you have no reason to question that, right?

A. I believe that's what he wrote.

Q. Now, we were talking yesterday about your evaluations. There was a little bit of confusion, so we'll just go back over it pretty quickly.

MR. VENKER: Mike, could you -- let's do Defendant's DDD, 243 and 244.

BY MR. VENKER:

Q. So, let's go at the very bottom of this exhibit, the very bottom. It says July 2008. You see that, don't you?

A. Yes, I see that.

Q. All right. This is Dan Skillman's signature, isn't it?

A. Yes.

Q. All right. And it says successful. So you had a successful rating at that time?

A. Yes.

Q. All right. And the date here, 7/23/08, that would have been after that time you told us about you were driving back from the lake, and you -- your wife or you called Dr. Walden's office to talk about how you were feeling shaky, and you had taken those additional pain medication pills.

Do you remember telling us about that?

A. I do.

Q. And that was in early July of 2008, wasn't it?

A. I believe so.

Q. Okay.

MR. VENKER: Let's go to the next page, Mike. And just blow it up a little bit.

BY MR. VENKER:

Q. I think we started this yesterday, but just for clarification, you were telling us that the rating here in productivity, the HS means highly successful, right?

A. Yes.

Q. All right. And the same for the quality. Highly successful in that category?

A. Yes.

Q. And then in the work habits as well, correct?

A. Yes.

Q. All right. And, so, it says Brian is always

punctual. So you always got to work on time, right?

A. Correct.

Q. And takes the time to maintain a clean and safe work site. Right?

A. Correct.

Q. And including taking care of all of the equipment assigned to him, right?

A. Yes.

Q. All right.

MR. VENKER: Let's go to, Mike, DDD, 251.

BY MR. VENKER:

Q. And this one -- let's go to the bottom again where Mr. Skillman signs. And, again, this is Dan Skillman's signature, correct?

A. Yes.

Q. So this is for the next year. So into -- at the very end of July of 2009, this would have been after your daughter was born, right?

A. Yes.

Q. Okay. And the --

MR. VENKER: Let's go to the next page, Mike. Let's blow up that box again so we can see it a little better.

BY MR. VENKER:

Q. So this is in 2009. And, so, rating is highly

successful. It says, "Mr. Koon demonstrated excellent workmanship with new technology when replacing the Budder Center's domestic hot water system."

You remember doing that, don't you?

A. Not specifically, no.

Q. Okay. Now, was it at this time, by July 31st of 2009, Mr. Koon, that you believed you were -- had already lost control of how many pills you should take? Was it already by this time, this evaluation in late July of 2009?

A. Addiction is a --

Q. No, sir, I'm just asking --

A. -- is a process.

Q. -- whether you remember, by this time that we're talking about here, in July of 2009, when you had lost control of knowing how many pills to take. That's what you told us about yesterday.

A. Yes.

Q. Okay. So, by this time, by July 31st of 2009, you had lost control of the ability to take the right amount of pain medication pills that Dr. Walden prescribed you. Is that what you're telling us?

A. What I'm saying is I'm not sure at the exact point that I lost control.

Q. Okay. But I'm asking you whether or not -- so

it sounds like you're not sure whether it was in the end of -- by the end of July of 2009. Is that what you're telling us?

A. I am not sure.

Q. Okay. So you're saying it could have been at this point in time, when you're getting a highly successful rating at work?

A. Possibly.

MR. VENKER: Let's go on to DDD, 262, Mike.

BY MR. VENKER:

Q. And, so, this is your rating given at the end of July 2010. You see that, don't you, sir?

A. Yes, sir, I do.

Q. And in that year, in 2010, you actually got a -- you got a $50 a week raise, didn't you?

MR. CRONIN: Judge, can we approach?

THE COURT: Yes.

(The following proceedings were held at the bench.)

MR. CRONIN: Judge, again, his supervisor made clear that was a cost of living increase, not a merit increase. The jury is being misled into thinking it's a merit increase.

THE COURT: Go ahead.

MR. VENKER: Here's what we're going to talk

about, Judge, it's a letter saying he took an OSHA course and he got a raise because he took this OSHA course.

MR. CRONIN: Judge, I would just ask that be clarified, Your Honor.

THE COURT: I'll let you clarify it on redirect.

MR. CRONIN: Okay.

(Proceedings returned to open court.)

MR. VENKER: Let's put up 256, Mike. Yeah, 256. Why don't you blow up, this first paragraph, so we can see it.

BY MR. VENKER:

Q. This is a letter from the City of St. Louis to Mr. Koon saying Brian Koon, mechanical maintenance worker, has a certain level of experience, and on his last service rating he successfully completed an OSHA safety course and is entitled to a $50 bi-weekly increase. Right?

A. That is correct.

Q. So this is a year later from the time when you're not sure whether you had lost control of taking the pills that Dr. Walden prescribed you, and you actually took a certification course, a safety course, and got a raise at work, right?

A. That is correct.

Q. All right.

MR. VENKER: Let's go on, Mike, 276. DDD, 276.

And let's do the bottom of this.

BY MR. VENKER:

Q. Okay. So this is your evaluation signed by Mr. Skillman at the end of July 2011, correct?

A. Correct.

Q. All right. And it shows successful performance at work, right?

A. Yes.

Q. All right. So this is a year after the last one, it's two years later than when you said you weren't sure whether you had already lost control of taking too many pills that Dr. Walden prescribed you. So --

But at this time, in 2011, in July, for that previous year you got a successful rating at work, correct?

A. Yes.

MR. VENKER: Let's go to 283, DDD, Mike.

BY MR. VENKER:

Q. And so this is your rating for -- dated July 23, 2012, at your job. Again a successful rating, correct?

A. Correct.

Q. And, so, this was in July 203 -- 2012, that was, what, four -- I guess two or so months after you say you pled with Dr. Walden to get you off your medications and you said he refused to let you do that.

Isn't that the time frame we're talking about here?

A. That is the time frame.

Q. All right. Okay. And, then -- I can go -- well, let's go through these. Because you --

MR. VENKER: Let's look at 299. DDD 299.

BY MR. VENKER:

Q. And, so, here's the -- an evaluation that's dated in October of 2014, correct? Again it says you got a successful performance rating at work, correct?

A. Yes.

Q. Okay.

MR. VENKER: And then, Mike, let's go to 303. DDD 303. If you could -- this line right here, Mike.

BY MR. VENKER:

Q. Okay. So, in -- so in that time frame of 2014, the records for you show that you actually got a 2 percent merit increase. Isn't that right, sir?

A. That's what it says, yes.

Q. All right.

MR. VENKER: And then, Mike, let's go to DDD 232.

BY MR. VENKER:

Q. So this is in October of 2015, again your job rating, Mr. Skillman has signed it, it again says

successful performance at work, correct?

A. Yes.

Q. All right.

MR. VENKER: And then let's go to -- let's go, Mike, to DDD 333.

BY MR. VENKER:

Q. Okay. And this is for 2015. Up in the top right corner we see September of 2015. Can you see that, sir?

A. I see that.

Q. Okay. So let's go down in the middle -- and -- and this record from your job notes that you got a merit increase at that time, doesn't it?

A. Yes, it does.

Q. Okay. Now, in June of 2014 you applied for work disability, didn't you, because you said you couldn't work?

A. I applied for disability under -- in case I wouldn't be able to work in the future, because I had back surgery.

Q. Okay. But you applied for permanent disability in June of 2014, right?

A. Correct.

Q. All right. And let's look at --

MR. VENKER: It's FFF, Mike, 1758. Let's blow

this box up here, Mike.

BY MR. VENKER:

Q. Okay. So the questionnaire asks you how do your illness, injuries or conditions limit your ability to work. This is your printing, isn't it, Mr. Koon?

A. Yes.

Q. Can you read that for us?

A. I cannot work because of my incessant pain. I find it extraordinarily painful to walk. I cannot lift, I cannot bend, it hurts to sit, which makes driving very hard.

Q. All right. And you never applied for disability when you were taking the pain medications that Dr. Walden prescribed you, did you?

A. No, sir, I did not.

Q. And this -- in June of 2014, how many of your surgeries had you had by that time?

A. I had had three.

Q. All right.

MR. VENKER: Let's go to the next page, Mike, 1759. Let's do this. Yeah.

BY MR. VENKER:

Q. So, this asks you what were you able to do before your illnesses that you can't do now. And you said I could work and function at home.

What did you mean by that?

A. It means I could --

Q. If you remember.

A. I could work and function at home.

Q. Okay. All right. Fair enough.

MR. VENKER: Let's go down, Mike, to the next --

BY MR. VENKER:

Q. And so, again, we're in June of 2014, and this line -- or this question number eleven says, "do the illnesses, injuries or conditions affect your sleep." You checked yes. And then read for us what you printed there, sir.

A. I cannot sleep more than a few hours at a time. The pain is too bad. And I can't --

Q. Okay.

A. Then I --

Q. Go ahead.

A. I can't read -- make it out.

Q. I think it says, "then I am awake for hours." Does that --

A. That appears to be correct, yes, sir.

Q. I get it about not being able to see distances, so I'm not trying to --

MR. VENKER: If I may approach, Your Honor.

THE COURT: You may.

BY MR. VENKER:

Q. I'll just give you a copy in case it's easier to read it here. We don't have too much more.

A. Thank you.

Q. Okay. And then down below here it then asks really what you can do or not do, right? So it says you can't tie your shoes or bend. Right?

A. Correct.

Q. You couldn't bathe, you have to use a stool in the shower. Right?

A. Yes.

Q. And then down at the bottom you say it hurts to squat and sit, it's very painful. Correct?

A. Yes.

Q. All right.

MR. VENKER: And then let's go to Page -- that same exhibit, Mike -- 1761.

BY MR. VENKER:

Q. And so, here, it says when you go out --

MR. VENKER: Let's do that, Mike, that section.

BY MR. VENKER:

Q. When going out, how do you travel. And you say here ride in a car. Right?

A. Yes.

Q. Okay. And then when going out, can you go out

alone, and you said no. Right?

A. Yes.

Q. And you said it was too painful for you to drive, correct?

A. Yes.

Q. Okay. Now --

MR. VENKER: Let's go on to Page 1762, Mike. Let's do this box here.

BY MR. VENKER:

Q. Now, at this time, in June of 2014, were you on any pain medications, Mr. Koon?

A. Yes.

Q. All right. Can you tell us what those were? Any opioids at that time?

A. Yes.

Q. Okay. And pretty -- what you would call lower doses, certainly, than what Dr. Walden was prescribing for you?

A. Correct.

Q. All right. Other medications, too? Pain medications in addition to opioids?

A. Pain medications in addition to opioids?

Q. Yes, sir. Any others?

A. I don't believe so.

Q. All right. Okay. And, so, this question asked

-- it says, "will you describe any changes in these activities since the illness, injuries or conditions began."

And can you read that for us, what you printed?

A. No longer can take walks. Pain distracts me in reading. The drugs make my vision wary.

Q. Wavy?

A. Or wavy.

Q. All right. Okay. So, in June of 2014, these drugs -- you're telling the Social Security Administration that the drugs make your vision wavy. And are you referring to pain medication?

A. Yes.

Q. All right. You never told Dr. Walden that the drugs made your vision wavy, did you?

A. I don't believe so.

Q. All right. I think you told us earlier, but just to clear it up, you said some -- gave some description earlier in direct examination about Dr. Walden.

Would you -- you were Dr. Walden's patient in -- beginning in 2001. You liked him, right? I mean, he was a good doctor?

A. Yes.

Q. Yeah.

A. He was a very good doctor.

Q. He was knowledgeable and certainly listened to you, didn't he?

A. Yes.

Q. All right. And I think you described him in your deposition as having -- thought he had a good bedside manner, correct?

A. Yes.

Q. And he would spend a decent amount of time with you, right? He didn't seem hurried or anything, did he?

A. No.

Q. Okay. And when you started to have your back pain, you went to see Dr. Mistretta for manipulation, the chiropractor, right?

A. Yes.

Q. All right. And you were taking Flexeril and Advil in that time frame, weren't you?

A. Yes.

Q. All right. But at some point those just weren't getting the job done for you, were they, in terms of pain relief?

A. Yes.

Q. Okay.

MR. VENKER: So let's look at, Mike, Exhibit A, SLUCare, Page 108. I think we're looking at -- if I can

find it. This. Let's go up a little bit higher.

BY MR. VENKER:

Q. And so this is in February of 2008, February 21, 2008, and, so, it's a checkup, it says here, "better relief with Advil, warm showers, although the patient now requires approximately twelve Advil a day to function and is still unable to perform all his normal activities at work."

Did I read that correctly?

A. Yes.

Q. Okay. So this is in -- this is February 21 of 2008. That's -- that's accurate, isn't it? Wasn't it an accurate description of your pain and your activity level at that time?

A. I believe so.

Q. All right. And when you and Dr. Walden were talking, he advised you to change -- to think about changing your job, right? Because it was a heavy, physical, demanding job?

A. Yes.

Q. All right. And that was really something that you both agreed would be beneficial for you, correct?

A. Yes.

Q. All right. And you actually tried to explore options for you to have a job that was not so physically

demanding, didn't you?

A. I looked into it, yes.

Q. Yes. And you talked about that with your wife Michelle, right?

A. Yes, I did.

Q. All right. But then ultimately you decided against that option. Is that true?

A. At the time it would not have worked out for me.

Q. Okay. But, again, that was the decision you and your wife made together?

A. It was a decision that I made, yes.

Q. Okay. And in terms of things you tried to do, you had some physical therapy in these time frames, didn't you? Some.

A. Yes, I had some physical therapy.

Q. Right. Was the physical therapy something that you could have continued but just decided it wasn't really working for you? Isn't that how it went?

A. I had a two week session with the therapist, and went through the therapy, and it helped somewhat. It was something that I could continue at home on my own.

Q. Okay. And did you do that?

A. Yes.

Q. And tell us what you did at home for physical therapy.

A. Stretching and core strengthening to get my abdominals stronger to help support my back.

Q. Okay. And was this something you did before the workday started or when you got home?

A. Before the workday.

Q. Okay. Were you following any kind of regimen that someone had prescribed for you to do the physical therapy on your own?

A. I had literature that the therapy -- or the therapist gave me.

Q. Okay. Like a pamphlet or something?

A. Yes, a handout.

Q. Okay. And how long did you do that, sir? How many years or how many months?

A. I continued for a while. I don't know exactly how long I continued doing it.

Q. All right.

MR. VENKER: Let's put, Mike, Exhibit JJ. I think we want to go to Page 4 of this one. Let's do the impression.

BY MR. VENKER:

Q. All right. So, this is the consult note with Dr. Heim. You see that, don't you? This impression from Dr. Heim?

A. Yes.

Q. Okay. He copies Dr. Walden with this -- this medical exam for you, right? So he would have sent it to Dr. Walden?

A. I believe so.

Q. Okay.

A. I'm not sure.

Q. So he describes you as chronic pain syndrome. Did Dr. Heim explain to you what chronic pain syndrome is?

A. No.

Q. All right. He thought -- he says it might be secondary to lumbar spondylosis. Did he explain to you what lumbar spondylosis is?

A. I can't recall, sir.

Q. Okay. It says, "although his diffuse pain involving his entire spinal axis cannot be attributed to this problem."

You told, basically, Dr. Heim that you were having pain along your entire spine?

A. I don't recall the exact conversation I had with him, sir.

Q. Okay. All right. He says he's -- you were going to him to be evaluated for whether you should have surgery, right?

A. Yes.

Q. All right. And, so, Dr. Heim's note says he's

recommending conservative modalities, meaning conservative methods, right, for your discogenic disease in your lumbar spine.

Do you remember him making that recommendation, these conservative recommendations?

A. I remember him referring me for injections for my back.

Q. Okay. Right. And so you went to see Dr. Christopher for the injections, and he says facet blocks, because that's what Dr. Heim basically ordered that you should do, correct?

A. Yes.

Q. Right. So that was in that narrow range of what Dr. Christopher was supposed to be doing for you, correct?

A. I believe so.

Q. All right. And Dr. Heim says he would hold on surgical therapies for gradually progressive and refractory back and lower extremity symptoms.

Did he explain to you what all that meant?

A. Sir, I don't recall.

Q. Okay. He says, "because surgical treatment would involve lumbar fusion." Did he talk to you about what a lumbar fusion was?

A. I don't recall, sir.

Q. Okay. Which would make it difficult for him to

get back to strenuous physical labor.

So, you're just saying you don't remember any conversation with Dr. Heim about how you should hold off surgery because it may affect your ability to perform your job?

A. I remember being referred to get injections in my back, sir.

Q. All right. We talked earlier -- yesterday you talked about your memory, and you kind of alluded to that today, that you have memory problems for this four year period.

You've not been diagnosed with any kind of a memory loss as a condition, have you, Mr. Koon?

A. No, sir.

Q. You haven't been treated for any kind of memory loss, have you?

A. No, sir.

Q. And in terms of your memory, you talked quite a bit -- we heard Dr. Fitzgibbons talk about how when you were with her you were very talkative.

Do you remember -- do you remember doing that with Dr. Fitzgibbons?

A. I remember talking with Dr. Fitzgibbons, yes.

Q. Okay. And we talked about this issue of you not remembering when you lost -- as you described it, you lost

control of the ability to take the right amount of pills.

You told us in your deposition, didn't you, that you don't really have any recollection -- let me put it this way. In your deposition you were asked whether or not you believe you ever lied to Dr. Walden or withheld the truth from him about your feelings about dependency with these medications at any point in time, and you said I very well might have.

You remember that question and answer, don't you?

A. No, but if that's what's in the deposition, then yes.

Q. Well, I can get your transcript of the deposition.

A. That's fine.

Q. Okay. And, so, what you're telling us is that you may well have withheld information from Dr. Walden about these -- these issues of possible dependency on your medication. Correct?

A. Yes.

Q. Okay. Now, when you went to CenterPointe, you were asked some information about -- talking about different instances, and one thing you talked about, and I think you talked about it yesterday, was this driving incident where you -- I'm not sure whether you were saying

you fell asleep at the wheel, or you kind of dozed off, and I'll let you tell us what you think happened.

A. I was driving my wife and my daughter home from my parents'.

Q. Okay.

A. And I ended up going up on a curb, and that brought me back. I mean, I was asleep. I went off the road, and went up over the curb, and the jolt woke me up, and I swerved back onto the road.

Q. Okay. Your swerved back on. Okay. Sounds like luckily nobody was injured, but you're sounding like it's a -- it sounds like a pretty scary event then?

A. Yes, it was.

Q. Okay. And, so -- and your wife was scared, too, right?

A. Yes.

Q. All right. And so when you say you fell asleep, I assume you're telling us this because you think there was some connection between your falling asleep, as you're telling us, and the medications you were taking?

A. Yes.

Q. Okay. So it wasn't like you were up till 4:00 A.M. the night before and you were on lack of sleep, you think the medications caused you to have this dozing off and not being in control of the car for that two seconds,

or whatever it was?

A. Yes.

Q. Okay.

A. I believe that it --

Q. Sure. And you don't -- do you remember when that was? I think you told us in your deposition you could only say it would have happened after 2009 when your daughter was born in July.

A. Yes, I don't recall the specific date.

Q. Okay. Because your daughter was in the car, so it had to be after she was born, right?

A. Correct.

Q. Okay. And, so, you didn't tell Dr. Walden about that episode, did you?

A. I don't know if I did or didn't.

Q. Okay. Well, it sounds like you were scared and your wife was scared. Did Michelle say, Brian, you've got to call Dr. Walden and tell him that you're falling asleep with these medications?

A. I don't recall if she did.

Q. Okay. And then you also described another episode where Michelle found you asleep on the front porch, I guess smoking a cigarette, at 2:00 A.M. or 3:00 A.M. in the morning.

Do you remember telling us about that?

A. It's something my wife told me about.

Q. Okay. Well, did she -- did Michelle say anything to you like she thought this was related to your medications?

A. I don't recall, sir.

Q. Okay. She didn't tell Dr. Walden about this episode, did she?

A. I do not know, sir.

Q. Never asked her whether she ever told Dr. Walden?

A. Sir, I'm not sure if that's something I knew at the time.

Q. Okay.

MR. VENKER: Let's go to -- Mike, let's go to Exhibit A, Page 694.

BY MR. VENKER:

Q. Okay. This is a --

MR. VENKER: Can you show the date on that, Mike?

BY MR. VENKER:

Q. So this is August 30 of 2012, this is a record from Dr. -- this is Dr. Walden's records.

MR. VENKER: Let's go down to the bottom where it says history of present illness. Down here.

BY MR. VENKER:

Q. So this is Dr. Walden's notes, and I know you said earlier you have no reason to doubt or challenge what he put in here. So he writes -- this is the last time you saw Dr. Walden, right, August 30, 2012?

A. I believe so, yes.

Q. Okay. But you were scheduled to see him in November, weren't you? When you left his office on August 30th, you were supposed to see him in November as a three month follow-up, weren't you?

A. I don't know, sir.

Q. You don't remember that?

A. No, sir, I do not.

Q. Okay. So, Dr. Walden writes main concern is low testosterone. Okay. Do you have a memory of talking to Dr. Walden that day and really saying your main concern was low testosterone?

A. I remember being tested for low testosterone by Dr. Berry, that's what bought it to my attention, and when I got the results I brought that to Dr. Walden's office, and then he had me tested himself for low testosterone.

Q. Okay. And then at the bottom it says, "believes his injection therapy" -- is that what you were doing with Dr. Berry at that time?

A. At that time, yes.

Q. Okay. Believes his injection therapy is helping and is eager to --

MR. VENKER: We've got to go to the next page. Very top, it's kind of a one-liner. Let's go back and just kind of piece these together. Go back to history and impression. Let's see that last sentence again.

BY MR. VENKER:

Q. "Believes his injection therapy is helping and is eager to wean the narcotics."

Do you remember that conversation with Dr. Walden? I guess not.

A. I believe that's what Dr. Walden wrote.

Q. Okay. Do you have any memory -- but you don't have any memory of that meeting with him, it sounds like?

A. Not particularly, no.

Q. Now, you talked -- you told us about going to St. Mary's. I think you said you had taken a one month supply in two weeks right before you ran out of medications, and then went -- your wife took you to St. Mary's Hospital on, what, September 9th of 2012?

Does that sound right to you?

A. I'm not sure what the exact date was, but my wife did take me to St. Mary's.

Q. All right. And, so, the one month supply at that time was a one month supply that was supposed to

start this weaning process of decreasing the doses, correct?

A. I believe so.

Q. All right. Okay. And could it have been that you took them in three weeks instead of two weeks, or do you remember?

A. I don't recall.

Q. All right. All right. So when you went to St. Mary's -- well, before that, let's talk about -- you told us yesterday that you had actually -- that you'd actually contemplated suicide, right, Mr. Koon? You told us about that?

A. Yes, sir.

Q. And you decided against it?

A. Yes.

Q. But -- obviously, I think everyone would admit that considering suicide is a pretty disturbing event, right?

A. Yes.

Q. And, so, you went to St. Mary's within, what, a day of that contemplation of suicide?

A. I'm not sure of the timeframe, sir.

Q. Okay.

MR. VENKER: Mike, let's go to Exhibit DD, 130. St. Mary's, 130. Here we go.

BY MR. VENKER:

Q. So, this is the St. Mary's records.

MR. VENKER: Let's pull this up, Mike.

BY MR. VENKER:

Q. So September 9, within a day or two of your saying you're contemplating suicide. And let's read this.

"Have you had recent life stressors that affect your ability to cope." And you -- this indicates you told them no. Isn't that what it says?

A. That's what is printed, yes, that's what it says.

Q. Any memory of telling them something other than that?

A. Sir, I don't remember being at St. Mary's.

Q. Oh, okay. And, so, the next says, "are you having thoughts of suicide or hurting yourself." Right?

And they wrote in that you told them no, you weren't having those thoughts. Correct?

A. That is what is written, yes.

Q. All right. And do you think they were asking you about whether you were considering suicide to try to help you? Is that why you think those people would ask you that question?

A. Sir, I don't remember being at St. Mary's. I don't know -- I can't respond to that. I have no memory

of being there.

Q. Okay. I'm just asking you, just as a matter of -- if a healthcare provider asks somebody who has contemplated suicide within a few days of seeing the healthcare provider if they have contemplated suicide, wouldn't the person tell them they had contemplated suicide within the prior few days?

A. Not necessarily, no.

Q. Okay. And then down below that it says, "based on clinical screening, this patient is at immediate risk for suicide." And the person writes in no. Right?

A. That's what is written, yes.

Q. And that would have to be based on the information you provided them, correct?

A. I believe so.

Q. All right. And, so --

MR. VENKER: Let's go to Page DD, 133, Mike. This box here.

BY MR. VENKER:

Q. So this is a psychosocial assessment. We're still at St. Mary's. Patient is calm, cooperative and interacts appropriately. Verbalizes no suicidal, slash, homicidal ideation. That's what the chart says from St. Mary's.

Again, you're saying you don't have a memory of

any of that?

A. No, sir.

Q. Okay. And then from St. Mary's you went to CenterPointe, correct?

A. Yes.

Q. All right.

MR. VENKER: Let's do R -- Defense Exhibit R, Mike, Page 50. If I can approach, Your Honor.

BY MR. VENKER:

Q. Let me give you this one, Mr. Koon, because I think it's going to be hard to read, even if we blow it up.

A. Thank you.

Q. All right. So, let's go down to the box. And this is the CenterPointe admission assessment. So you were there with your wife, right?

A. Yes.

Q. All right. And at that point in time, at least, you hadn't told your wife about the contemplating suicide, had you?

A. I don't recall, sir, when I told my wife.

Q. All right.

MR. VENKER: So let's go down, Mike, to the next box. Let's blow this up.

BY MR. VENKER:

Q. Okay. So, it says the first -- this is a safety risk assessment by the people at CenterPointe Hospital where you went for treatment for what you described to them as drug addiction. Right?

A. Yes.

Q. So you wanted to get help?

A. Yes.

Q. You were -- I mean, I -- you were rock bottom, right?

A. I was very low, yes.

Q. All right. And I understand that. I do. I'm not -- so, they ask you do you understand what killing yourself and killing someone else means, and you write -- they say -- you checked yes.

Is this your checkmark or is this somebody there who's helping you?

A. Sir, I don't -- I don't know.

Q. All right. Okay. So the next line says, "do you want to kill yourself or someone else." And the box is checked no as of that point in time, right?

A. Yes.

Q. It is at that point you decided that you weren't going to do this, hadn't you?

A. That I wasn't going to kill myself?

Q. Yes, sir.

A. Yes.

Q. All right. So that's certainly an accurate answer. Okay. And they asked you -- well, this next one -- so look at number four.

Have you ever tried to hurt yourself or someone else. If so, when. And you wrote -- I guess they wrote years ago, at 15 years old, and you -- it says cry for help in quotes.

And that's how you described it to them?

A. I don't remember, but if that's what is written down, I -- I would not dispute that.

Q. Okay. Right. But you didn't mention to them about this suicide contemplation you had just within the last two days?

A. Correct.

Q. Okay. And was there a reason for that, sir?

A. Sir, I don't recall the -- being intaked into CenterPointe.

Q. Okay. All right. Now, you told us in your deposition that you believe you bear no responsibility for what you have described as your addiction.

Didn't you tell us that in your deposition, sir?

A. I don't recall specifically, but if that's what is written in the deposition --

Q. Well, I can find it for you. I'm sorry. Let's just take a minute here.

A. That's fine.

Q. I'll tell you the lines, but it should be on this page.

A. Thank you.

Q. So, really, it's really line -- we asked a question, and you gave an answer. So on Page 202, line fifteen and sixteen, after the question was asked "do you think you are responsible, " you said, no, I don't take any responsibility in that, no, sir.

Did I read that correctly?

A. Yes, sir.

Q. All right. And, so, let's go to Exhibit quadruple U. It sounds funny, but I said it. I'm going to hand you a copy of this, too, sir, because I think the writing in here is also kind of difficult to see at a distance.

A. Thank you.

Q. So if you look at --

MR. VENKER: Let's do Page 3, Mike. And if we go -- I think it's here. I think it's right here.

BY MR. VENKER:

Q. So this is your writing, isn't it, Mr. Koon?

A. Yes, sir.

Q. Okay. Let's just read it for us.
A. Twelve step program, it works.
Q. And then next line?
A. Step one, something others. No, I am an addict.
Q. I think it says blame others, doesn't it?
A. I can't read my own handwriting.
Q. I'm sure it's correct. That's your writing, sir, you're not sure that's what it says?
A. Okay. Blame others, no, I am an addict, it's my fault.
Q. All right.
A. Acceptance and surrender -- or acceptance and surrender that I am an addict.
Q. Okay.
MR. VENKER: And then let's go to TT -- I'm sorry, it's -- it's quadruple T. Now let's go to Page 3. I think it's number eight.
BY MR. VENKER:
Q. And this is part of the notes you wrote at CenterPointe, too, isn't it, sir?
A. Yes, sir.
Q. All right. And, so, they were asking you different things that the -- your pain medications caused you to do, right?
A. Yes.

Q. And it says here, "not spending time with wife and child." Right?

A. Yes.

Q. And then lying to family about what's going on with you, right?

A. Yes.

Q. And then procrastinating about getting help or, quote, new doctor, right?

A. Yes.

Q. And then if we look at Exhibit R1. And it's Page 72. These are also CenterPointe records, Mr. Koon. You had different sessions, you -- you said you were in the hospital portion, and then after that you did therapy, right? At CenterPointe?

A. Yes, sir. I was in the detox, and then I went to the chemical dependency program.

Q. Okay. All right. And, so, one of the doctors you had there was a Dr. David Ohlms, correct?

A. Yes, sir.

MR. VENKER: Mike, just pop it up. This right here. Okay.

BY MR. VENKER:

Q. And, so, he was one of your doctors.

MR. VENKER: So let's go down, Mike, where it says patient identification. And chief complaint down

below. That first part.

BY MR. VENKER:

Q. And, so, Dr. Ohlms wrote that Mr. Koon is a forty year old white male patient, who's processed feelings regarding getting addicted to pain management medications prescribed by his PCP.

You see that, don't you?

A. Yes, sir.

Q. And next sentence is patient willing to take responsibility for his own behavior and acknowledge that he was aware of his increasing loss of control with his prescriptions.

Isn't that what it says?

A. That's what it says, yes, sir.

Q. And Dr. Ohlms -- you would have told that to Dr. Ohlms, correct?

A. Yes, I guess I would have spoke to Dr. Ohlms.

Q. Okay.

MR. VENKER: You can take it down, Mike.

BY MR. VENKER:

Q. Now after you got out of CenterPointe you had some surgeries, right?

A. Yes, sir.

Q. And you actually were prescribed some opioids by your doctors, correct?

A. Yes, sir.

Q. But you haven't been pulled into taking higher and higher doses, have you?

A. No, sir.

Q. All right. At times even you've basically refused any opioid medication at different times, haven't you?

A. Yes, sir.

Q. Saying that you don't think you need it at all?

A. Saying that I am not able to take it responsibly.

Q. Okay. Because if you could take it and it would not be anything that was dangerous for you, it is pain relief, right?

A. It is pain relief, yes, sir.

Q. Now you went and saw Dr. Norton as a chiropractor in late 2011; isn't that right?

A. Yes, sir.

Q. And you went to him because that was a non-opioid method of you getting some pain relief, correct?

A. It was to get adjustments for my back and neck, yes.

Q. All right. And, so, you had had good experience with those kinds of adjustments in the past?

A. I had had some success with it, yes.

Q. Okay. Earlier on in -- I think it was during your testimony, but maybe not, but -- you received a letter from St. Louis University, didn't you, telling you that the relationship with you as a patient had to be terminated?

A. Yes, I received a letter.

Q. All right. But you had already, before that time -- that was sometime in 2014 after you filed a lawsuit, correct?

A. Yes, sir.

Q. You had already found another doctor and other doctors before that time, hadn't you?

A. Yes, sir.

Q. You hadn't been to see Dr. Walden since August 30 of 2012; isn't that right?

A. That is correct.

MR. VENKER: I have nothing further, Your Honor.

THE COURT: Any redirect?

MR. CRONIN: Yes, Judge.

**REDIRECT EXAMINATION**

BY MR. CRONIN:

Q. Hey, Brian, if you are near St. Louis University and you get into a car accident tomorrow, where are you going to go to the ER?

A. Not there.

Q. Somewhere else, I guess, right?

A. Yes, sir.

Q. Brian, I just have one question for you. Or one series.

MR. CRONIN: Mike, can you pull up Exhibit 1, Page 223.

BY MR. CRONIN:

Q. Do you remember being asked about how it was Dr. Brinker that first prescribed the OxyContin?

A. Yes, I do.

Q. Okay. Is Dr. Brinker a SLU doctor?

A. Yes, sir.

Q. Is he in Dr. Walden's office?

A. Yes, sir.

MR. CRONIN: Mike, could you go to the encounter date? February 10th, 2009.

BY MR. CRONIN:

Q. Do you see that? Oh, I'm in the way. Okay.

MR. CRONIN: Can you go to the assessment, plan, Mike?

BY MR. CRONIN:

Q. This is Dr. Brinker's signature. Do you see that, Brian?

A. Yes, sir.

Q. Okay. What's that say? Will switch pain medication to oxycodone for better control.

Did I read that right?

A. Yes, sir, you did.

Q. It says switch pain medication to oxycodone for better control.

A. Yes, that's what it says.

Q. And then it says will follow up with Dr. Walden.

Did I read that right?

A. Yes, sir.

MR. CRONIN: Mike, can you go to Page 240?

BY MR. CRONIN:

Q. 2/17/09. Now, Brian, this is your follow-up visit with Dr. Walden. Can we go to the prescriptions at the bottom? Do you see where it says OxyContin, and still Vicodin?

A. Yes, sir, I see that.

Q. What happened to the switch?

A. There was no switch.

Q. Dr. Walden didn't switch you even though Dr. Brinker said to switch you; is that right?

A. Yes, sir. Yes, sir.

Q. And you're being given Ambien?

A. Yes, sir.

MR. CRONIN: I don't have any more questions.

THE COURT: Any recross?

MR. VENKER: Nothing.

THE COURT: Thank you, Mr. Koon. You can return to the gallery.

Let's take our first morning recess.

(Whereupon, Instruction 300.04.1 read to the Jury.)

THE COURT: We will have a short ten minute biological break recess.

(Whereupon, a short recess was taken.)

THE COURT: We're on the record outside the hearing of the jury. The jury was in recess. I have had discussions with the attorneys, anticipating that the plaintiffs are going to close -- in -- and in anticipation of the close, the plaintiffs resting, we're taking up the -- which I will allow the plaintiffs to rest officially in open court.

In anticipation of that, we're going to take up the motion for the defendant's -- Dr. Walden's, SLU, the directed verdict at the close of the plaintiff's evidence. You may proceed.

MR. MAHON: Thank you, Judge. Yes, we have a written motion that we've provided copies to counsel and to the Court and we will be filing today. I'm going to pick a few of the issues to mention and highlight in my

argument, but I'm not waiving any of the arguments set forth in the written motion, I want to incorporate those.

But, first, defendants don't believe that the plaintiffs made a submissible case for alleged medical malpractice against the defendants. One issue concerns expert Dr. Genecin. His opinions were inappropriate and insufficient because an expert opinion must be based upon an established standard of care rather than a personal standard.

Dr. Genecin did not rely on or present any authoritative medical literature, concepts or principles to support his opinions. He relied on the 2016 CDC guidelines, which are inapplicable to the issues in this case, created four years after the fact. He also relied on Washington State guidelines, which are inapplicable to the care in this case, which was provided in Missouri.

What Dr. Genecin did was base his opinions really on personal standards or beliefs, or standards that either did not exist during the time of the care at issue, and/or did not apply to Missouri practitioners.

And a kind of a sub-issue with Dr. Genecin is his testimony on standard of care was contradictory, and the law in Missouri is that contradictory testimony of a single witness is not probative. He testified that the alleged standard of care that's reflected by the of 2016

CDC guidelines are mandatory and must be followed, but then he admitted on cross-examination that the guidelines state they are voluntary, which is the opposite of mandatory.

And, so, I think his testimony on the standard of care is contradictory and not probative. Another issue about a submissible case concerns a claim for direct corporate negligence against St. Louis University. Plaintiffs have not made a submissible case on that because they lack the required --

THE COURT: I'll stop you for one second. I'm following along, but when you jump can you let me know what subparagraph you're on?

MR. MAHON: Oh, sure.

THE COURT: I didn't mean to interrupt. I've been -- I have tracked so far, but I --

MR. MAHON: Okay. Good. Now I'm getting down to paragraph twelve, Page 4, and this claim against St. Louis University requires expert testimony, and it's, I believe, couched in terms of a negligent supervision claim.

The third amended petition really only alleges two theories against -- solely against SLU that are not based on vicarious liability for Dr. Walden's conduct, and that's this negligent supervision and failure to abide by or have

appropriate policies and procedures.

Missouri law requires expert testimony to support either type of claim. And Dr. Genecin, he really didn't provide the testimony he needed to support either of those claims, because the Court limited his testimony to the opinions he expressed at deposition, which did not include any opinions in support of direct claim against SLU, other than for vicarious liability.

And, really, what Dr. Genecin failed to do is provide what independent act of the University, separate and apart from the alleged failures of Dr. Walden, deviated from the standard of care, one, and, two, actually caused injury to the plaintiffs. I don't think they provided that testimony, and so they didn't make a submissible case on that.

Getting over to Page 6, then, and the next section of the motion, plaintiffs failed to make a submissible case for punitive damages or aggravating circumstances --

MR. CRONIN: Judge, I'm sorry. Would it be possible to take these up in appeal? I mean, we can do them all at once, or --

THE COURT: Let's do them all at once.

MR. MAHON: The standard in Missouri for medical negligence claim is that plaintiffs must demonstrate that

the defendants conduct was willful, wanton or malicious. That's what's contained in Section 538.210.6, Revised Missouri Statutes. And not only do they need to prove that, but they need to provide sufficient evidence to meet the clear and convincing standard. It's not a preponderance of the evidence.

The law in Missouri is pretty clear that punitive damages are regarded so extraordinary or harsh they should only be applied sparingly, and the question is whether punitive damages be submitted to the jury is something that warrants special and careful judicial scrutiny.

To meet that clear and convincing standard, plaintiffs must prove the defendants conduct was tantamount to intentional wrongdoing, and then deciding whether to submit this type of a claim to the jury the Court must scrutinize the evidence in much closer detail than it does in cases where the standard of proof is a mere preponderance of the evidence.

And so it's a very strict test, is our point. And I don't think they've presented any evidence that either defendant's conduct was willful, wanton or malicious. Dr. Genecin talked about standard of care and negligence, but I don't think he provided any opinions about willful, wanton or malicious. And even if he did,

that's commenting on the state of mind of the defendant, which is not proper, it's up to the jury to decide that issue. So I don't think they met their burden for punitive damages to remain in the case any longer.

Do you have anything, Mike?

MR. BARTH: Yeah, the only thing I would add, Your Honor, in 1986 the legislature did specifically adopt the standard for medical malpractice cases in Chapter 538. And they specifically define punitive damages in the context of medical malpractice as willful, wanton or malicious misconduct. And I know we've heard a lot of stuff about recklessness and stuff, but the higher standard is what applies, and the legislature has made that clear.

The Tort Reform 2005 did not change that definition, and it's still the current definition, so I think this recent tort reform last year would not apply. So this would be the 2005 definition, which was still 1986, and it does have that heightened standard, and again it is clear and convincing evidence, and if there's any doubt as you're looking through it, I think the clear and convincing standard says they didn't meet it.

MR. MAHON: So basically defendants request the Court to direct a verdict in their favor in all plaintiff's claims.

THE COURT: All right. Thank you. Plaintiffs.

MR. CRONIN: Your Honor, as to the regular medical malpractice claim first, Dr. Genecin was read the actual standard of care definition in Missouri for medical malpractice cases. He specifically said that is the definition he was using when he was discussing breaches of the standard of care. So this is not a personal standard, it's clearly the standard of care in Missouri. And he listed out all of the ways that they breached the standard of care, including putting him on long-term opioids at all for back pain, failing to monitor, failure to assess, overprescribing opioids.

I'm happy to go through Dr. Genecin's testimony, Your Honor.

THE COURT: No, thank you, I recall.

MR. CRONIN: As for the monitoring claim about SLU, Dr. Genecin specifically said the standard of care required both St. Louis University and Dr. Walden to monitor, there was an objection made, it was overruled, he discussed that the standard of care required that a medication management system be in place.

We heard from St. Louis U's -- St. Louis University's corporate representative that they did nothing to monitor the amount of opioids, and they had no policies and procedures in place to monitor it.

As for the punitive damages claim, Your Honor, first, I have a few cases for you. I don't believe this is an argument that they made, but just in case, Judge, when an employer is vicariously liable for the acts of his agent, all that is necessary to award punitive damages against the employer is for the agent to be acting in the scope of employment and that his actions reach the level justifying an award of punitive damages. That is from the Flood V Holzwarth case, Missouri Court of Appeals, Seventh District. Essentially if the conduct of the agent is punitive, the employer is on the hook.

Judge, as for willful, wanton and malicious or conscious disregard, we have a recent Missouri Supreme Court case, Dotson, our two firms were involved in. In that case, it says -- the statute says willful, wanton and malicious.

THE COURT: I've read that.

MR. CRONIN: The proper jury instruction is conscious disregard. Essentially they mean the same thing. And in Schroeder, the Court has said that willful is equivalent to recklessness. Dr. Genecin discussed both recklessness and conscious disregard. We've heard all of the known risks and dangers of these opioids; addiction, death. The defendants knew about them. They knew about all of them before 2008. We've heard all the statistics

about how many people this is killing, it's been going on for a long time.

SLU said they knew about this problem years ago, before 2008, from their corporate representative. We heard the statistics that one out of 32 people, over 200 morphine equivalent dose, die of overdose. We heard SLU's corporate representative say, well, that means 31 out of 32 people aren't dying. Dr. Walden prescribed seven and a half times that amount. They had him on over 200 in 2009, over 500 in 2010, over 1,000 in 2011, over 1500 in 2012. Dr. Walden's video depo was played, he said he knew the amounts he had him on in '10, '11 and '12 created a probability of dependency and addiction. He knew he was creating a risk of injury, Judge. These amounts are excessive and colossal, according to Dr. Genecin, and he testified that Brian should never have even been put on it at all for his back pain, it was not helping him, but harming him. He testified this was done with no legitimate medical purpose.

We presented many dosing guidelines, all of them are at about 100 MED for no more than 90 days. I believe that SLU's corporate representative testified the risk of dying goes up steeply past that. This happened for four and a half years. Dr. Genecin testified this was reckless, that the amounts were reckless. The length of time was reckless. The lack of monitoring was reckless. No assessment. All

records. Giving three opioids at once with Ambien, reckless. He testified the evidence in this case supports a finding of recklessness and conscious disregard. There's nothing in the records about a risk assessment for one and a half years. The pharmacies warned Dr. Walden this was too much on multiple occasions, he kept prescribing. SLU does nothing to monitor opioids. Their corporate rep admitted these are unusually high doses. Their corporate rep, who's an internal medicine doctor, says he's never seen over 1,000. He agreed higher doses create greater potential for problems. They have no policies. And we heard about their relationship with pharmaceutical companies that make opioids, Judge.

I think that's clear and convincing evidence to support finding of recklessness and conscious disregard.

THE COURT: All right. Will you be submitting any written, or is -- I'm not requiring you to. I can make a decision based on oral. I'm just making it clean whether you are or not.

MR. SIMON: Oral at this time.

MR. CRONIN: Oral at this time. We have not seen, and I don't think a written motion has been filed.

THE COURT: Okay. All right. Give me a minute to gather my thoughts and I'll come out and --

MR. MAHON: I'm not going to respond to all

those things. Can I make a couple quick points?

THE COURT: Okay.

MR. MAHON: Just one thing on the monitoring claim, Judge. I think the issue here -- I think there's probably been some testimony about that Dr. Genecin believes that Dr. Walden should have been assessing and monitoring the patient. But I don't think we have heard any testimony from him about what type of other acts or other monitoring should the University have been doing separate and apart from monitoring that its employee, Dr. Walden, was performing. I don't think he got into that, because he never said that in his deposition.

And, so, he didn't say that, and he also didn't say what -- how these other independent acts of monitoring, separate and apart from Walden, that SLU should have done, that if SLU had done that, that it would have changed the outcome in any way here. I just don't think there was any testimony on either of those two issues. I just wanted to raise that.

And then I think, also, on the punitive damages, there's been a lot of testimony over our objection brought into the case about the risk of death and the risk of overdose. Which was certainly serious and scary things. But those are simply not in the case, did not happen here. And, so, I don't think that that can be testimony to

support a claim for punitive damages here, when the very issues that are being raised never occurred; death or overdose.

And, just -- Mr. Cronin mentioned that there was no legitimate medical purpose to the opioid therapy that was being provided. I think the jury has seen in numerous records, and even from Mr. Koon's own testimony, that there was a benefit, there was relief that he had received from the opioid therapy. So, I just don't think that's supported by the evidence.

THE COURT: All right. Give me a minute to gather my thoughts.

MR. SIMON: Thank you, Your Honor.

MR. VENKER: Thank you, Your Honor.

(Whereupon, a short recess was taken.)

THE COURT: All right. After considering the oral motions and the written -- the oral and written motion by the defense, and the oral motion by the plaintiffs, the Court finds that there has been substantial evidence presented by the plaintiffs such that a jury could find the injuries to the plaintiffs are a natural and probable consequence of the defendants acts or omissions.

As to the punitive damages, after scrutinizing the evidence, there has been substantial evidence presented by

the plaintiffs regarding the factors which the jury can consider regarding whether to award punitive damages.

The Court finds that a reasonable jury could determine that the evidence presented regarding the defendants acts or omissions rise to the level of intentional wrongdoings or omissions, and to do so they can do it by clear and convincing standard.

So your motion will be denied.

MR. MAHON: Thank you, Your Honor.

MR. VENKER: Thank you, Your Honor.

(Whereupon, a short recess was taken.)

THE COURT: Please be seated. All right. Counsel for the plaintiff, do you have any more evidence to present?

MR. CRONIN: No, Judge. Subject to leave to move for the admission of exhibits at the conclusion of all the evidence, the plaintiffs rest.

THE COURT: All right. The plaintiffs rest.

All right. Counsel for the defense, would you like to proceed?

MR. VENKER: Yes, Your Honor.

MR. MAHON: Yes, thank you, Your Honor. The defense would like to read for the jury the sworn deposition testimony of Caroline Koon, Brian Koon's mother.

Ladies and gentlemen, Your Honor, this is Arlene Reardon, a nurse paralegal from our office, she's going to read the testimony of Miss Koon.

THE COURT: Good morning. Make yourself comfortable, adjust the microphone.

MR. MAHON: Would you like this to follow along? Very good. And it's not necessary that this be transcribed, as we'll present the testimony in an exhibit.

THE COURT: You can proceed when ready.

MR. MAHON: Thank you.

(Whereupon, the deposition of Carolyn Koon was read to the jury.)

(Whereupon, a short recess was taken.)

MR. MAHON: That concludes the deposition testimony of Carolyn Koon.

THE COURT: Thank you, ma'am.

MR. MAHON: And, just for the record, that deposition of Caroline Koon was taken May 23rd, of 2016.

THE COURT: All right. You may proceed.

MR. MAHON: Next we would like to read a short deposition, sworn deposition testimony of Michael G. Burke, Sr., taken May 23 of 2016. Michelle Koon's father. Everyone, this is Michael David from our law firm. It's also not necessary to take down the testimony because we'll submit it in an exhibit.

THE COURT: All right. Mr. David, make yourself comfortable. You may proceed when ready.

MR. MAHON: Thank you.

(Whereupon, the deposition of Michael Burke, Sr. was read to the jury.)

MR. MAHON: That concludes the deposition testimony of Michael Burke, Sr.

THE COURT: Okay. Thank you.

MR. MAHON: Your Honor, we now would like to play a videotape of the sworn deposition testimony of Daniel Skillman, which was taken on May 20th, 2016.

THE COURT: You may proceed.

(Whereupon, the videotaped deposition of Daniel Skillman was played to the jury.)

MR. MAHON: That obviously concludes that testimony, judge. Can we approach real quick?

THE COURT: You may.

(The following proceedings were held at the bench.)

MR. MAHON: We've got another video, and it's about 50 minutes. 5-0.

THE COURT: Oh, we're going lunch.

MR. MAHON: That's what I figured. I just wanted to give you a heads up.

MR. CRONIN: I think we also need to talk about

what happens next, because they have an expert coming in and I need sufficient time to cross-examine him.

THE COURT: We're still going to lunch.

MR. CRONIN: No, I know, but we're talking about after that.

(Proceedings returned to open court.)

THE COURT: All right. We're going to take our lunch recess.

(Whereupon, Instruction 300.04.1 read to the Jury.)

THE COURT: It's 12:40. I need everybody back at 2:00. I've given a longer lunch so we can knock out everything, and we'll get an idea what we're going to do. I need you back at 2:00 sharp.

(Whereupon, a lunch recess was taken.)

THE COURT: Welcome back from lunch. Call your next witness.

MR. VENKER: Thank you, Your Honor. Defendants call Dr. Erik Gunderson to the stand. The Judge will swear you in.

THE COURT: I'll swear you in. Good afternoon. Doctor, raise your right hand.

***DR. ERIK GUNDERSON***,

having been duly sworn by the Court, testified:

THE COURT: Please be seated. Make yourself comfortable. Be careful, there's a step. Adjust the microphone. From time to time if you hear the attorneys say objection, if you would pause and let me rule on the objection before you answer.

All right. You may inquire.

MR. VENKER: Thank you, Your Honor.

BY MR. VENKER:

Q. Dr. Gunderson, would you tell the jury your full name?

A. Erik William Gunderson.

Q. And you're a medical doctor?

A. Yes.

Q. And where do you live?

A. I live in Charlottesville, Virginia.

Q. Do you have a specialty in your medical practice?

A. Internal medicine and addiction medicine.

Q. So, I've asked you to review the file in this case, correct?

A. Yes.

Q. All right. And you have arrived at certain opinions about the care provided to Mr. Brian Koon; is

that right?

A. Yes.

Q. All right. And before we talk about those opinions, I wanted to talk with you about your background and qualifications for a little while. All right?

A. Yes.

Q. Okay.

MR. VENKER: Mike, can you put up the first page of JJJ, defense exhibit.

BY MR. VENKER:

Q. So, Doctor, tell us where you went to medical school.

A. I went to Mt. Sinai Medical School in New York City.

Q. Okay. And then when did you graduate that?

A. In 1997.

Q. All right. And did you have any post-graduate training in medicine?

A. Then I did an internal medicine residency at Mt. Sinai Medical Center.

Q. Okay. And how about after that?

A. I stayed for a year after residency as a chief medical resident in the department of medicine.

Q. All right. And is there any significance to being a chief resident there after finishing your

residency?

A. It was a nice honor. Usually they invite four people out of the residency of thirty-six to stay on and have a combination of clinical, administrative and teaching responsibilities. It was -- that was the time that I started to work on curriculum development in addiction.

Q. Okay. And then you had a fellowship, right?

A. Yes. After chief residency I did a two year fellowship in the division on substance abuse in the department of psychiatry at Columbia Presbyterian, an addiction in psychiatry fellowship, even though I wasn't -- I'm not a psychiatrist.

Q. I was just going to ask you that. You're not actually a psychiatrist per se, correct?

A. Correct.

Q. All right. And, so, tell us a little bit how you got interested in doing this kind of fellowship dealing with addiction, Doctor.

A. So during the chief resident year, I -- one of the main projects that I have is to work on addiction medicine. I noted that a lot of the patients -- there wasn't much expertise about managing addiction in practice. And as I began to then develop an interest in that and start working on curriculum for the house staff,

I actually came to learn that there was a field of addiction. I didn't -- before residency I didn't even know that there was a field of addiction medicine.

So, my hope was to then get involved in addiction medicine education, which was why I went to do the fellowship, a clinical research fellowship on addiction, hoping to study addiction training, and disseminate and improve practices.

Q. So that was a two year fellowship?

A. It was.

Q. All right. And, so, you completed that in 2003. And, so, what was your career or medical education course after that, Doctor, after 2003?

A. After the fellowship, I got a faculty appointment at Columbia, and was working in the department of medicine in the department of psychiatry.

Q. Okay.

A. And I became a medical director of the newly founded buprenorphine program, which was an outpatient program in psychiatry treating patients with opioid use disorders.

Q. When you say buprenorphine, and I may not have said that right, that's along word, tell us what that is.

A. Buprenorphine is an opioid medication that is the active ingredient in Suboxone you may have heard

about.

Q. What is Suboxone? You better tell us more about that, Doctor.

A. Suboxone is a medication that is FDA approved for treating opioid use disorders. It became approved in 2002, and it paved the way for the availability of individuals to get opioid use disorder treatment in physician's offices.

So, before that, the only way to get opioid maintenance treatment would have been with methadone in a federally registered program. So, it was a major shift in care availability at that time.

Q. Okay. And, so, after you -- after you were the director of that clinic, did you do anything else still at Columbia University?

A. Well, I was involved in -- as medical director of their clinical pharmacologic behavioral unit. And I also was working in the primary care clinic.

So, I had a one day a week primary care practice that also was involved in seeing patients referred by house staff, which are medical residents, and some of the attending physicians who wanted to have their patients assessed for substance use disorders.

And many of those patients were those who had chronic pain and were on opioids. And, so, for that five

year period I helped out in assessing patients who were on opioid medication, and had chronic pain, and then also provided treatment for opioid use disorders, both in the primary care clinic, but also in the psychiatric program as well. The buprenorphine program.

Q. Let me ask you this. I see on your resume -- your CV, rather, there's something here with Columbia University that say 2008 to present, adjunct associate research scientist in psychology. Are you still in that role at this time?

A. Yes. I left Columbia in 2008 and moved to Virginia but was able to keep an adjunct research appointment to be able to still collaborate with some of the people there.

Q. Okay. And then in 2008 looks like you moved University of Virginia?

A. Correct.

Q. And tell us about that position there. Assistant professor it says.

A. This -- so, I moved in 2008 as an assistant professor in both the department of medicine and the department of psychiatry. It was in part a research position. I had gotten a grant from NIH to study office-based buprenorphine or Suboxone treatment in practice. I transferred my grant to UVA.

Q. Let me stop you for a second. I'm pretty sure everybody here knows what NIH is, but why don't you say it out loud for us.

A. I'm sorry. National Institutes of Health.

Q. And is that a government entity?

A. Yes.

Q. Sorry. Go ahead, Doctor.

A. And, so, in that -- at UVA, then I -- I continued to work in primary care. And although I didn't have an actual primary care practice, it became more focused on addiction medicine. And so I continued doing assessments of patients within their primary care program who had chronic pain, were on opioids, to try to help the residents and faculty there try to figure out what was happening, whether it was chronic pain versus addiction or somewhere in between, and then I would also then help with treatment.

Q. Okay. So you were working with doctors, people who were already doctors, to help them understand addiction?

A. Yes.

Q. All right. And, so, can you --

MR. VENKER: Can you scroll down a little further.

BY MR. VENKER:

Q. So, in terms of that -- that's why this addiction fellowship exists, because there's a need for that in the medical community?

A. Well, the addiction fellowship is -- is more of a training psychiatrist in addiction psychiatry. But part of that role is to train people in both clinical work and research and education. Sort of three mission of the fellowship.

Q. All right. And, so, we're just looking at your resume, your CV again, different positions you've got with the University of Virginia. That's the school of medicine there, isn't it?

A. Yes.

Q. All right.

A. And then was promoted in 2015 to associate professor.

Q. Okay. And do you have a -- are you affiliated with University of Virginia now academically?

A. I have a research appointment at UVA.

Q. Okay. All right. And, so, is part of your work as -- after your addiction fellowship, did you do any type of teaching, or curriculum design, anything like that, Doctor? Tell us about that.

A. I continued with -- with education for opioid

use disorder treatment, and then also at the interface of pain and addiction. Around 2006 or so, or '7, I don't know the exact year, I was able to get a grant from the Center for Substance Abuse Treatment, which is a part of the Department of Health and Human Services, a government agency, that funded me to develop a curriculum to help medical residents manage and understand the kind of pain addiction interface. We also had a grant to train physicians on the use of buprenorphine or Suboxone products in treating opioid use disorders.

Q. So let's take a look at your CV. I think this is what you're mentioning, but I want to make sure. Says 2013 to present. Lead mentor. Tell us what that's about. Is that what you're referring to?

A. No, that came later. In -- like in around 2000 -- in the mid 2000's, I was involved as a course director and trainer for physicians to be able to prescribe Suboxone. In order to prescribe Suboxone in practice, it's necessary to take an eight hour course. And then later became a national mentor through the Department of Health and Human Services.

There is a group of about 70 -- 60 to 70 mentors across the country that are physicians with opioid use disorder treatment experience, and they are in place to try to help practicing physicians be able to treat opioid

use disorders more effectively. And of those 60 mentors, there are four lead mentors across the country, and I was fortunate to be able to be one of those. Lead mentors were involved in selecting and providing help to the mentors themselves.

Q. Okay. Now, in terms of your teaching activities, have you won any awards for that, Doctor?

A. In 2007, after the curriculum that I developed for the internal medicine residents at Columbia led to getting the ambulatory teaching award, and that was from the ambulatory internal medicine clinic. So I think the residents really appreciated the course on addiction -- chronic pain versus addiction.

Q. Have you published any articles in the area of addiction or any -- collaborated on any book chapters in that area?

A. Around 2002 or '3 I wrote a book chapter on pain and addiction with Barry Stimmel from Mt. Sinai, and that was in the American Psychiatric Press Textbook on Substance Abuse. I wrote an article related to the curriculum studying its effectiveness serving residents. I wrote a chapter on managing pain and opioids, and managing pain in the unhealthy alcohol user in primary care. Those would be the pain-focused works.

And then there have been several articles on

treating opioid use disorders. Some review articles and then primary research studying Suboxone and other products.

Q. All right. Doctor, tell us about your practice now. What does your practice consist of?

A. So, in 2012 I left UVA clinically and established a multi-disciplinary group practice in Charlottesville with focuses on mental health in substance use treatment in a sort of multimodal fashion, integrating counseling mindfulness instruction, psychiatric nursing, and then there are collaborators or site, psychologists and dietician, for example.

And in that practice it's primarily -- my practice in the outpatient side is primarily substance use related, doing evaluations, treating substance use and how it may interact with mental health issues. For example, helping with polypharmacy, which is sort of a term to describe people being on a lot of different medications that may be causing them problems. Helping sort things out like that.

Q. All right. So, as we said when we started out, you've reviewed the file and you've arrived at some opinions about Doctor Walden's care of Mr. Koon, correct?

A. Yes.

Q. All right. And I'm going to ask you about

those, and I'd like you, Doctor, for the purposes of this discussion on that, throughout this time, to assume that Missouri's definition of standard of care as applied to Dr. Walden would be that a healthcare provider used that degree of skill of learning ordinarily used under the same or similar circumstances by members of that healthcare provider's profession.

You understand that, don't you?

A. Yes.

Q. All right. And the opinions you give me today on some causation issues, and we'll talk about those, you will answer those only if they are to a reasonable degree of medical certainty; is that right?

A. Yes.

Q. All right. So, do you have an opinion as to whether Dr. Walden provided proper and appropriate care, and met the standard of care, to Mr. Koon?

A. Yes, I do feel that he --

Q. Tell us about that.

A. I do feel that he met the standard of care.

Q. Okay.

A. And, so, I think that there are several factors that go into how he did this.

Q. Okay.

A. And it may be useful to even go back to

different -- there are different guidelines that are available to sort of help guide practice.

One of them is from the World Health Organization, and I like that one because it's -- it's simple, it's easy for me to follow, it makes sense. And it also was available and promoted at the time that Dr. Walden was prescribing. So, like, around the mid 2000's to late 2000's it was prominent.

And what that is, is that -- that -- at the bottom part of a pyramid of a pain, where pain is milder onset, we may want to start with milder approaches. Think non-opioid-based approaches. And that could be non-opioid pharmacologic, non-opioid medications, or even just non-medication treatments.

And then as the pain level advances, then we may escalate that to opioids, but perhaps lower levels of opioid use. And then as the pyramid goes up with more pain, then the pain management itself may become more aggressive, potentially with more opioid use. But also, you know, throughout this pyramid integrating non-pharmacologic approaches as well.

Q. Okay. And, so, how did -- using that World Health Organization stepped approach, stepped guidelines, how did that -- how did you do that with evaluating Dr. Walden's care of Mr. Koon?

A. So when Dr. Walden was managing Mr. Koon's pain initially, it wasn't -- he wasn't started on opioids at the beginning, he had tried NSAIDs, and a muscle relaxant, he had been to a chiropractor, and he started with a low dose of opioid at the beginning.

And I think that in -- over the course of his treatment, over the next couple of years, certainly the opioids escalated to -- to large amounts. But in that time, he -- he was appropriate in his use and referral to specialists, promoting and -- Mr. Koon had been involved in non-pharmacologic treatments at various times.

And I think that he did a good job in other ways. Such as in informed consent, for example. So, talking to Mr. Koon about the pros and cons and risks of treatment, discussing that with him, coming to sort of a mutual consensus of an understanding about what that risk is before going on to escalate treatment.

Q. Well, let's talk about that a little bit because we seen a lot of that in the charting that's already been discussed and shown to the jury, so we won't take them through that right now. But when you're saying informed consent and discussing the pros and cons or the risks and benefits, what are you -- can you elaborate on that for us, Doctor, what that exchange would be like?

A. So I think in many instances in primary care, a

typical conversation might not take place at all. I mean, in -- I mean -- and that would be the physician talking to the patient about, well, what are the risks of opioids. And for me in my practice, from around 2005 to 2010, all the patients that I screened I would ask when did you get -- when did you start opioids, were they prescribed. And for years I would ask them. When your doctor gave that to you, did he or she ever inform you about risks of dependence. And invariably the answer was no.

And, so, you know, one thing that as guidelines have advanced is that there has been stressing of the importance of talking to patients about what the risks are. This isn't just the decision that the doctor makes in a vacuum. You should -- you should be involved in that decision and know what -- what is at stake.

And, so, what some -- many people might do in that instance would be to just then -- if they discuss it at all, just say well, these are the risks. Okay? Maybe have a list or maybe there will be a chart -- a documentation in the chart discussed the risks.

But I thought that what was important about this informed consent is that he -- he documented a discussion of the risks, including dependence or addiction, but went one step further, which is unusual, in that he documented Mr. Koon and he were -- both concurred that the benefits

of opioid prescribing outweighed those risks moving forward.

Q. And what do you mean by that? Why is that significant to you, Doctor?

A. Because it's important that the patient knows what -- what's at stake. And that he's engaged in that decision of -- I mean, I guess engagement there. It's sort of a medical ethical reason. That we are not paternalistic, we say. We're not deciding for patients about their treatment. The patient should be involved in this discussion. And that's why informed consent is important.

A lot of times there may be consent without the informed part. So that you may say, well, I'm going to have this procedure, or that procedure, or that medicine, but if the doctor didn't actually go through and can tell you what it's about, then you're not really informed. How can you make an informed decision.

Q. Okay. And, so, from that part, in terms of that conversation -- so, did you see whether Dr. Walden had that conversation more than once with Mr. Koon over the course of his treatment?

A. There was one very detailed -- the one -- what I just described was one discussion in around 2009. And there were a few other discussions -- there was at least

one more about concerns about tolerance and dependence that happened, I think, around 2010.

Q. Okay. In terms of how Dr. Walden was evaluating Mr. Koon, how did you feel he was doing with that, in terms of functionality, side effects?

A. In a way, he was a bit ahead of the curve, as far as how he was assessing function or the fact that he was assessing function. In the mid 2000's to late 2000's, what was typical for primary care was to just focus on the pain number. You know, the pain -- pain is the fifth vital sign, in quotes, got promoted, in the mid '90s. And part of that movement was -- was to say that pain has to be assessed at every visit, and that patients have a right to have their pain treated.

And so there was a focus on learning the number. And that in part, along with other factors, led to a real market increase in prescribing in practice of opioids over the subsequent decade.

And, so, what the field would have kind of evolved to in the mid 2000's to late 2000's of what was a priority was not just looking at the number, but also looking at what is the treatment doing, what are the opioids doing as far as someone's functioning. We have to look broader than just pain. Pain, of course, is -- pain relief is, of course, important, but pain relief at the

expense of impaired function might not make it justified.

Q. And, so, one of the issues here, Doctor, that's been discussed is the refills that Mr. Koon got, and refilling them seemingly on a faster scale or faster time frame than the thirty days that Dr. Walden was prescribing.

And you've seen the records, haven't you?

A. Yes.

Q. Okay. And so do you have an opinion about that, in terms of the patient's tolerance for those medications, or just tell us what your opinion is about that.

A. Well, there certainly could be a number of reasons for escalation. Tolerance is one of them. With any chronic opioid administration over time, the patient will end up getting some degree of tolerance, which is defined as needing more medication to get the same effect, or that getting the same effect no longer works as well.

Q. Let me stop you right there, Doctor. So when we talk about tolerance like that, or needing to get more medications, is that indicative of somebody being an addict or abusing the opioids?

A. No, having -- it doesn't necessarily mean that someone is addicted. A lot of times people conflate the two. It's perceived of as if you are on the medication for a long time and you become tolerant, and also have

physical dependence, which is part of that, it's a physiologic response. Your body adapts to getting the opioids, both through tolerance and physical dependence, which we need to discuss.

Q. Right.

A. That goes hand-in-hand with your -- it's a physiologic reaction, not necessarily an addiction.

Q. So, let me ask you, though, when you say the tolerance and dependence go hand-in-hand, in that discussion, is the dependence you're discussing -- or you're mentioning, is that something that's indicative of some problem with the opioids for the patient?

A. Well, if you're confused you're not alone, because one of the -- and because we all are. The terminology through the main diagnostic manual in psychiatry that we use for making a diagnosis for years used the term dependence. So, opioid dependence. And that would be considered analogous to addiction in many ways.

And -- but that contrasts with physiologic dependence. So if you're taking an opioid on any regular basis for some period of time, it's likely that you'll get physically dependent on it.

Q. Is that expected or unexpected, Doctor?

A. It is fully expected.

Q. All right.

A. And, so, physiologic dependence is not the same as the diagnostic addiction dependence. So if I'm talking about dependence with you today, if I say just dependence, I'm usually referring to the syndrome of dependence, the addiction dependence. Whereas if it's the physical, the physiologic response, I'll qualify that hopefully as physiologic dependence.

Q. All right. So, back now to these -- as you've called it, the escalation of these -- the opioid medications for Mr. Koon.

So what's your opinion about that escalation course? How was Mr. Koon handling it based on your review of the records?

A. Well, I think even -- it might be useful to even rewind further, as far as getting back to standard of care in dosing. In that looking at -- in establishing functional goals, and understanding how the individual is using the pain medication, what is the -- what is the purpose of the pain medication, why are -- why are they needing it. What is the diagnosis.

And certainly Mr. Koon has a really arduous job. And he had evidence of disc disease, there was mild problems seen on imaging from back in 2006, and repeat imaging around 2007, at about the time that this -- the

opioids prescribed by Dr. Walden began, showed that, some progression of that disease.

And, so, you know, we have an etiology for the pain itself, and we have a goal of treatment, which was functional. And Mr. Koon was -- it was really important to him, as documented in the medical record, to keep working. I mean, he was the sole provider for his family. Yet in this role had a very -- a very arduous, challenging job physically.

Q. So tell us why that matters. Why does the fact that he's working matter? Because if someone's in pain, they're in pain. I mean, right, that's what would be the natural thought about it.

MR. CRONIN: Judge, leading.

THE COURT: Overruled. You can answer.

A. Well, what's important is that Mr. Koon's goal was to keep working, and needed help to keep working. And part of that functional process, if he's in severe pain -- well, he was in severe -- in pretty severe pain, that opioids helped reduce that, and helped him get to work and function.

And he -- and it did that for several years. And, so, I think that that was one of the main -- the main goals of treatment. Also, you know, as part of the practice, he -- or this practice decision making, he used

-- he got input from consultants. One of the consultants was a surgeon in -- I think it was Dr. Heim who saw Mr. Koon about a year or so into his treatment, and as they discussed pain management, one of the goals of treatment was to avoid surgery. That it was felt that his disc disease wasn't at a point that he required surgery, they wanted to buy some time and keep him working, and also his thought that if he were to go to surgery, that the most likely surgical procedure that he might need would be a spinal fusion. Where the vertebral bodies are fused together. And that the concern in that would be that he would lose range of motion, and with loss of range of motion he would be unable to keep -- keep working.

Q. Okay. Let me stop you for a second.

MR. VENKER: Mike, can you put up Exhibit A, SLUCare 147? Can you blow this up a little bit?

BY MR. VENKER:

Q. So this is the report for the MRI in April of 2008 I think you were referring to, Doctor, weren't you?

A. Yes.

Q. All right. And, so, it talks about, in part, the mild to moderate lumbar spondylosis, right?

A. Yes.

Q. And then it says L4-5 with an annular tear. Tell us what that is.

A. It's possible that with the combination of those factors that that could be contributing to his pain. The spondylosis was there in 2006, although at that point was deemed mild on imaging. And that's basically kind of degenerative joint disease. It's typically progressive and exacerbated through heavy labor.

Q. Okay. And how about the annular tear? In your experience, do you know whether that can be painful for a patient?

A. That I cannot comment on.

Q. Okay. All right. Thanks, Doctor. So in terms of Mr. Koon working then, so the medications were helping him keep working, correct?

A. Yes. And reduce his pain.

Q. All right. And reduce his pain. That's what I meant by that. And, so, that was something that he and Dr. Walden talked about together as a plan, right?

A. Yes.

Q. All right. And you saw from the records -- do you know what Mr. Koon was saying to Dr. Walden about his position or his need to work?

A. It was critical. It was critical to be able to support his family.

Q. Okay. In terms of any information in the records about Mr. Koon telling Dr. Walden anything about

how the medications may have been adversely affecting him, can you tell us what you saw there?

A. I didn't see much. I was surprised, in looking through the medical record through the four years of opioid treatment with Dr. Walden, there's very -- very little that was documented, as far as adverse effects. Which I was surprised about. Because it seems -- it's not consistent with kind of what we're hearing later. And so I was kind of curious about that.

Most of the -- many of the visits would show that -- that he was kind of managing, he was holding it together on his job. Certainly the pain was increasing. And a lot of times the pain increased after an injury, or with other challenges that took place in the work -- in the workplace.

Q. All right.

A. But overall he -- there wasn't a huge report of any major side effects or compulsive use.

Q. All right. In terms of the amounts, there's been a lot of discussion about the amounts of the opioids that Mr. Koon was on. Those -- there's no dispute those are high doses finally in the year of 2012, correct?

A. Yes, they are high doses.

Q. All right. You've seen patients who have been on doses in that range?

A. Yes.

Q. All right. Prescribed by other physicians?

A. Yes.

Q. All right. You yourself haven't prescribed in that high a range, have you?

A. No, I have not.

Q. Okay. All right. Anything else, then, about your review of Dr. Walden's care as to whether it was proper and meeting the standard of care, at least as we're talking about it in that broad topic right now? Because we're going to talk about other topics. They may kind of come back in, but --

A. I think the other factor that we didn't get to was not in any really specific guidelines, but I think of just quality care that he takes the time to speak to -- or at least the evidence is that he was taking his time to speak to Mr. Koon, he listened, they had good communication, and I think that that was -- it came about in reviewing the records, of seeing the documentation, the calls to him. And also I think it was reflected in Mr. Koon's deposition that I read, about that they had a pretty good rapport and felt a good communication back and forth.

Q. Why is that important, Doctor?

A. Communication is critical to be able to assess

what's happening. I mean, it's critical to know how a patient's functioning, are there any problems that are going on, to assess them. I mean, a lot of what we're doing in our assessment comes back to history. History of what's happening, how we communicate. And it kind of gets to the -- one of the -- in the curriculum that I worked on, that I had mentioned earlier, it was -- it was very interesting when I got called about this case, that the very first case that -- the curriculum is designed around some case reports.

Q. Okay.

A. And then there's a case presentation, and then we discuss it. And this was designed for medical residents, but I've administered it to med students, psychiatric residents, practicing physicians, and addiction psychiatrists, and I've also administered the curriculum nationally at national meetings.

And the very first case I was very specific in why I picked it. And it was quite similar, actually, to how Mr. Koon was -- was presenting around the 2008 to '9 period.

Q. Tell us about that, Doctor.

A. The case involves -- I can -- I mean, I have it here. I could -- I'm not going to read the -- I won't bother you with the whole thing. But -- maybe I don't

have it here. Yes.

MR. CRONIN: Your Honor, can we approach?

THE COURT: Yep.

(The following proceedings were held at the bench.)

MR. CRONIN: Is this something I've seen?

MR. VENKER: Yeah, he talked about it in his deposition.

MR. CRONIN: Judge --

MR. VENKER: You can take a look at it, if you want.

MR. CRONIN: Judge, I think this expert is about to talk about a different case. Our expert was specifically excluded from doing that.

MR. VENKER: Here, it was your Exhibit 7 in the deposition. It's just this one, case one.

MR. CRONIN: Okay. Judge, this is what our expert was excluded from doing, other cases he's reviewed.

MR. VENKER: This is a -- not another case he reviewed, this is a curriculum. It's an article.

THE COURT: It does say Plaintiffs' Exhibit 7.

MR. CRONIN: That's because it was marked at the deposition I took.

MR. VENKER: He's going to talk about a teaching tool. He's not naming any names. He can't.

THE COURT: What do you anticipate that he's going to talk about?

MR. VENKER: I think he's just going to -- if I understand it right -- he's the one that brought it up -- I think he's going to talk about how close this curriculum teaching example is to this case. That's all.

MR. CRONIN: Your Honor --

MR. VENKER: He brought it up. I didn't ask him the question.

THE COURT: All right. Okay. I'm going to sustain the objection. Because we don't know what's about to happen. And while I know he went down that road, I think you've got to bring him back into -- not off of another case.

MR. VENKER: Okay. All right. Thanks, Judge.

(Proceedings returned to open court.)

BY MR. VENKER:

Q. Just to save time, Doctor, let's talk about -- I know you had that hypothetical, but as opposed to talking about two fact matters, let's just talk about this one. I think you started to talk about the challenge factor of it. So let's talk about that.

A. All right. So, the challenge in this situation is really trying to figure out what -- what proportion of the problem is related to a chronic pain syndrome and what

proportion of the problem is related to addiction. And if you're struggling with this at this point, you're not alone. And this is one of the biggest challenges for primary care physicians in managing chronic pain with opioids and concern about opioid use disorders.

Q. Is it managing -- is it challenging only to internal medicine physicians or are there others as well?

A. Most of the studies -- I mean, at least as far as data that have surveyed practicing physicians have looked at primary care, so internal medicine or family medicine. But having, you know, administered this at different levels of training, to med student, practicing physicians, it's quite common.

Q. How about with pain management specialists, would it be the same for them?

A. It is. In fact, some of the addiction psychiatry fellows at Columbia are involved in taking some of these cases to then their pain management rotations to try to help pain management understand this.

And, so, I think that where this challenge comes from is that in primary care, or any physician specialty, we don't want our patients to suffer. We want them to be able to function and feel well. But we also don't want to enable their dependence. We don't want to facilitate their dependence. And so there is this balance of trying

to figure out, you know, is this helping. Is this someone who needs this treatment, or is this something else. Is this compulsive medication use or addiction.

Q. Right. And, so, you're familiar with the information in this case. So let's take Mr. Koon's work history, his evaluations. You're familiar with that part of the file?

A. Yes, I am.

Q. Okay. So how would you -- is that -- is that sequence of evaluations helpful at all in the very analysis you're talking about?

A. It was. Because he -- it helped demonstrate that he met his -- his goals of treatment in that --

MR. CRONIN: Your Honor, can we approach?

THE COURT: Yep.

(The following proceedings were held at the bench.)

MR. CRONIN: Judge, these are new opinions. These documents were not provided to him until after his deposition. I was told they were provided to him about a week ago. I don't think he should be able to rely on new information that I didn't have a chance to depose him about.

MR. VENKER: Well, this isn't really new opinions, Your Honor, he's talking about Mr. Koon's -- the

effect of the medication on him, and this is just part of his evaluation. He was provided them recently, that part is true, but his opinion is the same. He doesn't have a new opinion.

THE COURT: How is this -- I mean, he's offering an opinion as to how he performed, how the medication affected his --

MR. VENKER: Yes, his performance.

MR. CRONIN: I agree he can give an opinion about that. But to discuss documents he had not seen at the time of his deposition such that I could not question him about them is a new basis for his opinion that I have not been able to explore.

THE COURT: So you're saying --

MR. CRONIN: He didn't have these records until a week ago that he's about to talk about.

THE COURT: Okay.

MR. VENKER: He doesn't have any new opinions, Judge.

MR. CRONIN: I'm not saying he can't give the opinions he gave, but talking about how documents that he didn't have in his deposition support his opinions is a new basis for his opinions.

MR. VENKER: I say it's -- they're a new opinion or it's not. I don't think it matters.

THE COURT: Help me out. The way I recall it if they give new opinions --

MR. CRONIN: Sure, Judge. At a deposition they are required to provide to me all the bases for all opinions. That is my only opportunity to find all bases for all opinions.

THE COURT: Okay.

MR. CRONIN: He did not have this information, he did not say it was a basis of his opinion. Counsel has just acknowledged he didn't get the documents until a week ago.

MR. VENKER: Well, it was more than a week ago. But --

MR. CRONIN: Very recently. He said he seen the documents, but he can give his opinion on whatever he based his opinion on at the time of his depo. He can give his opinion based on that.

MR. VENKER: I think these are not new opinions. I think he can give the opinions he had before.

THE COURT: Okay. I'm going to agree with defense counsel. This isn't -- I think it would be damaging if these were somehow -- some kind of reports that no one has seen. But --

MR. CRONIN: I understand they've seen them.

THE COURT: That's my thought process, but let's

keep it tight.

MR. VENKER: Thank you, Judge.

(Proceedings returned to open court.)

BY MR. VENKER:

Q. Let's do it this way. I don't want to rush you, Doctor, but let's do it in kind of summary fashion. Could you just give of just kind of a snapshot, so to speak, of the before and after the medications for Mr. Koon and what his work evaluations showed and what your observation is about that?

A. Well, the work evaluations corroborated that he was able to function satisfactorily on the job. And also -- am I allowed to talk about the deposition of his superiors, or the people that did the evaluations?

MR. CRONIN: Your Honor, I would have the same objection. This is material he did not have -- I'm sorry.

THE COURT: I'm going to overrule it.

BY MR. VENKER:

Q. Yes, you may.

A. So I may?

Q. You may talk about it.

A. So I was able to -- upon review of the deposition of his supervisor in the city, I think that also attested to him performing satisfactorily on the job. Which helps corroborate, then, that he was able to

function in that position and reach one of the treatment goals. Sort of swinging back to sort of the treatment goal that he was able to work, he was holding it together during that time, at least on the job.

Q. So does it -- do you have an opinion as to whether he was benefiting from the medications?

A. I mean, it certainly seemed as though he was able to -- to benefit from it, as far as pain relief. And it also -- functionally it was reported -- it was documented in the medical record of Dr. Walden.

But it also was corroborated by other providers. And I think that part of -- you know, getting back to the standard of care, that it's not just one person's assessment. It's also getting corroboration, is another factor. And, so, we had some corroboration during those years of opioid treatment from -- from other prescriber -- or other providers. One of them, I think, that was quite important was in 2011 when he went to -- got a course of spinal manipulation. And I don't remember the name of the --

Q. 2011? Late 2011, Doctor?

A. Yeah, late 2001 --

Q. Dr. Norton.

A. -- going to a chiropractor.

Q. Dr. Norton, I believe.

A. Yes.

Q. Tell us about that, why is that significant to you?

A. So, he went to see Dr. Norton three times a week for a few -- a couple of weeks, and then a couple of -- a couple of times a week, and then it weaned off to once a week. And during those assessments the chiropractor noted that he improved with some of the chiropractic manipulation. You know, again, non-pharmacologic approaches. He also documented that his pain did increase after work. A lot of the sessions he -- many of the sessions attested to the fact that this is strenuous work, and at the end of his shift some of the times he was in quite a bit of pain. And the manipulations were helping him.

Q. Now, at this point in his course he's on something well over a 1,000 milligrams -- or close to 1,000 milligrams a day in morphine, right, at the end of 2011? I think 1,100 was the averages, I think, for that year?

A. I don't know offhand what the -- the morphine equivalent was, but it looks like -- I mean, he was up into the several hundreds of oxycodone per day.

Q. And, so, is that of any significance to you, at the same time he's seeking out chiropractic treatment?

A. Well, it is for a couple of reasons. I think that the chiropractic notes were pretty consistent in how they documented Mr. Koon attesting to the fact pain meds were helping him this, the opioids. He got benefit, it was documented in the notes, from chiropractic intervention, from rest, and from the opioid medication. And that was pretty consistent across his course of treatment.

But then we have to then get back to sort of this -- is this -- the pain addiction question. You know, what's the weighing of our factors in this. In general it's thought that someone who is addicted is -- may be less likely to engage in non-pharmacologic approaches. The idea that, well, you know, I'd like to send you to physical therapy, I'd like to send you to a chiropractor, oh, no, all I want are my meds, just give me my meds.

Typically it's thought a willingness to go to a non-opioid based approach might indicate someone that is more likely to have a chronic pain, not an addiction.

Q. In this situation here, Mr. Koon really sought out this chiropractor on his own, didn't he?

A. He did. And he went. And, I mean, in fifteen years of opioid use disorder treatment, including people that have chronic pain, it's hard to remember anyone that really would be that proactive about seeking relief, you

know, in a non-opioid based approach. I mean, it was pretty impressive that he was dedicated to his treatment and getting well, to go to the chiropractic visits three days a week and then, you know, for those several weeks.

And there were other non-pharmacologic approaches that he engaged in. I think it was around that time, it might have been the year before, that he requested physical therapy. And, you know, at that time he was working and he was trying to do physical therapy, and he went and was able to only go once a week. And he went to Dr. Walden and he said, well, I -- I want to be able to do more physical therapy, but I can't with my work shifts, could I get a couple of weeks' leave of absence to dedicate to physical therapy. Which is pretty unheard of, for me, in my work in the past decade or more, that, you know, someone who was really just coming in drug seeking doesn't do that.

And so I think that as we're balancing this out, you know, some of these factors are pointing more towards a greater component of a chronic pain syndrome. You know, it's less compelling in the record during this four years, both in Dr. Walden's record and the chiropractic record, and in other consultants, that this is -- that addiction is leading this escalation.

And so then that gets us back to your question a

couple minutes ago about escalation. You know, what's driving this. And, yes, it could be an addictive component, but we're not really -- we're not really seeing that. It seems more likely, to me at this point, that this is more related to just intractable pain. I mean, he's got a really hard job and wants relief and function.

Q. Okay. So let's -- so let's move on, just because I want to make sure we cover everything that we need to cover with you, Doctor.

And, so, do you have an opinion about whether or not -- what Dr. Walden's care -- whether that caused Mr. Koon's -- what we're calling opioid use disorder. Do you have an opinion about that?

A. Yes.

Q. And what's your opinion?

A. I don't think you can ascribe direct casualty to his prescribing an addiction. Addiction comes about in -- there are many different factors that are involved.

Q. Like what, Doctor?

A. There -- there are bio -- we might say that it's a bio-psychosocial disorder. So biology is involved. Someone's genetics --

Q. What do you mean about? Tell us about that.

A. Someone's genetics can play a role. And though we don't -- we don't know about Mr. Koon's biologic family

members, because he's adopted, there is an increased risk of opioid use disorders, and other substance use disorders in people who have -- who are adopted.

Other factors that can predispose someone to developing an opioid use disorder, or opioid misuse, is other substance use. And he is a heavy smoker, tried for many years to stop, had a lot of difficulty despite some lung challenges, and I think that there actually are data, believe it or not, on examining tobacco -- tobacco use as a predicator of opioid medication misuse. And that those who specifically have an early morning cigarette right when they wake up tend to be more likely to misuse their opioids.

And you can imagine why that might be the case in that the first cigarette of the day may relate to a kind of greater physical need, you know, the -- your brain chemistry and reward system is amped up with that cigarette. But you may respond differently to opioids.

Q. Let me ask you this, Doctor. Is there any data to support the idea or the theory that the dose of the opioids is somehow related to the occurrence of opioid use disorder?

A. There are -- there are no data to support a dose risk ratio. Some might -- might posit that that is the case, but we don't have actual data to say that as the

prescribed dose goes up, your addiction risk goes up. And -- and in practice, I've treated many people who were addicted to even very small doses of medication. Fifteen, twenty milligrams of oxycodone a day. In fact, one of my -- one of my early, you know, buprenorphine maintained patients was that, that I remember quite well.

And, so, I -- not getting into cases, I would -- specifically I would say that opioid addiction can occur at low levels, absolutely.

Q. Okay. Under 100 milligrams a day?

A. Definitely, yes.

Q. All right. And we've already heard testimony -- or we've discussed already the -- whether there is a ceiling -- a daily ceiling for morphine equivalent dosing of opioids. Is there a such a ceiling, Doctor, anywhere in Federal regulations, or anything like that?

A. There is no specified ceiling for pain management in prescribing for pain. There is no amount -- back to the other -- we're talking about amounts. In any addiction criteria for any substance, amount never comes into it.

Q. Okay. Let's talk about whether you have an opinion about when Mr. Koon's -- if the right term is opioid use disorder, when that either occurred or manifested itself. Do you have an opinion about that?

A. It's difficult to determine when -- when the opioid use disorder came about.

Q. Why is that, Doctor?

A. Well, I think that -- that there is sort of a discrepancy between what was reported in the record during those four years and then what we -- what was reported in the record after he went to rehab.

And, so, you know, in the record over the four years, both in Dr. Walden's and the chiropractic report, and other corroboration, we're not getting a sense that he was having this degree of impairment of function and compulsive use. You know, he documented that he was taking the medication as prescribed, including up to an even the visit with Dr. McKean, who was the psychiatrist. When he went to go see Dr. -- Dr. McKean in 2012 --

Q. That was in the summer of 2012, right?

A. -- for addiction treatment, she took a really nice history about his recent pain medication administration. And he was pretty on the dot. 7:00 A.M., took the long-acting oxycodone, and 7:00 P.M. And then also took the other medication on track.

Q. Well, what do you mean by that? Why is that significant to you in evaluating this aspect of the case, Doctor?

A. Well, typically -- typically what we would see

with a more -- I mean, in a patient who has an opioid use disorder, that the medication would become erratic. Or it might be reactive. You know, it might be taking more in response to stress. You know, more in response to other factors that are going -- going on.

And, you know, the way that he reported things was that it was pretty much dosing as prescribed. Except with -- you know, except with some of the increases. Now one predicator of addiction, you know, one factor during this time that could support a risk of addiction was running out early. There were many instances where he ran out early and increased his medication.

But he wasn't at the time describing running out early to manage his stress, or for mood altering effects. Basically he was taking more because he got tolerant and because he had more pain, because his disease was progressing in his back and he had a really arduous job.

And, so, I think when we were looking in the record, we're not seeing the kind of compulsive drug seeking part of this. It's more he's relief seeking than euphoria high seeking during this time.

Q. And, so -- at what point in time -- do you think Mr. Koon actually demonstrated opioid -- opioid use disorder at any time, Doctor?

A. I do. I do think he --

Q. Okay.

A. -- has an opioid use disorder, though.

Q. All right.

A. And I think that he struggled -- or struggles with the medication, I think that as he reported -- reported his symptoms at CenterPointe when he went to the rehab in the intensive outpatient program, and as he reported it to Dr. Fitzgibbons, you know, I take what he says at face value. You know, he's describing that he can't stop using. Some of that could be addiction, but if you have this degree of back pain and back disease, you know, that could also be a factor, though, too.

So I think it's really hard to know why is this description between, you know -- we're not seeing these kinds of -- this reports of -- the same degree of compulsive use from 2008 to '12, but then once rehab starts we're now getting reports that pain medication did nothing, that it was only consequences.

And it just -- it didn't really seem to be the case. So I don't understand what -- I can't say exactly what happened in that stretch.

Q. Let me ask you about Mr. Koon's visit with Dr. Walden on May 24th of 2012 when Mr. Koon says he told Dr. Walden that the medications were running his life. And that's in Dr. Walden's chart. You have seen that,

haven't you?

A. Yes.

Q. All right. So does that in any way typify or exemplify what you're talking about as to whether it's the pain medication or the pain, or you tell us?

A. Well, many people who are on medication daily, and need to take them, will describe it as running their life. They need the meds. It's not pleasant to have to take medication all the time. And it's not pleasant to have to worry if I go out somewhere -- as Mr. Koon had written, if I go somewhere and I don't have my medication, and I'm running out, what do I do, I have to go back and get medication. It's not a pleasant way to live.

And, so, you know, running -- running one's life could also occur in the setting of chronic pain just being on medication. But -- but he also at the same visit, which was curious, was documented at least that there were no adverse effects of the medications themselves. They were running his life, but he wasn't reporting adverse effects and was dosing as prescribed.

And so I think, you know, that is the discrepancy that's hard to reconcile. When did this -- when did this happen, you know. And in looking at that snapshot from 2008 to '12, it's difficult to know.

Q. All right, Doctor. Tell us about the inpatient

treatment at CenterPointe that Mr. Koon went to. Do you have an opinion about whether that was necessary?

A. I do have an opinion, and I don't think that an inpatient admission was necessary for treatment. I think he would have -- I -- it's possible to treat people with this degree of opioid use as an outpatient with Suboxone.

Q. Let me ask you first, though, what about the withdrawal symptoms that Mr. Koon went through. Could those have been avoided, in your opinion?

A. If he were to be treated in an out -- some withdrawal with Suboxone treatment is inevitable. So even if he were treated in an outpatient practice, in transition to Suboxone, there has to be some withdrawal to get from the oxycodone to the Suboxone.

Q. And how would those withdrawal symptoms differ, Doctor? I don't mean to interrupt you. But between what you're talking about in an outpatient treatment mode -- which means coming to an office, doesn't it? Coming to a doctor's office?

A. Yes. The types of symptoms would be similar. The severity -- I guess I would say that probably the duration might have been a little bit quicker. It was hard to -- looking at the inpatient notes, it was hard to sort of get a full time course during those several days. But typically, in an office setting, starting Suboxone,

the patient would be in withdrawal for, you know, maybe about a day. And once they start the Suboxone their withdrawal gets better pretty quickly.

Q. And, so, that compared to -- you saw the description, didn't you, of Mr. Koon's withdrawal in the medical records?

A. Yes.

Q. All right. And, so, how does that then compare to what you're talking about, one day's worth of withdrawal with Suboxone?

A. Well, it's hard to say. I don't -- I don't know that I would want to fully over -- you know, overstate one to the other. But, in general, what the induction literature -- it's called induction, the process of starting Suboxone. And some of this is literature that I've published in my research on, has covered buprenorphine induction, shows that when you initiate the medication it usually takes about a half an hour for it to start to work, peak effects are in about an hour or two, and usually by the end of that first day most people are feeling pretty well.

Q. Okay.

A. And so it doesn't need to be -- it doesn't need to be prolonged. And there's also no -- you know, I think that certainly it is an issue that can be successfully

treated in an outpatient setting.

Q. Okay. And in terms of what -- Mr. Koon's future with his opioid use disorder, do you have any opinions about that?

A. I think it's been -- it's been interesting to look at what happened after he got on treatment. And -- and in reviewing the records, it would -- seems to me that his highest level of functioning since 2012 has been when he was on Suboxone on maintenance. When he was on Suboxone maintenance treatment he was able to get through at least one surgery, including a surgery in which he was prescribed stronger opioid medication, and he was able to get through that, which seems to be -- I don't want to say relatively easy, but, you know, he was able to get through it.

He -- then there were financial problems, which unfortunately led to him ceasing the medication. And although that was a struggle, he got through that. The subsequent surgeries off Suboxone, I think there was one that was a challenge, I think he got about five months of opioid medication, and was having some struggles with it, but did come off the medication.

And now he is in -- in an outpatient pain management with Ultram, which is an opioid. And, so, he's getting an opioid now at a relatively low dose.

Q. What's the significance of that to you, Doctor?

A. Well, the significance of all of this together, starting with the Suboxone, is that it's pretty remarkable that he was able to come off of Suboxone involuntarily -- essentially, he couldn't afford it -- and not relapse to opioids.

Q. Why do you say that? Why do you say it's significant?

A. The data show that in Suboxone detox, roughly 80 to 90 percent of people who have an opioid dependence relapse within one to three months. Eighty to 90 percent when they come off the Suboxone go back to their opioids. Which is a huge -- a huge number.

And, you know, he -- he got off of this -- off of a high dose of Suboxone, it was 24 milligrams, which is a pretty high -- pretty high dose. And also had pain that persisted, and also had surgeries, and also got more opioids, and never -- never relapsed to doctor shopping, buying non-prescribed opioids. And I think it shows the high degree of resilience that he has and strength that he has.

And it also, I think, shows that when -- we're back to that balance, pain or addiction. It -- it points towards more pain, you know, of driving his opioid use, not the compulsive addictive behavior. The -- the opioid

addicted individual would -- would be more persistent and end up relapsing.

And that was when he was off Suboxone, and also Ultram. The fact that he's been able -- it hasn't been easy. I mean, there's documentation in some of his -- I think it was in some of his handwritten notes that may have been provided to Dr. Fitzgibbons, or in his report to Dr. Fitzgibbons, that managing on the Ultram isn't easy.

Q. What is Ultram, Doctor?

A. Ultram is a pain medication that has opioid and other chemical effects in the brain. It's a weak -- it's a weaker opioid. But it is an opioid.

Q. Does it have potential for addiction or dependency?

A. It does. There are cases reported in the literature of Ultram dependence. And I've treated patients who came in for primary Ultram addiction and treated them with Suboxone, or helped them detox.

Q. Well how is it that Mr. Koon is able to not get pulled further into addiction then if he's on this Ultram with his history? Do you have an opinion about that?

A. I think it -- I think it reflects a -- a less severe addiction severity compared to many people. Still -- I'm still -- I still think that there is an opioid use disorder, but I think that it reflects that the severity

is not there, and it also reflects his -- his strength to be able to navigate this.

And it's not easy being on Ultram every, like, four pills a day. And I think there was a report of -- that they were going to try to drop that a little bit. And the reason is that it -- it's unlike Suboxone, which is a very long-acting medication. You take Suboxone once a day, it provides 24 hour coverage. You don't get the peak and troughs of short-acting opioids. Ultram is not providing that much coverage. And there probably is some degree of ups and downs on it that can make things difficult.

Q. Doctor, is addiction considered a disease?

A. It is.

Q. Does it -- do those chemicals -- is it possible for them to -- I'm not sure alter the brain is the right term, so you tell me. Is there any impact on brain circuitry, if that's the right term?

A. There is. I mean, I think you -- you probably may have heard in recent years about addiction as a brain disease. And I think the old notion was sort of is it physical or -- physical aspects of drugs or the psychological aspects of drugs.

And I feel like that kind of differentiation is -- is antiquated. It's outdated. Because what is

psychology other than brain physiology. Psychology is your brain connections. And that involves different parts of your brain. Yes, there are reward centers in your brain, where you feel the pleasurable effects. But those pleasurable effects of drugs are also tied in to emotional centers. Memory centers. Impulsiveness.

And, so, how you react to cues, for example. I've had -- some people will see a bottle and it makes them want to use a pill. Some people report that they can't go in a grocery store where there's a pharmacy in the back because that's where they got their pills. The grocery store is the cue. And it elicits cravings and makes them -- puts them at risk for relapse.

And so this is tied in with sort of parts of the brain.

Q. Okay. And how about other patients? Do all patients react that way, or do some have other reactions to this process?

A. Well, fortunately the brain can heal. And people can do extremely well with treatment. And it -- and it's -- it is extremely gratifying. It is the best part of the job, is seeing people do well.

And in thinking about it -- I guess in thinking about these cues is useful. Sometimes people are able to not just see a bottle of pills, they may be handling the

medication, dispensing pain medication for a family member, without any kind of cravings, any desire to use it. Over time these cues and thoughts about drugs become adversive. Patients will be describing being disgusted by the pills and, you know, there's a negative association.

So the idea that -- so the brain can change for people over time, and it -- this idea that you will always be longing and craving and desiring more of a substance doesn't need to be the case.

Q. All right. I want to ask you about one thing, Doctor, before we close, and that is back in July of 2012, you were one of the doctors -- one of a number of physicians who signed a letter. The group is called Physicians for Responsible Opioid Prescribing.

A. Yes.

Q. You remember that letter, don't you, Doctor?

A. Yes, I do.

Q. And who was it addressed to?

A. The Food and Drug Administration.

Q. And why did you sign onto that letter, Doctor?

A. Well, I agreed with -- I agreed with the letter that was written by a group of thirty or so people from across the country.

MR. VENKER: May I approach, Your Honor?

THE COURT: You may.

BY MR. VENKER:

Q. Do you have a copy of it with you?

A. I don't.

Q. It's okay. If you need it.

A. So it was a -- basically a petition to the Food and Drug Administration about opioid medication and getting the medication label -- labeling to change.

Q. Why, Doctor?

A. Well, I think that -- that throughout the 2000's and into the 2010, '12 -- we wrote this in 2012, prescription opioid use had become a lot more problematic. And the prescribing at that same time was associated with that.

So as physician prescribing went up through the 2000's, problems associated with prescription opioids went up. Including overdoses, more people were admitting -- getting admitted to treatment for opioid use disorders, emergency room visits went up. More people were presenting with opioid use disorders.

So this was going hand-in-hand, prescribing was going up and problems with use were going up.

Q. And so what was the hope with this letter, Doctor?

A. Well, the hope was that -- that the FDA would change the labeling for prescription pain medication and

have labeling that was more in line with the data that were available. Because even though physicians were prescribing more and more pain medication, including for chronic non-cancer pain, there is -- there is limited data to support the long-term effectiveness.

Q. Okay.

A. And so it was hoped that by changing the label would send a message to physicians this is important. It sends a message reminding them that there is a lack of data about, you know, effectiveness, and a lack of safety data. And also that it would limit the ability of the drug manufacturers from promoting their products, you know, quite as widely. They would then have to adhere more closely to the FDA guidelines, which might rein in promotional materials.

Q. All right. Does the letter say that there should be a maximum ceiling per day of morphine equivalent dosing that no one should exceed?

A. No.

Q. Okay. What does it say about that?

A. Well, it says that -- risk -- we should acknowledge that risk goes up, but there is no -- there is no -- what PROP is advocating is more a change in labeling, not to say that prohibition on prescribing above 100 milligram equivalents of morphine.

So this is really just the labels. So striking the term moderate from non-cancer pain and saying that it should be listed for severe. Adding a maximum daily dose equivalent to 100 milligrams of morphine for non-cancer pain in the label in the 90 day supply. So that it couldn't be labeled for indefinite prescription.

Q. And, so, in this case, Doctor, how does that letter -- what you wrote to the FDA, how does that square with Dr. Walden and you saying that he met the standard of care?

A. Well, it's different. It's not about guidelines saying that you can't prescribe above these levels. It's basically a way for the -- the FDA labeling provides information. Information to physicians. So it -- what we were hoping is that this would force the FDA's hand to change the labeling that would then go to physicians. And physicians actually are impacted by FDA labeling. You may have heard about black box warnings on medications. You know, things like that that get taken up into practices. And hopefully that this would lead to more effective and safer practice habits.

Q. Okay. Doctor, you agreed to review this case. Of course you're being paid hourly for your time to review it, correct?

A. Yes.

Q. All right. Any sense on how many hours you have spent up to now in the case?

A. I haven't -- I haven't collated that yet. I submitted an invoice for ten or so hours, I think, in January or February. I don't remember the exact dates. If I had to guess, I mean, there were ten -- ten binders, lots of depositions, I would say probably in the twenty-five to thirty hour range. You know, with travel. I'm not sure.

Q. Okay. All right. And you've already been paid for some of that time, right?

A. Yes.

Q. And is that money you've kept, or bought a car with, or what have you done?

A. Well, the -- the rate is $475 an hour, and the initial check that I got was $4,000. At the end of last year, when I realized that I was going to be doing this, I was deciding upon whether -- this is the first time that I've ever done this kind of work, and I thought this might be interesting. But once I made the decision to do it, I -- I had a patient who was struggling, and I wrote off $2,100 of debt that this patient had. And subsequently I, since January, have discounted $6,100 in debt from patients.

So, it's nice to be able to use this to support

people and spend extra time with them and give them extra treatment when they need it.

MR. VENKER: That's all the questions I have at there time, Your Honor.

THE COURT: All right. Cross. While counsel gets up, why don't everybody stand and get the blood flowing.

(Whereupon, a short recess was taken.)

THE COURT: All right. Please be seated.

**CROSS-EXAMINATION**

BY MR. CRONIN:

Q. Dr. Gunderson, good afternoon.

A. Good afternoon.

Q. Are you good to keep going?

A. Yes.

Q. Dr. Gunderson, you gave a deposition in this case. Do you recall that?

A. Yes.

Q. It's the first time -- we didn't meet in person because it was video conference, but that was the first time we met, right?

A. Yes.

MR. CRONIN: Judge, permission to approach?

THE COURT: You may.

BY MR. CRONIN:

Q. Doctor, I'm going to give you a copy of this deposition. I don't know if you will need it, but just in case.

A. Thank you.

Q. I think that's the wrong copy. I'll take that one back.

A. Sure.

Q. There you go. Exhibit 170. Doctor, when you've been talking about looking in the records, looking in the records, what we see when we look in the records, whose records are you talking about?

A. The clinical visits that took place at the primary care, surgical consults, psychiatric records, chiropractic work --

Q. When you were --

A. -- clinical notes.

Q. When you were talking about communications with Dr. Walden, whose records are you talking about?

A. When I talked about, I'm sorry, communications with Dr. Walden?

Q. Yeah, what he's reporting to Dr. Walden. Those are Dr. Walden's records you're talking about, right?

A. Yes.

Q. Okay. And what's in those records is what Dr.

Walden wrote, not what Brian wrote?

A. Right.

Q. So we have to rely on what Dr. Walden put in those records for what they say?

A. Right.

Q. Not necessarily what Brian told him, right?

A. Right.

Q. Okay. And you mentioned smoking. Somebody who is a smoker is -- has an increased risk for becoming addicted to opioids, right?

A. Not addicted.

Q. Opioid use disorder?

A. Prescription opioid misuse.

Q. Okay. Brian was a smoker. Correct?

A. Yes.

Q. For years before Dr. Walden prescribed him opioids?

A. Yes.

Q. Dr. Walden knew he was a smoker?

A. Yes.

Q. It's in his records. Right?

A. Yes.

Q. Okay. Brian got an opioid use disorder. You agree?

A. Yes.

Q. Okay. Are you -- are you saying that Dr. Walden's prescribing of those opioids to Brian had nothing to do with Brian getting an opioid use disorder?

A. No.

Q. Okay. He wouldn't have it if Dr. Walden didn't prescribe them to him, right?

A. Not necessarily. I mean, the opioid use disorder is multifactorial in how it comes about, not just prescription.

Q. I understand, Doctor, but if you don't get any opioids -- you don't just wake up with an opioid use disorder, right? You have to get them prescribed from your doctor?

A. True. Yes.

Q. Okay. So you have seen some work evaluations and depositions of Brian's supervisors?

A. Yes.

Q. Those are not things that you had seen at your deposition, right? Before your deposition?

A. I don't recall if the -- I might have had the -- the evaluations. I definitely did not have the depositions.

Q. Okay. And was it Mr. Skillman and Mr. Bublis?

A. Yes. Definitely Bublis. I don't remember the name Skillman. But it was the commissioner --

Q. Sure.
A. -- and the supervisor.
Q. Did you read the whole depositions?
A. Yes.
Q. So you know Brian's performance ratings started going down in 2008?
A. Yes.
Q. And became worse in 2009?
A. Yes.
Q. And worse in 2010?
A. Yes.
Q. And Brian had instances of hurting himself at work in between 2010 and 2012, like hitting himself with a hammer? Right?
A. Yes.
Q. You read Mr. Bublis' deposition?
A. Yes.
Q. And he was Brian's foreman?
A. Yes.
Q. He took Brian off the road so he wouldn't be driving around the City of St. Louis, right?
A. Yes.
Q. Okay. He had somebody else drive him around?
A. Well, I think he didn't actually take him off the road. His deposition stated that we have two drivers,

and if we have two drivers, I would have the other driver drive. But he didn't actually prohibit him from driving.

Q. Do you recall Mr. Bublis saying that was my idea for him not to drive anymore? You don't remember that?

A. I don't remember if he said that or not.

Q. All right. Doctor, let's look at Exhibit 170-4.

MR. CRONIN: Mike, can you pull that up?

BY MR. CRONIN:

Q. This is the letter that you -- do you have a copy of the letter?

MR. VENKER: The PROP letter?

MR. CRONIN: Yeah.

MR. VENKER: He does.

A. Yes, I have it.

BY MR. CRONIN:

Q. All right. Now, Doctor, first, you're not saying the dose number doesn't matter, are you?

A. No.

Q. When prescribing opioids? Okay. You've seen doses in the range of what Brian was on in 2012, is that what you said in your direct?

A. Yes.

Q. When you're treating patients who developed opioid use disorders?

A. Yes.

Q. Those are the patients you've seen in those ranges?

A. For the most part, yes.

Q. Okay. And then you're treating them for the substance abuse disorders, right? That's when you see them?

A. I have a predominantly substance use practice, so I'm going to get -- I'm getting referred predominantly people that have opioid use disorders.

Q. Because they need help, right, Doctor?

A. Or --

Q. They need help with their disorder?

MR. VENKER: I'm not really going to object, just give him a chance to answer, that's all.

THE COURT: Everybody breathe.

A. So, I have a predominantly opioid addiction treatment practice. So, by definition, the referrals that I'm getting from clinicians are to assess people for an opioid use disorder, or the patients are self-referring for having an opioid use disorder.

So, among those who are on medications in this range, it will be skewed towards an addiction diagnosis.

BY MR. CRONIN:

Q. Okay. And, Doctor, I think you told us you've never prescribed that high of a dose, right?

A. I never have.

Q. All right. Now, Doctor --

MR. CRONIN: Mike, can you take me to the top?

BY MR. CRONIN:

Q. Doctor, this is a letter from a group called the Physicians for Responsible Opioid Prescribing. Is that right?

A. Yes.

Q. And you were -- are or were a member of this organization?

A. Yes.

Q. And you signed this letter?

A. Yes.

Q. And it was written to the FDA, correct?

A. Yes.

Q. In July 2012?

A. Yes.

Q. Okay.

MR. CRONIN: And can you highlight the top, Mike? The first paragraph?

BY MR. CRONIN:

Q. Doctor, this -- clinicians, researchers and health officials from all kinds of fields signed this. Is that right?

A. Yes.

Q. Pursuant to a Federal law. And other pertinent sections of the Federal Food and Drug and Cosmetic Act?

A. Yes.

Q. Okay. So, let's go to the next paragraph. The second paragraph. Let's see what the letter says.

At present the FDA approved indication for nearly all instant-release opioid analgesics is moderate to severe pain. For extended-release opioids, the indication is for moderate to severe pain when a continuous, around-the-clock, analgesic is needed for an extended period of time. These overly broad indications imply a determination by FDA that they are safe and effective for long-term use. As outlined below, an increasing body of medical literature suggests that long-term use of opioids may be neither safe nor effective for many patients, especially when prescribed in high doses."

Did I read that correctly?

A. Yes.

Q. And this is in a letter you signed?

A. Yes.

Q. Did you believe that at the time you signed the letter?

A. Yes.

Q. Do you still agree with it today?

A. Yes.

MR. CRONIN: Mike, can you pull up the next paragraph?

BY MR. CRONIN:

Q. Doctor, third paragraph reads, "unfortunately, many clinicians are under the false impression that chronic opioid therapy is an evidence-based treatment for chronic non-cancer pain."

That's what Brian had, right, chronic non-cancer pain?

A. Yes.

Q. Okay. And the dose-related toxicities can be avoided by slow upward titration. These misperceptions lead to overprescribing and high dose prescribing. By implementing the label changes proposed in this petition, FDA has an opportunity to reduce harm caused to chronic pain patients, as well as societal harm caused by diversion of prescribed opioids. In addition, FDA will be able to reinforce adherens to dosing limits that have been recommended by the United States Centers for Disease Control, the State of Washington, and New York City Department of Health and Mental Hygiene."

Did I read that correctly?

A. Yes.

Q. Did you believe that at the time you signed the

letter?

A. Yes.

Q. Do you still agree with it today?

A. Yes.

Q. Do you believe that misperceptions by clinicians lead to overprescribing and high dose prescribing?

A. I think that it can, yes.

Q. Okay. By the way, that mentions dosing limit recommendations by the CDC. Right?

A. Yes.

Q. What's the date of this letter?

A. 2012.

Q. We've been told in this courtroom that the CDC didn't make any dosing recommendations till 2016. That's not true, is it?

MR. VENKER: Your Honor, that is argument and it misstates the evidence.

THE COURT: Overruled as to misstate. It is argument. Save it for argument.

BY MR. CRONIN:

Q. Okay. Doctor, the CDC made dosing recommendations long before 2016, didn't they?

A. Yes.

Q. You're citing that with your letter?

A. Yes.

Q. Okay.

MR. CRONIN: Can we go to the bibliography, Mike? Let me see what page it's on. Page 6.

BY MR. CRONIN:

Q. That cites to Center -- a Centers for Disease Control article, right?

A. Yes.

Q. And when you cited in the body of your letter, footnote one, it was to this article, right?

A. Yes.

Q. What's the date? 2007?

A. Yes.

Q. That's before 2008?

A. Uh-huh. Yes.

Q. Were those -- I think you said what you were going to recommend in the letter was to be in line with what you cite to in your bibliography, right?

A. I think that recommendations for having cutoffs is important to consider.

Q. Okay.

A. Yes.

Q. And in your letter -- we're going to get to the recommendations. You were putting numbers in your letter to try to be in line with what was being cited to in the bibliography, right?

A. Yes. I don't have this 2007 document available.

Q. Okay.

A. Do you have a copy of that that we can review?

Q. I don't. Doctor, I assume you read the article before you signed the letter citing to it. Is that accurate?

A. Yes.

Q. Okay. And you cited the dosing guidelines from the Agency Medical Directors Group from Washington. Number two.

MR. CRONIN: Mike, can you show us number two?

BY MR. CRONIN:

Q. You also cited to that --

A. Yes.

Q. -- correct? Okay.

MR. CRONIN: You can pull that down, Mike.

BY MR. CRONIN:

Q. Doctor, in this letter you were seeking to change the labeling for opioids, right?

A. Yes.

Q. So you agree dosing limits like those proposed by the CDC and the State of Washington are a good idea, correct?

A. Well, it depends on how you are planning on using those limits. The limits are a guide, but they're

not absolute. And some of the limits are talking about risk. They're not saying that physicians should be prohibited from exceeding these amounts. Because some people benefit from them. Some people need pain relief at those amounts.

Q. You agree dosing limit recommendations --

MR. VENKER: Your Honor, I would like Dr. Gunderson to be able to finish his answer, if he had more to say.

A. I did. The guidelines here, where there are cutoffs for amounts, are relating -- are relating to overdose risk. That's where the 100 milliequivalent comes from. And although I don't have this -- it's been four years since I wrote this, I very well may have cited this 2007 article in my other work. It's a poisoning issue brief, unintentional drug poisoning. My guess is that the cutoffs that they're referring to pertain to overdose.

BY MR. CRONIN:

Q. Okay.

A. Not that we cannot go above a certain amount for patients who have pain.

Q. Doctor --

A. And I think the other thing about the cutoffs --

MR. CRONIN: Your Honor, on cross-examination counsel has the right to formulate the question, and this

was a leading question that required a yes or no answer. The doctor has now gone beyond the scope of the question.

THE COURT: Overruled. He gets to finish. Tighten up your questions.

A. What was proposed here in the cutoffs -- this document is about labeling, which is another factor. So the idea of the petition is to get the labeling changed, not to expect the FDA to enforce guidelines.

BY MR. CRONIN:

Q. Doctor, in your opinion, as the letter states, long-term use of opioids has not been proven safe and effective for chronic non-cancer pain. Agreed?

A. Yes.

Q. Okay. Let's look at the second page. These are the changes you were requesting, right, Doctor?

A. Yes.

Q. Strike the term moderate from the indication for non-cancer pain, correct?

A. Yes.

Q. Add a maximum daily dose equivalent to 100 milligrams of morphine for non-cancer pain. Correct?

A. Correct.

Q. Add a maximum duration of 90 days for continuous daily use for non-cancer pain. Correct?

A. Yes.

Q. You still agree with those?

A. Yes.

Q. Now, you weren't saying recommended dose in duration. Those say maximum, don't they?

A. This is for labeling.

Q. Okay. Does it say maximum?

A. A maximum labeled dose for 90 days. This is FDA labeling.

Q. Okay.

A. There's a difference between labeling -- it's a very important distinction. And I apologize if I didn't -- if I didn't explain it well enough when we -- in my initial deposition. But it's important.

Q. Doctor, when you said maximum daily dose, did you mean as in don't exceed it?

A. No. It's the labeling. It means a maximum label dose of not to exceed 100 milligrams. That -- the labeling is not saying to physicians you can't give them 110 milligrams.

Q. That would be prescribed --

A. Yes. The labeling basically provides information to physicians about the quality evidence. In the sentence before, where it said proven effective -- it's a very important word, proven. Because proven implies that there is a body of literature to justify its

use and to support its effectiveness.

Q. And there is no such body of literature?

A. There is not enough literature to prove its effectiveness.

Q. I think you said to justify its use. Those are the words you just said, right?

A. No, I think I said prove. You know, there is not proof -- there is not proof. I mean, it doesn't mean that you can't go above 120, 100 milligrams. The labeling is a way -- it's a sort of -- a stamp of approval from the FDA that if a product is labeled for something, then you can be assured, hopefully, that the FDA has read the evidence and said that this is an appropriate indication supported by the literature. Proven.

Q. Doctor, you had included scientific basis for your proposals, correct?

A. Yes.

MR. CRONIN: Mike, can you go off from that? Can you highlight this section, one through nine?

BY MR. CRONIN:

Q. Doctor, number one says over the past decade a four fold increase in prescribing of opioid analgesics has been associated with a four fold increase in opioid-related overdose deaths and a six fold increase in individuals seeking treatment for addiction to opioid

analgesics.

Did I read that correct?

A. Yes.

Q. Number two says prescribing opioids increased over the past fifteen years in response to a campaign that minimized risk of long-term use for -- is that chronic non-cancer pain?

A. Yes.

Q. And exaggerated benefits. Did I read that correctly?

A. Yes.

Q. Number three, long-term safety and effectiveness of managing chronic non-cancer pain with opioids has not been established.

Did I read that correctly?

A. Yes.

Q. Number four, recent surveys of chronic non-cancer pain patients receiving -- what's COT? Do you know what that is?

A. Chronic opioid therapy.

Q. Have shown that many continue to experience significant chronic pain and dysfunction.

Did I read that correctly?

A. Yes.

Q. Number five, recent surveys using DSM criteria

found high rates of addiction in chronic non-cancer pain patients receiving chronic opioid therapy.

Did I read that correctly?

A. Yes.

Q. Number six, a large sample of medical and pharmacy claims records found that two-thirds of patients who took opioids on a daily basis for 90 days were still taking opioids five years later.

Did I read that correctly?

A. Yes.

Q. Number seven, patients with mental health and substance abuse co-morbidities are more likely to receive chronic opioid therapy than patients who lack these risk factors, a phenomenon referred to as adverse selection.

Did I read that correctly?

A. Yes.

Q. Number eight, three large observational studies published in 2010 and 2011 found dose-related overdose risk in chronic non-cancer pain patients on chronic opioid therapy.

Did I read that correctly?

A. Yes.

Q. Number nine, chronic opioid therapy at high doses is associated with increased risk of overdose death, emergency room visits, and fractures in the elderly.

Did I read that correctly?

A. Yes.

Q. And, Doctor, I asked you at your deposition, you still agree with all of those, right?

A. Yes.

Q. Okay. And I think you said in your direct, when you sent this letter you wanted to send a message to physicians. Right?

A. Yes.

Q. Okay. They haven't gotten one yet, have they, Doctor?

MR. VENKER: I'm sorry, I'm not sure I understand your question. It sounded argumentative.

BY MR. CRONIN:

Q. The message about describing opioid therapy for chronic non-cancer pain.

THE COURT: Overruled.

A. I think that the -- I think that the message is emerging. I think that knowledge and concern of physicians now, in of 2016, is different than it was in 2008 to 2012. And I think that they -- I think that it would be hard not to get the message when every day or every other day it seems like you open up the newspaper and there's a headline, something about prescription opioids.

And so I think that they may be getting the message, but the point of this letter is that they should be getting the message from the FDA. They shouldn't be getting the message from consequences in the newspaper. Or consequences from emergency departments. Or overdoses.

Q. Because from those sources isn't working, is it?

A. No. From those sources it means that human suffering has already taken place. That's why.

Q. And --

A. It's not that they're not getting the messages, it's -- because how can you not get the message when your communities are seeing overdoses, when your communities are seeing people being admitted for treatment. Accidents. Poisonings. Of course you're seeing that.

This is about the FDA's responsibility. And they -- they should be using evidence. The statements up there, I agree with. But another thing, in the first section, when we focused on a word, what is a word? Proven we talked about. What is this? This is scientific basis. Scientific. And the science should be guiding FDA. FDA is a main purveyor of information to physicians. And it's a missed opportunity.

Q. Doctor, I'm going to switch gears for a second. You specialize in addiction medicine, correct?

A. Yes.

Q. You focus your study and practice on substance abuse?

A. Yes.

Q. Specifically treating dependence and addiction?

A. Yes.

Q. And, Doctor, you were retained as an expert by the attorneys for Dr. Walden and St. Louis University in this case?

A. Yes.

Q. Dr. Walden was Brian's primary care physician?

A. Yes.

Q. And that's what Dr. Walden is, a primary care physician?

A. Yes.

Q. You are not practicing as a primary care physician, correct?

A. Not at present.

Q. You have not had a general internal medicine practice in, what, four years?

A. No. 2008.

Q. Okay. Eight years?

A. Eight years.

Q. Okay.

A. I have worked in a general medical clinic alongside medical residents and attendings. I left in

2012.

Q. So you did not have a general internal medicine practice during the time period in which are you commenting on the standard of care for a general internal medicine practice?

A. Correct.

Q. What you primarily do, Doctor, in your practice is work with individuals with mental health and substance abuse disorders?

A. Why.

Q. Am I right, Doctor, you've been on the advisory board for a couple pharmaceutical companies, correct?

A. Yes.

Q. One of them, Orexo, funded some research you did about a drug to treat opioid abuse?

A. Yes.

Q. And that company also makes or is developing opioids, right?

A. Yes.

Q. Okay. And the position on their advisory board is a paid position?

A. Yes.

Q. Do you agree, Doctor, that an expert's role in a case is to be nonpartisan, just to provide truthful answers to the questions asked?

A. Yes.

Q. What are opiates, Doctor?

A. What are opiates?

Q. Yes.

A. Opiates are substances that bind -- that -- your body's opioid system in the brain that typically come from the poppy plant.

Q. Morphine, Codeine and heroin are opiates?

A. Yes.

Q. And opioids include opiates which are derived from the poppy, but also synthetic or semisynthetic opioid compounds?

A. Correct.

Q. All right. The prescriptions Brian was getting, Vicodin, oxycodone IR, or immediate release -- is that what that means?

A. Yes.

Q. And OxyContin. Are those opioids?

A. Yes.

Q. And whether it's opioids or opiates, they bind to receptors in the brain generally the same way and have the same effects?

A. Generally, yes.

Q. In other words, oxycodone binds to the receptors in the brain generally the same way that heroin does?

A. Yes.

Q. Opioids are highly addictive narcotics. Do you agree with that, Doctor?

A. They -- they definitely can be addictive, yes.

Q. They're classified as Schedule II narcotics by the DEA?

A. Yes.

Q. Meaning, by the DEA's definition, they have a high potential for abuse with use potentially leading to severe psychological or physical dependence. Is that correct?

A. Yes.

Q. In other words, they can be dangerous, right?

A. Yes.

Q. Doctor, you agree, I think you've commented on it, we're in the midst of a prescription opioid epidemic in our country, right?

A. Yes.

Q. Can you tell the jury about it?

A. Yeah. I alluded to it a little bit earlier, about how things have come about. Many people think that this began in the mid '90s with the promotion of the concept of pain being the fifth vital sign, in quotes. So what that meant was that at every visit that you might go to where you might get your vital signs measured, that

your clinician --

MR. VENKER: Did we lose the mic?

THE COURT: Sorry about that.

A. That your --

THE COURT: I hit something. Keep going.

A. That -- so -- at any -- any time that you might be at a clinician's office where you might be getting regular vital signs measured, this idea of pain as the fifth vital sign would include that you should be asked about your pain. And that that pain should be qualified on a ten-point scale.

And, so, coupled with that idea that pain be included as a vital sign, physicians should be asking you about your pain. Also that we need to be more aggressive about pain. That pain management was deemed a right, you know, a human right, that we need to be treating pain.

And, so, pain, as a problem of being under treated, raised -- got raised in awareness. And simultaneously there were pharmaceutical companies that were then promoting their medication as safe and saying if you are treating, for example, with a long-acting preparation, OxyContin, for example, for chronic non-cancer pain, that the risk of addiction is very low. And the data that they cited was poor -- it was poor quality data. And with that promotion was the idea -- so

pain is under treated, we need to treat pain, we need to treat it at every visit, and this is a safe thing to do, especially with long acting. So long-acting prescriptions went up.

And then other factors involved -- and so this led, in part, to an increase in prescribing.

MR. VENKER: Your Honor, may we approach briefly?

THE COURT: You may.

MR. CRONIN: Your Honor, I can move on.

MR. VENKER: Well, I think we need to approach just briefly.

(The following proceedings were held at the bench.)

MR. VENKER: I'm really just doing this to preserve the record. To the extent opioid use has been an epidemic has been referred to, I know the Court ruled time and again my objection is overruled to that, I just want make the objection to this witness being asked those questions again. I'm confident you're going to overrule it, because you have, but --

THE COURT: I will stay consistent. But let's not dwell on this longer than we need to.

MR. SIMON: I'll ask some specific questions.

MR. VENKER: So it's overruled?

THE COURT: Yes.

(Whereupon, proceedings returned to open court.)

BY MR. CRONIN:

Q. Okay. Doctor, let me ask you some specific questions. You've written that the prescription opioid epidemic is a major public health problem.

A. Yes.

Q. And am I right, treatment for opioid abuse has kind of become a whole industries?

A. It's expanding. Treatment is still -- there still is an unmet need, though. There are many more people, unfortunately, that need treatment than are getting it.

Q. You agree, Doctor, we've seen a large increase in prescription opioid misuse, prescription opioid dependence, which is used -- let me ask you this. Opioid use disorder, dependence, addiction, are those used often interchangeably?

A. Yes.

Q. And when we say -- when we talk about DSM-IV dependence, is that used interchangeably with addiction sometimes?

A. Yes.

Q. Because in DSM -- the earlier diagnosing for mental health illnesses, is that what the DSM-IV is for?

A. Yes.

Q. And DSM-IV didn't have a diagnosis for addiction or opioid use disorder, right it?

A. No.

Q. And DSM-V has an opioid use disorder diagnosis?

A. Yes.

Q. And so when we talk about DSM-V opioid use disorder, we can use that interchangeably with addiction, right?

A. Yeah, sort of.

Q. Okay. We've seen a large increase in prescription opioid misuse, prescription opioid dependence, and also a large increase in overdoses and hospitalizations, right?

A. Yes.

Q. The increase in complications, including overdose, has mirrored the increase in prescriptions by physicians?

A. Yes.

Q. And when I asked you -- well let me ask you. Can you give me an approximation of the number of people dying from these opioid overdoses per year in our country?

A. It's, I think, around seventeen to nineteen thousand.

Q. The number of opioid prescriptions filled in the

United States per year equals the number of people in the United States. Is that correct?

A. I don't know the exact statistic on that.

Q. Is it close?

A. It's in that range, yes.

Q. Doctor, there are physicians who are way overprescribing opioids. Do you agree with that?

A. Yes.

Q. And that's one of the reasons for our prescription opioid epidemic, isn't it?

A. It is -- it's a contributing factor.

Q. You have supported the fight against this epidemic?

A. Yes.

Q. Do you agree something needs to be done to deter doctors from overprescribing opioids?

MR. VENKER: Your Honor, may we approach?

THE COURT: You may.

(The following proceedings were held at the bench.)

MR. VENKER: I'm going to object to the form of this question, it's asking about deterring doctors. I don't think that's an opinion he gave. I don't think it's an opinion he's here to give. He's here about standard of care, he's here about causation. It sounds like this is

some kind of question related to plaintiff's punitive damages claim, and so I object to it for that purpose as well.

MR. CRONIN: Judge, this is cross-examination. I don't really get to ask him what opinions he told Paul he would give. He's an addiction expert, specifically an opioid addiction expert.

THE COURT: Okay. Here's what I'm -- I'm going to sustain the objection as vague. I wrote down something needs to be done. You -- that's a vague question. I think you need to tighten the question up. I'm not shutting down the line of questioning, I just don't know what something needs to be done --

MR. VENKER: He also used the word deter, Your Honor. Something needs to be done to deter physicians. So that sounds like somebody taking a policing action or something. And I object to it.

THE COURT: I'm not going to preclude the deter. I think you need to couch it in a language that he used. The -- the -- well, I'm not going to -- but he used a -- a -- yeah. I think stay away from deter. But I'm not precluding the -- that thought process.

MR. VENKER: The objection is overruled?

THE COURT: In part.

MR. VENKER: And sustained in part. Thank you.

THE COURT: Yeah.

(Proceedings returned to open court.)

BY MR. CRONIN:

Q. Do you agree that physicians need to be deterred from continuing to overprescribe opioids?

MR. VENKER: Your Honor, same objection.

THE COURT: Overruled.

A. I think that physicians need more education about how to effectively and safely prescribe.

BY MR. CRONIN:

Q. Wouldn't you agree with me, Doctor, that one of the contributions to this epidemic is regular primary care physicians prescribing large quantities of opioids when they don't really know enough about them?

A. I think that proportionally that contribution is probably less than other factors. From national survey data, where some of these numbers come from, most of the medication that is being misused is not direct from the physician. It's not that someone is directly going in and saying, you know, here are my -- I need meds. The medications are getting to people who are misusing it, maybe from physician's prescription, such as medicine cabinets, medication left over, people prescribing too much for an acute painful procedure. Maybe some of you have had dental work and you had a tooth pulled and you

got not one or two Vicodin, you probably got twelve or sixteen, or whatever it was.

And, so, what people do is that -- when they get extra medication that they don't need, they save it, and it's in the medicine cabinets of America. And then a lot of the misused medication is -- it may be coming from physicians, but not direct in a doctor-patient relation.

And, also, there has been an expansion of illicit networks of prescription opioids. People are getting medication from, you know, the Internet, and non-prescribed medications are getting into the pool of misuse. Fentanyl, you may have heard about, has been a big resurgence, and a lot of fentanyl is not actually coming from doctor's prescriptions, it's sort of illicit markets.

So I would disagree that the primary care is driving this. That statement is not supported by the -- by the literature.

Q. How about this, Doctor. Do you agree that improved education of primary care physicians is needed to help find -- help integrate better practices?

A. Yes, that has been the focus of my career since 2003.

Q. There is room for improvement for primary care doctors across the spectrum for any prescribing of

opioids. Would you agree with that?

A. I mean, any is very broad, but I would say that there is room for improvement of primary care providers across the spectrum in opioid prescribing, yes.

Q. Doctor, you wrote in 2009, "in a primary care setting a third of patients that get put on opioids for chronic non-cancer pain demonstrate opioid or other substance abuse." Did you not?

A. Yes.

Q. Is it true that primary care physicians often do not address or that they miss the diagnosis of substance abuse?

A. That is true.

Q. Doctor, if a doctor is prescribing opioids and the patient is getting addicted to the opioids he's getting prescribed, whose faults is it? The addict's fault?

MR. VENKER: I'm just going to object to the vagueness, Your Honor.

THE COURT: Overruled. He can answer.

A. I mean, I'm not sure that necessarily it has to be someone's fault. I mean, I think that it can be a -- various factors that lead to an addiction.

There's a tendency to try to sort of point the finger and point blame at any untoward outcome, but

sometimes it's the way someone reacts to medication, sometimes it's someone's biologic risk in hereditary, sometimes it's environmental factors. Sometimes it's a combination.

So, I don't really find that -- a lot of times that fault, you know -- I mean, I understand why we're here, but it -- it may not be necessarily productive in many ways to look at things that way.

BY MR. CRONIN:

Q. Doctor, there are serious risks associated with the use of opioids, correct?

A. Yes.

Q. Dependence?

A. Yes.

MR. VENKER: I'm just going to object as asked and answered, Your Honor.

THE COURT: Overruled.

BY MR. CRONIN:

Q. Addiction?

A. Yes.

Q. Opioid use disorders?

A. Yes.

Q. Overdose?

A. Yes.

Q. Death?

A. Yes.

Q. Those are all known risks?

A. Yes.

Q. And they were known before 2008?

A. Yes.

Q. As well as motor vehicle accidents from somebody who is intoxicated on opioids. That's a known risk?

A. Yes.

Q. Opioids should only be given if more conservative treatments have failed, right?

A. I mean, in general, as an approach, it makes sense to start with conservative approaches, but -- only very -- specific and failed is also specific. I mean, if -- depends on how you define failure.

But if conservative approaches are not working and you're not meeting your functional goals, then adding opioids may be -- may be indicated.

Q. Doctor, can you pick up your deposition, please?

A. Uh-huh.

Q. Can you go to Page 58? Lines three to ten. Doctor, do you remember being asked this question and giving this answer -- I'm sorry, you're not there yet.

MR. VENKER: Your Honor, I'm just going to object. It's not impeaching.

A. Yes.

BY MR. CRONIN:

Q. Okay. Doctor --

THE COURT: Hold on one second. Approach.

(The following proceedings were held at the bench.)

MR. CRONIN: Here is the question and answer, Your Honor, right here. Page 50, lines -- I'm pointing to 58, sorry.

THE COURT: Fifty-eight, lines three to ten.

MR. CRONIN: Judge, that's not the answer that he just gave.

MR. VENKER: He did.

THE COURT: He just said --

MR. VENKER: In general.

MR. CRONIN: He gave a vague answer, not a direct answer like he did in his deposition.

MR. VENKER: I thought he started this answer with that statement.

MR. CRONIN: Judge, I point out Mr. Venker was just cross-examining my expert with statements from the depo before even asking him the question.

MR. VENKER: I wasn't cross-examining your expert with that, I just asked him the question, the same question.

MR. CRONIN: Did he give the identical answer.

I'm entitled to impeach him for not giving it.

THE COURT: Okay. Number one, I've not precluding you from impeaching the witness when he gives a substantially different answer. The witness said in general. So, I don't know that this is rising to the level of impeachment because he said in general. But if you find something else, I'm not going stop you from impeaching the witness.

MR. SIMON: I'll ask a different question.

(The following proceedings were held in open court.)

BY MR. CRONIN:

Q. Doctor, do you agree in general it is appropriate that opioids should only be given if more conservative treatments have already failed?

A. I mean, as I stated a minute ago, and consistent with what I reported, is that -- and while that may be general appropriate, the only, you know, may be concerning. And also failed. You know, what is failure in this situation?

So, you know, in general, it's appropriate, but does something have to have a complete failure if -- if not meeting your treatment goal is a failure, then -- maybe then it would make sense to continue.

MR. CRONIN: Your Honor?

THE COURT: You may.

BY MR. CRONIN:

Q. Doctor, can you take a look at Page 58, lines three through ten. Do you recall being asked this question and giving this answer?

Do you agree that opioids should only be given if more conservative treatments have already failed?

Answer: In general, that is appropriate.

Did I read that correctly?

A. Yes.

Q. Okay.

A. And I feel like I answered it quite similarly. I don't feel that those answers are really mutually exclusive.

Q. Doctor, do you agree the lowest possible effective dose of opioids should always be used?

A. I mean, again, always is a big statement. But in general, yeah, I think -- yes, I think that the minimally effective dose is something that guides my practice, and I think is appropriate.

Q. Doctor, what is hyperalgesia?

A. Hyperalgesia refers to a syndrome of increased pain sensitivity in people that have been on long-term opioid treatment.

So what happens is that -- once you've been on

the opioids for a long time, your body may adapt to them in such a way that any kind of noxious stimulus will raise your perception of pain. You know, that your pain may be worse because of that sensitivity.

Q. Patients receiving long-term opioids can become more sensitive to pain. Is that a decent summary?

A. They may, yes.

Q. All right. It's a syndrome of heightened pain sensitivity that occurs in some individuals who have been receiving long-term opioids?

A. Yes.

Q. Is it used interchangeably with the term sensitization?

A. Not -- it's not -- sensitization, I think, could have a different connotation in different situations, but I think you could conceive of it as sensitization.

Q. Okay. Hyperalgesia is a real medical condition that happens to some people that are on long-term opioids?

A. It seems to be the case.

Q. Is that something that doctors who prescribe long-term opioids should be aware of, in your opinion?

A. I think it would be useful for them to know that, yes.

Q. Especially if a patient's pain seems to worsen during chronic opioid use?

A. That would be one potential factor in escalation.

Q. And that's what seems to have happened to Brian Koon, right? His pain got worse as his opioid treatment progressed?

A. Well, you're actually asking two questions. You're asking that -- his -- he seems to have hyperalgesia is not necessarily -- having a -- having your pain increase does not necessarily mean that it's hyperalgesia. Hyperalgesia may mean an increased pain sensitivity. So it -- it could be a factor. It could be contributing to his increased pain perception.

But other factors could be tolerance, as we talked about earlier. Other factors could be progression of disease. Acute on chronic disease. Acute strain at the end of a workday. So hyperalgesia is one possibility.

Q. Okay. Doctor, you would agree opioids should be used for the shortest time necessary?

A. In general, that would make sense, yes.

Q. Doctor, there are no studies that have even evaluated effectiveness of long-term opioid use for patients with non-cancer pain. Isn't that true?

A. Well it depends on how you define long term, but the -- the longest studies that I'm aware of that have looked at opioids in chronic non-cancer pain have been

about sixteen, seventeen weeks. So not -- not long term.

Q. There are no high quality long-term clinical trials demonstrating the safety and effectiveness of opioids for chronic non-cancer pain that have ever been conducted?

A. Not beyond this window.

Q. You are not aware of any studies that provide -- have provided any kind of empirical evidence that long-term opioid use is safe and effective to treat chronic low back pain, correct?

A. The studies that I was referring to before were low back pain studies. So roughly about -- I think it's sixteen, seventeen weeks.

Q. And, Doctor, do you agree that when physicians are exercising their clinical judgment they should keep in mind the available evidence that is either present or lacking?

A. Yes.

Q. If a doctor puts a patient on opioids, the doctor must monitor the patient for signs of misuse or addiction, correct?

A. That should be hopefully integrated in practice, yes.

Q. And patients may not be able to recognize the problem themselves when they become addicted, right?

A. Well, addiction is a diagnosis. I mean -- and would they -- would they necessarily come in and say I am addicted? You know, at this particular phase. I think that it's sort of a continuum over time. And that sometimes in that continuum you will start to see some compulsive use. You may start to see some nonmedical use, and use for reasons other than pain.

So I think people are actually really in tune to that. They really know why they're taking the medication, when they're taking it, what are their reasons.

So I think -- do they necessarily walk in and say I'm an addict today? Maybe not. But in this -- in this continuum, they are actually, I think -- in my experience of probably treating 1500 or more people in the past ten, fifteen years, they've been really able to describe what happens in that process. From initial exposure, to the escalation, to problems, compulsive use.

Q. And you're talking about when they described it to you when you're treating them for the addiction, right?

A. No, when I'm assessing them. And including patients, like, in primary care that I talked about earlier when primary care physicians or residents or other people -- pain management physicians in the community will send people to me and say, you know, can you please evaluate this person. Patients may come in.

Patients actually sometimes tend to over diagnose addiction, believe it or not. In fact, they may -- patients tend to say -- because they're physically addicted -- well -- nobody is physically -- because they're physically dependent they conflate that with addiction. And they say, well, if I don't have it I get sick, I must be addicted. If I don't have it, I have pain, I must be addicted. If I don't have it, I can't function, I must be addicted.

And that's absolutely -- that's actually not necessarily the case at all. And I've seen many people over the years who came in, who are on chronic stable dosing of pain medication, and for whatever reason they saw something in the news -- I know you don't want cases. If I can give an anecdote. Rush Limbaugh was in the news, had Percocet issues, and a patient came in and said -- maybe it was oxycodone, and the patient said I'm on OxyContin, I'm addicted, stop the medication suddenly and, you know, this was not someone who had compulsive use, was taking it as prescribed, and was benefiting from it. And although that person had physical dependence, this wasn't addiction.

And, so, I think -- you know, it goes both ways.

Q. Doctor, in addition to whatever a patient is saying, the doctor has to be observing the behavior?

A. Yes.

Q. Okay. Things like consistently going through pills early. That's something a doctor should look for?

A. Yes.

Q. Asking for higher doses, that's something a doctor should look for?

A. Both of those things could signify opioid misuse or an opioid use disorder.

Q. Okay. Withdrawal incidents, that's something a doctor should look for, right?

A. When patients come off the medication, it's important to know are they developing physiologic dependence, tolerance, withdrawal, yes.

Q. And why is that significant? If a patient doesn't get medication for a little while and has some withdrawal, what's the significance of that?

A. It -- it clues you in to where they are physiologically. It lets you know that they're having some acclimation to the medication. And it may help guide you in managing access. If someone has indication of withdrawal, then we might not want to stop them suddenly, for example.

So knowing that someone is experiencing opioid withdrawal can then help you treat them, you know, appropriately. If you want to taper them -- you know, if

you want to taper someone who has withdrawal, then it tells you something about that. It tells you that, well, maybe they need to be tapered rather than just stopped.

Q. How about -- what does it tell you about continuing to prescribe higher doses of opioids if somebody is something withdrawals?

A. If someone is starting to exhibit some physiologic signs of dependence, then with that physiologic shift it may be necessary to prescribe more to get the same effect. So, the body's physical adaptation to the medication may lead them to need more medication to continue to manage their pain.

Q. Can it be indicative that the patient has already developed physical dependence?

A. Well that's one of the criteria for physical dependence.

Q. Okay. Did you see anything in Dr. Walden's records about Brian conveying a withdrawal incident to Dr. Walden?

A. I know that there were multiple instances of tolerance that he reported, and there was a report of -- I think there were a couple of times that he ran out early and had some withdrawal. I think he reported he was having trouble going to work. And also there was a withdrawal, I think, syndrome reported around 2012, prior

to going to rehab as well.

Q. How about 2008?

A. 2008, I think I have my notes, I can look, I think that at some point -- I think that there was some -- there was some tolerance that was developing in 2008.

MR. CRONIN: Mike, can you pull up Exhibit 1, Page 124, please?

A. Yeah, opioid -- 7/8 -- July 8th, 2008, there was a report of opioid withdrawal. He was out early.

BY MR. CRONIN:

Q. And, Doctor, is this the record you're referring to? I've got it blown up for you here. It says, "did increase hydrocodone dose, then tried to decrease dose, and then felt very bad, shaky, nose running, sweating, weak, yawning and moody, then took the med and felt better within the hour. Needs help."

Did I read that right?

A. Yes.

Q. That's a withdrawal incident in July 2008, isn't it?

A. Yes. That's the same one that I mentioned here.

Q. Okay. Four years before 2012?

A. Yes.

Q. Shouldn't that have been a clue for the doctor that there could be some kind of opioid disorder or

dependence problem?

A. Actually not. This is a physiologic -- a physiologic effect that's not necessarily a compulsive addiction effect. So we talked about how you can be physically dependent on something; if you don't get it, you get sick. But it doesn't mean that you're addicted.

In fact, the criteria for addiction, you don't even need to have any physiologic dependence to be addicted. Using the old DSM criteria for this. You can be addicted and not be physically dependent.

So who would that be? That might be someone who compulsively uses excessive medication on the weekends, you know, here and there. And when that person uses an opioid, uses more than intended, says, oh, it's the weekend, I'm going to take a couple Percocet with friends. And they end up tripling the dose. They end up tripling the dose and then make poor decisions, experiencing harm from that. They try not to do it, and they do it anyway. Or they try to use one or two Percocets, and then they end up using five.

You know, that person may be doing this once a month. You know, they could be doing it once every other week. And they could meet addiction criteria without having to take it every day.

Q. Doctor, you're aware the CDC guidelines?

A. Yes.

Q. Okay. They recommend starting with a low dose of opioids for a few days, trying to stay below 90 milligrams MED as a general rule, right?

A. Yes.

Q. And generally trying not to prescribe for more than a 90 day duration, correct?

A. This is the newly released CDC guidelines that just came out like a couple months ago.

Q. Yes. Right.

A. Yes.

Q. That's what they recommend, correct?

MR. VENKER: Can we approach real quick?

(The following proceedings were held at the bench.)

MR. VENKER: I'm not sure that we need to renew this objection again, Your Honor, about guidelines. I just want to renew the objection. I realize you've overruled it before. But since he's talking about the CDC guidelines right now, and any others that he may, if I could have a running objection to that I won't interrupt.

MR. SIMON: Sure.

THE COURT: Okay.

MR. VENKER: Overruled, then?

THE COURT: Overruled.

(Proceedings returned to open court.)

BY MR. CRONIN:

Q. They also recommend avoiding refills and keeping it abbreviated, don't they?

A. Especially to start.

Q. And you agree that those recommendations represent good medical practice?

A. I mean, I think they are important things to consider and that hopefully, as clinicians think about these practices, that treatment will become safer and more effective.

Q. Doctor, you agree that exceeding the threshold of around 90 to 120 milligrams MED the risks tend to go up when the dose exceeds that?

A. Overdose risks in particular go up, yes.

Q. Above that, it might be somewhere around 100, there's an increased risk of certain adverse outcomes, namely opioids?

A. Yes.

Q. Can you tell the jury what addiction is?

A. It's a chronic compulsive maladaptive pattern of behavior of compulsive substance use that has certain -- a multitude of factors, neuro, behavior -- neurobiological, behavioral, psychosocial.

Q. Continued or compulsive use of the drug despite

negative consequences. Would that be an okay definition?

A. Yeah, that would include some aspects of addiction. The DSM abuse would be more use despite harm, whereas the addictive or dependence part might incorporate the compulsive aspects.

Q. Do you agree that for a long time in our country, Doctor, for decades, our society's response to drug abuse has been to assume that people addicted to drugs are just morally flawed and lacking in willpower?

A. That has been a theme of societal views on addiction, yes.

Q. You agree addiction is a complex problem in which an individual's willpower is compromised?

A. I mean, I think that willpower can be impacted, but I think that people are still able to make decisions. You know, that their ability to make decisions may be impaired, but not taken away.

Q. Okay. As you said, addiction or substance abuse disorder to a drug is a brain disease, right?

A. Yes.

Q. Okay. Opioid addiction isn't a moral or mental weakness, it's a chronic medical condition that results from changes in the brain?

A. Yes.

Q. It alters circuits in your brain, right?

A. Yes.

Q. Including those responsible for mood, behavioral control, judgment, decision making, learning, and memory?

A. Yes.

Q. If somebody is on a high amount of narcotic opioids for a long period of time, does it make sense that it can affect their memory?

A. In general, opioids are not associated with amnesic effects. What that definition is referring to is how the use of the -- of the medication, or the substance, gets tied in with memories.

So people, places and things get -- is a common phrase about triggers for relapse. So if we look about places. Patients who are addicted may be in a certain place, and they have a memory associated with that. Like I mentioned earlier about the grocery store, and how people with prescription opioids don't like to -- some that I've worked with don't like to go to particular grocery stores. They have a memory. So the substance is tied into that memory center. And so when you're using the definition there about memory, it's -- it's incorrect in that, in what you were saying or alluding to impairing memory. It's actually how the substance use gets paired with memories. That's what that's referring to.

Q. Do opioids bring dopamine to circuits of the

brain?

A. Yes.

Q. And is that what causes euphoria?

A. It is -- it's one mechanism. The -- our dopamine pathways are part of the addictive pathway in the brain.

Q. And succussation of use of opioids produces dysphoria?

A. Yes.

Q. Which is what?

A. Decreased mood, hopelessness, like not enjoying things.

Q. Can an opioid use disorder or addiction essentially take over a person's life?

A. In certain instances, depending upon how you define take over, yes, it can have a really negative -- really negative impact on someone's life.

Q. It can have a profound negative impact on someone's life?

A. Yes.

Q. Okay. Do you see patients with opioid use disorders that struggle to focus on anything other than the pills, getting the pills, taking the pills, refilling the pills?

A. Struggle -- could you repeat, please?

Q. Sure. Do you see patients with opioid use disorders that struggle to focus on anything other than the pills; getting the pills, taking the pills, refilling the pills?

A. Once they get -- once they get in treatment, many do incredibly well. And, so, that focus on the pills goes away with treatment. And it's very -- it's very gratifying.

Q. Doctor, can you go Page 101 of your deposition, please?

MR. CRONIN: I'm looking at line thirteen.

BY MR. CRONIN:

Q. Doctor, do you remember being asked this question and giving this answer.

Do you see patients with opioid use disorders that struggle to focus on anything other than the pills; getting the pills, taking the pills, refilling the pills.

And answering yes.

A. Yes, I mean, this is before you they come into treatment. I think I answered the question -- not seeing this, I answered it as my patients. Getting in treatment.

Q. Okay. Can opioid addictions strip away a person's ability to feel emotions like joy, love, happiness, or to interact with others?

A. Certainly having an opioid use disorder can lead

to some of these complaints.

Q. Can opioid addictions ruin relationships and tear apart families?

A. Yes.

Q. Families like Brian's and Michelle's, right, Doctor?

A. Families can be impacted by an opioid use disorder. But I think that my -- I would -- I think that while it -- his opioid use disorder has impacted their relationship, I think that there probably are multifactorial -- you know, other potential contributing factors as well.

Q. Doctor, you didn't have the benefit of seeing their testimony in here the other day, did you?

A. No.

Q. The opioid use disorders often create trust problems between spouses?

A. Sometimes, yes.

Q. Can they make spouses feel neglected or like their significant other loves the drug more than them?

A. Yes, sometimes.

Q. And these are things you see in your practice?

A. Sometimes, yes.

Q. And is that consistent with what Brian and Michelle testified to, that you reviewed?

A. From their depositions?

Q. Yes.

A. It's possible that some of the strain that they were experiencing was related to opioids.

Q. And opioid use disorders result in child neglect?

A. Sometimes.

Q. By the addict?

A. Sometimes.

Q. Can it create emotional distance between the addict and his children?

A. Yes.

Q. And often, even after a patient gets off the drug, they live with the guilt of how they may have emotionally harmed their child during the years of drug use?

A. Guilt is a prominent part of some people's recovery process, unfortunately.

Q. And from Brian's deposition, Doctor, that guilt is what Brian is living with now, isn't it?

A. Yes, he -- I mentioned that earlier, that his -- I think I mentioned that. Or he is experiencing guilt surrounding his use, unfortunately.

Q. Doctor, would you agree that Brian's opioid -- opiate use contributed to cause strains in his

relationship with his wife and in his relationship with his daughter?

A. I think it's -- I think it's hard to know the degree to which it causes some strain. I think that there are probably a lot of other factors that could be contributing. But I think that it probably did impact him negatively during those years for sure.

Q. And those relationships?

A. Yes.

Q. Contributed to cause a negative impact on those relationships?

A. Yes.

Q. Doctor, do -- sometimes do opioid addicts feel like there's no way out and kill themselves?

A. Sometimes.

Q. Did you see Brian's testimony that he put a gun to his head while sitting on his bed and thought about pulling the trigger?

A. Yes.

Q. Does that -- are you familiar with instances where opioid addicts have done that?

A. Specifically like that?

Q. Well, committed suicide.

A. Yes.

Q. You agree that Brian's opioid use at least

contributed to cause those suicidal thoughts for Brian, don't you?

A. The amount of contribution is -- is difficult to assess, and also it -- it's also unclear, you know, the extent to which there were suicidal ideation. Because it -- there's a discrepancy -- there's a discrepancy in some of the reporting of that. So I'm not sure how to reconciling his testimony -- or his deposition. I didn't see his testimony. But his deposition. And -- and some of the records, such as Dr. McKean, who's the psychiatrist, other clinicians where -- in CenterPointe where suicidal ideation was not documented.

Q. Doctor, can you go to Page 107 of your deposition? Lines nineteen through twenty-four.

Do you recall being asked this question and giving this answer.

Do you have an opinion about whether Brian's opioid use contributed to cause him to have suicidal thoughts.

Answer: I think that at the time the opioid use was involved in his mood dysfunction and those suicidal thoughts, yes.

Did I read that correctly?

MR. VENKER: I'm just going to object as not impeaching, Your Honor.

THE COURT: Overruled.

BY MR. CRONIN:

Q. Did I read that correctly?

A. Yes.

Q. Okay. Brian went through withdrawals, correct?

A. Could I -- could I address -- could I address that?

Q. We're moving on, Doctor. Mr. Venker can redirect, if he would like to.

A. Okay.

Q. Do you agree Brian went through withdrawals?

A. Yes.

Q. You've read in Brian's testimony the types of symptoms he went through during the period he was having withdrawals at CenterPointe?

A. Yes.

Q. Do you agree those are exactly the type of symptoms you would expect him to have gone through given the amounts he was on?

A. Well, given -- you could experience those amount of withdrawals on a much lower dose of opioids. So I would expect those -- that those types of withdrawal symptoms can occur in people who are on even lower doses, you know, 40 milligrams a day.

Q. And, Doctor, by the way, you don't think Dr.

Walden's plan of trying to gradually reduce Brian's dose would have worked, do you?

A. I -- I didn't think that it would -- I don't think that it would have worked.

Q. That wasn't a good plan to get Brian off of the opioids, was it?

A. I mean, I -- to say it wasn't a good plan is, you know, I think more qualitative than I would say, because he did actually start to make some improvement initially. And I think, you know, as far as what is the standard of care, what is the standard practice, I think that the way that they -- the way that it was approached between Dr. Walden, Dr. Berry, and Dr. McKean, was coming -- putting together a protocol that was within the standard of care.

And what -- what they did was consolidate the dose -- the plan was to consolidate the dosing, to structure treatment with that, and add injections, address some of his psychiatric symptoms with Cymbalta, which also might help with some of the nerve issues with pain.

And, so, in that whole series of questions that you asked about, you know, mood, he had -- he had -- while opioids could be affecting his mood --

MR. CRONIN: Your Honor, I think we've moved beyond the question.

THE COURT: Are you objecting? Are you objecting as to nonresponsive?

MR. CRONIN: Yes.

THE COURT: Sustained. Ask another question.

BY MR. CRONIN:

Q. Doctor, you think it is unlikely that he would have been able to successfully taper off the medication, correct?

A. Yes.

Q. He was going to have to go through some detox or withdrawal symptoms one way or another?

A. Yes. Actually, not necessarily. That if he were to transfer to methadone maintenance, he would not have needed to experience withdrawal. So that would be one treatment modality where he wouldn't need to experience withdrawal.

Q. Doctor, can you go to Page 111 of your deposition, please. Lines one through three.

But he would have gone through some detox or withdrawal symptoms either way.

Answer: Yes.

Did I read that correctly? Are you on 111, one through three, Doctor? Maybe I gave you the wrong page and line.

A. I am, but your question, I think, might have

referred to a couple of the other questions. So when I answered it as a yes, I may have been answering something different than as you just asked me right now. So I -- if I could have a moment to please verify.

Q. Doctor, did I read the question and answer correctly?

MR. VENKER: Your Honor, may we approach?

THE COURT: You may.

(The following proceedings were held at the bench.)

MR. VENKER: So I think what he's asking about, Judge, is Tim read these three, but the question really was up here, and Suboxone is mentioned, which is this other drug which he said he would have withdrawal. He wouldn't have with methadone. The way Tim is asking this it sounds like he was saying he would have had withdrawal either way. So I object to that narrow question and answer as really not being complete impeachment of the doctor.

MR. CRONIN: Judge, I asked the identical question to him.

MR. VENKER: No, you didn't. You asked him -- you asked one question right here, you said lines one through three.

MR. CRONIN: I don't have to read three lines of

testimony. He gave a very clear answer to a direct question, and it was yes. I've asked if I read it correctly. That's -- that's the end of it.

THE COURT: Let's. Let's move on.

(Proceedings returned to open court.)

BY MR. CRONIN:

Q. Doctor, Brian should have the right to decide if he wants to go to an inpatient program, right?

A. Yes.

Q. I mean, you don't think he went to CenterPointe for fun, do you? That's what he felt he needed to do?

MR. VENKER: Your Honor, I'm just going to object as argumentative.

MR. CRONIN: I'll rephrase.

THE COURT: Rephrase.

BY MR. CRONIN:

Q. That's what Brian decided was best for him, correct?

A. Yes.

Q. And you don't fault him for that in any way or begrudge that decision, do you?

A. No. I -- in my deposition I specifically said that.

Q. All right. And, like we said, you agree that Brian, at some point during his treatment with Dr. Walden,

developed an opioid use disorder?

A. Yes.

Q. Okay. And we can't really know exactly when it happened, right?

A. Right.

Q. Because it isn't something that happens all of a sudden, it's a process?

A. For many people it's a process, but for some people it can occur pretty rapidly. I think that I said we can't -- earlier in my testimony I think I said that we can't really know -- ascertain when it happened, because we don't have the -- the history during that span of time to be able to pinpoint.

Q. Doctor, do you think that asking an addict when exactly he became addicted or lost control is kind of a ridiculous question?

A. Not at all.

Q. You don't?

A. Absolutely not.

Q. Addicts know exactly the moment they lost control and they became addicted?

A. Some. Yes. Actually, they do. Some people will describe their first use. People that have anxiety, social phobia, have experienced trauma, they first get exposed to the opioid, and they say I've arrived. You

know, here I am. This is the real me. And they know in that moment that things have shifted.

And so I think everyone is really different in how they can progress in this process.

Q. Doctor, you are an opioid abuse expert, right?

A. Yes.

Q. And you can't tell this jury when Brian developed his opioid use disorder, can you?

A. No.

Q. Can opioid addiction lead to acute depression?

A. It can.

Q. Do you agree that Brian suffered from depression during or following his opioid use?

A. He -- he did experience depression, and he also had some depressive symptoms reported prior to starting treatment as well.

Q. Do you agree that Brian suffered from depression that was either caused or contributed to be caused or exacerbated by his opioid use?

A. I think that the opioids contributed to depression. It would be hard to call it primary when he had a history of depression as a teenager, and then depressive symptoms in 2007 prior to starting opioids.

Q. You reviewed the deposition and notes of Dr. Fitzgibbons?

A. Yes.

Q. And you agree with her opioid use disorder diagnosis and also the major depression diagnosis?

A. In general I agree with her diagnosis. I think she had -- I think there were a couple of things that were inaccurate, but I in general agreed that there was an opioid use disorder diagnosis.

Q. Okay. Patients were opioid use disorders will continue to take the opioid despite various side effects or negative consequences in their lives?

A. Yes.

Q. Patients with opioid use disorders frequently request early refills?

A. Sometimes they do.

Q. Can that be a sign or indication for an opioid use disorder?

A. Sometimes it is, yes.

Q. As is the lack of ability to take the medication as prescribed, that can be a sign or indication for opioid use disorder?

A. Yes.

Q. And, Doctor, there are many instances for all three types of opioids where Brian was going through them early?

A. Yes.

Q. For four years?
A. Yes.
Q. And when he ran out early, a new prescription would be provided?
A. Yes.
Q. Four times for morphine, rather to fill in the gap before a new prescription for Vicodin, OxyContin or oxycodone?
A. If the record states four times for morphine, then it does, but I don't remember that specific, for four times. So --
Q. Because it isn't mentioned once in Dr. Walden's records, is it?
A. I'm not sure.
Q. You saw it in the pharmacy records, right?
A. You know, I don't know the exact number, if it was for four times or not. I might in my notes. But I don't know.
Q. Okay. Doctor, do you agree that Dr. Walden did not recognize some of this risk that Brian was in before giving opioid medication?
A. Yes.
Q. By the way, you talked about some things -- other things that were tried. You remember the two surgical consults, Dr. Heim and Dr. Place?

A. Yeah. Yes.

Q. That was in May of '08?

A. I can check.

MR. CRONIN: Your Honor.

THE COURT: Attorneys approach.

(Whereupon, the following proceedings were held at the bench.)

MR. CRONIN: A juror wants to use the bathroom.

THE COURT: How much longer do you have?

MR. CRONIN: I've got about ten more minutes.

THE COURT: How much do you have, roughly?

MR. SIMON: Fifteen minutes, maybe. For my redirect.

THE COURT: Yeah.

(Whereupon, proceedings returned to open court.)

THE COURT: All right. So, ladies and gentlemen, what we're going to do is we're going to take a short break. We're going to make it a short bathroom break. Anybody that needs to go to the bathroom, go to the bathroom. We'll take a ten minute break, and then we've probably got about thirty more minutes and we're done. So we'll get you out of here -- my goal is to get you out of here, that being said, around 5:30. But I don't want to torture you.

(Whereupon, Instruction 300.04.1 read to the

Jury.)

THE COURT: Ten minute bathroom break.

(Whereupon, a short recess was taken.)

THE COURT: Please be seated. Doctor, you are reminded you're still under oath. You may continue.

BY MR. CRONIN:

Q. Doctor, on your direct you talked about other things that were tried for Brian's back pain. Right?

A. Yes.

Q. You talked about physical therapy?

A. Yes.

Q. Do you remember that? Dr. Place referred Brian for physical therapy, not Dr. Walden, correct?

A. I don't recall who made the actual referral.

Q. Okay. You didn't know that?

A. I don't really find it germane to the case, you know, and my assessment.

Q. Okay. And pain management to Dr. Christopher, that's something Dr. Heim referred Brian to, not Dr. Walden. Did you know that?

A. Yes, I did.

Q. Okay. And neither of things are referrals that Dr. Walden made, again, after 2008, up till 2012, correct?

A. I think the next injections were 2012. I'm just trying to remember.

Q. With Dr. Berry?

A. Yes. There were other non-pharmacologic treatments, though, that we had talked about earlier.

Q. I'm asking about physical therapy and pain management. Were those done in '09, '10, '11?

A. I think those were in '09.

Q. They were in 200 -- there was one injection in 2009, right?

A. Yes. Towards '8 he started with Christopher.

Q. And the surgical consults that I started to ask you about, those were in May of '08?

A. Yes, I have one of them here with a May 30th, '08.

Q. Okay. And Dr. Walden didn't ask for more surgical consults from May of '08 ever again?

A. Not that I'm aware of. I mean, unless -- I don't know whether --

MR. VENKER: Can I interrupt for just a second? Is the microphone on? I can't hear. It might just be my hearing, I've got to admit.

THE COURT: My mistake.

MR. VENKER: No, no, that's fine.

BY MR. CRONIN:

Q. Brian went to see Dr. Berry in the spring of 2012, right?

A. Yes.

Q. Dr. Berry did an MRI?

A. Yes.

Q. Also something Dr. Walden had not done since the spring of 2008, correct?

A. Correct.

Q. What did it show?

A. It showed that he -- I don't have the full report here, but it showed progression of his disease and disc bulge in his lower spine and neck. In his neck, I believe.

Q. Now the prescription duration we're talking about in this case started in February of 2008, correct? Vicodin?

A. Yes.

Q. What is the first date in Dr. Walden's medical records where you see mention of a risk/benefit analysis?

A. It was August 20th, 2009.

Q. A year and a half after he had him on opioids, right?

A. Yes.

Q. You said -- you talked about a detailed discussion. When was that detailed discussion?

A. In 2009.

Q. What does it say? What's the detailed

discussion in the record?

A. He discussed -- I don't have the exact wording here, but he -- I think it was 2000 -- let me just pull it up.

Q. Sure. Do you recall that --

A. He described -- I'm sorry. I'm sorry.

Q. Do you recall it just says discussed possible adverse effects and risk of dependence, we both agreed the benefits clearly outweighed the risks in the use of narcotics analgesics?

A. Yes. I think the detailed discussion he mentioned as detail in 2011, it might have been, had a long -- I think it said, like, a long or detailed discussion -- yeah, long discussion on tolerance and dependence was in 2011. And informed consent, adverse effects, and risk of dependence was 2009.

Q. When Dr. Walden first started prescribing Brian on opioids in February of 2008, there was no plan as to how long he would be on it, correct?

A. No.

Q. And there are vastly more prescriptions than there are actual visits with Dr. Walden?

A. Yes.

Q. Do you recall from his deposition Dr. Walden admitted he began to think it was a good idea to reduce

Brian's dose and begin to wean him off opioids by February of 2010?

A. I think that was documented even earlier than that. There was a plan to wean in 2008, and then there was also a weaning trial in 2010. Sounds right.

Q. But Brian's dose of opioids was never reduced all the way to the middle of 2012, correct?

A. Correct. Sometimes, though, I think a weaning trial doesn't necessarily mean that you give someone less medication. A weaning trial is exactly that, it's a trial. You talk to the patient about, you know, you've been on opioids for a while, that in 2008 it's been a little bit, how do we know if these treatments are still needed for you. You know, are you still benefiting from them.

So, you know, a weaning trial doesn't mean that you just cut someone down in the dose, you may have a conversation with them and say, hey, let's try to reduce the dose and see how you feel. Maybe you feel better, or maybe you feel fine, or the same, in which case that helps give us information about the pros and cons of continued treatment.

Q. Doctor, at the time of your deposition you didn't really know the average daily doses that Brian was on from 2008 to 2012, did you?

A. I knew the doses of the oxycodone products. But in general practice we don't day-to-day necessarily make a conversion to morphine equivalence necessarily. I mean, I think that the morphine equivalent usage has increased. Now with prescription monitoring programs, which aren't available in this state, it will pop up in -- some electronic records will pop up. But in general, you know, I -- I look at the oxycodone daily dose.

MR. CRONIN: Mike, can you pull up Exhibit 37, please?

BY MR. CRONIN:

Q. Doctor, can you see that?

A. Yes.

Q. Do you see the average daily dose per year for 2008 through 2012?

A. Yes.

Q. Do you see that in 2009 it's 208?

A. Yes.

Q. 2010, it's over 545?

A. Yes.

Q. In 2011 it's over 1,173?

A. Yes.

Q. In 2012, it's over 1,555?

A. Yes.

Q. Do you understand that these numbers are not --

not disputed in this case?

A. Yes.

Q. Doctor, do you remember that I asked you in your deposition if 1,000 to 1500 morphine equivalent dose of opioids per day was excessive?

A. It's a high dose. I mean, how do you define excessive? I don't remember my exact answer, but I would guess that I answered that excessive would be defined as how you weigh the pros and the cons, or what are the benefits, what are the problems with use.

Q. Doctor, you told me it's a very high number.

A. Yeah.

Q. Do you remember that? Okay. And you see this bar graph that -- the numbers kind of go in line with those numbers. You see 2008 we're at about 50, 2009 it goes up in correspondence with Exhibit 37?

A. Yes.

Q. Okay. Do you see where I drew that red line?

A. Yes.

Q. That's the number you put in your letter to the FDA, right? 100?

A. That was the number that we put for FDA labeling of the medication.

Q. Okay. These numbers in '10, '11, '12, these are outrageous numbers, aren't they, Doctor?

MR. VENKER: Objection, argumentative.

THE COURT: Sustained. Rephrase.

BY MR. CRONIN:

Q. What do you think about the numbers, Doctor?

A. It's a high number.

Q. Would you prescribe like that?

A. I have never prescribed in that level. I mean, I don't do -- I'm not a pain management physician. But I understand that there are some patients whose benefit-risk ratio warrants high level prescribing.

Q. Let me ask you about that, Doctor. Dr. Walden isn't a pain management physician either, is he?

A. I -- maybe I should qualify that by saying that some physicians who are providing pain management. If I implied pain management specialists, I didn't mean to.

Q. How about this. Dr. Walden is not a pain management specialist, correct?

A. Correct.

Q. Okay. Do you agree that at some point while Dr. Walden was still prescribing Brian opioids the pros of continuing the opioids no longer outweighed the risks?

A. Yes.

Q. And, Doctor, Brian's four surgeries. In your opinion, were they to address the same cause of the back pain that Dr. Walden had been prescribing opioids for?

A. I mean, they certainly were a factor in what was happening. We talked about hyperalgesia, we talked about tolerance. But those were major sources of his pain, correct.

MR. CRONIN: Thank you, Doctor, I don't have any further questions for you.

THE COURT: Redirect.

MR. VENKER: I'll try to make it brief, Your Honor.

**REDIRECT EXAMINATION**

BY MR. VENKER:

Q. Dr. Gunderson, I'll try to -- I'll try to move through this. So, Mr. Cronin asked you a question about Brian Koon being a smoker. There's no prohibition against involving a smoker with opioid pain medication treatment, is there?

A. No, there's not.

Q. So just because he was a smoker doesn't mean there was some -- some -- something that he should be excluded from opioid pain medication?

A. No, there are a couple of studies that looked at risk factors for opioid misuse, and these studies have shown that those people who smoke the first cigarette right when they get up are at risk. This is not common knowledge in practice. In fact, when I am administering

the curriculum and I get to this point about risk stratifying, I ask every single group to say which factors do you think are most prominent. And even though that is a major one, no one has recognized that tobacco is a risk. So, it's not common knowledge.

Q. Okay. And Dr. Walden was certainly in line with the standard of care in terms of his recognizing of any potential addiction risk for Brian Koon, wasn't he?

A. Yes. Most primary care physicians are not aware of some of these risk factors that are -- like the smoking factor that I talked about. Or mood instability is a risk factor. Prior trauma is a risk factor. Prior medication misuse, other substance use. But this isn't generally, you know, known or screened for in practice.

Q. All right. This is something that an addiction specialist such as you would know?

A. Or someone interested in education to try to improve practices. That's part of why I'm doing this.

Q. Mr. Cronin asked you about your -- whether you ever practiced as an internal medicine physician. Let me ask you this, Doctor, are you Board Certified in internal medicine?

A. I am Board Certified, yes.

Q. Tell us what is the significance of that is. How do you get board certified? Just briefly, in fifteen

words.

A. You complete residency training and pass boards -- a board exam in internal medicine, you complete continuing education classes.

Q. All right. And you're also Board Certified in addiction medicine, aren't you?

A. Yes.

Q. Now, there were a lot of questions about the opioid epidemic. This case does not fall within the opioid epidemic, does it, Doctor?

A. No. This is -- I mean, I think that when we think about prescription -- or prescription docs. You may have heard the term script docs. People that are prescribing excessively, not spending time with their patients, not assessing them, not monitoring them or following up with them over time. That is one connotation of, like, direct to patient involvement of physicians.

Q. All right.

A. And we talked about some of the other medicine cabinet issues.

Q. You talked about the long term -- the studies for long-term benefit of opioid for chronic pain. You're really talking about randomized controlled trials, correct?

A. Yes.

Q. All right. So there's still anecdotal evidence of benefit from opioids on a long-term patients for the patients themselves, isn't there?

A. Yeah. I mean, ultimately what it comes down to is that the patient is important, you know, listening to the patient. And just because we don't have an -- if there's an absence of high quality evidence, it doesn't mean that there is no effectiveness. It just means we don't have these precision trials.

Q. Okay. You talked -- you were asked about these 2016 CDC guidelines. Do you remember that?

A. Yes.

Q. You're familiar with those being voluntary guidelines, correct?

A. Yes.

Q. Of course they didn't come out until early this year, right?

A. Yes.

Q. All right.

A. And there's actually been some controversy about them that there's a concern that they are overly restricting, and that by having these guidelines come out that patients will then get denied access to pain medication because physicians will -- I mean stop being willing to prescribe.

Q. Okay.

A. Actually some of the fallout from the PROP document, you know, there was some concern about that, too, that this was overly restricting.

Q. Okay.

A. But -- okay. I'll stop.

Q. Are you familiar with any of the statistics on patients with chronic pain and suicide rates for them? Do you know anything about that?

A. I don't -- I don't know the rates. I do know that chronic pain and depressive symptoms are associated. That chronic pain can worsen mood, and also worsened mood can -- or deteriorated mood can exacerbate one's experience of pain. So if you're depressed, you may experience pain more severely than other people. So, this is very interrelated between these factors, what we're talking about.

Q. Is it common for patients with chronic pain to have depression, Doctor?

A. Yes.

Q. Okay. After all the questions that Mr. Cronin has asked you, have you changed any of your opinions that you gave to us on your direct examination? Have you changed any of your opinions since I asked you those?

A. No.

Q. Okay.

A. I mean, there's only --

MR. VENKER: That's all I have.

A. I mean, there might be one comment I would make, though. But we can't? Okay.

Q. We're at the end of the day, so --

A. Okay. Thanks.

MR. CRONIN: No further questions, Judge.

THE COURT: All right. May the doctor be excused? Doctor, thank you, you're excused. You're subject to being recalled, so please don't talk to other witnesses about your testimony. Thank you, sir.

All right. Attorneys approach.

(There was a discussion held off the record.)

THE COURT: Ladies and gentlemen, I just want to give you an idea of how the rest of this trial is going to go. I kept you past 5:00. I apologize for today. Monday I anticipate we're going to have a doctor in the morning, and then Dr. Walden in the afternoon. I anticipate Tuesday morning you will get closing arguments and you will get the case Tuesday morning. We are going to stay after you go home tonight, we're going to hammer out a good chunk of the jury instructions so that we will be able to keep rocking and rolling. So I do know I'm keeping you late, but just so you know I'm making them

stay late as well, okay?

Again, this is not anything due to them, these issues are my issues.

So, this weekend -- we are already here at the weekend.

(Whereupon, Instruction 300.04.1 read to the Jury.)

THE COURT: Have a good weekend, thank you for your service, see you Monday morning at 8:30. Monday morning, 8:30.

(Whereupon, court recessed at 5:10 P.M.)

JUNE 27, 2016

(The following proceedings were had in open court, out of the presence of the jury:)

THE COURT: All right. We're on the record outside the hearing of the jury to discuss a letter that was sent from the defense counsel to the Plaintiffs' counsel.

You may proceed.

MR. CRONIN: Your Honor, this is a supposed letter from the Missouri Board of Healing Arts dated February 17th, 2016 purporting to, I don't know if it's exonerate or close the investigation into this matter about Dr. Walden's treatment of Brian Koon.

One of defense counsel is cc'd on the letter.

They clearly had it four and a half months ago. It was sent to us for the first time this morning, a week into trial at 7:08 a.m. It wasn't on their exhibit list. It wasn't produced in discovery. It was clearly requested, Judge.

Request for production, number two, all records and reports of any kind relating to the events set forth in the petition. Request number five, all non-privileged correspondence pertaining to Plaintiff. Request number 12, all investigative reports regarding the events set forth in the petition.

Judge, this is intentional sandbagging. It is not a coincidence that this was sent to us for the first time on the day Dr. Walden is taking the stand, after we have closed our case. All discovery has been done in the case for some time. We have no way to respond to this, your Honor. We have no idea to know what was sent, what was reviewed. There's no doubt in my mind the pharmacy records and the dosing tables showing how much was given wasn't sent to them.

Johnny Simon from our office in March called the Missouri Board of Healing Arts to see if there was an investigation, and they told us no. So there was no way for us to know anything about this. We can't know what they sent, what was reviewed, what kind of standard is applied, everything the investigation consisted of. We could not

question Dr. Walden about it. We could not get records from the Missouri Board of Healing Arts about it.

This is a very clear violation of the discovery rules. It's incredibly prejudicial to Plaintiff. It would not come in, Judge, even if we had it. We've had things like this excluded in other cases. The standard is completely different. The same's evidence given in this exhibit is not the same evidence the jury hears.

So, Judge, not only are we moving to exclude any mention of an investigation, we're moving to strike the Defendant's pleadings.

THE COURT: All right. Response?

MR. MAHON: Yes, Judge. I think we completely agree that the standard for a Board of Healing Arts inquiry is completely different than the standard that's at issue in this case. And the only reason that this is brought out now is just because in the Plaintiffs' case there was some testimony about DEA matters, Board of Healing Arts matters, whether other physicians losing their license or being investigated by the DEA or other criminal authorities, which is a completely different standard and totally irrelevant to the case here.

We objected to those, that testimony, that information. That was overruled. And it's only now in response to that door being opened about other ancillary

proceedings with different standards that this letter -- we intend to use it today.

In terms of the discovery of it, this is privileged material. This is protected by the peer review statute, Missouri peer review statute. And so it's not something that's discoverable, and it wouldn't be used in this case but for the door being opened on that issue where the jury is being left with the impression that, well, maybe Dr. Walden is being investigated or maybe he should be by the Board of Healing Arts.

What this letter shows is like in all medical negligence cases that are filed in Missouri, the Board has -- it has been brought to the Board's attention. The Board looked into it and closed the file.

So I think it is relevant now to rebut the testimony in the Plaintiffs' case insinuating that Dr. Walden has been or should be investigated by the Board of Healing Arts or some sort of criminal authority. So that's really the purpose that it's coming out.

MR. VENKER: He's not been disciplined. Dr. Walden's not been disciplined, your Honor. This letter says their file is closed, but Dr. Genecin in his testimony clearly implied that somebody like Dr. Walden prescribing what he prescribed would be investigated, would be losing his license, and the DEA would also be

after him. So that's why we're doing this. I agree that but for that we would not be able to come into court, we wouldn't come in to court, and just offer a letter from the Board of Healing Arts and say, you know, we're innocent.

THE COURT: All right.

MR. CRONIN: Judge, briefly --

THE COURT: Hold on. In terms of my memory, I remember the phrase DEA. I do not remember the phrase Board of Healing Arts being mentioned in this trial. Unless my recollection is wrong, I don't --

MR. CRONIN: Your Honor --

THE COURT: I'm aware of what the Board of Healing Arts is, and so I did hear DEA. I did hear the other stuff which I do know you objected to. But I have never heard the words Board of Healing Arts mentioned ever in this entire trial, even pretrial so --

MR. CRONIN: Your Honor, your Honor excluded Dr. Genecin from saying he's seen other doctors having their license under review for less. He said it in the depo. It was objected to in the trial, and your Honor excluded him from saying it.

THE COURT: Yeah.

MR. VENKER: I'm reading where we're talking about it on the record, your Honor, but I'm trying to get

to the actual crux of it here.

THE COURT: Okay.

MR. MAHON: Just for the record, these are just my notes, and we'll find it in there, but I did have that there was testimony from Dr. Genecin about state boards and the DEA trying to protect patients from the high risk of dying from backaches. That's one quote that I had in my notes from him. It did mention state boards. It didn't say Healing Arts, but it did say board.

MR. VENKER: On page 215 of the trial transcript that we have thus far, I think there's some highlighting, not secret notes of mine or anything, but you can see, I think it's also later, but somewhere he actually talks about, Dr. Genecin, I mean, talks about --

MR. BARTH: On page 215, line eight, Dr. Genecin says, quote, this is a level at which state licensing boards and the Drug Enforcement Agency -- and then we came up here for an objection that was overruled.

And then he says on line 17, this is a pattern of utilization that the regulators such as state licensure boards and the DEA are trying to protect patients from. So it's definitely been opened up with state license. The door has been opened, your Honor.

MR. VENKER: Again, we made that objection, Judge, because we don't believe that should be an

appropriate line of inquiry for a medical malpractice case.

THE COURT: Okay. So it's not just a motion to exclude.

MR. CRONIN: It's a motion to strike the defendant's pleadings, Judge.

THE COURT: Clarify what do you mean by that.

MR. CRONIN: It is an abuse of the discovery process. In another case I'm familiar with, the defendants produced documents the weekend before trial, and the Judge struck their pleadings, all of their affirmative defenses, all of their denials; we moved straight to damages.

You cannot withhold information from the other side that you have for four and a half months and spring it on them six days into trial.

MR. BARTH: The peer review privilege is 537.035. I can't remember which subsection, but it clearly states even the existence of peer review is protected from discovery. This is one of those strange circumstances.

THE COURT: Well, I can tell you what I'm going to do. Number one, reading the transcript, the Drug Enforcement Agency door was opened, but the Missouri's Board of Healing Arts, you just said the state licensure

was a general statement. It wasn't specific to the State of Missouri that would call into question whether this particular doctor was under review by this particular board.

I do not think that it rises to the level that we need to strike proceedings. I don't think it was a gotcha moment. I think it is a legitimate request to see if a door has been opened and whether this should be rebuttalled. So in that terms, I don't think any type of extraordinary means need to be brought up.

I don't think after reading the transcript that -- the testimony was in line with my previous rulings. Your objection was timely, in terms of the same when the issue was brought up you did object; but I don't think it opens the door that this letter in regard to any specific actions.

Number one, I don't even know what this -- I don't even know how the jury would use this because it doesn't -- it says it has voted to close the case. The interpretation of what's closing the case means and that is, what's the standard. That's a whole ancillary tangent that does not need to be gone down.

There is no evidence that's been presented by the Plaintiffs that Dr. Walden is under investigation by the DEA or is under investigation by the Healing Arts. If that was the case, then I would think there would need to be some

rebuttal. I do think in terms of couching the behavior, I believe, he talked about it, but I don't think he made any specific allegations to Dr. Walden under my read.

So, two things, there are not going to be any sanctions, but this particular letter regarding Dr. Walden will not be admitted.

MR. SIMON: Thank you, your Honor.

MR. VENKER: One further aspect of it, Judge. I obviously respectfully disagree. But the tenor of this testimony because it's implying that Dr. Walden either would be or should be investigated, we plan to have Dr. Walden testify that he has not been disciplined by the Missouri Board of Healing Arts and they have not told him he is subject to any discipline for this case.

THE COURT: And why are you saying that?

MR. SIMON: Your Honor, I don't think they can bring up the fact that he was investigated and not disciplined.

THE COURT: I agree.

MR. SIMON: Right.

THE COURT: That is -- the letter, to me, says that he's been investigated, and it has been closed. That is why I don't want the letter to come in because I think that implies -- actually everybody has a view on what that means, but I do think you can say that he has not been

disciplined by the DEA or by the licensing board because I think that is a fair rebuttal to what the -- and I believe when I talked about this that I thought if something was said that there -- part of it, you got to trust the jury and your ability to say, hey, they say A; here's our counter argument, and they give it the weight necessary.

But I'm not foreclosing the door that you can't say, have you been investigated by the DEA, no. Are you under review by the licensing boards, and he says no.

MR. VENKER: Not only that, Judge, he ought to be able to say that the licensing board has closed their investigation and I haven't been disciplined.

THE COURT: No.

MR. VENKER: Why can't he say that part?

THE COURT: Because what I don't want is the fact that the jury to get the opinion that he was investigated -- to me investigated is a negative -- in order to be investigated you must have done something wrong. And so I precluded them from making --

MR. VENKER: Okay.

THE COURT: Allowing them to say that he has done -- that he is under the shadow of doing something wrong, and so I'm giving you the opportunity to say that --

MR. VENKER: He's not been disciplined.

THE COURT: -- he's not been disciplined. But investigation, I think we get down a rabbit hole. I know it's a thin line.

MR. VENKER: I understand your ruling.

THE COURT: Okay.

MR. SIMON: So, your Honor, as I understand it, they're allowed to ask Dr. Walden whether he has been disciplined by whatever agency, but they are not allowed to suggest, introduce or infer that there was an investigation and that the investigation was closed or as a result of an investigation he was found not at fault.

THE COURT: Exactly.

MR. VENKER: It will just be that simple question and a simple answer.

THE COURT: Works for me.

MR. SIMON: Thank you, your Honor.

THE COURT: Other than that are we ready to roll?

MR. SIMON: Yes.

MR. VENKER: Yes.

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(The proceedings returned to open court.)

THE COURT: Good morning, please be seated. Welcome back.

All right. Counsel for the defense, you may

proceed.

MR. VENKER: Thank you, your Honor.

We call to the stand Dr. Anthony Guarino.

Sorry, your Honor, he'll be here in a minute.

(Counsel approached the bench and a discussion was held off the record, out of the hearing of the jury.)

MR. VENKER: Here's Dr. Guarino.

THE COURT: All right.

MR. VENKER: Would you step up to be sworn?

***ANTHONY GUARINO***,

having been duly sworn by the deputy clerk, testified:

**DIRECT EXAMINATION**

THE COURT: All right. Doctor, if you'd have a seat right over here. Be careful, there's a step. Make yourself comfortable; adjust the microphone.

From time to time you may hear the attorneys say objection. If you can pause and let me rule on the objection before you answer.

THE WITNESS: Yes, sir.

THE COURT: You may inquire.

BY MR. VENKER:

Q Dr. Guarino, good morning.

A Good morning.

Q Can you tell the jury your full name?

A Anthony Herbert Guarino.

Q And you're a Medical Doctor?
A Yes, I am.
Q Do you live here in St. Louis?
A Yes, I do.
Q Where do you work right now?
A I'm employed by Washington University in St. Louis.
Q Okay. And do you have a medical specialty?
A Yes, I'm a pain management expert.
Q Okay. And do you have any academic affiliations?
A With Washington University. I'm an associate professor.
Q Okay. My office has asked you to review this case to review Dr. Walden's care of Mr. Koon in this case, haven't we?
A Yes.
Q And we provided you some materials to review as part of that process, correct?
A Yes.
Q That included medical records, depositions of Mr. and Mrs. Koon, for example, Dr. Walden, family members of both Mr. and Mrs. Koon, the city workers and other medical records. You remember that, don't you, Doctor?
A Yes.

Q All right. And have you arrived or formed any opinions about Dr. Walden's care of Mr. Koon?

A Yes.

Q Okay. Before we talk about that, let's go back and talk about your qualifications and background as a pain management specialist, and then we'll go on and talk about those opinions. Is that all right, Doctor?

A Yes.

Q All right. You're -- you were born in Baltimore, Maryland, correct?

A Yes.

Q All right. And then you went to undergraduate college where?

A Well, I went to Yale University.

Q And what did you study there?

A I studied molecular biophysics and biochemistry.

Q And that was a four-year degree?

A It was.

Q And then did you study any further after that?

A Yes, I have a master's degree in religion.

Q And how long of a program was that master's?

A Two years.

Q And so, I don't know too many people with a master's in religion. What is that study about?

A For me, I had wanted to become a doctor, really

out of junior high school and studied hard and was fortunate enough to matriculate at Yale. But during that time, I also have my faith, wanted to understand more about my faith and understand more about traditions, and I saw this as a good time before really getting into my medical education and training to do that. So before going to medical school, I went to divinity school at Yale.

Q Any pastors or deacons or priests in your family or extended family?

A We -- I was raised Catholic, so there are friends in the family who are Catholic but -- actually, there's a lot of different denominations in my family --

Q Sure.

A -- but no one that I can say specifically in that.

Q That influenced you that decided to do that master's in theology?

A Well, it was a master's in religion.

Q Sorry, religion.

A No, it was more self-motivated.

Q After that, obviously, you went to medical school. Can you tell us where you went to medical school?

A I went to the University of Maryland in Baltimore which was my hometown.

Q And is that affiliated with any academic institutions?

A University of Maryland.

Q And you did an internship and residency; is that right?

A Yes, I did.

Q So how long was your internship? What was it in?

A I did an internship in medicine, similar to what Dr. Walden does, and that was for a year at Sinai Hospital. Then three-year residency in anesthesiology at Johns Hopkins Hospital. And then a one-year training in pain management at Johns Hopkins Hospital in Baltimore.

Q Okay. So that last year you mentioned, so that was a fellowship after your residency, correct?

A Yes.

Q And so tell us a little bit about the specialty of pain management. Tell us -- give us an overview of what it includes in terms of the different methods. Sometimes we heard the term modality. That just means method, doesn't it?

A It can be. Pain management can involve many different things. So I was trained initially, again, as an anesthesiologist. So I learned how to place needles in people's bodies in different places to inject things to

help them with symptoms. But also an important part of our training, which in many ways could be seen as an extension from the operating room, is learn how to use medicines, a wide range of medicines, including opioids, and how to dose things properly and use things in a way to help people have a better quality of life. I think that's the essence of pain management is improving people's quality of life.

And so that's -- and so I used a needle, I use a prescription pad, but I'm also aware of surgical interventions and physical therapy and psychological support. So I use all those things in different ways as a means of reaching a goal which could vary, but in essence is less pain and improved function.

Q And I don't want to get off on a tangent, but it sounds like you certainly don't think that opioids are the panacea or the cure-all for all pain situations?

A No. Opioids are a tool in helping to manage pain. But sort of like a carpenter, a carpenter doesn't use a hammer for everything. In pain management, we don't use opioids for everything; but it's a valuable tool, and it can be used in ways to help people.

Q Okay. And in terms of your philosophy of using opioids, let's talk about that for a second. We've heard the phrase lowest effective dose or minimally effective

dose. Tell us about what that means or you and whether you've used that concept in your practice.

A Yes. So opioids, like all medicines, have risk, and they have benefits. The whole goal in writing any medicine is to help someone with their problem. But too much of anything, opioids, even Tylenol, too much of something could be harmful.

So that's the -- when one prescribes a medicine, they need to think about that, and so you want to use enough to get the job done, but not too much to cause a problem.

Q Okay. All right. So let's go back to you finished your fellowship in pain management at Johns Hopkins and then what -- where did your career or medical education go next, Doctor?

A Well, I spent six months at a private practice in northern Virginia before accepting a position offered to me by Washington University; and then I moved here to St. Louis, and have been there -- been here ever since, and married and have kids.

Q So tell us your position at Washington University, what was -- when you started here, what were you starting as?

A I started out as an instructor, which is the lowest rank in academic echelon, and over the years have

advanced through assistant professor and now an associate professor. An associate professor is sort of a senior position at the University. The next step up would be a full professor, which I don't know, hopefully will happen in time, but that's how it goes.

Q All right. How much of your time now is split between seeing patients, sometimes referred to as clinical practice, versus other areas of your time spent on your administration or education? Tell us about that.

A So, I approximate 90 to 95 percent of my time I'm working with patients. That's what I like to do the most. But outside of that, I teach. I teach the residents. I teach medical students, residents and fellows at Washington University.

And then I have administrative duties I need to do as part of my position directing a practice at Barnes-Jewish West County Hospital, and I sit on some committees to help contribute to the community at the hospital.

Q Okay. Have you been involved in writing either books or presentations on either opioid medication or pain management generally or about back pain, chronic back pain? Have you written on those topics, Doctor?

A Yes. So I've been -- basically since leaving my training in 1997, I don't remember the exact number of my

publications, but I approximate I probably have 30 or 40 total publications, both reviewed by my peers and just general articles that I've written, and I've written two books about pain management.

The first book I funded myself. It was a self-published book that where I went through all the general principles of pain management to educate people. That took a couple years to write, but I got it done.

And then Johns Hopkins Press decided that they wanted my book to be part of their, the group of books that they want to promote, and so I did further editing of the book and modified some things; and that book was published under a different title a year or so later. And so that's how I got to have two books published.

Q Okay. All right.

A And the issue of opioids is certainly in both books, and I have several articles that are written about opioids.

Q All right. And you've given presentations to other physicians about the appropriate use of opioid medications, haven't you?

A Yes, so there's a range of types of education I've done; some that are paid and some that are not. The not paid are the things I've done regularly, including these lectures for medical students, residents and

fellows. Where when I say it's not paid, because as a faculty member at the University I got paid for, in essence, for productivity, which means the number of patients I see or the procedures I do. And that's not -- so educating is being a part of the community and doing something. That's why you're there. That's why I choose to be at the University because I like to educate.

And then --

Q You've done some presentations for some specific opioids, haven't you?

A Yes. And then outside of the University, several pharmaceutical companies have hired me over the years to educate fellow physicians on how to properly prescribe medicines. And these are paid positions, paid opportunities, where I go out and usually meet with a small group of physicians and educate them on how to properly prescribe medications in order to help people and not harm them.

Q And why do you feel that's a worthwhile or important thing to do, Doctor, to educate these physicians?

A Well, as physicians, just like all of us, there's a lot of information out there dealing with all sorts of things; and at times it may be difficult to stay on top of all the information. And so in that pain has

been focus in the last -- the first decade of this century there was a big emphasis on educating everyone to address pain.

So there was a need and there continues to be a need for experts to educate people on what pain is and how do you manage it and the various opportunities. And so in relation to opioids, many doctors may not have been trained during the time of learning how to properly prescribe opioids, so I was somewhat of an ideal person to do that because of all my experience. And so companies would hire me so that I can educate how to do this safely and properly.

Q Okay. All right. And we'll talk about it later, but obviously as you said in your practice, you do prescribe opioid pain medication to treat patients, correct?

A Yes, I do.

Q And we'll talk about that. And so we're going to ask you now what your opinions are. Before I do that, let me ask you to assume that the -- because I know you have reached an opinion about whether Dr. Walden rendered proper care within the standard of care, correct? That's one of your opinions?

A Yes.

Q And then the other opinion you have is about

whether or not Mr. Koon had the indicia or factors of being an addict while Dr. Walden was treating him, correct?

A Yes.

Q And so I'd like you to assume for your opinions about whether Dr. Walden gave -- that he gave proper care and was within the standard of care, that in Missouri the definition of proper standard of care would be the exercise of that degree of skill or learning ordinarily used under the same or similar circumstances by members of the defendant's profession. You'll use that definition, Doctor. Is that agreed?

A Yes.

Q And then when you give any opinions on medical causation, you'll limit those opinions to those which you hold to a reasonable degree of medical certainty, won't you?

A Yes.

Q Okay. And so I will ask you then, generally, tell us what your opinions are, and then we'll talk about them in some detail.

So your first opinion is what, Doctor?

A So, the standard of care issue, the question is did Dr. Walden do things that would be considered within the standard of care. So one needs to have a benchmark or

a ruler to decide yes or no. And so for me, I go to the Missouri state guidelines for prescribing opioids.

Q Can I interrupt you just for a second, Doctor? Because we will talk about that. But in this case we've heard thus far from the Plaintiffs about this Interagency Guideline on Opioid Dosing. It's Plaintiff's Exhibit 50-4.

MR. VENKER: May I approach, your Honor?

THE COURT: You may.

Q (By Mr. Venker:) I'm just going to show you this, Doctor, and we'll talk about it briefly.

You're aware of this document, aren't you, Doctor, the "Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain", published by the Washington State Agency Medical Director's Group.

A Yes.

Q Okay. And so does this document, this Plaintiff's Exhibit 50-4, represent the appropriate standard of care for Missouri physicians in 2008 to 2012, Doctor?

A No, it doesn't.

Q Why not?

A First of all, Washington State's 2,000 miles from here. It's a guideline followed by people in the State of Washington. It's a guideline that has not been

adopted by people around the country. It does raise some points that I think are helpful in consideration in writing opioids, but it's certainly not authoritative in dictating what should be done.

Q All right. If you look at the second, page two, just under the introduction heading. What does that first sentence say?

A It says, "This guideline is part of a year-long educational pilot to improve care and safety when treating chronic non-cancer pain with opioids."

Q Okay. So it's part of some other educational pilot, correct, Doctor?

A Yes.

Q All right. We've also heard discussion of the -- of course you're familiar with the very recent 2016 Centers for Disease Control guidelines on pain management, correct?

A Yes.

Q It was talked about as Plaintiff's Exhibit 50-6.

MR. VENKER: May I approach, your Honor?

THE COURT: You may.

Q (By Mr. Venker:) And you're of course familiar with this document, aren't you?

A I am.

Q And it is a guideline that came out just this

year published by the CDC, correct?

A Correct.

Q So you're familiar with the document as well, aren't you, Doctor?

A I am.

Q Does this document reflect or represent the standard of care for Missouri physicians in 2008 to 2012, Doctor?

A No.

Q Okay.

A Well, this is four years after Dr. Walden finished care of Mr. Koon. None of us should be held to a standard for something four years after the fact.

Q Okay.

A That being said, it's a guideline that was recommended; it's not required, but recommended. And I think there's some very good points that I think and hope will improve the providing of opioids to people in the country.

Q All right. If you look at page four -- I'm sorry, page two, above that heading of "Rationale", there's two sentences, three sentences at the bottom of the paragraph. Would you read that, just above that heading "Rationale"?

A "The recommendations in the guidelines are

voluntary rather than representative standards. They're based on emerging evidence including observational studies or randomized clinical trials with notable limitations."

Q Let me stop you there. When it says notable limitations, as a practicing pain management specialist, what does that mean to you?

A Well, so there are a lot of different studies on medications, and some things -- and things can say different things based on how you interpret data.

So one of the claims that the people who wrote this paper, wrote these guidelines, was that there are no long-term studies for benefits of opioids for people taking opioids for over a year. But what they fail to inform for someone who doesn't know this is that very few studies, like less than 1 percent of studies look at things for over a year.

Most -- all studies go through a governmental panel, and they basically are all about three months in duration. Occasionally you will see studies going out to a year. But if you limit your analysis to just things that are over a year, you basically have just -- you biased your presentation to a specific interpretation of information that's out there.

Q All right. So when you say studies, are you talking about, we've heard some reference to clinical

trials. Sometimes in the news you hear randomized double blinds trials. Is that what you're talking about?

A Correct. All the studies.

Q Okay.

A So that's in -- everyone tries to do or use the best studies that are out there. Basically the better the study, the more money and work and effort is involved. So that doesn't -- does not always occur.

Q In your experience, Doctor, in treating patients since you have here in St. Louis and even before, but since St. Louis in 1998, have you found that at least some patients benefit from long-term opiate pain management therapy?

A Yes. I have many patients in my practice who have been on opioids for, you know, since I've been here in 1998 who are benefiting from the medicines and not showing any problems with the medicine.

Q Now you mentioned the Missouri guidelines, I think. So let's talk about that a little bit.

Mike, can we put up Defendant's OOO-1? Let's go to the heading in the first paragraph.

So, Doctor, tell us what this is. It's Defendant's OOO-1 Exhibit.

A So this just highlights who produced this, you know, this document, which has had significant impact on

how medicine is practiced in the state. So we want to know who made it up. It's the Board of Healing Arts. It's appointed by a task force. And who's on that task force, board members who are predominantly physicians, but there were also some people from the community and input from the Governor's Council on Pain and Symptom Management. So, you know, the Governor had influence on things as well. And they were charged to generate language to help address this issue.

Q So this is the guidelines put out by the Missouri Board of Registration for the Healing Arts, correct?

A Yes.

Q It's the licensing board for doctors in Missouri, correct?

A Yes.

Q And this actually says, this document you're reading to us, it says it's effective -- these guidelines are effective January 2007, correct?

A Yes.

Q And so were they in effect in 2008 through 2012 when Dr. Walden was providing care for Mr. Koon?

A Yes.

Q All right. By way of overview, can you give us a sense of these? For example, do these guidelines

contain any set limit or ceiling of the amount of milligrams per day of opiate medications to patients?

A No.

Q Okay. Tell us how these guidelines work for physicians in terms of guiding them in their care of patients using -- when they're using controlled substances for pain control?

A In essence, it establishes boundaries. It repeats several of the things that we know that the DEA or the Drug Enforcement Agency expects of physicians who prescribe opioids. And then it establishes what in Missouri are the boundaries for acceptable or permissible care when using opioids.

Q Okay. And in doing that, there's a Section Two, isn't there?

A Yes.

Q All right. And let's turn to that, Mike. It's on page three, kind of in the middle of the page is the heading. Okay. For starters, that's good.

Okay. So the board talks about these different guidelines, and I'm not sure we're going to get to every one of them, but they're one through seven with different components, correct?

A Yes.

Q And so in terms of these seven -- this first

one, number one, is evaluation of patient. From your review of the medical records and depositions, do you have an opinion whether Dr. Walden met the guidelines, Section One, evaluation of the patient?

A Yes, he did.

Q And we'll talk about that in more detail, but how about number two, the treatment plan. Do you have an opinion whether Dr. Walden complied with the guidelines for the treatment plan?

A Yes, he did.

Q And how about number three, informed consent and agreement for treatment. Did Dr. Walden comply with that appropriately in your opinion?

A Yes.

Q And how about number four, periodic review? Did Dr. Walden comply with that portion of these Missouri guidelines?

A Yes.

Q And how about consultation, section five? Did Dr. Walden comply with that in terms of his care of Mr. Walden -- I'm sorry, Mr. Koon?

A Yes.

Q Number six, medical records. It talks about a physician keeping accurate records. Did Dr. Walden, in your opinion, comply with that section of the guidelines?

A Yes.

Q And number seven, there's really no issue for number seven. I don't think we need to talk about that.

So, Doctor, let's talk about -- let's talk a little bit why as a pain management specialist you have -- you expect to give opinions in this case about the care provided by Dr. Walden who is an internal medicine physician but who does have pain management as part of his practice. Tell us about that.

A So the standard of care, there is questions, you know, what specialty should evaluate it. Well, in Missouri, the prescribing of opioids is not specific for one specialty. There's nothing in these guidelines saying you need to be a certain type of doctor to prescribe opioids.

And in fact, in this state and around the country, 70 percent, approximately primary care physicians like Dr. Walden, write opioids for patients. So they are the most common prescribers.

I am a prescriber, an author and what have you, and so I know a lot about opioids. I educate people on opioids. And so when asked can I render an opinion, I certainly know enough or have the requisite amount of information to make conclusions concerning the care provided by Dr. Walden.

Q All right. And is there -- is there any standard of care principle or concept that would say an internal medicine physician should not be involved in any long-term opioid therapy for a patient above 100 milligrams of morphine equivalent daily dose or anything like that?

A There is nothing in this Missouri guideline that says that you need to stop at a certain milligram. Nothing.

Q And is there anything that says once an internal medicine doctor gets to that 100-milligram level, they need to refer the patient to a pain management specialist. Is there anything like that in the guidelines?

A No.

Q And so in terms of the opinions you're giving us today, part of that is if Mr. Koon had been transferred to you as a patient for pain management, correct, in terms of what you would deem appropriate, true?

A Yes, that could happen.

Q And so I wanted to talk about the details of the care, but let's talk a little bit about the amounts of opioids that Mr. Koon received from Dr. Walden's prescriptions. Those amounts are considered what we've been calling high dose. Is that an accurate description?

A Yes.

Q Not a lot of patients would be able to handle that level; is that true?

A Absolutely.

Q So these are unusual, right?

A Yes.

Q You have patients with this level of dosing, Doctor?

A Yeah, I have a handful of patients that are similar types of doses.

Q And for similar periods of time?

A Yes.

Q So were the amounts that Dr. Walden prescribed excessive?

A Excessive would be more than what is needed. And what I look at in determining what was needed is was the goal met and were there problems getting to that goal. The goal being clearly, as I read the records, was Mr. Koon wanted to continue to work at a job that is difficult. It's straining on the back.

He wanted that goal; and Dr. Walden, after trying various modalities, tried various things, physical therapy, chiropractic care, seen by surgeons, there were a wide range of things tried, ultimately came to the conclusion that opioids may be an option to pursue, and he subsequently started prescribing them for Mr. Koon.

And the whole goal being to help control the pain. Opioids are not a cure; it's just a help with the goal of working. And that's what I saw happen during the four years under Dr. Walden's care. He was given opioids, and he was able to work. And the opioid use, yes, it increased in time and there could be various reasons why that occurred.

But it did occur, but the goals were met; and dysfunction, problems, that could occur with opioids like traffic tickets or being written up by your employer or legal problems, I didn't see any of that. Anything that would indicate there was a problem.

And then you have Dr. Walden evaluates him, doesn't report seeing any impairment. You have 40 visits by a chiropractor; he doesn't see anything that reports impairment. You have physical therapists, at least ten visits, no impairment noted. You have a rheumatologist in 2011, didn't see any impairment. You had people who manage other medical problems for him; nothing reported about being impaired.

So if someone's impaired, that absolutely should stop you and make you reconsider things. But none of that was present in the records to indicate to me that there was a problem with the opioids, albeit high-dose opioids. And so therefore it was a reasonable thing to do at that

time in that condition at that time in Missouri.

Q Okay. Thank you, Doctor.

Let's look at -- Mike, let's look at Defendant's Exhibit III-1. So let's look at -- there's one for hydrocodone, Mike. Can you find that? Okay.

So, Doctor, this is a bar graph for hydrocodone also called Vicodin, right?

A Yes.

Q Can you tell us what we're really looking at here in terms of -- I mean, we know that Mr. Koon, that Dr. Walden started Mr. Koon on hydrocodone or Vicodin in February of 2008, right?

A Yes.

Q And so this date actually picks up at the end of 2008, doesn't it?

A Correct.

Q And so because from the beginning in February of 2008 to this pint, the doses were increased up to this level, correct?

A Yes.

Q And this is really the maximum dose for Vicodin, correct?

A Correct.

Q And why is the maximum dose -- because it's an opioid so I thought we said there was no limit.

A Well, for just an opioid. Hydrocodone, it says, 10/500. The ten refers to the milligrams of hydrocodone.

Q The opioid part?

A The opioid. The 500 refers to another analgesic, acetaminophen, also known as Tylenol. So our bodies can only break down a certain amount of Tylenol before it becomes a danger or a poison. So there's a limit that we need to impose on the amount of hydrocodone/acetaminophen prescriptions so that we don't -- so we get help but also limit the -- or prevent, help prevent that chance of damage to the liver.

Q So the acetaminophen, what organ or organs does that affect if the patient gets too much, Doctor?

A It would affect the liver.

Q Sometimes referred as liver toxicity?

A Yes.

Q All right. And so this maximum limit that Dr. Walden stopped at, I mean, he had to make that decision, didn't he, to stop because harm would occur or possibly occur with the acetaminophen to Mr. Koon over that level, correct?

A Yes.

Q That was his clinical judgment, wasn't it?

A Yes.

Q Can doctors prescribe more than that amount

sometimes to patients of the Vicodin?

A If they do, they run the possible risk of damaging the liver.

Q Okay. And so this bar stays the same. So does that mean that the hydrocodone or Vicodin stayed the same level pretty much to the middle of August 2012?

A Yes.

Q All right. Okay. Let's go to either one of the next ones, Mike. Either the -- that's fine.

So here's the OxyContin. So tell us a little bit about OxyContin as an opioid, Doctor.

A So OxyContin is a medication that as oxycodone that's formulated in a way that it will stay in your system for a longer period of time than a shorter-acting medicine like the hydrocodone pill you previously saw. So that contin, C-O-N-T-I-N, is short for continuous. So it's a way of keeping a medicine in the body longer to help someone with pain.

Q Okay. So was there a period of hours it supposedly lasts?

A It's usually written twice a day. So that's the expected time that it would last, but the hydrocodone pills that you saw in the previous slide may be written four to six times a day. So it's convenient or easier, I think, for a person to take a medicine once or twice a day

than to have to take it four to six times a day.

Q Okay.

A So these medicines have that appeal for compliance.

Q All right. And so beginning -- I think the OxyContin began, you may correct me, I think it actually began in February of 2009 when Dr. Brinker and Dr. Graham wrote that description, correct? This picks up in October of 2009. Do you see that, Doctor?

A Yes.

Q There were changes up to this point, but we're picking up in October of 2009, right?

A Yes.

Q So we're seeing here, and I don't know whether there is the axis or the pole or whatever, but this says number of milligrams per prescription, right?

A Yes.

Q So that means for each 30-day prescription, that's the number of milligrams. So that's what these represent, these numbers here, Doctor?

A Yes.

Q So tell us what this represents. I see -- it looks like boxes kind of in a row. Can you explain to the jury what this is really showing about the dosing?

A So, Mr. -- what this shows is that how he was

dosed with medicine appears to be stable for varying periods of time. So you see the first period is one year. So right here we see one year. So the initial dosing of the medicine was one year that he was on this dose of OxyContin. The next step up he was on this dose for five months.

Q Let me stop you for a second. He was already on the hydrocodone, correct?

A Yes.

Q So he's got the two opioids at the same time.

A Yes.

Q Anything inappropriate about that for Mr. Koon?

A No.

Q All right. Okay, I'm sorry. Go ahead.

A Next is another period of five months where he's on a standing dose of OxyContin. And then you see in 2011 to 2012 for approximately one year he was on the same dose of OxyContin.

Q Does that look like, again, in your opinion would that be considered an escalating or unstable cycle of increasing of the opioids, or how would you describe it, Doctor?

A Well, it shows the doses were increased in time but they were not increased every time. That he was on a set dose for periods of five months to approximately a

year. So that this was a slow increase. It wasn't a rapid, uncontrolled, unmonitored increase of medicine.

Q We still have to talk about the oxycodone, but let's take this last 11-month period. Is there any significance of that to you in terms of how Mr. Koon was handling that medication, or how it was serving him or benefiting him, I should say?

A It appears in relation to his records that this dose was adequate to help control his pain for an approximate 11-month period.

Q Let's do the next one, Mike. The oxycodone.

Okay. So the oxycodone. This says oxycodone 15. Tell us about oxycodone.

A Oxycodone is similar to hydrocodone in that the dosing needs to be more frequent. Oxycodone doesn't stay in the system as long as OxyContin, but it also is a dosage of medicine that one will commonly use in their practice to help get control of pain quicker. So this medicine would act more quickly in the body versus the OxyContin. And the slide shows similar to the last slide that the dosages were again, pretty stable, eight months, three months, I can't see that number clearly, but it looks like ten.

Q Ten months, yes.

A Ten months, ten months, and then there's this

period where he was weaned off of the opioids. So I think it helps you to understand that the dosing of the medicine was not -- was done in a slow, controlled, monitored way.

Q Okay. So the increases we see are on this chart, just as an example are, we see it go up presumptively at the very beginning, once, and then twice, three times, four times, four increases over the span of the time we're looking at on Defendant's III-1-001, is that right?

A Yes.

Q And, again, you told us you provided similar levels of pain medication to patients similar to what Mr. Koon was?

A I have.

Q Have you treated also individuals who require high-dose morphine but with special conditions such as multiple sclerosis or sickle cell disease?

A I have treated all those medical problems.

Q And in those, are those patients -- we've heard about cancer patients. Those patients can receive high doses, but are they evaluated the same way as even patients who don't have those conditions in terms of how the medicines are affecting them?

A Yes. The body -- the brain doesn't say, this is cancer or this is not cancer. The brain says, this is

pain. And likewise medicines for pain are processed in the same manner. This is a medication that helps with pain.

Q Okay. So those patients, they're not medicated to the point of being impaired mentally or physically, are they?

A That's certainly not the objective.

Q Just because someone has sickle cell disease and they're not a hospice patient, no one says, okay, the sky's the limit; we can just dose them up with opioids so they don't feel any pain?

A Correct.

MR. CRONIN: Can we approach?

(Counsel approached the bench, and the following proceedings were had, out of the hearing of the jury:)

MR. CRONIN: Your Honor, I'm hesitant to continuously object, but all of these questions are leading. I just ask the Court to advise Mr. Venker that they could not be leading questions. If I were to object to every question, the jury gets mad at me.

THE COURT: Some of them are leading; some of them are not. I'm not going to tell you when to object. So far the whole point is to elicit the testimony such that it comes from the defendant, so just be cognizant.

MR. VENKER: Thank you, your Honor.

(The proceedings returned to open court.)

Q (By Mr. Venker:) So, Doctor, some patients -- let's just talk about -- I think we heard the concept that dosing for opioids, maybe for all medicines is patient dependent. Is that a phrase that you're familiar with?

A Yes.

Q Can you tell the jury about that concept, that physiological concept, in patients? And you can talk about other medications in addition to opioids, but just to demonstrate to them that physiology.

A So sensitivity to opioids varies across a spectrum. And that really in many ways we believe is related to a person's genetic makeup which can deal with everything to how one absorbs the medicine into their system, to how it's broken down, and how the receptors in the brain respond to the medicine that you're given. So each level there is variance among everyone. No one is exactly the same. That's the genetic aspect of us, that we all differ a little bit. And that can manifest itself in the reaction to medicines.

So, for some people, they may need very little medicine. Or, for example, an opioid. They may need very little opioid to get relief. And for some, they may need a whole lot to get relief. And it is -- it can be a

manifestation of their genetic makeup in how they respond to the medicine in their body.

Q And so, as you say, the genetic makeup, are there recognized features of those genetics in terms of what might be causing the patient to either need a higher dose because they're absorbing it at a certain level; or what's been done on that in terms of research, Doctor?

A There has been research in looking at what are called cytochrome enzymes, which are the -- there are hundreds of them in various places in the body. But the main thing that we could look at or think about are these receptors in the bowel where, for example, you take a pill and just imagine you have carriers in the bowel. You may have -- some of us have a hundred carriers, and others -- we'll just draw extremes. And the other might have one carrier, but you get the same dose of the medicine. And the carrier only functions at one rate.

So the person with a hundred carriers is going to get a lot more in their system than the person with one carrier. So the stuff that doesn't get in your system, goes out in waste.

Likewise, the stuff that gets put into a person's body, it gets broken down. If someone has enzymes that are working at let's say, you know, working, they do a job one times an hour; and then another person

has enzymes that are working at a hundred times an hour. Well, the person who his enzymes are working at one time an hour, they don't break down a lot of the medicine. So that medicine stays in their system, and it's going to appear much stronger than someone who has a hundred enzymes working to break it down. So the hundred enzymes, they break it down.

And so it appears or it feels to them they're not getting much of an effect, but it's really just their body just breaks down the medicine much quicker.

Q Okay.

A And then likewise with receptors in the brain, the -- what are called the mu opioid receptors, which is the target that we know opioid receptors modify that pain signal going to the brain.

Well, if you have one receptor, you're going to -- you don't have as much of a -- you won't have as much of a response to an opioid than if you had a hundred receptors. For a hundred receptors, when that opioid presents, you're going to have a lot more opportunities to modify the signal.

So there's various levels where the genetic makeup can affect how our body processes opioids.

Q All right, Doctor. So let's talk about, a little bit back to this whole dosing limit idea.

So is there any FDA, federal government, any limit for I'm just going to say pure opioids, it's not mixed with any other ingredient, like that acetaminophen, just pure opioids, is there any set daily dosing limit for that anywhere?

A For a pure opioid, there are -- I will preface this and say generally there's no upper limit, but there's certain opioids that have some limits for other issues. Those two medicines are one. Morphine that's formulated in a daily pill called Avinza.

Q Hold on, Doctor. Mike, can you put up PPP -- I'm sorry, PPPP?

So, Doctor, can you see that?

Mike, why don't you blow that up? Okay.

So I see Avinza up here on the left, Doctor. Can you use the pointer and show --

A That's it.

Q So morphine sulfate. So what is Avinza?

A So it's a formulation or a pill that contains morphine that has a continuous nature to it. But it has a limitation in that a chemical that's used to make it when it's present in high doses, you could potentially damage the kidney.

Q Okay.

A So that high dose being 1,600 milligrams of

morphine in a day. So above that dose, you need to be concerned that the chemical called formic acid may damage the kidney. Similar to with the hydrocodone and the acetaminophen combinations, you need to stop at a certain level because you've got to be concerned that the acetaminophen may damage the liver.

Q Let's advance this, Mike, and see if --

MR. CRONIN: Judge, can we approach?

(Counsel approached the bench, and the following proceedings were had, out of the hearing of the jury:)

MR. CRONIN: Judge, these are new opinions. I heard nothing about this in his deposition, and we're talking about a drug that was not being prescribed to Brian Koon.

MR. VENKER: These are opioids, Judge. These are opinions he gave about patient dependent dosing. He definitely talked about that. This Avinza is a way to --

THE COURT: We'll see where it goes.

(The proceedings returned to open court.)

Q (By Mr. Venker:) Let's see, Doctor, if we can find -- if I give this to you, do you think you can find it quickly, Doctor?

A I know it's in the product insert but --

Q Here you go.

A This is in the -- right here, 2.2, fourth

paragraph.

Q Okay. So what page number, Doctor?

A Well, it's Section 2.2.

Q Okay.

A I think this is PPPP-006.

Q I think I see it down there, down towards the bottom of the page? Okay.

So why don't you point to the jury where it says the 1600?

A Right here.

Q This paragraph right here. It says, "The daily dose of Avinza must be limited to a maximum of 1,600 milligrams a day."

Dr. Walden's dosing of Mr. Koon never got to 1,600 milligrams a day, did it, Doctor?

A Correct.

MR. CRONIN: Your Honor, objection, relevance. These are not the medications Brian was on and these are completely new opinions that were not disclosed in his deposition.

THE COURT: I'll let you handle it on Cross.

Q (By Mr. Venker:) So, Doctor, it says though that the Avinza doses over 1,600 milligrams a day contain a quantity of fumaric -- am I saying this right, fumaric acid?

A Yes.

Q All right. It says, that has not been demonstrated to be safe.

So this FDA warning is not saying that the opioid portion of this drug is not safe; it's saying that the fumaric acid portion has not been demonstrated to be safe, correct?

A Correct.

Q And may result in serious renal toxicity. What's renal toxicity?

A Your kidneys.

Q What is fumaric acid?

A It's a chemical used to -- in part of the creation of the tablet that contains the morphine.

Q Okay. And so would this Avinza possibly even at 1,600 milligrams per day of morphine equivalent dosing be combined with other opiates if appropriate?

A Yes.

Q To go even higher?

A Yes.

Q Now, given that, about the high doses and how the opioids can be basically as high as clinical judgment of the physician, you told us a little bit earlier, but tell us again about your philosophy of morphine dosing, that is, minimally effective dose?

A Well, absolutely. If you can get the job done with -- well, first of all, before you even go into use of opioids, you consider and try other things. Everything from physical therapy, maybe chiropractic care, then nonsteroidals, which are aspirin-like products. And this is all done by Dr. Walden.

And then you might -- then you come to analgesics, which are stronger than the aspirin products as a whole, and you could go to a medicine called tramadol, which is also known as Ultram or Ultracet when combined with acetaminophen. Mr. Koon displayed or reported to Dr. Walden that he didn't respond to it. And that's why he ultimately was started on an opioid, hydrocodone/acetaminophen combination called Vicodin.

But you know, in my practice, I try to get the job done with as little as possible, but that may not do the job. So I titrate to get to the dose that does get the job done with the minimal amount of side effects. And so for some people it may be we'll just say, you know, 5-milligram morphine equivalent a day; and some we've gone all the way up to 2,000 or more. But generally a lot of people, most people, we can get the job done with under a hundred milligram morphine equivalent a day.

Q Let me ask you, Doctor, is that level of a hundred milligrams morphine equivalent milligrams per day,

that is good for most people, that works for them?

A The majority, absolutely.

Q And so but there are patients like Mr. Koon -- let's talk about the -- the pre-- the 2001 to 2007, or I guess early 2008 time period where Dr. Walden was treating Mr. Koon. Any pain complaints from Mr. Koon during that time period to Dr. Walden?

A There were a couple times where he had back pain episodes that were evaluated. He had x-rays taken, sent to physical therapy, was put on medications for short periods of time, including one time where hydrocodone was used.

Q Any untoward effects of that round of Vicodin or hydrocodone?

A No.

Q Okay. And it wasn't continued after that, just one, a few-day supply; or what do you remember about that?

A It was a several-day supply.

Q But during that time, other than that one or two events of opioids, Dr. Walden didn't prescribe opioid pain medications to Mr. Koon, did he?

A Correct. It was a six-year period where he was providing care, and no opioids were provided. Well, no opioids were provided on a sustained basis.

Q All right. So in this case the first time that

Dr. Walden considered and decided to go ahead with opioids for Mr. Koon was in early 2008, wasn't it?

A Yes.

Q All right. And so you remember seeing in the records about that February 21, 2008 examination in the office visit that Mr. Koon came in?

A Yes.

Q All right. Can you tell us what you remember about that visit in terms of information Dr. Walden was taking into account?

A Well, a medical student evaluated him and reported details of the severity of the pain. The thing that really stuck out in my mind was that the episode of pain was so severe that he was laying on the floor for 45 minutes. That sounds pretty bad to me. So this was a severe episode and definitely appears to have been much worse than the problems he had in the past.

Q Okay. And then -- that was reported in those records as having happened a few weeks before February 21; you remember that?

A Yes.

Q And then sometime later, I believe it was the 29th of February, 2008, Mr. Koon contacted Dr. Walden's office about his pain being increased. Do you remember that?

A Yes.

MR. CRONIN: Objection, leading.

Q (By Mr. Venker:) Tell us what you remember about that, Doctor.

A Well, at that time hydrocodone was started. He was previously trying to use tramadol, but tramadol, or Ultram, and Mr. Koon reported that this was ineffective. So Dr. Walden took the next step, which I think is quite logical, was to go to Vicodin, the hydrocodone combination, because he was already -- and he also knew from his medical history that one of the other options would be to use codeine, but codeine, Mr. Koon reported to him, caused severe constipation.

So Dr. Walden, in essence, was following the World Health Organization analgesic ladder, which is to start with the mildest opioids and to slowly step up. And this in some ways is mirrored by the government's grading of opioids as classes five, four, three, two, one for controlled substances. The lower the number, the higher, the more potent the medicines are.

And so he had advanced from -- to a level three at that time which was hydrocodone combination, which I think was a reasonable step.

Q Okay. And I don't want to belabor this. Let's go back. Mike, can you put up Exhibit A, SLUCare, page

108? I apologize we're going to back up just a little bit because I want everybody to be able to see. This is -- let's blow up the top here.

So you talked about -- so this MS Roman numeral three from your practice means --

A Medical student third year.

Q This is the February 21, 2008 visit. And so Dr. Walden's typed note talks about Mr. Koon saying something happened when he was drying off with a towel. You remember that, right?

A Yes.

Q So here's what the medical student wrote, "He fell to the floor at that time and wasn't able to get up for 45 minutes. The pain is" -- I can't read it -- "located in the midthoracic spine directly over the vertebrae." It says, "No radiation around the chest or the legs. The pain is described as a severe burning pain, worse with exercise or prolonged immobility or rise."

A Yes.

Q "Better with Advil, warm showers." Although this is where he talks about being on approximately 12 Advil a day. And so is that a lot of Advil?

A That's a lot of Advil. Generally I'm very concerned when someone's telling me they're taking 12 Advil a day. Advil, aspirin products, we know can cause

ulcers in the stomach. And when taking this type of medicine chronically increases your chance for having kidney problems, heart attacks and strokes. So this is not a benign medicine, and 12 a day is a lot of Advil to take.

Q Mike, let's go to SLUCare record page 110, Exhibit A, still Exhibit A, sorry.

So this is February 29th, we were talking about that, 2008. This is from the telephone records of Dr. Walden. It says here, "Would you call more pain med for patient." And they're talking about Vicodin, right, Doctor?

A Yes.

Q And so somebody's called in a prescription, right?

A Yes.

Q And here, "Discussed with patient." Do you see that?

A Yes.

Q Okay. And so that's Dr. Walden talking to Mr. Koon, correct?

A Yes.

Q Okay. And that would be a conversation you'd expect him to have before he began prescribing opioids to a patient, right?

A Correct.

Q And from your review of the case and the depositions, what would that discussion have been, Doctor?

A That prior treatments do not appear to be as effective as we had hoped. That this is the next stage of use of an intervention to help you with your symptom and that risks are associated with it. And side effects can happen with the medicine and making sure that basically the -- that Mr. Koon understood this before prescribing it.

Q Okay. Is there any indication in this note that this was now going to be some long-term opioid therapy course for Mr. Koon?

A No.

Q All right. It's just a Vicodin prescription, right?

A For 30 pills.

Q Right, okay. And so it's 30 pills. Does it say is there any refills possible? I see 30 --

A I see 1R, one refill.

Q Okay, so 60 pills, okay. So at this time, Vicodin was a Schedule III class opioid?

A Yes.

Q All right. And so what's significant of that and this phone call prescribing medicine to Mr. Koon?

A Well, at that time, you know, it was a medicine that could be called in. Subsequently, the classification of hydrocodone has changed and hydrocodone can no longer be called in. You need to write out a prescription.

Q And that change occurred after 2012, you know that as a practicing doctor?

A Yes.

Q So during the time that Dr. Walden was treating Mr. Koon, Vicodin or hydrocodone, could be prescribed essentially over the phone, but of course, assuming good clinical judgment was being used?

A Yes.

Q So in terms of after that decision was made to prescribe the Vicodin, things progressed. I'm not going to go through every detail. But obviously Dr. Walden and Mr. Koon talked about his future pain management after that encounter with that prescription going to the future, correct?

A Yes.

Q And going through the records, did they discuss what the plan was going to be?

A Yes.

Q Tell the jury what that was.

A I see it as evidence that they talked about what the goal was, that Mr. Koon wanted to work at a job which

was very demanding; and that Dr. Walden was going to help him accomplish that goal in the context that surgery was not an option. He had seen two spine surgeons that said that in essence. Injections had been ineffective or inadequate. Physical therapy hadn't done the job. Chiropractic care gave short-lived response, and his response to nonsteroidals was inadequate.

Q Let me stop you for a second. You talked about the two surgeons who evaluated Mr. Koon. Dr. Walden actually referred Mr. Koon to an orthopedic surgeon Dr. Howard Place?

A Yes.

Q To evaluate him to see whether surgery would be helpful for his pain condition, correct?

A Yes.

Q And Dr. Place, as you just said, said that he did not think it was appropriate or would be helpful for Mr. Koon?

A Correct.

Q And then after that, there was an MRI done. And so did the MRI contain information?

MR. CRONIN: Judge, can I object to the continuously leading nature of the questions?

THE COURT: Sustained. Rephrase.

MR. VENKER: I apologize.

Q (By Mr. Venker:) Was there an MRI performed on Mr. Koon in this time frame when the surgeons were evaluating him?

A Yes.

Q And did that MRI contain any information about what could have been causing Mr. Koon's pain?

A Yes.

Q Tell us what that is.

A So Mr. Koon's whole spine, cervical, thoracic, and lumbar spine showed signs of degeneration, which is not uncommon. We all degenerate. There's scientific data saying that in our teenage years, our spines can start to show some signs of degeneration. So that's not surprising. But for many that is -- many people in time that degeneration can become symptomatic. And when you become symptomatic to degeneration in a joint or the musculoskeletal system, we call that arthritis.

So, in essence, Mr. Koon had arthritis throughout his spine; but in addition his MRI showed what is called an annular tear. So there are bones in the spine. In essence, it's a column of bones surrounding a column of nerve, the spinal cord. And off the spinal cord goes nerves into the body. The bones, they are separated in the front by disc, and in the back there are joints that are called facets.

But the disc showed signs of degeneration at various sites, and one site had a tear it. And the significance of that tear is that there are chemicals inside the disc. So imagine the disc is sort of like a jelly doughnut. In the center that jelly, if it gets out, it can be very caustic. It can really irritate nerves and cause a lot of pain.

So in 2008 Mr. Koon had an annular tear at L4-5, and that absolutely could cause a lot of pain. So he has two different things working at causing him pain. And the problem with an annular tear is sort of like if you can think about a tear in your skin, if you don't let it heal and continually stress it, it's going to continually get aggravated and continually be open. I think that's part of the problem Mr. Koon had.

Though he had times where he was off for a couple weeks or physical therapy, in essence he kept on going back and doing a job that I think aggravated not only the arthritis in his back but that tear in his spine. And those symptoms in total caused him a lot of pain.

Q Mike, can you put up Exhibit A-147. Let's get the date on this.

Okay. So here's an exam date for an MRI. Can you see that from where you are, Doctor?

A Yes.

Q Okay, great. And so you were talking about this annular tear, correct?

A Yes.

Q And so -- and they also talk about the cervical spondylosis. Is that what you were referring as well?

A Yes. Spondylosis is the medical term for arthritis in the spine.

Q And I see, is there not one but two, or am I misreading this, annular tears, I mean?

A Yes, there is two in his back. One at L3-4, which means the disc between L3 and L4. There's five lumbar vertebrae. Basically between your ribs and your tailbone or right above the tailbone, there's five vertebrae. And between the third and fourth, there's a tear; and between the fourth and fifth, there's a tear.

Q So he has two?

A There are two tears, absolutely.

Q So annular tears can occur as the normal result of degenerative disc disease, correct?

A As one degenerates, you lose the elasticity of the tissue, which means things don't bounce back. So stress on things could -- so stress on the disc at one time when you're young doesn't cause any symptoms or problems, but when you're older because you degenerated, it doesn't bounce back. And the disc, if it doesn't

bounce back, it can tear or rupture or herniate, any of those things.

So Mr. Koon has two sites where he had tears in his disc, which again can cause a lot of pain.

Q All right. Let's talk a little bit again, let's go back on the issues of proper care and standard of care. We've heard different discussions about different approaches to pain management when somebody is on opioids. So let me ask you some questions.

Does the Missouri guidelines require physicians or the standard of care to use what's called urine drug screening for patients on opioids?

A No, it is not required. It is something that they suggest you consider if you have a high-risk patient.

Q And how about -- what would a urine drug screen have shown in this case?

A Well, it's interesting. I mean, whether you obtain a urine drug test or not on Mr. Koon based on all the information, including his deposition and the records, it wouldn't have made a difference.

Q Why do you say that, Doctor?

A Well, urine drug tests are -- we use urine drug tests to really show two things. One, that a person isn't using street drugs. Two, that they're taking the medicines prescribed, and they're not taking any

additional medicines.

Well, Mr. Koon never reported using any elicit drugs. He never reported going to another doctor to get additional medicines. So the urine drug test would have been what we considered normal while he was under the care of Dr. Walden.

Q Now, in terms of the risk and benefit assessment that -- as to whether Dr. Walden did a risk and benefit assessment for opioids for Mr. Koon, you told us about one conversation already.

Did Dr. Walden do it at other times?

A There's evidence in the records that, yes, he talked at different times, not only his deposition but there were times where he reported in his records where a conversation occurred where Dr. Walden concluded based on the conversation that the benefits of using opioids outweighed the risk associated with the opioids.

Q Okay. Is that decision on either using opioids to begin with or prescribing them to begin with and continuing them, is that a decision to be made by the physician or by the patient, or how does that work?

A I would base knowing -- reading Dr. Walden's information and, again, the depositions, that it was an agreement, that Dr. Walden did not dictate you must do this. He made a -- he discussed with him an option, a

known option, and Mr. Koon understood what was being offered and then proceeded to take medicines that were prescribed.

Q Okay. Put up if you would, Mike, Exhibit A-292. And this is -- let's get the date up here real quick.

So August 20th of 2009. And okay. So here's what Dr. Walden is charting. "Back pain, increase OxyContin to 40 milligram BID." What does BID mean?

A Twice a day.

Q And, "Yes, continue Vicodin, as needed for breakthrough pain." Tell us what breakthrough pain means.

A So the OxyContin is the medicine that would cover the -- or hopefully will cover just most of the pain. But despite that, there are times when the amount of medicine in the system may decrease and the pain may become more prominent, or times when an activity is more stressful than typical, and those times will call breakthrough pain. And so the additional medicine was to address that problem.

Q Then it says, "Discussed possible adverse effects and risk of dependence." You see that, don't you?

A Yes.

Q And so that would be, again, from your experience in the practice, a discussion about dependence being both physical dependence and psychological

dependence?

A Yes.

Q Which sometimes can be called addiction, right?

A Yes.

Q And then it says, "We both agree that the benefits clearly outweigh the risks in use of narcotic analgesics." Correct?

A Yes.

Q So not only has Dr. Walden talked to Mr. Koon; it's actually charted, correct?

A Yes.

Q Is there any requirement in the Missouri guidelines that physicians chart or document whether they've had risk-benefit discussion with patients for whom they're prescribing opioid medications, Doctor?

A Well, it's required that they have a discussion; but there isn't a requirement for a formal contract, as you would say or think, that needs to spell all of it out.

Q So they have to have a discussion, but there's no requirement that it be charted as such, correct?

A Yes.

THE COURT: All right. Attorneys, approach.

(Counsel approached the bench, and the following proceedings were had, out of the hearing of the jury:)

THE COURT: Are we at a good place to take a

little break?

MR. VENKER: Sure, that's fine.

(The proceedings returned to open court.)

THE COURT: Ladies and gentlemen, we're going to take our first morning recess. The Court again reminds you what you were told. Please don't discuss the case with anyone. Please don't form an opinion about the case. Please don't do any research. And please do not communicate with anyone about the case by any means.

Court will be in a 15-minute recess.

(At this time a recess was taken.)

o0o

(The proceedings returned to open court.)

THE COURT: All right. Please be seated.

You may proceed.

MR. VENKER: Thank you, your Honor.

Mike, can you put up Exhibit A, SLUCare page 460?

Q (By Mr. Venker:) So let's get a date first. That would be August 18th, 2011, about 2 years after the last one we just read.

Let's go down to assessment. Assessment and plan. Yeah, it's that one, assessment and plan.

Okay. So assessment and plan. So part of the plan charting Dr. Walden has done, do you see this?

A Yes.

Q What does number two say? Can you read that for us?

A "Back pain - continue narcotic analgesics - had long discussion concerning tolerance and dependence."

Q And again, a discussion between Dr. Walden and Mr. Koon; but he's already told him this, right? Why would a doctor do it again?

A Yes.

Q To be safe? Because he's concerned?

A Well, I think that it's just part of an ongoing conversation that he was having with Mr. Koon and just a time where he chose to document it.

Q Okay. All right. Now, one of the issues in this case, Doctor, is Mr. Koon and the prescriptions that Dr. Walden wrote and then Mr. Koon getting refills for those prescriptions early on some type of regular basis. You know about that, don't you?

A Yes.

Q Mike, would you put up SLUCare 116, please? Let's focus in -- let's get the date first. April 16th, I believe, 2008. And then down here, can you blow that up a little more?

So this is April 16th. So he hasn't had the opioids very long, has he?

A Correct.

Q So this is a note from Dr. Walden's charts saying, "Having to take more than prescribed dose of pain meds; they do work, he just has to take more."

Do you think this is a danger sign at this point in Mr. Koon's treatment about his consumption of opioids, Doctor?

A Well, if there's no relationship, if there's no understanding of the patient, it possibly could be.

Q Okay.

A But I'm reading this in a context of an awareness that Dr. Walden had been working with Mr. Koon for seven or eight years; and based on his relationship, he's making a decision that in this situation that he was not getting enough medicine. And this is a phenomenon that we call pseudoaddiction in which something appears that it could be interpreted as addiction or it could be interpreted that he just wasn't getting enough medicine to address the pain.

And my interpretation is that Dr. Walden interprets this call as Mr. Koon not getting enough medicine or analgesics to control his pain, and he subsequently adjusted the dose.

Q And early on when a patient is taking, first taking opioid medications, is there any adjustment period since you mentioned it?

A There's adjustments -- adjustments can vary, especially when you start out, to find that right dose, could take weeks and in fact months. And even then there may be further changes because people can develop a tolerance, which means that the amount of medicine that helps at one period of time may become less effective in time. And there are a variety of reasons why that can occur. And therefore dosages may need to be adjusted further to get the same amount of relief that he had initially.

Q Mike, can you put up -- let's go back on this one.

So in this case Dr. Walden decided to increase Mr. Koon's Vicodin based on that information that he had gotten, that we see in this telephone call?

A Yes.

Q Was that an appropriate thing to do?

A That's a reasonable thing to do.

Q So, Mike, can you put up OOO? We'll go to page -1-006. And you're going to shoot me because I want to go back one page. Sorry.

Okay. So this is the Missouri Guidelines for Use of Controlled Substances, right, Doctor?

A Yes.

Q All right. And so let's go back to the page

again. So here, this Section 3, for definitions, right?

A Yes.

Q Okay. And let's go to page six now, Mike.

So this is a continuation on the next page of the definitions. And you mentioned, Doctor, this one down here, pseudoaddiction, right?

A Yes.

Q And that says, "A pattern of drug-seeking behavior of pain patients who are receiving inadequate pain management that can be mistaken for addiction."

So tell us how that concept of pseudoaddiction relates to your opinions in this case about Mr. Koon and his taking of the medications over time?

A So, there are multiple times where Mr. Koon and/or his wife called and said that he was not getting enough relief or that he used his medicines up faster than what was prescribed. At that point, Dr. Walden had to weigh various options.

On the one hand, Mr. Koon wasn't getting enough relief. He could have been extended out and one could say, well, maybe there is a genetic problem, and we talked about that earlier. Maybe he developed tolerance. And on the other side, maybe this is addiction.

So Dr. Walden had to decide at each point, which of these things is present. The thing about

pseudoaddiction, we know that increasing a medicine so that a person gets more relief will typically calm down the problem. And in the context that the care Dr. Walden provided was based on a relationship. He knew Mr. Koon. Starting in 2001 through 2012 is 11 years. That's a long time where a lot of time is spent.

So he made a decision based on his relationship and what he knew about Mr. Koon. And I think Dr. Walden described Mr. Koon as a straight shooter, that he found him reliable. And so he decided that this was pseudoaddiction, and he refilled medicines early and/or increased medicines when Mr. Koon requested because of his understanding of who Mr. Koon was that's based on a relationship, as well as meeting the goal. The goal was working. And he, in fact, was able to work throughout the time period he was under Dr. Walden's care.

Q Okay. Thank you.

Mike, let's go to the bottom here.

So this is something that you've talked about, Doctor, tolerance. This, again, is in the Missouri Board of Healing Arts guidelines. It says, "Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect." And so that happens with opioids?

A Yes. But --

Q All right. And we saw that with -- go ahead.

A But it's not just unique to opioids. It happens with a lot of different medicines. So this is not a unique phenomenon with opioids. We can see that with insulin, some medicine for people's hearts. So this is a common problem that just happens.

Q Okay. Mike, let's go up to the top of the same page, and we're going to pick up this second one.

So here's another definition for the Missouri Board of Healing Arts guidelines, analgesic tolerance. This says, "Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction."

What's that mean, Doctor?

A Well, I think there's a couple things that are clear from this. First of all, that tolerance can occur, and that increasing the dose of medicine to get the same level of analgesia -- analgesia means pain relief. But there's nothing said about a maximum dose as in don't go over this dose or it's wrong. There's nothing saying that there's anything wrong about a dose.

So it's increase it to achieve a level of analgesia and that tolerance may or may not be evident during opioid treatment and does not equate with

addiction. So tolerance does not mean they're addicted. So that someone says, hey, this medicine isn't giving me enough relief should not be equated with, oh, you're an addict and therefore don't need a different type of care.

Q All right. Mike, let's go down to this -- in the middle, this physical dependence paragraph. So physical dependence -- and I'm just going to focus on the last two sentences. Can you highlight those, Mike?

So it says, "Physical dependence is an expected result of opioid use." Well we hear a lot about people saying he's drug dependent or he's dependent. So why is this statement saying what it is, Doctor?

A Well, once you start writing a medicine for someone on a regular basis, an opioid, you expect dependence. But this is highlighting that that does not mean it's addiction. So that's what this is emphasizing.

Q All right. Thanks, Doctor.

You noted earlier in one of the -- let's go to Exhibit A, Mike, 110? You were talking with us, Doctor, about a dialogue, a conversation between Dr. Walden and Mr. Koon. This is the February 29th, 2008 phone call where Dr. Walden actually prescribed the Vicodin, and you were noting that -- so this says, discussed with patient and Tylenol #3, you talked about this already; I'm not trying to run this over again. But then you mentioned

about the severe constipation, right?

A Yes.

Q That Mr. Koon told Dr. Walden he experienced severe constipation with Tylenol 3, right?

A Right. It's not uncommon because they had a relationship. And if Mr. Koon had a problem, he would have communicated it to Dr. Walden; and that's what he did in relation to Tylenol #3 and what one would have expected with other subsequent prescribing as well.

Q So as part of what a physician should do in Missouri, in 2008 to 2012 at least, was it required that Dr. Walden place Mr. Koon on what's been called a bowel regimen of any kind for his opioid medication?

A Not required. Basically studies show about 45 percent of people who take opioids will develop constipation. So it's not the majority, but again, many people are aware of their bowels, and they do things to address it accordingly.

Q In your practice have you had patients who have taken it who have constipation as a result of opioid medications?

A Yes.

Q And they've talked with you, and you've talked with them about that issue?

A Yes.

Q Before I forget, Doctor, obviously you're reviewing this case; and we're paying you for your time to review the case, correct?

A Yes.

Q Tell us about that. What's your charge per hour?

A Well, my charges are all based on working with a consultant who's an attorney who knows what people like myself with my credentials and my training have determined is a reasonable rate.

So he determined, and I charge, $500 an hour for review of records. I charge $2,000 an hour for videotaped depositions. And I charge $10,000 a day for appearing in court. This is all consistent with my training and expertise.

Q Okay. And Doctor, let's talk about your last opinion, that is, your other opinion about whether Mr. Koon appeared to be or had indicia of being an addict while he was under the care of Dr. Walden, all right?

A Yes.

Q So can you -- is there a definition of an opiate addiction, what would it be described as?

A So addiction involves the compulsive use of a medicine that leads to a corresponding decrement in function. And there's three things that need to be in

place for addiction to occur.

One, you need to have the genetic makeup, meaning, you know, we all inherit genes from our parents. But you know, like it or not, some of us are more predisposed to becoming addicted versus not. So if you don't have a predisposition to potentially being addicted, it will not occur.

Then, secondly, you need to be in an environment that condones it, meaning either a family or social setting or community that says it's okay to use a narcotic.

And, third, you need access. It needs to be provided to you. So those things need to be present.

Q Are there behavior attributes of someone who's an addict? We've heard about drug seeking, compulsive taking of drugs?

A Right. Well, they can be challenges. And I'm not denying it, that there is a question. When someone compulsively uses a medicine or takes it faster than predicted, that is a question. Is this person addicted? Then one has a take a history. One has he evaluate. One has to consider what's happening.

And in this case, I need to defer to Dr. Walden's judgment. Dr. Walden, you know, evaluated and made decision of whether he was addicted or not. And

then we look externally, well, what could help us to know whether Dr. Walden had it correct? He was able to work. There's no --

MR. CRONIN: Your Honor, can we approach?

THE COURT: You may.

(Counsel approached the bench, and the following proceedings were had, out of the hearing of the jury:)

MR. CRONIN: So, Judge, a couple things. He just interjected blaming Brian's family for his addiction, which was subject to a motion in limine.

MR. VENKER: He what?

MR. CRONIN: He interjected blaming Brian's family, which was a motion in limine.

Second, Judge, this is a pain management specialist. They had an addictionologist who came in here and said Brian became addicted, and now they're going to have a physician, and it's not in his area of speciality to say no, he wasn't. He can't have it both ways. Their addictionologist said he became addicted during Dr. Walden's care.

MR. VENKER: I think as a pain management specialist -- he's not an addictionologist, that's true. But from his perspective, this is the kind of person that Dr. Genecin said Mr. Koon should have been referred to as part of his care by Dr. Walden. Dr. Genecin said he would

defer to a pain management specialist.

So I think I have a right to have this physician, from his perspective, talk about -- he has to know whether he thinks somebody's addicted or not; he's a pain management doctor.

THE COURT: Number one, I don't believe he's violated the motion in limine. I believe the context in which he's talking about genetics is not -- doesn't violate it.

Second, I think that this is an appropriate area for Direct, and I'll allow you to Cross it.

MR. CRONIN: Thanks, Judge.

(The proceedings returned to open court.)

Q (By Mr. Venker:) All right. So in terms of your practice, you have to monitor patients to make sure they're not either creeping up on becoming addicted or displaying signs of addiction, correct?

A Yes, I would say approximately a hundred people a day I need to evaluate in this manner. Whether these are people that are calling for refills or there's something that's abnormal in how they use their medicine, I have to go back and I got to reevaluate and I got to ask these questions. Is this person tolerant? Are they exhibiting pseudoaddiction? Or is this addiction? And I need to at times look into external factors. It's

sometimes not clear.

So there's a variety of things that get weighed in to the equation. And likewise, external factors can help clarify things. I mean, the ability to work, no driving tickets, what other health care professionals saw or see. All these things get weighed in the equation. So it's not always a simple yes or no phenomena, and sometimes it can take time to tease out what exactly is happening.

Q So, for example, you're familiar in this case, there was an occasion, for example, when Mrs. Koon called Dr. Walden's office to say a relative had gotten into Brian Koon's pain medications. Does that indicate something is amiss and Brian is consuming drugs faster or somehow showing signs of addiction from that episode or one episode like that?

A That is an episode. Again, Dr. Walden had to stop and reevaluate and say, is this -- on the one hand is this just, hey, he's just not getting enough medicine. And then either the medicines need to be continued, adjusted or changed. Or is this addiction. And so one has to look at something to guide you.

So Dr. Walden has one thing to guide him, a relationship that now is over ten years. His interactions with him and his clinical judgment and, in fact, we have

to say Dr. Walden's been a physician for decades. And so he's been using opioids for decades, so he's familiar with the issues of writing opioids.

And so he has his judgment to base things on, and then he has these external ways of making decisions. And like I said, one of the things could be, you know, if someone has a ticket or an impairment that is manifested in front of others that could guide his decision making. But ultimately Dr. Walden is deciding based on his judgment whether it's appropriate to refill.

Q All right. So on that occasion when Michelle Koon called Dr. Walden, he chose to believe her that it was an innocent inadvertent episode from a relative, correct?

A Well, in that case, yes, that was -- a different issue, but yes.

Q That was a reasonable thing under the circumstances to exercise his judgment in that way?

A Well, he exercised his judgment that way, absolutely.

Q In terms of people becoming addicted, what is the percentage of -- we've heard the phrase that opioids are at a high potential for abuse. I think we've even heard highly addictive.

Tell us what the percentage is of people who

using opioids become addicted?

MR. CRONIN: Objection, your Honor, new opinion.

THE COURT: Approach.

(Counsel approached the bench, and the following proceedings were had, out of the hearing of the jury:)

MR. VENKER: I can find it in his deposition if you want.

MR. CRONIN: He gave no specific percentage in his deposition. I think he said small, but he didn't give a specific percentage.

MR. VENKER: He may have said --

THE COURT: Overruled. Keep going.

(The proceedings returned to open court.)

Q (By Mr. Venker:) Go ahead, Doctor.

A As I understand, you want to know what percent of the people become addicted. So first of all, we have to start, go very wide and say, well, what percent of Americans have chronic pain. It's -- they say -- different numbers vary, but one out of three. That's a hundred million people. So that's a lot of people who have chronic pain.

So not everyone who has chronic pain seeks out care. People have headaches or backaches or other types of pain that may be ongoing, and they manage it at home.

But there's probably about a third of people

seek out medical care. And when people seek out medical care, the question is how many of the people that seek out medical care actually get put on continuous opioid therapy? And the number's actually kind of small. It's about 5 percent. That's a rough approximation, so we're down to a smaller number of people who actually get exposed to taking opioids chronically.

Then the question is, well, those patients who take it chronically, you know, the numbers vary. How many of those individuals exhibit problems? The numbers vary, but I'm going to say 5 percent again, just a rough approximation.

So if you get all the way down and say, well, how many people have problems with opioids? I will say approximately two people out of a thousand who take opioids have problems using opioids. They develop an opioid use disorder. So two people out of the thousand, but that's only, again, 5 percent of people who have chronic pain get opioids. So it's a small number, but it's not insignificant. And that's why it's important that people monitor and ask questions and manage this problem.

Q All right. So in terms of Mr. Koon, you talked already about these external factors. In terms of his treatment, let's take that highest period of medication he

was on from I believe it was September of 2011 through into the summer of 2012. We'll just call it that, all right? And during that time, did Mr. Koon seek any non-opioid treatment for his pain?

A Yes.

Q Can you tell us what that was?

A He was seeing a chiropractor quite regularly. So there is a form of therapy that I really think Mr. Koon was trying to help manage his symptoms and get better, and it wasn't just taking an opioid; it was doing chiropractic care.

Q And in your experience as someone -- again, in your experience, who is either near addiction or at an addiction level, would that be typical for such a person to seek non-opioid pain treatment?

A So in my experience, an addict is consumed with taking an opioid and really doesn't want to do or think about anything else. That's what addiction is involved. It's a totally focused on the drug. And so for someone to then go out and seek out chiropractic care, which mind you, for some people is discomforting, and some people don't like have manipulations and various things done to their body. So you're submitting your body to something being done. That's just not consistent with what I can appreciate to be addiction.

Q And, Doctor, you're not an addictionologist, correct?

A Correct.

Q And so the jury has already heard another expert, we called Dr. Gunderson, who's an addiction specialist. I take it you would defer to his opinions on the area of addictionology?

A Yes.

Q And you're giving your opinion about the addiction issue from your perspective as a pain management physician assessing whether or not one of your patients and for this case Mr. Koon gave off indicia of being addicted, correct?

A Yes.

Q And, Doctor, just to wrap up then, your two main opinions are that Dr. Walden provided proper care and met the standard of care in treating Mr. Koon; and again, if he had been referred to you, you would have seen this as appropriate treatment, correct?

A Yes.

Q And, again, as a pain management specialist, from your perspective, Mr. Koon did not display any indicia of addiction, and he was a nonaddict from your perspective, correct?

A Yes.

MR. VENKER: I have no further questions.

THE COURT: Cross-Examination?

MR. CRONIN: Thank you, Judge.

**CROSS-EXAMINATION**

BY MR. CRONIN:

Q Dr. Guarino, you gave a deposition in this case, right?

A Yes.

Q You were under oath?

A Yes.

Q Okay. And you know it was typed up, right?

A Yes.

Q There was a court reporter. You know I have a copy of what you said in your depo, right?

A Yes.

MR. CRONIN: Permission to approach, Judge.

THE COURT: You may.

Q (By Mr. Cronin:) Dr. Guarino, I'd like to provide you with a copy. It's Exhibit 150, and I'll point you out to any pages I'd like you to refer.

Doctor, I want to start close to where we left off. Your hourly rate for review in this case is $500 an hour?

A Yes.

Q And up until your deposition, you had already

billed about $32,000, right?

A Yes.

Q And you charged $2,000 an hour for your deposition because I wanted to videotape it, right?

A Yes.

Q Otherwise, you charge a thousand dollars an hour?

A Correct.

Q And you've actually had a judge in another case order that you couldn't charge $2,000 an hour for a depo, haven't you?

MR. VENKER: Object to the relevance, your Honor, collateral matter.

MR. CRONIN: It's an excessive amount, Judge.

THE COURT: Overruled.

Q (By Mr. Cronin:) That's happened, hasn't it, Doctor?

A As I recall, this is from years ago, an attorney challenged the rate that was charged, and the attorney who retained me decided to pay the fee involved. And so I don't -- I never was given anything from the Court to understand what you're claiming the Court said.

Q Doctor, your deposition in this case was about seven hours; is that fair?

A It was six hours.

Q Six. So you charged about $12,000 for your deposition, right?

A Um, no, I charged 8,000. So maybe I was -- I think -- I know it was a six-hour deposition, but I believe the rate was -- I believe I charged $8,000.

Q How much additional review have you done since your deposition, how many hours?

A I would say probably 20 hours.

Q So that would be another $10,000?

A Yes.

Q So we're up to 50; 32 plus eight plus ten, right?

A Yes.

Q Okay. And then you're charging $10,000 per day. So you're going to charge $10,000 for your testimony today?

A Yes.

Q So $60,000 from your consulting work in this case?

A Yes.

Q And, Doctor, you have served as an expert witness in litigation many times before?

A I've been in court -- the last time I was in court was three years ago. I've been in court, I believe, 13 times over a 15-year period. So I guess if 13 is

considered a lot over 15 years.

Q Sure. Doctor, most cases don't go to trial, right?

A Yes.

Q You first started doing litigation consulting about 15 years ago?

A Yes.

Q And you get retained on about ten cases per year, you told me?

A Yes.

Q You're working on about 20 legal matters right now?

A Yes.

Q And you told me you've made over a million dollars in your career from medical malpractice litigation consulting, correct?

A I think that's a reasonable approximation.

Q But you couldn't give me an exact number?

A I haven't totaled the numbers, but I think that's a reasonable approximation.

Q You're on at least three different expert service directories?

A Yes.

Q What are those?

A SEAK, TASA and medQuest.

Q Those listings are to market yourself to get litigation consulting work; right, Doctor?

A Yes.

Q And, Doctor, you've been sued for malpractice twice before, right?

MR. VENKER: Your Honor, may we approach?

THE COURT: Yep.

(Counsel approached the bench, and the following proceedings were had, out of the hearing of the jury:)

MR. VENKER: I object to this, Judge. We raised this in a motion in limine. This is really irrelevant to Dr. Guarino's qualifications.

THE COURT: Where are you going with it?

MR. CRONIN: My understanding was the ruling was I could not do it with the defendants, but I could with the experts if I kept it brief, and I had one question.

MR. VENKER: I still object to it, your Honor.

THE COURT: What's your next question?

MR. CRONIN: My question is and in one of them -- he talked about all his training putting needles in patients. One of them was an epidural injection, and the patient had permanent brain damage.

THE COURT: No. I think you asked your question. I'm not going to strike it. You need to move on.

MR. VENKER: Objection sustained then?

THE COURT: Yes.

(The proceedings returned to open court.)

Q (By Mr. Cronin:) Doctor, as you've told the jury, you're a pain management and anesthesiology physician?

A Yes.

Q You specialize in pain management?

A Yes.

Q And you agree that experts should not testify outside their field of expertise, correct?

A Yes.

Q Doctor, you've been retained as an expert by Dr. Walden and St. Louis University to give opinions in this case?

A That's incorrect.

Q You've been retained by their counsel, how about that?

A I have been retained by counsel.

Q Okay. Dr. Walden is a primary care physician?

A Yes.

Q And you do and have not ever practiced as a primary care physician as he does, correct?

A Well, I did a year of medicine at a Johns Hopkins affiliated hospital, which is very similar to what

Dr. Walden has done; but at this point in my career, I am a interventional pain management expert. And so I do -- I receive patients different from Dr. Walden, but we -- yes.

Q Doctor, my question is very specific. You do not and have not practiced as a primary care physician as he does; is that correct?

A When you say as he does, I assume that you're talking about currently, and I would say --

Q He is a primary care physician.

A Yes. Then I would differ from him, yes.

Q And this is not the first time St. Louis University has retained you to testify in a case?

A I was retained about 12 years ago, I believe -- 11 years ago for a different case concerning an injection.

Q We don't need to get into the details, Doctor. St. Louis University has retained you before, right?

A Well, yes.

Q Doctor, many people have died because of opioids, correct?

A Yes.

Q The annual number of deaths from prescription --

MR. VENKER: Your Honor, can we approach?

(Counsel approached the bench, and the following proceedings were had, out of the hearing of the jury:)

MR. VENKER: I'm not -- it's Cross-Examination.

I'm not sure I need to do this, but I want to preserve our record on the opioid epidemic, and I don't think I need to in Cross.

THE COURT: Your objection is still on the record.

MR. VENKER: And it's overruled?

THE COURT: It's overruled.

MR. VENKER: Thank you, your Honor.

(The proceedings returned to open court.)

Q (By Mr. Cronin:) Doctor, the annual number of people that currently die from prescription opioid overdoses exceeds the number of people that die from motor vehicle accidents; isn't that right?

A Yes.

Q Over 2 million people in the United States suffer from substance use disorders related to prescription opioid pain relievers, correct?

A I don't know that exact number. I would need to see the reference in order to confirm or deny that.

Q Do you recall being asked that in your deposition?

A I may have.

Q I tell you what, Doctor. You've told the jury that it's a small percentage of people that get addicted when they get opioids, right?

A Yes. Not insignificant, but small.

Q Okay. Two out of a thousand?

A That would be my approximation.

Q Okay. You didn't give that statistic to me in your deposition when I deposed you, correct?

A I wasn't asked.

Q You haven't given us any literature with those statistics, correct?

A I read the literature, and the literature speaks for itself.

Q Doctor, should we take these opioids off the Schedule II DEA list?

A I don't believe so.

Q Can we wave off this idea that there's an opioid epidemic?

A I don't agree with that.

Q Not everybody gets the amount of opioids prescribed to them that Brian Koon did, do they?

A Correct.

Q And, Doctor, you told me you've seen reports that regular internal medicine or family doctors are prescribing opiates while lacking the requisite knowledge to know what they're doing. Did you tell me that?

A Yes.

Q And you have, I believe, told the jury that you

do not believe Brian became addicted to opioids, right?

A Correct.

Q You're not a psychiatrist or psychologist?

A Correct.

Q You're not an addictionologist?

A Correct.

Q You understand that the defendants did retain an addictionologist, Dr. Gunderson, who testified in this case, right?

A Yes.

Q Did you have an opportunity -- his deposition was after yours. Did you have an opportunity to read his deposition?

A Yes.

Q And you told me you would defer to that addictionologist on whether addiction happened, didn't you?

A Yes.

Q Did you know he told the jury on Friday that Brian did become addicted to opioids?

MR. VENKER: I just going to object to him being asked about what another witness said, your Honor. That's unfair to the witness.

MR. CRONIN: I'm asking if you were told that.

THE COURT: Overruled.

A From what I understand, he raised the issue, which I think is out there, is dependence considered addiction. Because there were several people that evaluated him, Mr. Koon, and said he was opioid dependent. And I'm aware that some people will say opioid dependent means the same thing as addiction, but I don't, and I base that on the Missouri guidelines.

Q So, Doctor, I think what he was telling us is -- you know what the DSM is, the diagnostic tool for mental illnesses?

A Yes.

Q And at the time, back in 2012, DSM-IV was the applicable DSM?

A I don't use the DSM --

Q All right.

A -- so I don't know the exact number they're at these days.

Q Sure. How about this? As to what certain diagnoses are in the DSMs and what they mean, would you defer to Dr. Gunderson on that?

A Yes.

Q And you based a lot of your opinions on Brian not having become addicted, didn't you?

A I base my opinions off of reading the records and evaluating in total the information from physicians

and health care practitioners who were involved with Mr. Koon's care as well as the depositions reporting what people have observed.

Q Doctor, did you -- didn't you tell me that if Brian became addicted, since Dr. Walden is not an addictionologist, he would be expected to refer him to the appropriate health care professional?

A Yes.

Q Mike, can you pull up exhibit 150-6? Just highlight the top.

Doctor, you've seen this before, correct?

A Yes.

Q And this is the Washington University physicians policy on conflicts of interest in clinical care?

A Yes.

Q And specifically regarding contacts with pharmaceutical companies and representatives, right?

A Yes.

Q And we talked about this in your deposition?

A Yes.

Q Washington University is your employer?

A Yes.

Q You are subject to this policy?

A Yes.

Q Okay. Do you agree that physicians should never

allow contact from pharmaceutical representatives to unduly influence their medical decision making?

A Yes.

Q Any relationship between a physician and a pharmaceutical company or representative should be free of bias and financial inducements. Do you agree with that?

A Yes.

Q Can we go to page three? Blow up paragraph nine. Just paragraph nine. Thank you.

Doctor, this says, "Pursuant to the WUSM policy on conflict of interest in clinical care (approved March 16, 2006) meals, sporting event tickets, golf outings, gift baskets, travel and any other free goods or services should not be accepted from vendors."

Did I read that correctly?

A Yes.

Q Now, at your deposition, you told me that you were not precluded from doing that, correct?

A Well, what I do is, a company who pays me to come someplace and educate people, I inform the University. The University knows everything I do. In fact, every patient who comes into my office is informed and is given a piece of written literature saying that I speak for this company, and that if you sense any bias, you're given an opportunity to choose another option.

That being said, I write -- for the companies that hire me, the amount of medicines I write in relation to all other doctors is very similar. I write mainly generic medicines. 95 percent of my prescriptions are generic, and that is a public fact.

Q We'll get back to that in a second, Doctor.

A Uh-huh.

Q At your deposition you pointed out this says should not and does not say must not; isn't that what you told me?

A Correct.

Q And you specifically told me you do accept such gifts, right?

A And then inform the University.

Q Okay. And you agree that gifts from pharmaceutical companies can actually influence a doctor's medical decision making?

A They could.

Q Whether the doctor knows they're doing it or not?

A That's possible.

Q And you agree that any physician getting money from the pharmaceutical industry creates a risk of affecting professional judgment, correct?

A Yes.

Q All right. We'll come back to that later.

Doctors should not be too busy or have too many patients to take the time to perform good medical care. Do you agree with that generally?

A I think that's a good generality.

Q You agree doctors must stay educated and up-to-date with the medicines and changes in medicine in order to prevent harm to their patients, correct?

A Yes.

Q And compared to other pain management physicians in the area, you would call yourself a prominent prescriber of opioids, correct, Doctor?

A I -- because I've been practicing for so long, yes, I have a large patient population.

Q And you agreed you would be considered a prominent prescriber of opioids, correct?

A Prominent because of the size of number of patients I see, yes.

Q Even the pharmaceutical companies that you market products for have told you that you are a significant opioid prescriber, correct?

A They have.

Q Someone can get addicted to opioids within a few months or a few weeks or even a few days; is that right?

A Yes.

Q If a patient develops a pattern of getting continual early refills, that needs to be evaluated by the physician?

A Yes.

Q Do you agree with this statement: A physician's basic understanding about addiction should be sufficient for one to know that it can be lethal and to show disregard to that in one's prescribing is reckless?

A I think that's reasonable.

Q Doctor, you were asked a lot of questions about Missouri guideline, right?

A Yes.

Q Missouri guideline doesn't set the standard of care, correct?

A No, I disagree. I think that it does set a standard of care expected for people who are prescribing opioids in Missouri.

Q Doctor, the Missouri guidelines don't contain any recommendations about maximum daily dose one way or the other, do they?

A Correct.

Q They don't give a number that you can't go above; and they also don't say the sky's the limit, correct?

A Correct.

Q All right. And there's no recommendations regarding the duration of opioid treatment?

A Correct.

Q And those guidelines were lobbied for by an organization funded by pharmaceutical companies; is that right?

A I don't know that. I just know what the state has sent me and what they expect me to follow.

Q Doctor, you summarized those guidelines for me as indicating it is a judgment decision made by the physician, right?

A I don't understand your question.

Q You summarized what has to be done under the guidelines as it's a judgment decision made by the physician, right?

A There is a lot of judgment in deciding within the boundaries established by the Missouri guidelines on how to practice.

Q Okay. It doesn't mean any amount is okay?

A Correct.

Q Okay. And doctors can exercise their own clinical judgment and still fall below the standard of care?

A It's possible.

Q Now, what this guideline does say is that you

have to keep accurate medical records about prescriptions you're writing to patients, right?

A Yes.

Q Every time you write a prescription to a patient you need to put it in your medical records?

A Yes.

Q Okay. Including the dose, the number of days, the number of refills, that all has to be in the medical records?

A It should be.

Q Okay. Otherwise it's violating the guideline?

A Yes.

Q And it's violating the standard of care. Would you agree with that?

A It may be, yes.

Q And, Doctor, there was a section --

THE COURT: Hold on a second. The witness needs a water. Does anybody have a water?

MR. CRONIN: I've got a bottle that hasn't been opened yet.

Q (By Mr. Cronin:) Doctor, there's a Section 7 that we didn't look at that was skipped, and it's about complying with controlled substances laws and regulations?

MR. VENKER: Your Honor, may we approach?

THE COURT: Yes.

(Counsel approached the bench, and the following proceedings were had, out of the hearing of the jury:)

MR. VENKER: I'm here because I'm not sure where this is going in light of our earlier positions about the DEA or anything else. Maybe I'm jumping the gun.

MR. CRONIN: I have one question. There are controlled substances laws and regulations that have to be followed. That's the only question.

MR. VENKER: I don't dispute that.

(The proceedings returned to open court.)

Q (By Mr. Cronin:) Doctor, Section 7 is about compliance with controlled substance laws and regulations?

A Yes.

Q And there are controlled substances laws and regulations that are required to be followed, correct?

A Yes.

Q We talked about the CDC guidelines at your deposition. You're familiar with them?

A Yes.

Q They're for primary care physicians; isn't that right?

A Yes.

Q Which primary care physicians is the number one

prescribing group for opioids?

A Yes.

Q You told me you think those CDC guidelines are a reasonable thing because there's a serious concern in our society regarding opioids?

A Yes.

Q And the CDC has made recommendations, and they're for chronic non-cancer pain, and they're 90 MED for 90 days, right?

A MED means morphine equivalent --

Q Right.

A -- per day. For 90 days. One needs to then reevaluate and decide whether you're reaching a functional goal before continuing that therapy.

Q And you recall Dr. Walden in his deposition agreed himself you generally shouldn't go over about 120 morphine equivalent dose?

A I read that.

Q Doctor, you talked about a drug called Avinza? Did I say that right?

A Yes.

Q Because I haven't heard of that drug before. Brian wasn't on Avinza, correct?

A Correct.

Q And the document that you showed was published

by a pharmaceutical company called Pfizer, right?

A I didn't show it.

Q The document that was published to the jury, on the bottom we could see it was from Pfizer's website. Do you recall that?

A I didn't look at the bottom.

Q How about this, Doctor? Did you mention the drug Avinza anywhere in your deposition?

A No.

Q That's the first time I had an opportunity to hear you mention the drug Avinza is today?

A I assume so based on your response.

Q And you did not bring that document to your deposition?

A Correct.

Q And that was not about non-cancer pain like Brian had; that was for any type of use?

A The recommendation limiting it to 1,600 milligrams a day was for pain, and it did not differentiate malignant from non-malignant pain.

Q It didn't differentiate cancer pain, terminal cancer pain, from chronic low back strains, right?

A Correct.

Q And that drug's been discontinued, hasn't it?

A It's still available.

Q It was discontinued a year ago by the company that makes it. Are you not aware of that?

A It's still in use.

Q Mike, can you pull up Exhibit 150-9? We'll just do it this way.

Doctor, you wrote an article about opioid prescribing back in 2007 for patients with chronic pain?

A Correct.

Q Okay. Does that look like that's it? "An Assessment Protocol to Guide Opioid Prescriptions for Patients with Chronic Pain".

A Yes.

Q And we're not going to be able to read the rest of it, right?

A I think it would be difficult.

Q I have it. Let me just -- let me see if you still agree with some of the things you wrote.

"Patients with chronic pain note an improved quality of life as a result of the use of medication, whereas addicted patients continue to request greater quantities of medications and cannot articulate the effect the increased doses of medications are having on their lives."

Do you recall writing that?

A It sounds similar to what I would have written.

Q Okay. Do you agree with that?

A Generally, yes.

Q Do you agree addicted patients will continue to take a medication despite various side effects?

A I agree with that.

Q Doctor, I've got a cleaner copy I'll give to you. This is Exhibit 150-9. I want you to be able to -- you don't have to take my word for what it says.

In this article you laid out ten assessment steps in pain management, correct?

A Yes.

Q And you still -- you're able to see them, right?

A Yes, it's in front of me.

Q Okay. You still agree those should be done for every patient prescribed opiates?

A They represent a starting point to improve quality of care and minimize the risk of inappropriately treating patients who complain of pain.

Q Okay.

A I'd have to go through each point. This was written nine years ago, and I write things regularly so --

Q I'll ask you about each one. Number one says "Diagnosis with Appropriate Differential". Should that be done before a patient is put on opioids?

A Yes.

Q Number two says, "Psychological Assessment Including Risk of Addictive Disorders". Should that be done before a patient is put on opioids?

A Yes.

Q Number three says, "Informed Consent". Should an informed consent be done before a patient is put on opioids?

A Yes.

Q Number four says, a "Treatment Agreement". Should doctors enter into a treatment agreement about opioids before they put a patient on them?

A Yes.

Q Number five says, "Assessment of Pain Level and Function Before and After Intervention". Should that be done for a patient on opioids?

A Yes.

Q Number six says, "Appropriate Trial of Opioid Therapy with or without Adjunctive Medication". What does that mean?

A Well, it means that opioids should not be the first therapy to be used. You try other things, such as nonsteroidal agents, for example. Then that should be evaluated before you start opioid therapy.

Q Number seven says, "Reassessment of Pain Score and Level of Function". Should that be done throughout

opioid therapy for a patient?

A The improvement absolutely needs to be understood.

Q Number eight says, "Regular Assessment of the 'Four A's' of Pain Medicine" which are analgesia, activity, adverse effects and aberrant behavior. Should those four be regularly assessed and reassessed?

A Yes.

Q Number nine says, "Periodic Review of Pain Diagnosis and Comorbid Conditions, Including Addictive Disorders". Should doctors continuously review for those symptoms?

A Yes.

Q Number ten says, "Documentation". And is that basically you need to document everything you see going on with your patient and all the prescriptions?

A Yes.

Q And, Doctor, these are all to assist in identifying the possibility of addiction, right?

A Well, this is in order to prescribe opioids properly.

Q Okay. By the way, Doctor, Brian was exhibiting signs of addiction, wasn't he?

A That is an interpretation. As I said, it also could be interpreted as pseudoaddiction, tolerance or an

underlying genetic disorder.

Q Well, pseudoaddiction is what I was going to ask you about.

You think most of the time that patients are exhibiting signs of addiction to opiates, they're only engaging in drug-seeking behaviors that mimic addiction because they're not being given enough pain medication. Is that correct?

A You said a lot. And I can say that every person is evaluated individually. And for some, inadequate pain relief from a medicine may be just what they say, they're just not getting enough relief from the medicine. And for some it may be that they are -- that they have addiction. So that is something one needs to consider each time one writes a prescription.

Q Doctor, you are not aware of any empirical evidence that supports the phenomenon of pseudoaddiction; is that correct?

A Well, pseudoaddiction has been a term used in the pain management community for over 20 years, but it has not been studied as something where one can point to a scientific study. It's more of a behavior that individuals in basically the whole pain management community generally accepts as a phenomenon.

Q There's some pretty strong disagreement in the

medical community about whether that's a real phenomenon, isn't there?

A I wouldn't say strong. I would say, yes, there are individuals who disagree with the idea of pseudoaddiction.

Q Pharmaceutical companies came up with the idea of pseudoaddiction, didn't they, doctor? Isn't that who first came up with it?

A I became aware of the term through a physician who published a paper on it, Dr. Portenoy, in the late 1980s, so I don't look at him as a representative of pharma.

Q Doctor, you mentioned that you've written a book about lower back pain?

A Yes.

Q Is this one of them, "Get Your Lower Back Pain under Control - and Get on with Life" by Dr. Guarino?

A Yes.

Q And in your book, you say that managing low back pain requires a multi-pronged approach. Do you agree with that?

A Yes.

Q Back pain is the most common cause of chronic pain in the United States, correct?

A You know, this book was written ten years ago.

I would say just the whole process of degeneration, but I think the back is absolutely the primary thing that people complain of. It's certainly in my practice.

Q By some estimates it effects 80 percent of adults at sometime during their life; is that right?

A That is correct.

Q Low back pain is the most common reason for visiting a physician after head colds?

A Yes.

Q One out of every two working Americans have back problems every year?

A Yes.

Q Should all of them be put on chronic opioids?

A Absolutely not.

Q But it was okay to do it with Brian?

A Well, he had a relationship with Dr. Walden and had failed a wide range of things so that was a decision that Dr. Walden did in conjunction with Mr. Koon.

Q He didn't try anything else, other than Advil before he put him on opioids, Doctor, isn't that right?

A He tried tramadol. He did physical therapy. These are -- he had activity modification. That's several things.

Q When did he put him on tramadol? Because that's nowhere in his records.

A Several times he was tried on tramadol. He was tried on tramadol, I believe, February 21st. And when he failed that, that was when he had the telephone conversation with Dr. Walden, and the tramadol was stopped. The issue, again, of codeine was said that wasn't an appropriate medicine to follow because of a side effect, and Vicodin was started.

Q We'll look at the record, but February 21st was a muscle relaxer and Advil, not tramadol, correct? We'll look at the record?

A The record's up there, but I know that tramadol was tried.

Q You wrote that people -- and you believe it should have been. It should have been things like Advil, then tramadol, before you go to opioids?

A Assuming that there are no problems or complications with those medicines for the patient, that is a reasonable option.

Q By the way, Doctor, you had a problem with 12 Advil; you were concerned about it?

A Yes.

Q Okay. But you're not concerned about 40 high-strength opioids per day?

MR. VENKER: Let me just object as argumentative, your Honor.

THE COURT: Sustained. Rephrase.

Q (By Mr. Cronin:) Does 40 high-strength opioids per day, Doctor, concern you?

A It depends. It depends on what's happening. If the person is functioning and not misusing or abusing it, then that may be what's needed.

Q Let's go back to your book. You wrote that people with low back pain should look for a physician board certified in pain management, correct?

A Yes.

Q And a reputation for caring.

A Yes.

Q Many doctors, including most primary care doctors, don't want to treat low back pain. Is that your assessment?

A That's my assessment, yes.

Q They're apprehensive about prescribing narcotics to help people with chronic pain because they may still believe some myths about these medications, that treating a patient with narcotics will make him or her an addict, for instance. Do you believe that?

A That's true.

Q Do you believe that's a myth?

A Well, as I said, two out of a thousand people who are put on opioids become addicted. That's not zero,

but it's certainly enough to concern me that we need to be aware of these medicines when prescribing them.

Q Do you agree that most primary care doctors are not sufficiently trained to manage chronic low back pain, although some don't realize or admit it?

A I think in a general sense; it's not specific for everyone. But for a lot of primary care physicians, I think that's a safe statement to make.

Q Primary care physicians generally are not trained in the complete range of options available for effective treatment of low back pain, correct?

A I would say in a general sense. Again, it's not -- I can't say that for every internist but in a general sense.

Q Mike, can you pull up Exhibit 1, page 110?

Doctor, this is a record that we looked at during -- highlight that right there -- during your direct examination, do you recall that? Do you recall looking at this with Mr. Venker?

A Yes.

Q And you said it talks about discussed with patient. Do you see that?

A Yes.

Q Discussed with patient allergies, right? That's what that says. Discussed with patient allergies.

A I interpreted it differently. To me I see discussed with patient and then secondly allergies. Granted, there's a lot of different things written on the paper; it's not neatly written out. And then I also refer back to Dr. Walden's deposition in which he relates how he approached the patient, and I guess I believe what Dr. Walden said.

Q Okay. And, Doctor, you told the jury when you were looking at this that there's a bunch of other things you assume he said to Brian because they should have been, right?

A I think that absolutely there are things that generally should be discussed with a patient concerning opioids.

Q And then there's no mention of risks or benefits being discussed with Brian until August of 2009?

A Well, I interpret this as the stepping-stone to an ongoing conversation that Dr. Walden was having. And, yes, he didn't necessarily type or write it out in his records, but certainly there's evidence from day one that Dr. Walden was engaged in evaluating and considering what he was doing as well as Mr. Koon. Because Mr. Koon is an intelligent man based on the records I read. So he certainly understood things and was given literature from not only -- from the pharmacy for sure and certainly had

access to information from the Internet to further inform.

Q Doctor, my question is just the words risks and benefits don't show up in the records until August 2009, correct?

A I don't have all the records in front of me to look for those exact words together.

Q Mike, can you pull up Exhibit 1, page 460?

This is from August 18th, 2011. This is another record that you were shown and asked to talk about. And it says, "Had long discussion concerning tolerance and dependence." Right?

A Correct.

Q "Return in six months." Right?

A Yes.

Q Is that appropriate with the level he was on? In August 2011 he said, I don't need to see you again for six months.

A I refer back to the Missouri guidelines and say that there's nothing stating an exact time period. So whereas I would do things differently, I can't fault Dr. Walden for creating an interval of six months. Again, he had a good relationship with Mr. Koon, and that's the basis for that time interval.

Q Doctor, you wouldn't do that, right? For the level he was on, you would have him back every month or

two?

A Well, in my practice I see people every three months. And, again, if I have a good, ongoing relationship, that's the interval; but it varies depending on a variety of other issues that may determine shorter or longer periods of time.

Q Dr. Walden never quantified Brian's pain level with a score, correct?

A He did not write a visual analog scale score.

Q Ever.

A I don't recall seeing that.

Q And Dr. Walden kept giving Brian bigger and bigger doses of opiates for about four and a half years?

MR. VENKER: I object as argumentative, your Honor.

THE COURT: Rephrase.

MR. CRONIN: Your Honor, this is an exact answer he gave in his deposition.

THE COURT: Then overruled.

Q (By Mr. Cronin:) Dr. Walden kept giving Brian bigger and bigger doses of opioids for four and a half years, correct?

A I agree with that.

Q Okay. And you talked about two surgical consults with Dr. Place and Dr. Heim. Those were in May

of 2008?

A Yes.

Q No more surgical consults after that?

A Correct.

Q Despite the tears that you talked about were continuously reoccurring?

A Yes, but that's also I think done in the context that Mr. Koon was a poor candidate for surgery. And I work with spine surgeons all the time, and I read right through the records. And you know, Mr. Koon smoked and was pushing his body to extremes. And someone who does that is not going to be a good candidate for surgery.

I think it was an appropriate assessment by Dr. Place and Dr. Heim, both an orthopedic and a neuro spine surgeon. And pain management is ultimately the thing that one falls back on, whether it's through an internist or a pain management specialist.

Q Doctor, did you know that Brian had been prescribed 1,620 pills by Dr. Walden before he was sent for either of those surgical consults?

A I did not count of number of pills.

Q In 2008, Dr. Walden placed Brian on long-term standing doses of chronic narcotic opioid pain medication of an unfixed duration, correct?

A Correct.

Q After 2008 he was no longer trying any other treatment options for Brian's pain other than prescribing opioids?

A Well, I think he was aware that Mr. Koon was seeking out chiropractic care. And Mr. Koon had 40 visits with a chiropractor over a four-year period. That's a lot of visits. And I know I don't always state in my records generally whether somebody is seeing a chiropractor, but I believe Dr. Walden was aware of that.

Q I want to ask you a couple more things about your book. When prescribing pain relieving medications, a doctor should always start with the lowest strength?

A Correct.

Q Try nonsteroidals first, then tramadol-related products before moving onto opioids?

A Yes.

Q What date is it again that you think he tried tramadol?

A Between 2001 and 2007, I recall seeing at least once, maybe twice, where he was given tramadol.

Q For back issues that cleared up. But we're talking about when it started again in January of 2008 in this case, right?

A In January of 2008, I'd like to have the records in front of me in order to look through this information.

Q Do you remember being shown the record about him injuring himself when he was toweling off?

A Yes.

Q That's February 21st, 2008?

A Yes.

Q Okay. And from then until he was placed on opioids February 29th, 2008, Brian was just given a muscle relaxer and Advil and then straight to opioids, correct?

A Again, because the way you're phrasing your question, I would like to have the records set before me to confirm or not what you're saying.

Q We'll ask Dr. Walden about them.

Last two, opioids have the highest risk of addiction and are among the most potent agents at the physician's disposal, correct?

A Of the ones that are legal, and there's a class one that the government says you cannot write unless you have a special permit.

Q And, Doctor, you write in your book about something called the "Your Mama Rule", right?

A Yes.

Q Basically prescribe to a patient the way you would prescribe to your own mother?

A Yeah. I mean, you know, we hope to have a physician to care for us, and that's what I see from

Dr. Walden. He cared about his patients, and that's what I try to do with my patients. I try to care and make a difference in helping them.

Q Patients who are given narcotics must be monitored to make sure they take the medications as prescribed, correct?

A Yes.

Q And there are vastly more prescriptions in this case than there are actual visits?

A Yes, there are more prescriptions than visits.

Q Mike, can you pull up Exhibit 37?

Doctor, have you seen this before?

A I believe you showed it to me at my deposition.

Q And you understand these are the undisputed average daily doses for Brian throughout the period we're talking about?

A Correct.

Q And in the end, it's a little bit over 1,500 morphine equivalent dose per day, right?

A Correct.

Q And you do prescribe this much?

A I have and I do, yes.

Q In fact, you go past it; you go over 2,000 sometimes?

A I have, yes.

Q Doctor, what's the Hippocratic Oath?

A Well, I don't memorize the whole thing.

Q No, I'm not asking you to say -- what generally is the Hippocratic Oath?

A Above all do no harm.

MR. VENKER: Can we approach, your Honor?

THE COURT: Yep.

(Counsel approached the bench, and the following proceedings were had, out of the hearing of the jury:)

MR. VENKER: Are we going somewhere with this?

MR. CRONIN: He already answered.

MR. VENKER: Just so he knows, Hippocratic Oath does not contain that phrase. I'm not going to do anything now, but just for future reference.

(The proceedings returned to open court.)

Q (By Mr. Cronin:) Doctor, do you believe the core of the Hippocratic Oath is to do no harm?

A Yes.

Q That's part of the standard of care?

A Well, about any medical care, yes.

Q Doctors must never needlessly endanger their patient, correct?

A Correct.

Q That is also part of the standard of care?

A Yes.

Q Physicians must make judgment decisions based on their training, knowledge and expertise to choose the safest course of treatment, right?

A Yes.

MR. VENKER: I object as -- well --

Q That's part of the standard of care?

A I think that's a -- I'm going to stop for a second.

Q Sure, you can answer, Doctor.

A No, I think that absolutely safe and reasonable assessment of all options should occur and then progress as you see necessary to help someone. And yes, there are more risks with stronger medicines, but go ahead.

Q And patients may not know what the safest course of treatment is; that's what they're going to their doctor for?

A Correct.

Q Patients rely on their physicians to meet the standard of care. Do you agree with that?

A I think so, yes.

Q It's not the patient's responsibility to make sure his physician is meeting the standard of care. Do you agree with that?

A Yes.

Q Patients should be able to trust and rely upon

their physicians. Do you agree, Doctor?

A I think that's reasonable.

Q I'm going to switch gears a little bit.

Do you remember when we were talking about money from the pharmaceutical industry creating a risk of affecting a physician's professional judgment?

A Yes.

Q You have professional relationships with pharmaceutical companies that manufacture and sell prescription opioids?

A Yes.

Q You've been on advisory boards for opioid manufacturers?

A Yes.

Q And those are paid positions where you've made on average about five to $10,000 per year?

A Yes.

Q Dating back about ten years?

A Yes.

Q You've been on six of them?

A I know several; I didn't count the exact number.

Q Including Purdue Pharma?

A Yes, 15 years ago.

Q Well, your physician advisory -- you marketed for them 15 years ago; your physician advisory board

position was recently?

A Oh, that was for Hysingla, yes, so that was something recently I did.

Q Now, Purdue Pharma, they invented and up until recently were the exclusive maker of OxyContin?

A Generally, but Endo Pharmaceuticals had a OxyContin product that came out for about 18 months, but that was subsequently taken off the market.

Q OxyContin is what Brian was on?

A Yes.

Q That was his main opioid for most of the treatment period from 2009 to 2012?

A Yes.

Q All right. We'll get back to Purdue Pharma in a second.

In addition to paid positions on physician advisory boards, you've also gotten paid by pharmaceutical companies that manufacture opioids to go around and give lectures and talks?

A Yes.

Q Specifically about prescribing opioids, correct?

A Well, at the beginning it was just prescribing opioids; but for the last ten to 15 years, it's rigidly defined by the government. Basically I am limited to presenting the information that the government says okay

concerning an opioid product, and I've been doing that for the last ten to 15 years.

Q Doctor, you get paid per talk, correct?

A Yes, I do.

Q And you get paid by the pharmaceutical companies?

A Yes.

Q And you've done thousands of those, right?

A I don't know if I would say I've done thousands. I probably at this time average doing one to two talks a month. In the past, I've done up to eight talks in a month. So it varies. But over the years, that probably is way under a thousand, but I've done talks.

Q And when you do those talks you highlight the medication marketed by the company that is paying you to give the talk?

A That's who hired me, and that's what the -- yes.

Q From 2001 to 2011 Cephalon Pharmaceuticals paid you to go around the country giving presentations to other doctors how they should prescribe opioids for chronic pain patients, correct?

A Yes.

Q And for the ten years you did that, you were earning about 50- to $100,000 per year from them?

A I think that's reasonable.

Q So about half a million to a million dollars from that pharmaceutical company?

A Yes.

Q 2006 to 2012 Endo Pharmaceuticals also paid you to go around the country giving presentations to other doctors about prescribing Opana, which is an opioid, for chronic pain patients, correct?

A Yes.

Q And they paid you for that?

A Yes.

Q In 2002 to 2005, Organon Pharmaceuticals also paid you to go around the country giving presentations to other doctors about prescribing opioids for chronic pain patients, correct?

A Yes.

Q And they paid you for that?

A Yes.

Q And then circling back to Purdue, from 1999 to 2001, Purdue Pharma paid you to give presentations to other doctors about prescribing OxyContin?

A Yes.

Q The presentation is listed in your CV. It's entitled "OxyContin as a Therapeutic Agent for Purdue Pharma", correct?

A Yes.

Q And that would be a part of the marketing for OxyContin for Purdue Pharma?

A Yes.

Q Doctor, at your peak, you were earning about $250,000 a year to give talks marketing opioids for pharmaceutical companies; isn't that right?

A Well, I did have a year or two where I was making $250,000 a year speaking for pharmaceutical companies, but that wasn't all for opioids. I gave talks for other products that are used to help people with pain.

So that was a portion, but I certainly have talked about a lot of other agents that we use commonly in pain management, antidepressants and antiepileptic drugs, for example.

Q Now 50 people a day are dying from prescription opioids, right?

MR. VENKER: Your Honor, I just object as argumentative.

THE COURT: Overruled. You can answer.

A I don't know the exact number of people who die a day, but I've heard that statistic, and so I'm not going to challenge it.

Q Sure.

Mike, can you pull up Exhibit 150-17?

MR. VENKER: Your Honor, may we approach?

THE COURT: Yep.

(Counsel approached the bench, and the following proceedings were had, out of the hearing of the jury:)

MR. VENKER: Your Honor, I believe this is going to be some plea agreement that Purdue Pharma had with the government back in 2006 or 2007. It has no relevance to Dr. Guarino, so we object on those grounds.

MR. CRONIN: Judge, it's about fraud committed by Purdue Pharma in the marketing of OxyContin, which he did for them. This all goes to bias, Judge. It's a government document --

THE COURT: No way. Not coming in. No. No.

MR. CRONIN: Judge --

THE COURT: No. Overruled -- I mean, sustained.

(The proceedings returned to open court.)

Q (By Mr. Cronin:) Doctor, let me ask you this. When you were marketing for Purdue Pharma, were you aware of whether the things you were being asked to say to doctors were true or not?

A Well, when I was marketing for Purdue in regards to OxyContin, I made my own slides. And so I had just come out of training, relatively speaking, from Johns Hopkins, and I brought the principles that we -- I was taught at Johns Hopkins and shared it with the community and I gave local talks. And OxyContin was an option. But

people needed to understand how to write the medicine. So that was how I was hired, is to educate people on opioids as an option and then as an option how to do it safely.

Q Doctor, OxyContin was being marketed as virtually nonaddictive, wasn't it?

MR. VENKER: I'm going to object to lack of foundation, your Honor.

THE COURT: Sustained. Let's move on.

Q (By Mr. Cronin:) Doctor, when you were marketing for Purdue Pharma they paid you for each speech or talk you gave and for all of your travel, right?

A Yes.

Q Doctor, you consider yourself a foremost expert on opioids.

A When you say foremost, I don't know how I'm going to interpret that, but I would say --

Q How about lead, a leading expert?

A I am a leading expert.

Q Did you go on the national summit on March 30th to help stop the opioid epidemic?

MR. VENKER: I'm just going to object, your Honor. That's argumentative.

THE COURT: Overruled. He can answer.

A No, I did not.

Q (By Mr. Cronin:) Would you have gone if somebody paid you to go?

MR. VENKER: Objection, your Honor, argumentative.

THE COURT: That's argumentative. Sustained.

Q (By Mr. Cronin:) Doctor, you agree that paying doctors to market particular drugs can inappropriately influence what they prescribe?

A That absolutely is a potential.

Q Mike, can you pull up Exhibit 150-12?

MR. VENKER: Can we approach, your Honor?

THE COURT: Sure.

(Counsel approached the bench, and the following proceedings were had, out of the hearing of the jury:)

MR. MAHON: Judge, I think now he's going to get into Dr. Guarino's involvement about eight years ago in giving a written opinion in a case brought by the Federal government, a civil federal suit pursuant to the Controlled Substances Act. And this is totally irrelevant, a collateral matter, doesn't have anything to do with the case here.

It's not even the same standards. It's a Federal civil lawsuit dealing with Medicaid, alleged Medicaid fraud of a physician; and Dr. Guarino issued a written opinion about the billing practices of the physician in the context

of that lawsuit.

MR. CRONIN: This doctor gave an opinion in a case in the Eastern District of Missouri, a criminal over prescription of opioid case. The doctor was convicted of many counts of prescribing opioids for no legitimate medical purpose, and he gave the opinion it was all within the standard of care, and the doctor was convicted. It goes to his credibility. It's the crux of my Cross-Examination. It's the last part.

THE COURT: It can't be the crux of your Cross-Examination, but hold on, let me get this right. You're saying a doctor was convicted of -- what was the doctor convicted of?

MR. CRONIN: Writing illegitimate opiate pill prescriptions to patients on Medicaid and thus committing Medicaid fraud.

MR. VENKER: That's a civil proceeding, your Honor.

MR. CRONIN: The standard is higher in that case, Judge. It's exactly what he's doing in this case.

MR. VENKER: That's a whole different case.

THE COURT: Okay.

MR. VENKER: Should we take a break?

THE COURT: Well, are you going to --

MR. VENKER: How much do you have to go?

MR. CRONIN: This is the last --

MR. VENKER: Okay. Let's hang in there.

THE COURT: Okay.

MR. CRONIN: It's going to be simply what he was charged with and convicted of, and then I'm going to show what his opinion was and say in this case you're saying that Dr. Walden met the standard of care. This goes directly to credibility.

MR. VENKER: This is a Medicare case from 2007. This is Judge Jackson's order. She takes into account a Board of Healing Arts finding that he was an appropriately competent physician. She basically says the government overreaches by trying to accuse him of killing people when they use state coroner certificates of death. She finds state coroners can be non physicians and that they haven't proved that.

So I just mean, this is a whole nother little side trial. If you go towards the back, it's where she relied on the Board of Healing Arts. I think it's over here, your Honor.

MR. CRONIN: Judge, he is an expert. This is an opinion report that he was hired to give. We're entitled to get into the opinions of other cases.

THE COURT: Take a deep breath. I'm not saying it's not probative. I understand your argument, Judge,

this is probative. I'm trying to weigh how prejudicial it is and whether it's going to confuse the jury. That's where I'm at right now. All right?

MR. CRONIN: Judge, I don't need to show him the report; I can just ask him what the case was about and the opinions.

MR. VENKER: It's a huge document that Judge Jackson referred to.

THE COURT: What is the question that you're going to ask?

MR. CRONIN: I'm going to say --

THE COURT: Let me look at it.

MR. CRONIN: This is an opinion report written by you in '08 in a criminal over prescription case brought by the U.S. government.

MR. VENKER: It's not a criminal case, for one.

MR. CRONIN: Yes, it is.

MR. VENKER: No, it's not.

MR. CRONIN: Do you see my cites, Judge? He answered all of them exactly how I asked the question.

THE COURT: Here's what I'm going do. You can ask -- this is what --

MR. CRONIN: The only thing --

THE COURT: Huh-uh. You're not going --

MR. CRONIN: I'll stick with that. I'll stick

with your question.

MR. SIMON: Judge, this is good enough for us.

THE COURT: It's improper for them to talk about -- it's okay to impeach him, but I don't think you should go into more than that.

MR. CRONIN: So can I then state --

THE COURT: No.

MR. CRONIN: -- anything about the standard of care?

THE COURT: Nope.

MR. VENKER: While we're here, why don't we read the question, and I'll make my objection.

THE COURT: The Court has looked at the line of questioning the Plaintiffs were going to proceed. The defense has objected to it. The Court in weighing the probative value versus the prejudicial value thinks the initial question was more prejudicial than probative. However, the Court does feel that this is an area that is probative for the jury in terms of determining weight and credibility to the witness.

The Court has written what the Court finds is a question that will allow the Plaintiffs to get into the probative value, however will not go into vast detail of the case. The Court came up with, you testified on behalf of a doctor who was eventually convicted of Medicaid fraud for

over prescribing opiate pain pills. The defense objects.

MR. VENKER: We object and of course just continue our objection that we made to this, I believe even as early as the motion in limine. We think any part of this topic is totally irrelevant and highly prejudicial to Dr. Walden and SLU, and we continue our objections with all respect even to that question.

THE COURT: That's okay. Okay.

MR. VENKER: It's overruled.

THE COURT: It's overruled.

MR. VENKER: All right.

(The proceedings returned to open court.)

Q (By Mr. Cronin:) Dr. Guarino, you have testified on behalf of a doctor who was eventually convicted of Medicaid fraud for over prescribing opioid pain pills; isn't that right?

A Which doctor? This was --

Q Dr. Paskon.

A Dr. Paskon. And the Missouri board said he was a great physician, and I concurred with their assessment, and I represented him in a Federal court concerning --

MR. VENKER: Your Honor, let me --

A -- care provided.

THE COURT: Done. Move on.

Q (By Mr. Cronin:) Doctor, your opinion in

this case is that the Defendants met the standard of care, right?

A Yes.

Q And your opinions are based on Dr. Walden's records, right?

A It's based on a wide range of things, but the records are certainly part of it.

Q Okay. Dr. Walden's records, would you say, are the most important records in the case; he's the defendant doctor in the case?

A Well, yes, they are very important.

Q Would you agree that your opinions are only as good as his records?

MR. VENKER: I'm going to object to that. I'm confused by that question, your Honor.

THE COURT: Clarify.

MR. CRONIN: I'll withdraw it, Judge.

I don't have any further questions for you, Dr. Guarino. Thank you.

THE COURT: Any Redirect? And then we'll break for lunch after the Redirect.

MR. VENKER: It will be brief. I'll be mindful.

**REDIRECT EXAMINATION**

BY MR. VENKER:

Q Doctor, I don't know if I asked you. You're

board certified in pain management, are you?

A Yes.

Q And in terms of some of the opinions you gave -- some of the testimony you gave on Cross-Examination you -- well, let me ask you this.

The opinions you gave to us on Direct Examination about Dr. Walden giving proper care and meeting the standard of care, you haven't changed that opinion at all after Mr. Cronin's Cross-Examination, have you?

A Not at all.

Q And the same is true for your opinion, again, from the perspective of a pain management specialist, whether you believe Mr. Koon exhibited any indicia of being an addict during the time Dr. Walden treated him, you still hold the same opinion you told us, don't you?

A Yes, I do.

Q All right. And so, in your practice you get patients referred to you from primary care physicians just like Dr. Walden, don't you?

A Yes.

Q Okay. And you told us earlier that the Avinza drug is still in use, isn't it, Doctor?

A Yes, I believe so.

Q And this testimony that you were asked about for

Dr. Paskon, that was almost ten years ago, wasn't it, Doctor?

MR. CRONIN: Judge --

Q It was almost ten years ago, wasn't it?

A Yes.

Q Okay. That's all I have.

MR. CRONIN: No questions, Judge.

MR. VENKER: No further questions, your Honor.

THE COURT: All right. Ladies and gentlemen, we're going to break for recess. It is 12:15. We're going to break, I'm going to give you one hour. I need everybody back at 1:15 sharp because we're going to hit it right back at 1:15.

The Court again reminds you what you were told at the first recess of the case. Until you retire to consider your verdict, please don't discuss this case with anyone. Please do not form or express any opinion about the case until it's finally given to you to decide. Please do not do any research or investigation on your own and don't communicate with anyone by any means.

Court's in recess until 1:15 sharp.

(At this time the noon recess was taken.)

(The following proceedings were held out of the presence of the jury:)

THE COURT: We're on the record to -- something

is improperly labeled?

MR. MAHON: I just wanted to be sure that we properly identified the Division of Professional Registration State Board Registration for the Healing Arts letter dated February 17, 2016. Dr. Walden. We've marked this as Exhibit HHH-1, page 1. And so I'd like to introduce this through the testimony of Dr. Walden.

We were on the record before about the Court's ruling about the -- this letter itself is going to be excluded is my understanding, but yet we can inquire as to whether Dr. Walden's licensed -- or whether he's been disciplined in any way from the State Board.

Is that a correct understanding?

THE COURT: Yes.

MR. MAHON: I think that's it. I just wanted to make a record of it. I'm not sure that I had documented it.

THE COURT: You referenced the letter, but we didn't give an exhibit number.

(The following proceedings were held in the presence of the jury:)

THE COURT: Please be seated. All right. Welcome back from lunch.

All right. Counsel for defense, you may proceed.

MR. VENKER: Thank you, Your Honor. We call

Dr. Douglas Walden to the stand.

THE COURT: Good afternoon, Doctor. Maureen is going to swear you in.

***HENRY DOUGLAS WALDEN, M.D.***,

having been duly sworn by the deputy clerk, testified:

**DIRECT EXAMINATION**

THE COURT: Dr. Walden, have a seat right over here. Be careful, there's a step.

Same thing I've told everybody else. If you hear somebody say objection, pause, let me rule on it before you answer.

THE WITNESS: Yes, Your Honor.

THE COURT: All right. You may inquire.

MR. VENKER: Thank you, Your Honor.

BY MR. VENKER:

Q I know you've been here all week, but why don't you tell the jury your full name.

A Henry Douglas Walden.

Q And, sir, you're a medical doctor?

A Yes, I am.

Q And tell us about your area of specialty.

A I am an academic general internist.

Q Okay. Tell us a little bit about what that means.

A Well, I work at St. Louis University. I teach

medical students and residents. I see patients in the hospital. I see patients in the outpatient setting. I help coordinate care among multiple specialists when patients need that. I give consultations for specialists and surgeons when they want an assessment of patient's ability to perhaps go to the operating room, to optimize their care. Things of that nature.

Q All right. And you know obviously that we're here because of this claim by Mr. and Mrs. Koon that you overprescribed opiate -- opioid medications for Brian Koon for a period of about four or four and a half years. You know that, don't you, Doctor?

A Yes, I understand.

Q Let's talk about your care of Brian Koon. Before we do that, let's talk a little bit about your medical and education and work experience background.

Do you -- first of all, you're a native St. Louisan?

A Yes, I am. I was born in St. Louis at St. Mary's Hospital, where my mother was an obstetrics nurse. We lived in St. Louis on and off through my childhood as I was growing up. My father was an engineer with McDonnell-Douglas. He worked on the space program, and so every time the space program took a step from Mercury to Gemini to Apollo or so forth, McDonnell-Douglas

would get a new contract and we would move to a new location. So St. Louis was basically home. We lived in Florida, around Cape Canaveral. We lived in California, back to St. Louis. But I considered St. Louis home. We lived mainly in the north suburbs of Berkeley and Hazlewood and Florissant.

Q All right. And then at some point, obviously, you went to college. Where did you go to college?

A I went to college at Northwestern University in Evanston, Illinois, just north of Chicago.

Q And when did you graduate college?

A I completed Northwestern in 1978.

Q And then what did you do?

A At that point I went to medical school and came back to St. Louis and started medical school in 1978.

Q Okay. Let's talk about the medical school decision a little bit. How did you decide to become a physician?

A Well, I had always been interested in math and science and I always was pretty good at that, and so I thought that was my strength. My mother was a nurse, my father was an engineer. And when it came down to it at the end, I kind of was deciding between those two areas.

My last two -- top two choices for college actually were to go to either the School of Engineering at

Washington University or to go to Northwestern and do premedical studies. And I thought that it maybe was a little too early in my life there as I was coming out of high school to commit to an engineering career so I thought it's a little bit freer if I went into the liberal arts at Northwestern.

And so I was interested in investigating premedical studies at that time. I thought that medicine would be a good fit for my science and math background and I thought it would be a good way to serve society and serve my fellow man, so to speak.

Q All right. And so you went through medical school. Did you receive any scholarships?

A Yes. I received a National Health Service Corps scholarship to finance my medical education.

Q Tell us how you -- what that's about or how you did it or what you are obligated to do.

A Well, the National Health Service Corps is a program from the federal government, and they finance your medical education. They'll pay your tuition and some of the fees. And for every year that they finance your education, you provide a year of service in a health manpower shortage area that they've designated. So once you finish medical school and finish your residency, then you do -- then you do your service time.

Q Okay. And so you did finish medical school. And what year did you finish it, Doctor?

A Medical school, I finished in 1982.

Q Okay. And then you -- you were a chief resident?

A Right. After medical school I entered residency at St. Louis University in internal medicine. It's a three-year program as an M.D. to continue to get more training and skills. And then in the third year they choose two of the resident class to be the chief residents for that year.

Q Okay. And the significance of being selected as a chief resident?

A Well, the chief resident has a lot of responsibilities. They do a lot of administrative work to help organize the residency training program. They set up a lot of the educational program for the residents. And they generally try to choose two of them, what they think are the highest functioning residents to serve in that position.

Q Okay. All right. And so you -- you did your residency and completed that. And then did you do any further education, Doctor?

A Later down the road I did do further education. After I was at St. Louis University as a full-time faculty

member, I did go back to school on a part-time basis at the School of Public Health at St. Louis U. And over a period of probably three years or so, stretching out the study, I obtained my master's of public health.

Q Okay. So you did that. So let's go back, we talked about this scholarship. So you finished your residency in 1985; correct?

A That's correct.

Q And then -- so did you then go ahead and provide the service that you had agreed to provide in terms of medical care based on your scholarship?

A Yes, I did. I served four years with the National Health Service Corps in the north -- several of the north city clinics of St. Louis. So I started at a clinic known as the Yeatman Clinic at Grand and St. Louis Avenue. I served there for approximately two and a half years before the federal government closed that clinic. And they moved me over to one called the Union-Sarah Health Center which was at Delmar and Euclid, where I served another year or so. And then I finished my last six to seven months -- because they closed that one also, the Union-Sarah Clinic. And I went to the Myrtle Hilliard Davis Comprehensive Health Center on Martin Luther King Drive and served the last seven months of my four-year obligation.

Q All right. And during that time, during those four years of providing medical service to those communities, did you maintain any academic affiliation with St. Louis University School of Medicine?

A Yes, I did. I was a member of the voluntary faculty of the university in the department of internal medicine.

Q Okay. And so did that involve teaching at all at that time? Or did you have any active role?

A Yes, it was a teaching role primarily. I taught primarily the medical students in small groups as they presented patients that they had evaluated in the hospital. And so I kind of led the discussion and facilitated the learning of the third year medical students.

Q Okay. And was there a time after you finished that public service that you then went on as a faculty member at St. Louis University in a more involved educational capacity?

A Correct. After I finished the four years of service from 1985 to 1989, I then took a full-time position as a faculty member at St. Louis University.

Q Okay. So in starting out, what's the -- I mean, I'm not that -- what would that have been? Associate or assistant or --

A It was at the assistant professor level. I think there's an instructor level where most people come in. But once you pass your board examinations, you kind of automatically get a promotion to assistant professor.

Q Okay. And you are board certified in internal medicine; is that right, Doctor?

A That is correct.

Q Explain to us, just a little bit, what it means to be board certified. What does that say about a particular physician?

A Well, to be board certified, you have to complete the required eligibility, which means you have to do a three-year residency. You have to do that in a satisfactory fashion. And then after that, once you're determined by your program to be board eligible, you then have to take a rather grueling two-day examination, paper -- at that time it was a paper and pencil examination. And pass that examination and then you are board certified.

Q All right. Are all physicians board certified in their various areas of specialty?

A No, they are not.

Q Is it a small percentage who are board certified in each of those areas?

A I would say, at least at St. Louis University,

most all of the physicians there are board certified.

Q Okay.

A I think that's pretty much an expectation of all of the faculty to be a board certified physician.

Q All right. Okay. So let's talk a little bit -- well, let me ask you this: Have you won any awards for your teaching or instructing there at the medical school?

A Yes. I have won several awards. The resident class, as they graduate each year, gives an award called the Osler Award, named after Sir William Osler, one of history's great medical teachers. And so I've won that award several times. I've won awards from the medical school for teaching the medical students. And I was inducted into St. Louis University's first class of Academy of Medical Educators so --

Q All right. What was that, Doctor?

A Well, this is an attempt by the institution to recognize the best teachers and to have the best teachers help other teachers improve their skills in medical education. So we may be a little bit behind the curve because these similar academies exist at other medical schools. But we inducted five individuals into that class. Two of the deans and two of the departmental chairman and then me. To -- it's both an honor and it's a duty to help others -- faculty members to develop their

teaching skills.

Q Okay. Let's talk some about your -- your experience as an internal medicine physician. I know we've talked about different specialities, and I'm sure people here in the courtroom have had both a primary care physician as well as a specialist. But from your perspective as a primary care physician for patients, just give us an idea of the things you deal with for that patient and how you handle trying to make sure you're providing them the appropriate care they need. Whether from you or someone else.

A Well, internal medicine's a very broad field. It consists pretty much of any medical problem an adult patient might bring forward. So many of our patients have the common problems of adulthood. High blood pressure, diabetes, asthma, chronic lung disease, congestive heart failure. There's a whole list of things that they bring into the office.

It can be sometimes a very complex situation. As people develop more and more diagnoses and live longer and longer, we see patients that have long lists of chronic medical problems. And it's my job to treat those chronic medical problems. It's my job to refer patients, if they require referral, to a specialist. It's my job to coordinate the care of those patients when they're seeing

multiple specialists. It's my job to consult on those patients when they need it. It's my job to take care of them in the hospital when they require hospitalization. So many different aspects.

Q All right. Give us an idea of what your -- kind of what the cross-section of your -- the demographics of your patient population is. Do you see only people over the age of 21 one, for example. Both men and women. Just tell us about that generally.

A Generally, the patients I see are probably 16 or older. Both men and women. Our location at St. Louis University in the city gives us a very diverse population of people that we take care of.

Q Okay. About how many patients are in your -- do you see now and -- I guess it's kind of hard to estimate in terms of talking about a fixed number, but just give us an idea of what the number of patients would be in that patient population for you. You know, whatever the approximation would be.

A It's very hard to figure what your panel is because people are coming and going and changing insurance plans and moving from the area and so forth. But as I look through my patient population, I think there's probably a panel of about 700 patients that I take care of on a regular basis.

Q Okay. All right. And so do you see patients five days a week then?

A I'm actually in the office -- in the outpatient office Monday through Thursday. Friday I have administrative time for the teaching program and actually do a lot of the formal lecture didactics for the third-year medical students.

Q Okay. Let's talk about your experience in treating patients with acute pain and chronic pain. So I realize that's probably a pretty broad categories. In terms of people with acute pain, just give us a couple of examples of what that would be where someone goes to you as opposed to going to the emergency department, for example.

A We see people with all kinds of pain. I mean, a lot of times many orthopedic type injuries, we'll see rotator cuff syndromes and osteoarthritis and different types of tendonitis. We'll see people with abdominal pain, chest pain, headache, back pain. I mean, pretty much any kind of pain will oftentimes report to the outpatient office for evaluation for one of the academic general interns.

Q Okay. And so how about people with chronic or longer term pain? What are some example there?

A Well, here we see -- we see patients with --

well, some of the more severe patients that have active cancers and are on hospice care are individuals we take care of. Patients with sickle cell anemia. People with acute and chronic pancreatitis. Patients that have had multiple orthopedic surgeries, many times failed surgeries, that were unable to relieve their pain would be common types of chronic patients we would see.

Q Okay. Obviously this case is focusing on opioid pain medications, and so let's talk about that a little bit. Of the 700 patients that are in your patient population, Doctor, how many of those patients are on some kind of opioid pain medication?

A Well, I did a very careful count of this in preparing for this trial, and I have 18 patients that I follow on a regular basis that take opioid analgesics.

Q All right. So 18 out of 700 patients?

A That's correct.

Q And of those 18 patients, are there any who are at or below the 100 milligram a day of the morphine equivalent dosing that what we've been talking about in this case?

A Yes. As I went through and identified the patients and determined their morphine equivalent dosing, 14 of the 18 were below 100 morphine equivalent dose.

Q All right. Okay. And then of the other four

then who are on opioids, what range are those patients at? If you remember.

A Well, three of the patients have dosing between 100 and 300. Each one of them has special circumstances, I think, associated with that. That dosing. One of those patients just transferred to my care from a pain management physician who was leaving the area and asked me to take over the opioid prescribing.

Q Okay. So in that situation, you had to make a decision whether to keep the opioid dosing at the same level or to adjust it?

A Yes. I have to make that decision pretty much every time I see the patient. This patient had reached a -- a very steady state and was getting excellent relief from their opioids, with very few adverse effects. So I chose to continue that medication without change.

Q How long has that patient been on those opioids at that dose, Doctor?

A That patient's probably been on that dose for -- it's probably in the neighborhood of three to four years.

Q All right. You mentioned three of the 18 are on that level. Any other -- the last one, I guess, is the only one left off. So tell us about that patient. What level of dosing is that person?

A That -- the last patient is -- is unusual. And

is, I think, among the subset of patients that require high dosing of opioids. She's an individual who was -- she has peripheral neuropathy and she has both cervical and lumbar spine disease. She is taking methadone as her medication for opioid. Her current dose on methadone is 2,160 morphine equivalent doses. She was --

Q Did that patient originate with you, Doctor?

A No. Dr. -- Dr. Hagop Tabakian, who was our pain management physician at St. Louis U between 1998 and 2008, was providing her care and actually had her dose of opioids titrated up over 3,000 morphine equivalent dosing.

Q Who took it downward, Doctor?

A Well, when I began taking care of her, she and I, in conjunction, came to an agreement that it would be reasonable to try to reduce her dosage because it was high. We kind of very systematically came down on her dose to make sure she continued to tolerate things well. Sometimes as folks become older, that's easier to do. And we were able to move her dose from 3,000 down to 2160. I actually saw her in the office just two weeks ago, and she looked beautiful. She was tolerating the medication extremely well, was having no adverse effects and was getting good relief.

Q How long had this patient been on this dosing or the dosing that Dr. Tabakian had her on -- had her on

before she came -- before you took over the care?

A He had her on that dose for approximately eight years.

Q Okay. All right. And -- all right. And so obviously you evaluate that patient on opioids as you would any in terms of side effects for her?

A Yes.

Q Okay. Now in terms of the dosing, the daily dosing, we've heard a number of different levels and whether there are ceilings or not. Let me ask you a few questions about this, Doctor. I think you have said -- or it's been said that you said that you agree that generally most patients would not need more than 100 milligrams of morphine equivalent dosing per day or even maybe 120 morphine equivalent dosing.

Am I recounting that correctly?

A That's correct. In general, those doses usually are sufficient for -- for many, many patients.

Q And so tell us about your approach to using opioid medication for patients in terms of the dosing -- I'm not sure it's right to call it dosing philosophy. But do you have an approach that you use in terms of how much is enough or in terms of just the concept? I don't mean necessarily the numbers. I mean, the least amount or what do you --

A Yeah. I definitely believe that the patient should take the lowest amount of medications that effectively accomplishes the goals of treatment. That varies tremendously patient by patient. So we have to individualize care when you see a patient that has pain. Some patients don't tolerate opioids at all, and we simply can't take that route. Some people tolerate them extremely well and get tremendous benefits from them.

Q All right. And so is there any daily set ceiling of dosing on the opioids you have prescribed for Mr. Koon over these four and a half years? And we have three of them; right? OxyContin --

A Right.

Q -- oxycodone and hydrocodone. So tell us about hydrocodone. Is there a set limit for that?

A For hydrocodone, because it's combined with the acetaminophen, which is the -- which is Tylenol, there is a set limit. It's not based on the concern about the hydrocodone; it's based on the concern about the acetaminophen. Individuals that get too much acetaminophen can develop liver toxicity, liver failure, require liver transplants. And so we just don't want to go there. So there is a limit to not exceed a certain amount with the hydrocodone acetaminophen combination.

Q Okay. Mike, can you put up III-1. Let's go to

the -- I think it shows the hydrocodone on the bar graphs.

Okay. So Doctor, here's Defendant's III-1-002, which is the bar graph for hydrocodone 10-300. Do you see that?

A Yes, I do.

Q So this particular graph starts in December of 2008, but you had started Mr. Koon in February of 2008 on Vicodin hydrocodone; correct?

A Yes. I started him on very low doses at the beginning.

Q Okay. And so this shows -- this part of the graph shows the flatline, if you will, of that hydrocodone prescription from the end of December -- the end of 2008 through until mid August of 2012; correct?

A Right.

Q And the reason of the limit was you told us you were observing the potential injury caused by too much acetaminophen; correct?

A That's correct.

Q All right. So let's talk about the -- one of the other two. The oxycodone, if you will. Whether that has a dosing limit?

A The oxycodone -- he was on two different types of oxycodone. They were different delivery systems for the oxycodone. The oxycodone is not combined with any

other agent like the acetaminophen and so it's just a pure opioid alone. So here the FDA says there really is no ceiling on the amount. The amount that's used is individualized patient by patient to make sure the benefits significantly outweigh the risks.

Q So let's talk about that a little bit. When you say the FDA says there's no ceiling, you're not suggesting that anybody could prescribe any daily dose of it, are you?

A No. There certainly -- you certainly wouldn't use excessive dosing. You have to individualize that to the patient that you're taking care of. And patients are very different in many ways. A lot of it's genetic differences, but there's many other differences between patients that require us to look at that individual situation, that individual patient, and make decisions that are in the best interest of that patient.

Q How about the last of the three, the OxyContin. Has the FDA put a set daily dose limitation on that, Doctor?

A No, sir. It's very -- I mean, it's the same medication as the oxycodone. Only on a preparation, it's a long-acting form.

Q All right. And some of the patients you've dealt with that are not -- that are not people simply with

chronic low back pain where you've had patients such as those you mentioned already, cancer patients or hospice patients -- how about sickle cell disease patients? Have you ever had -- have you ever treated those?

A Yes. I've taken care of sickle cell patients, both in the hospital and on the outpatient basis.

Q All right. And do those patients use higher than -- again, higher than, let's say, the 100 milligrams a day morphine equivalent dosing or -- or is it also variable even in that subgroup?

A It's variable in that subgroup. Some of those patients require substantial doses in order to relieve their pain. Sickle patients have both acute pain problems and chronic pain problems so it kind of depends on the individual patient. Some sickle cell patients get admitted to the hospital with an acute pain crisis, we take care of that acute pain crisis, they get better, they can go home without any opioid. And other sickle cell patients, particularly the ones that are getting older, develop chronic pain issues and, even when we get through their acute pain crisis, require substantial doses of opioids to function.

Q Okay. Let's talk about how you -- and we'll talk about it in the context of your care of Mr. Koon here soon, but let's talk about the concept of how is it that

you watch, observe patients to make sure that when you see them as to whether they're getting an appropriate dose level, if that can even be determined, by talking to them or whatever you do during an office visit. Tell us about that and how you approach that issue, Doctor.

A Well, the routine office visit for any patient usually consists of taking a history, performing parts of a physical examination and reviewing laboratory studies and imaging studies with them. So we do that for all patients, even those on opioids get that routine. But for opioid patients, there's a special framework that's often used, one that I teach to the students and to the residents, what's called the four As.

Q Tell us about that.

A So the four As is just a -- it's just a pneumonic to help you remember -- the four different items that you want to talk about all begin with A. And so the first A is analgesic effects. So you want to determine whether the medication is effective for their pain. Not necessarily that it eliminates their pain, but that it's helping with their pain.

And the second A is for activity. And this A is primarily to help remind you that you want to assess function. And function is a very big thing in the case with Mr. Koon because function is the major reason we were

using opioid analgesics, to enable him to function, enable him to work, enable him to keep his job and bring home a paycheck and so forth.

The third A is adverse effects. So there's a long list of long-term effects of opioid analgesics. I don't go through every one of them. There probably are 85 or 90. People would stop listening to me if I did. But I usually go over the ones that are the most frequent or the most serious.

Q So what would those be, Doctor?

A Well, the most frequent ones would be things like do you feel dizzy or lightheaded. Do you feel lethargic or drowsy. Do you feel confused or disoriented. Are you having nausea or vomiting, abdominal pain or constipation. I usually just go through a laundry list of possible adverse effects. Those are the most frequent ones.

Q Okay. Is this -- you say this is part of your practice to go through with the patient each time you see a patient who's on opioid medication, is that what you're saying?

A Yeah. Either each time they're in the office or also on telephone conversations. You can do this in no more than a couple of minutes and go through it pretty quickly.

Q Okay.

A The other adverse effects that you have to talk about are the ones that are most serious. So the ones that are most frequent aren't often the ones that are most serious. The ones that are most serious are much less common, but include things like respiratory depression, which is the cause of death in people who do die from opioids. And addiction. And so I go through those two items to make sure that every patient's aware that those are risks. Although not common risks, they are present risks and they need to be aware of them.

Q Okay.

A The last A is aberrant behaviors.

Q What's that mean?

A Well, that means you need to look for things that don't seem to fit or might be clues to you that the patient has a problem with addiction.

Q Like what, Doctor?

A Well, things like what we call doctor shopping. Going to multiple doctors to try to obtain opioids. Using an opioid for a reason other than pain control or pain management. Losing prescriptions, having prescriptions stolen, accidentally knocking your prescription for oxycodone into the toilet and losing it. If these things happen multiple times, then you get concerns.

Q Okay. I was going to ask you, what if it happens just once? Is that one time enough to cause you to conclude that, in fact, this person has got an issue?

A No. You have to -- you have to think about it a lot as to what's going on as to -- as to why that might happen. I mean, certainly anything can happen once and accidents do occur. You have to look for patterns of behavior. And in specific situations, you have to look to see if it's something that you think this particular patient may be trying to manipulate you. Manipulative behavior is another one of those aberrant behaviors. I have seen enough people that have tried to manipulate me. Over time I just get a feeling when I'm getting manipulated. And you have to see are you getting that feeling that you're being manipulated by the patient and -- or not. Or is this just something that's an accident that happens. And that does happen sometimes.

Q So there's been some discussion here already about the relationship between the doctor and patient. Do you consider that relationship to be important in terms of providing care for your patients, Doctor?

A I consider it to be absolutely essential to helping me.

Q Why is that?

A Well, particularly for opioids, there are

patients that in my practice I simply wouldn't prescribe opioids for. I just don't have the feeling of trust and confidence in them that would make me think that that's going to be a good place to go. So being able to identify your patient as somebody who is going to be reliable and trustworthy and truthful to you, I think, is very important.

Q Okay. Let's talk about your relationship with Brian Koon. Do you remember when Brian Koon first became your patient? What year?

A Yeah. Brian Koon came to see me in 2001 to establish as a primary care -- to establish as a primary care patient of mine.

Q What do you remember about meeting him or those early years in terms of interacting with him?

A I remember Brian very well. Brian -- I knew Brian had gone through some -- some difficult times earlier in his life. I knew he was adopted --

Q From the history you took from him?

A From the history I took from him. I knew he had some issues with some psychiatric illnesses in his late teens. I was very familiar with his history of Hodgkin's lymphoma, which was diagnosed in his early 20s and treated with --

Q Have you had other patients who have had

Hodgkin's?

A Yes, I have.

Q Before Mr. Koon and after?

A Yes, definitely.

Q All right. I'm sorry. Go ahead.

A But I knew Mr. Koon had extensive Hodgkin's disease, both above and below the diaphram. And had been treated with extensive radiation therapy and been essentially cured of his Hodgkin's disease. And so I knew he'd been through a number of rough times. But I was always very impressed by Mr. Koon. Mr. Koon was a --

Q In what way, Doctor?

A Well, he was -- he was a very reliable individual. He was what I call a straight shooter. He told you -- he wasn't a real talkative person. But he's like many men, when they come to the doctor, they are more task oriented than they are chatty. But he was -- he was a very reliable, responsible person. He seemed to understand his medical problems very well. He asked good questions. I thought we had established a very good relationship.

I actually admired Mr. Koon in many ways. And one of the ways is that he was one of the hardest working folks I'd seen. His work ethic was just tremendous. And he -- I often thought at times I wish we could get

residents and students sometimes to have the work ethic that Mr. Koon had.

Q Okay. All right. And so through those first -- from 2001 to 2000 -- I guess early 2008 or late 2007, I take it you just helped Mr. Koon and treated him for a variety of different either conditions or health issues that he needed help with; right?

A Correct. The very first meeting, I remember we talked about his Hodgkin's lymphoma. He was a little concerned about that. We did a CAT scan to make sure there was no evidence of lymphoma. It had been a number of years, eight years after his cure so I felt pretty confident that he was free of that.

He had hyperthyroidism. At that time it was presumed to be due to his radiation therapy. So I evaluated and treated his hyperthyroidism.

Q Any other conditions, sir?

A Well, he was a smoker. And I am very active to try to get people to quit smoking. I think it's a major health risk. And we worked actually quite hard to try to accomplish that goal. And I don't think we were ever completely successful in that venture, but that was an issue for us.

He had some erectile dysfunction issues, and I prescribed for him on occasion Viagra and Cialis, which I

think helped with those -- with those issues.

Q Any other miscellaneous conditions, Doctor?

A He had occasional episodes with acne. Sometimes it would break out on the back, and we would treat that with antibiotic therapy. He had occasional -- it seems to me maybe at least -- maybe one episode where he had what was thought to be an asthma exacerbation. And I think in 2007 there was also an episode where I saw him and I thought he might be depressed and I recommended he take antidepressant medications.

Q Okay. What medication was that, Doctor?

A That was Citalopram, which is a trade name of Celexa.

Q Okay. Let's talk about this -- in this early time frame, did you treat Mr. Koon for any back pain issues? Do you recall those ever arising or him coming to you for treatment?

A Yes. I think about 2003 or so, he came into us with his first episode of back pain. In taking a history, we determined that it -- probably back in 2002 at least he'd had episodes of back pain and had seen chiropractors. And from 2002 to 2007 or so, he had intermittent episodes of primarily low back pain, I believe, which was treated conservatively. He sometimes received plain film x-rays to make sure there wasn't a fracture or some destructive

lesion in the spine. I know in 2006 we did a total spine MRI to look at his spine to make sure there wasn't anything surgical that was going on.

But most of those episodes resolved with relatively conservative care. Occasionally -- he definitely got non-opioid medications, and on occasions in this those situations he received an opioid medication for a short-term course and his symptoms resolved.

Q All right. And you were aware, weren't you, that he was -- Mr. Koon was early on in that time frame seeing a chiropractor for some help?

A Right. I knew he had seen a chiropractor on several occasions to get adjustments for episodes of low back pain.

Q Okay. And then in early 2008, you examined Mr. -- Mr. Koon came in for an office visit on February 21. We're going to put this -- let me find the page here of Exhibit A. So it's 107.

All right. And, so Doctor, this is -- just so we can see the date. So February 21, 2008. And so as a professor of medicine at St. Louis University, when you see a patient like Mr. Koon, are you sometimes examining him with other either medical students or medical residents? Tell us about that.

A Yes. In my practice, for my panel of patients,

I often have medical students that work with me. And the routine would be the medical student actually is first in the room to see the patient. They do their history, they do their physical examination. They come out, find me, report their findings, report their thoughts about what to do next. And then the two of us go back in the room, and I repeat many aspects of that history and physical and we come to a conclusion about where to proceed.

Q All right. And so every time you saw Mr. Koon in your office, was there always a resident or medical student there with you?

A No, not always. It varied depending on the visits. Sometimes we -- we don't ask the medical students to see that many patients. We want them to take time and evaluate fully and completely. So if the student is otherwise occupied with a patient, I'll go in and just see patients on my own. If they become available, then they can join me for the next patient.

Q All right. So on this visit, these are your typed notes.

Mike, I just want to -- we're going to go back to this one, but click to 108 for a second. Next page. Okay. We've seen this earlier today. I want to blow this up.

Okay. So this is MS Roman numeral three;

correct?

A Right. That's a third year medical student.

Q All right. And we'll come back to that. Let's go back to 107.

And so -- let's blow up this first paragraph. And so you are -- Mr. Koon is in for an office visit?

A Yes.

Q And so 36-year-old male with hyperthyroidism, Hyperlipidemia. What's that?

A Elevated cholesterol.

Q Depression and smoking, who is here for followup. He complains of back pain in his thoracic region. He states he threw his back out when toweling off after a shower.

Well, let me ask you this, Doctor. When you type your notes, before you type your notes up, do you review the medical student's notes?

A Well, actually this is not the -- this is the point in time just before we entered the electronic medical records. So when I saw Mr. Koon on February 21st, I actually dictated this note and someone transcribed it for me.

Q Right. But I mean as part of your experience with the medical students, do you read the information they glean from Mr. Koon?

A Yes. I read their information quite thoroughly.

Q Because you're grading them on how to do it; right?

A Yes.

Q They're learning how to chart?

A Part of their -- part of their learning is to write their note and to learn from writing how to chart it in the medical record.

Q St. Louis University, your involvement and the professors there at the School of Medicine, really the hospital ends up being a teaching hospital. Isn't that what they call it?

A Right.

Q All right. So it says causes him significant pain midline location. What does that mean?

A Well, his pain here, number one, is in the thoracic region, which is the middle spine. And it's also not in the -- it's not in the musculature of the spine. It's right on the midline or vertebral bodies of the spine.

Q Then it says that he's seen a chiropractor who has done some manipulation of the spine with some improvement of his lumbosacral pain.

Do you remember who that chiropractor was?

A I think that was Dr. Mistretta. It's kind of

interesting he has lumbosacral pain, which actually also is low back pain. So the pain he's got at this point is mid back and low back. We're seeing kind of more of the spine involved.

Q Okay. And then it says he does heavy lifting on his job and has been on a restricted lifting schedule over the past month since his injury.

Now, would you have put him on that restricted lifting schedule?

A No, I don't think that was something that I did. I think that was probably something done by his employer.

Q Okay. All right. This says noticed no radicular pain. It says the pain isn't shooting to extremities or --

A Right. It's not going down the arm or the legs.

Q And it says no numbness or tingling is present; correct?

A Correct.

Q Okay. So let's go to page 108 again, Mike.

So we're back at this medical student's note. And again, I'm not going to belabor this, we saw this earlier today. It says the pain began approximately four weeks ago when he was drying off with a towel after a shower. He fell to the floor at that time and was unable to get up for 45 minutes. And then he describes the

location of the pain.

So in your experience as an internal medicine physician, if a patient falls on the floor and can't get up for 45 minutes, how do you -- what kind of event is that? Minor one or significant --

A Oh, it's a significant event. The fall is a significant event in and of itself because I wouldn't be expecting Mr. Koon at age 36 to be falling. But being unable to get up for 45 minutes was extremely unusual. I -- I suspect that it was because he had a lot of pain, but I can't tell precisely.

Q All right. And it said here -- let's go down a little bit, Mike. So he also reports that he was taking approximately 12 Advil each day.

A Correct.

Q And is still unable to perform all his normal activities at work. Again, is this -- Doctor, what's your assessment of his situation with that?

A Well, 12 Advil is 2400 milligrams. If we use the 200 milligram tablet that's sold over the counter, he's taking 12 of those. And that's the maximum amount we would even use by prescription. So he's on a maximum amount of anti-inflammatory.

And Mr. Koon's -- he's a tough individual, but his main concern was his ability to work. And so his

restriction in not being able to work was -- was one of the major concerns we had.

Q Okay. Mike, let's flip back to 107 again and let's look at assessment and plan. Can you enlarge that for us.

Okay. So back pain tender to palpation over the thoracic spine. We will check PA -- and that's posterior and anterior; right?

A Right.

Q And lateral x-rays -- so it's all about the x-rays -- of the thoracic and lumbosacral spine to rule out compression fracture. So your concern at that time is he had some kind of a compression fracture?

A Well, there's a couple of things that were concerning. One was the fall. So people can develop fractures when they fall. And also when there's direct pain right over the vertebral body, that's a concern that there may be something wrong with that vertebral body. So I wanted to make sure there wasn't a fracture present before we -- so we could identify the cause of the problem.

Q All right. And so down at the bottom it says -- well, first of all, you say continue the -- and I'm not going to be able to say that.

A Cyclobenzaprine. That's a muscle relaxant that

we used.

Q And he was using that at the time?

A Yes.

Q All right. And then the Advil. So you're telling him to continue the Advil. Is that what he was taking, that approximate 12 --

A He was taking the 12 Advil per day.

Q And then you -- he's got insomnia at that time apparently. Yes?

A Correct. It appears that he has the insomnia and depression. This actually was something that we had talked about on a visit later -- earlier in 2007. But he seemed to be clinically better at that time.

Q Okay. And then it says followup appointment in six months.

A Right.

Q So basically you're thinking six months away. He's not on any opioids yet; right?

A Correct. He's not on opioids.

Q Then it says he is to call me with an update on his back pain in one month; correct?

A Correct. We were going to follow up on this particular problem prior to that next visit.

Q So he basically had told you he's had this episode of falling, he's taking 12 Advil a day, he still

can't do his job fully. And you just say, well, let's get these x-rays done, call me in a month and we'll see where to go; right?

A Right.

Q And then the next contact you have with him is on February 29th; right?

A Correct.

Q It's 110, Mike.

Okay. Okay. So this is a telephone call. So Mr. -- is it Mr. Koon who has called in?

A Yes, it appears to be Mr. Koon calling.

Q All right. And so what -- what message were you given about this, Doctor?

A Well, again at this point in time we're -- this is before we're in our electronic health records so we're in a paper record. And what happens here is our nurse takes a message from Mr. Koon and then relays it on to me. So she takes the information that's listed on there saying that he was in the office on the 21st.

Q All right.

A Had the x-rays done. Now this is, of course, about eight days later, I guess.

Q Yes.

A He says his back is still giving him trouble, still having discomfort. And the Advil is not helping.

Q Okay. That's a no sign?

A Right. That means not. Not helping.

Q Sure.

A And then she takes the medication -- she takes the medication allergy list too. So the Tylenol No. 3 causing severe constipation is something our nurse takes.

Q Slow down. You lost me there.

Mr. Cronin was earlier talking about the allergies. Is that your writing?

A No. That's the nurse writing, taking the message. So she wants me to know what allergies he has.

Q Okay.

A Now Tylenol 3 causing constipation is not really an allergy, but it oftentimes gets lumped into the -- into the allergies. It's a side effect of -- adverse effect of the codeine in the Tylenol 3. It's there so that I have that information.

Q All right. Is this your handwriting here?

A That's my handwriting, which says called --

Q To --

A Something something.

Q Called pharmacy?

A Looks like it.

Q That's your writing as well?

A That's my writing. It says discussed with

patient.

Q Okay. So what would you have discussed with Mr. Koon that day?

A Well, after 30 years or so in practice, you develop scripts that you use in situations like this. And so whenever I am either suggesting a new therapy to a patient or a patient is calling in asking for a new therapy, I have a script that I use routinely.

Q You mean with your practice in terms of what you tell the patient?

A Correct. Right. What I would tell the patient, what I would inquire about. When patients are calling in with a specific concern, they want -- this one says would you call something pain medication for patient. He's talking about pain medication. So I would -- I first start by asking him if he has a specific idea of what he would like and what his thoughts are about what he needs it for and the benefit for it.

Q Okay.

A So I get his kind of framework for what he thinks he needs.

Q And you had just seen him a week earlier.

A I had just seen him a week earlier so I knew the situation quite well and actually had asked him to follow up with me about the situation.

Q All right. So did you have a -- this is a long time ago. Do you have a memory of this phone call?

A I don't know exactly what I said at this time. But I can tell you what I would normally say or the script I would use.

Q Sure. In your practice. Go ahead.

A But then typically we would talk about an option. So in this case the option was the Vicodin, which is the hydrocodone acetaminophen medication.

And, again, relatively quick time, within a couple of minutes, I can run through him -- with him my thoughts about what the natural history of his problem may be with his back pain and concerning the interference with his job duties and his home duties. I can run through with him a list of the adverse effects that we might experience with a medication like this. And I can inform him about some of the more serious side effects that we could see.

Q Okay.

A And I can inform him about the alternatives to treatment. And that can be done relatively quickly, within just a couple minutes. And I use that kind of a script, kind of informed consent script, to discuss with him. And then I ask him what his thoughts are about those issues, make sure he understands what I've just told him.

And then we come to a conclusion about what the next step should be.

Q All right. And so at this point you decide to go with the Vicodin. Did you consider anything like Ultram or tramadol as opposed to Vicodin?

A Well, at this point I'm considering all possibilities. So there's possibilities of switching his Ibuprofen to some other medication, but that's not likely to help much since he's on maximum doses. I could use Ultram. I know he used it before. There may have been something in our conversation that made me think that that may not have been terribly effective. And I didn't think it would likely be very effective given my visit with him eight days earlier. Codeine seemed to be off the list. Tylenol No. 3 --

Q So the Tylenol 3 here, you're saying that's the same as codeine?

A That's Tylenol with codeine added to it. So even if I recommended that, it didn't seem likely he would have taken it so I wouldn't really go there. Even though constipation can be treated. I went to a different agent, and we talked about the hydrocodone. He'd been on this before and it had been helpful for him in the past. So I think -- between the two of us, I think we felt that would be a reasonable next step.

Q Okay. And so you prescribed the Vicodin. I think the -- I think the next office visit that he had with you was April 1st?

Mike, let's go to 113, same exhibit.

So this is April 1st, 2008. You know, we're going to go through some of these, Doctor. We're not going to go through every one. So this is April 1st. And you -- the phone call, I think, was February 29th. So we're basically about a month further than we were before; right?

A Correct.

Q Okay. And so this recites that you saw him then on the 21st. And he's -- the x-rays are back. He's saying he's got worsening pain; correct?

A Correct.

Q Okay. Any reason to doubt him at that point?

A No, no reason to doubt Mr. Koon.

Q Okay. You have to be thinking with the worsening pain, does he need more pain medication. At least one of the thoughts; correct?

A One of the thoughts, yes.

Q Okay. And now he says low back pain which radiates into both legs, right greater than left. Is that a new symptom?

A Yes. That was not present on the 21st. In

fact, he had primarily thoracic pain then, which is mid-spine pain. Now he's having more trouble with his lower spine.

Q Okay. All right. Then down below it says he uses two to three Vicodin after work is complete and that helps him. Do you see that?

A Yes.

Q Any issues -- well, let's talk for a second -- Vicodin, we've heard the phrase, I think -- I thought we did earlier, breakthrough pain. I mean, is Vicodin for breakthrough pain? Or tell us, Doctor.

A Well, Vicodin is hydrocodone and acetaminophen. It's a short-acting analgesic. It gets into the system within 30 minutes or so. It will peak in a couple of hours and generally be eliminated from the system in four to six hours. So it's there to help get through the tough times to lower the pain and it's -- at this point he's on a relatively low dose of that Vicodin. So times like when he's working and spending a lot of time in manual labor would be a typical time where after that day is complete, he probably would have more pain and more discomfort.

Q Right. This amount of taking two or three of these Vicodin tablets in the evening, that is not a matter of concern in terms of the volume or the amount of milligrams he's taking?

A No. This is a low dose medication which will not lead to any dependence.

Q All right. I want to go down -- I just noticed something on this chart. So let's go down, Mike, maybe the next -- physical exam.

And so one thing that was talked about, you heard -- you heard Mrs. Koon talk about Brian's weight going down. You heard her testimony, didn't you, Doctor?

A Yes, she did.

Q And here it says -- well, 207 pounds is what that shows; right?

A Correct.

Q All right. You've reviewed the chart, obviously, for this case. And what did you find about Mr. Koon's weight throughout this time period, these four years, Doctor, in terms of what the fluctuation of his weight was during that time?

A Well, Mr. Koon's weight was relatively stable during that time. There were some times when he climbed up into the 220s, and then I kind of got on his case and asked him to make some changes and bring that weight down. His weight typically ran somewhere between 199 and 209. That would be a typical range to see him in for most of the visits that I took care of him. I don't recall his weight ever falling anywhere below 199.

Q Okay. And Mr. Koon is a fairly tall man, isn't he? About six three or close to it?

A Yes, he is.

Q All right. And so for him to weigh even 199 is the -- I know my doctor pushes me on this. What is it, body mass index?

A Body mass index.

Q Right. Okay. And so the body mass index for Mr. Koon, even at weighing 199, would that be a bad number? A good number? What would it be?

A No. That would be -- that would be a very reasonable number for someone with Mr. Koon's heighth and build.

Q Okay. Did you ever, in all your records, see where Mr. Koon weighed as little as 160 pounds or anything close to it?

A No. Never during the -- the 11 years that I took care of him.

Q And the last office visit he had with you was August 30th of 2012; correct?

A That's correct.

Q All right. And so let's look on the same page at Assessment and Plan. And so here's the plan going forward. Back pain, etiology unclear. Possibly due to herniated disc. Will start piroxicam.

A Piroxicam is another anti-inflammatory agent like Ibuprofen.

Q Okay. He'll continue the Vicodin 5/500 every four to six hours as needed. So again, that means he's taking it for this periodic pain?

A Right. It's a short-acting medication that's designed to be used on an as-needed basis by the patient.

Q All right. And then you ordered an MRI?

A Correct. I ordered an MRI at this point for concern that he might have a disc herniation or some process that would require treatment with a surgeon.

Q All right. And so that's pretty much his entire spine, isn't it?

A Yes. That is the whole thing from top to bottom.

Q All right. And did that -- did that MRI occur or not?

A Yes, it did.

Q And you were provided with that -- with the report for that?

A Yes, I was.

Q 147. 147, Mike.

All right. So this is the -- the MRI. You're familiar with this; right, Doctor?

A Yes, I am.

Q All right. And so the conditions here -- the impression from the radiologist is mild cervical spondylosis without spinal canal -- so basically it's what?

A He has degenerative disease throughout his cervical, thoracic and lumbar spine.

Q Okay. And that includes these two notations we saw earlier today of the annular tear; correct?

A Correct. In his low back, between the disc that separates the third and fourth lumbar vertebrae, he has an annular tear. And the disc separating the fourth and fifth vertebrae, he has an annular tear.

Q All right. And we've already heard Dr. Guarino describe the annular tear. I'm not going to ask you to go through all that detail. From internal medicine, at least in your experience, what is your understanding of an annular tear and what it means for a patient?

A Well, the annulus is a band of fibrous tissue that surrounds the disc. And so the disc is kind of a gelatinous material that's very flexible so it can move, change position. But this fibrous tissue that surrounds it is not -- is -- when it's torn like this can cause pain as one of its manifestations.

Q Okay. And so this was something that was read out or at least observed by the radiologist; correct?

A That's correct.

Q You relied on that report? You didn't review the MRI yourself with any idea of making any kind of diagnosis yourself; correct?

A I review the MRI myself. I actually look at the images, but I don't do the official reading. So this is read by the radiologist who has special expertise in reading MRIs of the spine.

Q All right. So now he had this MRI that showed these two annular tears. What did you do next in deciding how to help Mr. Koon?

A I felt it was a reasonable next step to have a surgeon evaluate him to make sure there wasn't -- I didn't think by looking at the MRI that there actually was a surgical lesion present, meaning a disc protrusion or herniation. But the annular tears bothered me. The degenerative changes actually bothered me since Mr. Koon was a little young, and I wanted him to be seen by one of our spine surgeons to both tell me whether he thought any kind of surgical intervention would help and to see if there were any other modalities that he thought would be helpful to relieve his pain.

Q And so give us kind of an overview of what happened then with this surgical consult, the first one, and then we already know there's a second one. So tell us

about those.

A Well, the first one was for Dr. Howard Place. Dr. Howard Place is SLUCare orthopedic surgeon who specializes in back surgery. I think he's one of the finest surgeons in the midwest for back surgery. I particularly like to refer to him because he's somewhat conservative about doing surgery. If he really doesn't think someone is going to benefit from surgery, he doesn't recommend surgery.

Dr. Place saw him in the office. So he saw Mr. Koon, he reviewed his medical record, he reviewed the MRIs. And he not only reviews the radiologist's interpretation of the MRI, but he also looks at the films himself because he has expertise in determining these things. And he found no indication for surgery and felt that a round of physical therapy would be the reasonable next step, in addition to his current medications.

Q Okay. And so did Dr. Place order anything other than physical therapy for Mr. Koon at that time?

A Dr. Place did order some additional plain film x-rays to look at the pelvis, I believe. He wanted to make sure there wasn't other pathology in some of the joints of the pelvis. The sacroiliac joints, I think, were maybe his concern. But he did order some additional x-rays to evaluate.

Q Other than the physical therapy, was there anything that Dr. Place ordered relative to trying to help Mr. Koon's pain?

A Well, Dr. Place -- I -- he -- Mr. Koon had started on Ibuprofen. I had switched him to another anti-inflammatory, piroxicam. Dr. Place switched him to his third anti-inflammatory, which was Relafen. So it was a third one in a series of six that he would eventually receive over time.

Q And then Mr. Koon saw a neurosurgeon; correct?

A Correct. He saw Dr. Heim, the neurosurgeon.

Q Did Dr. Place make that referral?

A No, I don't think Dr. Place made the referral. It was my impression that Mr. Koon sought out Dr. Heim himself. Neurosurgeons and orthopedic surgeons both do spine surgery. So I think it's like a second opinion to Dr. Place.

Q Okay. That was -- how did you react to that decision by Mr. Koon to go ahead and see the neurosurgeon?

A I thought it was a great idea. I think second opinions are very valuable, and I don't think there's any problem at all with that.

Q Okay. And so Dr. Heim examined Mr. Koon, and what was -- what did he conclude as far as you were informed?

A Well, Dr. Heim, I think, did basically the same evaluation Dr. Place did. Looked at the same MRI study that Dr. Place did. And came to the same conclusion that Dr. Place did. That surgical intervention was not indicated at this time. There wasn't a specific lesion on the MRI that was going to relieve Mr. Koon's pain.

In addition to the physical therapist and the chiropractor, then he referred Mr. Koon to Dr. Christopher, Dr. Ann Christopher, the pain management physician.

Q Okay. What did she do? What did Dr. Christopher do for Mr. Koon?

A Well, she once again evaluated his problem independently, doing her own history and physical examination. And began injection therapy with epidural steroid injections to help try to eliminate Mr. Koon's pain.

Q Okay. Do you know how many times Mr. Koon saw Dr. Christopher in this time period we're talking about, the middle of 2008?

A I'm not sure exactly. I think there were -- he saw her probably for four to five to six maybe injections. I'm not absolutely sure.

Q Okay. And so do you know whether Dr. -- whether Mr. Koon saw Dr. Christopher later in time? Later in 2008

or even beyond.

A Yes, he did. He saw -- she saw Mr. Koon again in 2009 on several occasions to do injection therapy again.

Q Was that something that Mr. Koon sought out himself or did you direct him to Dr. Christopher?

A I don't remember. I've always encouraged Mr. Koon, I think, to have a pain management physician involved in his care. Whether I specifically sent him at that time in 2009, I can't recall.

Q Well, now why do you say that, Doctor? You feel comfortable managing pain for your patients, don't you? Why would you encourage Mr. Koon to consult with a pain management specialist?

A Well, in Mr. Koon's case, it was becoming apparent that this pain was difficult. That this was challenging. I think in this day and age, many times we practice in multidisciplinary teams. I think the -- having different people as part of a team of care to provide different services and have different perspectives is very helpful in caring for the patient.

So Dr. Christopher provides a different perspective than Dr. Heim does, it provides a different perspective than the physical therapist, a different perspective from the chiropractor, a different perspective

from myself. So within that team, we can feel confident that we're providing him the best care that is possible.

Q Okay. So in terms of what Mr. Koon was being treated for, then during that summer then of 2008 he had had that MRI and the surgeons had told him that surgery wasn't to -- wasn't going to be beneficial. So what was the course and the plan at that point?

A Well, my hope -- and I think Mr. Koon's hope -- was that courses of anti-inflammatory medications, injection therapy, physical therapy, maybe surgery -- but it wasn't really indicated -- would be enough to help him through this episode and it would be like one of his previous episodes where he had resolved, got better and proceeded on, but it didn't really work that way in this particular scenario.

Q Mike, can you go to page 195 in this same Exhibit A.

So this is -- I think the date -- so August 19th of 2008? Let's go to -- let's go down some. Can you make it a little bigger.

So this is August 19th of 2008. Sounds like Mr. Koon is doing better with his back. That's what we see here; right?

A Correct.

Q Okay. And then here's Dr. Ann Christopher who

you mentioned; correct?

A Correct.

Q And now he's taking six Vicodin -- he's taking Vicodin six times per day, with plans to wean back in one week. So tell us what the significance of that is, Doctor.

A Well, number one, the Vicodin is part of his multidisciplinary care. So I think it is actually offering him significant benefit, along with the other things that he's receiving. But in conjunction with these other modalities, it's my desire that he -- if we start scaling back on treatments here, that the opioids would be a reasonable first place to start and we kind of scale back on the opioids if we can.

Q Okay. And so how -- how is that done? At this point he's taking this -- this medication for breakthrough pain; right? So it's basically subjective as to when he decides to take it. There's not a set time. He should take it only so many times per day; right? But within that time frame --

A Right. It's dependent on Mr. Koon as to how often he takes it and when he takes it. The medication now is still at a relatively low dose. And so --

Q Okay. Well, so he says he's doing better -- he tells you he's doing better with his back; right?

A Correct.

Q But then he also says desires to return to full work duties. Do you remember whether he was not at full work duties at that time?

A Well, at a variety of points along the way during this first six months he was on restricted duty at work and was not able to carry out his full duties.

Q And that was due to --

A That was due to the back pain.

Q Okay. Because at this point the medication level he's on is -- what milligrams morphine equivalent a day are we talking right now in August of 2008?

A Well, at the maximum -- it depends, of course, on how much he's actually taking.

Q Sure.

A And the Vicodin comes in five milligrams, seven and a half and ten milligram tablets. So at the very maximum, he would have been on 60 morphine milligram equivalence at this point if he took it regularly everyday consistently at the highest dose of Vicodin.

Q All right. And so with plans to wean back in one week. Is this a plan that you talked about? Was this your plan or Mr. Koon's plan?

A This was a mutual agreement, I think. And it was highly dependent on -- it's more or less a trial to

wean this. It depends a lot on how he does and how much pain he has and how well he can function in the absence of the Vicodin. So we both agreed it was a reasonable attempt to try to cut back.

Q Okay. And so was the decision to discuss this weaning a result of Mr. Koon telling you he's having side effects? Or is it just let's see if he can get by with less opioids?

A At this point I don't recall any side effects at all from the medications. In fact, I think he's really doing better with the medications. So I think this was -- at this point this is simply an attempt to use as little medicine as we actually need in trying to bring it down.

Q Okay. So at this point, I don't see any -- well, let me ask you this. Was there any charting or any comments that you remember from Mr. Koon as whether he had any issues or side effects from the opioids? Whether it was constipation or light-headedness or any of the things you mentioned earlier?

A It's hard to know exactly at this point. I don't recall anything at this point. In fact, the only side effect I can recall Mr. Koon bringing to my attention was constipation. He did have some constipation as a result of his opioids, but that's --

Q What do you remember telling him about that,

Doctor, when he talked to you about it?

A Well, constipation is very common with opioids. If you look in the PDR descriptions of these opioids, they'll quote a number of about 23, 25 percent. I actually think it's probably higher than that, probably in the 40 percent range. So most people -- a lot of people don't have it at all.

But when he does have constipation, I recommend that he increase his fiber intake, he increase his fluid intake, he increase his activity, which sometimes is difficult for people that are having chronic pain. And then there's a variety of things over the counter that people can get at the pharmacy. I think there's full shelves of medications that some work better for one person than another, and I allowed him to do a little bit of experimentation to see what works best for him.

Q We've heard the phrase bowel regimen. Tell us what that is.

A Well, bowel regimen just refers to a fixed set of medications that will help treat constipation for opioids so --

Q Okay. Was there a reason you didn't put Mr. Koon on any bowel regimen at this time in 2008 when he was taking the Vicodin?

A The frequency of constipation goes up to about

40 percent, which means that 60 percent or so don't have constipation at all. So what I do typically is ask people to report problems so we can then devise a regimen. But I don't feel that it's necessary to start a medication where 60 percent or so of individuals that are never going to have trouble. So I don't recommend a routine one.

Q All right. So when Mr. Koon talked to you about any constipation, did you -- did you consider putting him on a bowel regimen then?

A Well, I recommended the conservative treatments with fiber and fluids, activity and over-the-counter laxatives. And then asked him to let me know if these things were not effective for him.

Q Okay. And so let's -- let's do this, Doctor. Let's talk about the -- let's do III-1. So Doctor, we have three different bar graphs. They are for these three opioids that will you prescribed for Mr. Koon. And you're familiar with the dates and the amounts on these bar graphs; right?

A Yes, I am.

Q Okay. And so can you tell us -- and I realize the three are separate, but we just put them all on the same chart, or the same graphic. But in terms of the -- what we see, we're looking at III-1-001, which is the OxyContin 15. And what we see are again squares and

boxes, moving left to right. Do each of these boxes -- the next box to the right, what does that represent? Does it represent a change in the medication and then --

A It represents an increase in the dosage that was made to the medication. This is for the short-acting oxycodone he had.

Q And so can you tell us how many times you changed it, let's say, before it dropped in July of 2012.

A Counting the initial dosing that began in December of 2009, he had three increments in the dosing after that time.

Q Okay. And is there some parameters for dose increases that is -- do you just increase it whatever you want? Or does it stay a certain percentage in relationship to the existing dose? Tell us about that.

A Well, in the context of Mr. Koon's case, when we started the intermediate -- or the immediate release oxycodone, he is already taking the long-acting oxycodone and he's taking the hydrocodone. So he's what we would call an opioid-tolerant patient. Someone who has been on doses of opioids that are over 60 morphine milligram equivalence for several weeks. So when people get into this situation where they're opioid-tolerant, they usually tolerate increases fairly well. But what I decided to do to here rather than to move quickly is to do kind of slow

incremental adjustments over a period of months to make sure to see how he tolerates each incremental increase.

Q Okay. So the first one we see on the left here starts in December 2009; correct? And it goes over to what, August 6th of 2010?

A Yes, it does.

Q All right. That's about eight months or so, isn't it?

A Correct.

Q All right. And so for eight months for the oxycodone 15, that's the dose Mr. Koon was on?

A Correct. And that corresponds to one tablet four times daily at the beginning.

Q Okay. And then in August -- August 6th of -- is it 6th or 16th? Sorry. 6th of 2010, you decided to increase it at that point; correct?

A That's correct, yes.

Q All right. And then he was on that increased dose for that particular medication for about three months, it looks like, until November 5th of 2010; correct?

A That's correct.

Q All right. And then on November 5th, 2010, through to December -- or really of 2011 so ten months or so, he was on the next increase; correct?

A Correct. That's the last increase there on -- in 2011 on the oxycodone, yes.

Q Okay. And then September 14th, 2011, you increased it, and it stayed at that level until July 9th of 2012. That's about ten months; correct?

A That's correct.

Q All right. So we could do this with the other two medications, Doctor, but let me ask you this: Can you tell us how many times you changed the dose for Mr. Koon -- let's just deal with the increases. I know at the end here we have some tapering going on with this particular exhibit that we're looking at. But let's just talk about the changes where you increased the doses on here. Let's take all three together. How many changes?

A There were a total of ten changes of medication over the course of four and a half years. Several of the changes in the OxyContin were -- were mainly to titrate him up on that to find the best effective dose. So that effectually took the first four dosage changes. So there were an additional six changes. So on average, I guess, about two per year.

Q Okay. So the ten changes you're talking about where you increase the doses, you're talking about all three drugs; right? Just so I'm clear.

A That's all three. The hydrocodone, once we got

that one up to its maximum, of course, doesn't change because I'm not going to increase that one beyond the safe level for the hydrocodone acetaminophen.

Q Sure. Okay. Now, in terms of these medications, it looks like towards the end then, sometime in July of 2012, at least for the oxycodone, it started to decrease. And that was a result of -- to what they call tapering or what you call tapering; correct?

A That's correct.

Q So I'm going to jump back, but before I go there, I want to make sure, so in July 2012, these are prescriptions you wrote where you reduced the dose for Mr. Koon?

A In July of 2012, yes, I wrote prescriptions to decrease his amount of medication.

Q All right. So let's go -- so we're going to wind the clock back a little bit to April, to May of 2012, and talk about that. So in all the time up to that point, in May -- let's say May 24th of 2012 -- had Mr. Koon ever exhibited to you any signs that you considered concerning about whether or not the opioid doses he was on should be reconsidered or were of concern to you?

A The only thing that I had to think about were some of his refill requests. I think there were some times where he requested refills earlier than I would have

expected. So each one of those, I had to kind of deal with individually as they occurred.

Q What do you mean by that?

A Well --

Q Because I mean, there are quite a few of them; right?

A There are quite a few of them. Many of them are three to four days early, which doesn't create any real concern for me. It doesn't create a medical problem. In fact, we encourage patients to call us early for refills so they can get them and have them when they need them so they won't have symptoms of withdrawal.

With our electronic medical record, there's a lot of different steps we have to go through to make sure the medication or prescription is actually ready to take to the pharmacy and get the medication. So they're encouraged to call early. They're encouraged to stay on top of their medication supply and to call, to make sure that they're going to have a supply of medication to continue on.

So those three or four days early prescriptions really don't create an issue. The ones that create problems for me that I have to really think through are the ones that he calls in a week or ten days or even two weeks early.

Q Why is that different, Doctor?

A Well, because that's beyond the boundaries of what I'm expecting him to do. It creates a concern that there may be -- there may be problems with pain that's left untreated and I need to readdress his pain medication. These may be -- this may be a sign that he's got some addictive qualities that are going on that I need to consider as to whether or not this is a possibility of an addiction. And every one of those situations, you have to kind of look at separately and evaluate individually.

Q All right. And so what did you determine about those -- the refills that were early?

A Well, Mr. Koon was in a lot of pain. He had a lot of pain issues. And Mr. Koon had a lot of anxiety and concern about having adequate pain medication because he knew that if he didn't have his pain medication, he was going to hurt. And so many of those times, I think, were related -- were very strongly related to pain. One of the things I look for very carefully with patients on opioids are try to determine are they taking the medication because of pain or are they taking the medication because of something else. And in Mr. Koon's situation, I was convinced that he was taking the medication because of pain.

Q Okay.

A And the situation where we're all in agreement as we were about him needing pain relief and needing to work, that framework helped me to determine what the best next steps would be.

Q All right. So did there ever come a time when Mr. Koon told you that he -- that he wanted to do something different? That he wanted to make a change with his medication regimen?

A Yes, there was.

Q And when was that, Doctor?

A That was in 2012. Actually the first -- the first hint of this came when Mrs. Koon called late in April of 2012 and said she wanted to investigate the first steps in decreasing Mr. Koon's medication.

Q Okay.

A That was a -- that really did create some concern for me because up until this point every call I had received from Mrs. Koon, there had never been any concern about wanting to decrease medication.

Q Okay. So when was this call again, Doctor?

A This would have been late in April of 2012.

Q Okay. And was that before or after you ordered a pain management consult for Mr. Koon?

A The pain management consult came in early April so this would have been about three weeks later.

Q Okay.

A After the order was placed for the pain management consult.

Q Okay. And so -- so you talked with Mrs. Koon about this. What did the two of you -- did you work on a plan for that?

A I thought this was an issue that probably was best not dealt with on the phone and so I encouraged Mr. Koon to make an appointment with the office so we could sit down and talk about it in more detail.

Q So that meeting did happen. Yes?

A That meeting did happen. It happened in May of 2012.

Q Mike, let's put up Exhibit A, 571.

And Mr. Koon was alone; correct?

A Yes, that was Mr. Koon alone.

Q And so -- Mike, let's go to 570 -- 574, Mike. I'm sorry.

So let's do kind of halfway down. History of present illness. All right. So this is your dictation for the May 24, 2012 visit. You write that Mr. Koon desires to get off of narcotic analgesics. That's what it says; right?

A That's correct.

Q It says they are running his life; correct?

A I think those were the exact words that Mr. Koon used, yes.

Q Tell us how Mr. Koon appeared that day.

A Mr. Koon appeared that day much like he appeared on other visits. He was expressing his desires and communicating in a very straightforward rational way.

Q Okay. And then he says to see pain management for the second time in about ten days. So by this time, by the time he sees you on May 24th, he's already seeing Dr. Berry as the pain management specialist; right?

A Right. He's seeing Dr. Berry at St. Mary's at this point. He saw him earlier in the month of May.

Q And then you say after MRI and x-ray obtained -- oh, I see. So he's going to go see Dr. Berry after the MRI and the x-ray are obtained?

A Well, he's -- the first visit that he saw Dr. Berry, Dr. Berry ordered x-rays and an MRI but he had not yet reviewed them with Mr. Koon or expressed the point of action.

Q Okay. And so the chronic pain syndrome -- Mike, let's go down to that. So continues -- it says he continues to experience pain without change in pattern. What does that mean?

A It means he's still having quite a bit of pain, even with his current dose of medications.

Q Okay. And it says continues on narcotic analgesics without change from previous visit. Do you remember the last time you saw him as of this date, Doctor?

A I don't recall when the last visit prior to this was. We didn't make any dosage changes anywhere around the time of this visit.

Q Right. The last dosage change, I think, was around September of 2011. Isn't that right?

A That sounds right.

Q So denies noncompliance. What does that mean?

A That means he is taking them in a reasonable fashion, I think trying to take them as prescribed.

Q Okay. Any reason to doubt him?

A No. No reason to doubt him.

Q All right. How about the fact that he's still on this cycle of refilling these prescriptions early? Is that noncompliance?

A No. I think that represents his pain and his anxiety about his pain. I think Mr. Koon is making every effort to do as well as he can possibly do with the medications, but he's still working at this point and he's still causing trouble in his back through his work. I think he's trying to make the best of a difficult situation with his back pain.

Q All right. And then it says no new adverse effects. What does that mean?

A It means he's not complaining of any specific adverse effects related to the opioids.

Q It says no new ones.

A Right.

Q Does that mean there were some before or there weren't some before? What does it mean?

A It's kind of hard for me to say at this point exactly what that means. I think to me it means he really wasn't having anything that needed to be addressed at that visit that represented a problem related to his opioids.

Q All right. And so you've been here so you've heard the testimony that Mr. Koon said that he begged and pleaded with you on this visit to take him off medications right away and that you basically refused. Did that happen, Doctor? Did Mr. Koon say that to you?

A No, he did not beg and plead with me. I did tell him that I thought at this point in time that it was best for him to continue his current medications until we had more information from Dr. Berry about his MRI and about other options for pain management.

Q So basically Mr. Koon walks in your office and says the pills are running my life. Why aren't you assuming he's an addict at that point?

A Well, there's a lot of things missing here from the picture of an addict.

Q Such as?

A I don't actually like the word addict at all.

Q Okay. Sorry.

A It's kind of a derogatory term.

Q I didn't mean it that way. I really didn't. Dependency, if you want to use that term.

A Anyway, I think there were a lot of things that really weren't present in Mr. Koon's case that would indicate addiction. I think his primary motivation, even at this point in time, is to get pain relief. And his primary motivation to get pain relief is to work. And he is anxious about his medications. He's anxious about making sure he can work and continue to keep his job. But he's not engaging in a lot of the aberrant behaviors that we see in addiction so he's not --

Q Such as? Remind us what those are, Doctor. Those aberrant behaviors.

A Well, he's not seeking medications from another provider so --

Q Did he ever ask you to increase his pain medication since September of 2012 up until this visit in May of -- I'm sorry, September of 2011 up to the visit in May of 2012. Did he ever ask you to increase his pain

medications?

A No, he didn't ask for an increase in the medications. He continued to take the same dose of medications he'd been on. There were no real funny events that were going on that made me think I was trying -- I was being manipulated by Mr. Koon at any time. Our relationship was very straightforward.

So the lack of a manipulative behavior, he wasn't altering medications in any way -- I mean, sometimes with addiction, people will smoke the medication or inject the medication or do funny things to get highs with the medication. He wasn't doing this. He wasn't losing prescriptions. He wasn't coming in and complaining to me that he's lost them and flushed them down the toilet and things like that. He was very responsible, I thought, about trying to get pain relief and trying to manage a very challenging situation with his job and pain. None of the things that I would associate with addiction were really present. A lot of things were missing. My opinion at this point, I did not think he was addicted to his pain medications.

Q All right. And so he leaves your office on May 24th. And what's supposed to happen next for him? At least in terms of your care of him.

A Well, at this point I need more -- I need more

information and more assistance from Dr. Berry. So Dr. Berry needs to see him, interpret his MRI, interpret his x-rays and provide a treatment recommendation. I am actually in agreement about reducing his doses of opioids, but feel that we need some alternate method to control his pain. And so the next step actually was to get Dr. Berry's recommendations.

Q Okay. And so did that happen? Did you get Dr. Berry -- do you know what Dr. Berry's recommendations were?

A Yes. Dr. Berry felt that injection therapy was a reasonable step now to resume. It had been a while since he'd had previous injection therapy with Dr. Christopher so he wanted to restart the injection therapy. And at least my understanding was he had referred the patient to see Dr. Melanie McKean, a psychiatrist.

Q Okay. We've heard a little bit about Dr. McKean, but what did you know about her in 2008?

A Dr. McKean was a SLUCare psychiatrist so I knew her very well. She had managed -- comanaged some of my patients. So I thought she was an excellent general psychiatrist.

Q Okay. And so what was your understanding as to why Dr. Berry ordered that she become involved or referred

Mr. Koon to her?

A Well, once again, it's important, I think, in this situation where we're going to try to take a relatively major step in reducing the opioids to have a multidisciplinary team together. And so at this point we don't need a surgeon; we need a psychiatrist. And a psychiatrist is going to be very helpful in providing counseling to Mr. Koon concerning how to manage pain in the absence of the opioids as we start to reduce them. She also can be very helpful in managing what she determined was depression. And so she wanted to treat his depression, and I think there's a -- it's a very complex relationship between pain and depression. It's very difficult to make much progress in pain relief if the individual has depression.

Q Okay. So you saw Mr. Koon then on May 24th. I believe your next office visit was August 20th, 2012. Does that sound right to you?

A That probably is correct, yes.

Q Okay. But in the meantime, before you actually saw him in your office -- let's go back, Mike, to III, the bar graph. Let's leave that one up.

So this is the oxycodone bar graph. And, so Doctor, in July -- okay. I'm going to have you put Exhibit A up. Sorry, Mike. 588.

Okay. So this is -- there's a date up there in the right corner. So this is July 6th of 2012. This is a telephone record; right, Doctor?

A Yes, correct.

Q So tell us generally what this is about and then we'll narrow in, unless you want to see the record itself.

A Well, this is a telephone encounter, I think, initiated by Mrs. Koon, to let me know that Mr. Koon had --

Q Let's do the top half, Mike. Yeah, there you go. There you go.

A So Mr. Koon has gone through his supply of oxycodone. This is the short-acting immediate release oxycodone.

Q Let me stop you. So this really kind of works from the bottom of the page upwards, doesn't it?

A Yes. I think the bottom is the first --

Q I'm sorry. Let's go to the bottom. Okay. So this is July now of 2012. Pharmacist calling, concerned about patient getting large amounts of pain meds, getting it frequently. Wife told pharmacist that she has to hide his meds and that he found them and took them all.

Did you ever have any information before this that Mr. Koon had to have the meds hidden from him?

A Earlier in his care, his wife had mentioned that

she was going to help manage the medications.

Q All right. Was that a warning flag for you?

A It was -- no, actually I wanted her to -- I thought that was a good thing that she was going to be able to assist him in managing medications because he was anxious about his pain. And I think she was very -- she was actually very helpful in doing that.

Q Okay. And so the pharmacist states they can't fill the script written on July 2 -- now we're talking about July 6th -- because it is too soon. The pharmacist is basically calling you asking you what to do; right?

A Correct.

Q And so then it says asked what you want to do. Then it says wife states patient has an appointment with psych to start getting him off meds. So this is July 6th. That's Dr. McKean?

A That would be Dr. McKean, yes.

Q So that very day -- okay. Let's go -- let's work our way up to the next box, Mike, or the next bar.

So she's calling to ask for -- patient's wife, Mrs. Koon, is asking to talk to the provider. This is after -- patient saw psych this morning. Dr. Melanie McKean. And wife needs to speak to provider about what was discussed.

Okay. Let's go up one more, Mike.

Okay. So she's calling. Again, let's go to where it says talked with wife. And with pharmacist. Was that you?

A I talked with the -- both the wife and the pharmacist that day.

Q And what did you decide to do? What was your understanding of the situation?

A Well, Mr. Koon had run through his medication too quickly. His immediate release oxycodone. And at this point in time, this whole interaction follows the office visit that we had in May where we had come to a mutual agreement to start to decrease medications and come up with a weaning protocol for him.

Q Okay. But so -- so you decide that together. So it looks like Mr. Koon is taking these meds quicker than he's supposed to. Why not just say, well, this is just a weaning process that's failed? We'll just go back up to the old higher dose. Why not do that, Doctor?

A Well, at this point actually we haven't started him on a full wean yet. We're still waiting for Dr. McKean's input and for Dr. Berry's assistance with the injections.

So at this point I'm concerned about his use of the short-acting oxycodone, and I go ahead and start my own taper and wean at this time of the short-acting

oxycodone. So I prescribed a one week's supply and reduced the dosage at that point on his short-acting oxycodone.

Q Okay. All right. And so that's July 6th. Any other contact or communication -- let's go to -- let's go to Exhibit A, 620, Mike. Page 620. And so let's do the middle box right -- yeah, that one right there.

So what is this talking about now? This is July 19th or 20th. The record actually has both dates in it. But go ahead, Doctor.

A Right. So I began writing one-week prescriptions for the short-acting oxycodone for Mr. Koon. Unfortunately for the Koons, when they take these to the pharmacy, they're charged the copay for the medication the same as if they had gotten the larger supply.

Q All right.

A So the wife is calling me at this point saying, you know, basically I'm having to pay a lot more money to get these one-week supplies. Can you write this for me in a full four-week or month's supply at the lower dose.

Q Okay. So let me stop you now. At this point, with you -- you're saying you're trying to make sure Mr. Koon stays on track with this weaning that you know is coming. What about this request to switch from one week at a time and go to a full month at a time? Is this a

warning flag at that point in time?

A It has potential to be a warning flag, yes. And so I had to consider that possibility at the time I made the change. It's not entirely clear that this is a warning sign. I think it's a very -- sometimes very rational decision by a patient to say you're making me spend $80 when I could just spend $20, can I keep my $60 in my pocket. And I'm thinking, well, it makes some sense, and so it's kind of one of those things financially that I'm not trying to -- to hamper the Koons' financial issues. If they can save $60, I'd like to do that. But the total amount that was written in this one month's supply was decreased so that they were getting lower amounts of the immediate release oxycodone.

Q Oh, okay. So the amount you had been writing was less than what the oxy -- I'm sorry, the oxycodone?

A Oxycodone, yes.

Q -- what the oxycodone scripts had been earlier?

A Correct.

Q So you're pursuing the taper?

A That's correct.

Q Okay. All right. Okay. And so -- okay. So let's go to the next -- let's put that III bar graph back up there again. Put the oxycodone back up.

Okay. So -- so we're talking about somewhere in

this time frame right here, Doctor?

A The smallest bar there is the one week's supply.

Q All right.

A The second bar there that says what -- 540 milligram --

Q 5400, yes.

A 5400. That's the new one-month amount where previously it had been 9,000.

Q Okay.

A So it's been dropped back from 9,000 to 5400.

Q So this would have been the one he was at before this wean started; right?

A Correct.

Q So then you dropped it back to 5400 from there.

A Correct.

Q All right. So that's one month's worth; right?

A Correct.

Q And then it actually drops significantly after that. Was that another part of a wean?

A Yeah. That's the -- that's kind of a different supply that was given to him as we start the -- kind of a forced taper that began in late August of 2012.

Q Okay. And so did you have a conversation with Dr. McKean before Mr. Koon saw you on August 30th?

A Yes. I talked to Dr. McKean by phone on August

the 15th.

Q Okay. Tell us about that.

A Dr. McKean and I had a long conversation about determining what the best next step would be for Mr. Koon's medication. We came to a conclusion at that point that we all -- we all agreed that it was time to step down on his medication.

Dr. McKean and I decided that it would be best to take all of his medications, the entire group, the OxyContin and the oxycodone and the hydrocodone, and to put it all together into long-acting OxyContin and taper that five to ten percent every two weeks until he got to a dose that Dr. McKean said would be reasonable to use Suboxone. I think her eventual plan was to arrange for him to have Suboxone therapy at some point. But we thought that a taper of all of his medications was appropriate so on the 15th we talked about that extensively.

On the 16th, Mr. Koon went to see Dr. McKean in her office, where she explained that taper to him. And on the 17th of August, we began the taper of his medications.

Q All right. Okay.

THE COURT: Counsel, approach.

(An off-the-record discussion was held at the bench.)

THE COURT: Ladies and gentlemen, we're going to take a quick 15-minute break for the afternoon to get your blood flowing after lunch.

The Court again reminds you, as you were told at the first recess, until you retire to consider your verdict, you must not discuss this case with anyone. Please don't form any opinion about the case until it's finally given to you to decide. And no research or investigation. Don't communicate with anybody by any means.

Fifteen-minute recess.

(A recess was taken, after which the following proceedings were held in the presence of the jury:)

THE COURT: Please be seated.

You may continue.

BY MR. VENKER:

Q Dr. Walden, before we keep moving forward into this time frame in the summer of 2012, let me go back and ask you, what if on May 24 Mr. Koon, or any patient, had asked you, pleaded with you, or simply just asked you, said I want to get off my meds as soon as I can, tomorrow? What would you have done? Would you have told him to stay on the meds?

A No. That would change the situation quite a bit. I think that's why a lot of these decisions are very individual and very specific to the situation that you

encounter. At the time Mr. Koon and I talked about getting off his medications, there was not an urgent need to do it immediately. There was no urgent situation there. And so it was best, I thought, to make sure the whole multidisciplinary team was on board, to make sure he had optimal pain management through Dr. Berry and through Dr. McKean. And I thought that would give him the best opportunity to really successfully come down on his medication. But no, if he had asked for immediate help, that certainly would have been provided.

Q Okay. Would you have considered referring him to a patient treatment center of some kind?

A Yes. That would have been one of the options.

Q All right. Let's go back now to where we were talking, this August time frame now. You were telling us how Dr. McKean -- you talked with her on August 15th, I think you said, about what the plan was going to be. And you were at this point cooperating with her because she was the one that was going to kind of quarterback the Suboxone use to help Mr. Koon lower his -- his opioid dosing down -- hopefully down to zero; right?

A Yes, eventually.

Q Okay. And so when you then saw Mr. Koon on August 30 -- he came to see you on August 30; correct?

A That's correct.

Q Exhibit A, 694. And so let's go down to History of Present Illness. And what does Mr. Koon tell you on August 30, 2012 is his main concern?

A Well, the main concern now is the low testosterone level. He had a level checked by Dr. Berry a few months earlier. And I got a call shortly before this visit on August 30th from Mrs. Koon asking to set up an appointment so we could -- we could talk about this and discuss possible treatment.

Q Okay. And then it sounds like he's having injection therapy. Was that again with Dr. Berry?

A That's with Dr. Berry, yes.

Q Okay. And it says -- this is where we get the page break. So it says believes his injection therapy is helping and is eager to -- it says continued -- wean the narcotics; correct?

A That's correct. He was very eager to keep this -- the wean had already started. It started back on August the 17th. I had prescribed him the agreed upon weaning of the long-acting medications. And so we had taken all of his medication and put it all into the long-acting oxycodone, extended release oxycodone. And he was to take only that and then decrease by five to ten percent every two weeks.

Q Okay. And so this August 30th visit was about

what, maybe not two weeks into that process?

A Right. This would have been right about two weeks into that process. Exactly.

Q And so tell us -- you say the wean. So the first two weeks, were they at a certain level and then the second two weeks of those four was a lower level?

A Right. So the first two weeks, he was to get 240 milligrams in the morning, 240 milligrams at mid day and 240 milligrams in the evening. And he was to take that for two weeks. And then after that he goes down to 240 milligrams in the morning, 180 milligrams in the mid day and 240 in the evening. So then he drops down 60 milligrams total dose at that two-week interval.

Q All right. And this was something that -- did you and Dr. McKean talk about this? Or was this particular stepping dose her plan? Or how did that go exactly?

A I think we talked about it together and kind of came up with a -- with a mutually agreeable plan that we thought had merit and was slow enough that would be -- would be possible to be successful.

Q What is the conventional wisdom about how quickly weaning can occur if you're talking about getting the patient down to hopefully a very low or zero number of opioids?

A Generally a wean of five to ten percent a week is reasonable. We went a little bit slower in Mr. Koon's case to give him full opportunity to adjust to that weaning protocol.

Q Okay. And then after the August 30 visit, was Mr. Koon going to come back to see you?

A Yes. He had an appointment to see me in November of 2012. I also ordered some laboratory studies on that visit of August 30th, including his testosterone, but also kind of a wide basis for chemistries and kidney function, liver function and so forth, which he went to the laboratory that following day on the 31st and had drawn.

Q Okay. All right. And so did you see Mr. Koon ever after August 30th of 2012, Doctor, as his doctor?

A No, I did not. That was his last visit to see me.

Q Okay. Did you try to -- your office try to contact Mr. Koon after that to see whether he was returning?

A Well, not to see if he was returning, but to -- I mean, he was due again to have another taper, another month's worth of medications filled, to taper on his medications, yes.

Q All right. And so those -- obviously no one

came to refill that; correct?

A No. That prescription for the next month's taper was never picked up and never filled.

Q Okay. And so in terms of that, in terms of patients leaving your practice, is that something that happens, that sometimes patients just decide to go elsewhere? Or what do you do? What's your practice to do when that happens?

A It happens. It's sometimes hard to predict exactly. I think at this point in time on this tapered dose of medication, we had a follow-up appointment set, we had a schedule set to -- to continue the taper down with every two-week decreases. And more or less -- I contacted Mr. Koon about his laboratory studies by mail. Put a letter in the mail to let him know what they showed. But at this point in time, I guess in my thought the ball kind of is in Mr. Koon's court now. It's his time to taper and taper successfully.

Q Okay. Dr. McKean was involved in this?

A Correct.

Q Now Doctor, you do patient care. You don't do any kind of research for any kind of -- any kind of clinical trials or anything like that, do you?

A I have participated kind of as a fringe investigator in some NIA sponsored work, but it's --

they're trials that the Department of Neurology had with stroke, and when they need a -- kind of an expert internist to manage blood thinners or blood pressure medications in these trials, I sometimes assist with those. But I'm not a principle investigator and I don't -- I don't do research at all for a living.

Q All right. I meant to ask you, you heard the testimony earlier this week about a driving episode that Mr. Koon was driving and either fell asleep or went off and hit the curb. Did Mr. Koon ever tell you about that, Doctor?

A No, he did not.

Q All right. And how about Mrs. Koon? Did she ever tell you about that episode?

A No, she did not.

Q All right. And there was also testimony that Mr. Koon had fallen asleep outside on the front porch. You remember that testimony?

A I remember that testimony.

Q Did either Mr. Koon or Mrs. Koon tell you about that at all?

A No.

Q And if they had told you about either of those events and said they thought it was due to the medication, can you tell us what you would have done?

A Well, I would have looked at that -- again, this is a matter of balancing the benefits versus the risks. And I think this would increase the risks side here if this is really what's occurring. I think I'd have to put it in the context of exactly what the situation was at the time. Certainly, motor vehicle accidents are potentially very serious. So that one, I think I would have considered quite seriously. Someone falling asleep who works hard at manual labor, that one I might have thought differently about. So it kind of depends on the context. I think each situation requires, you know, kind of a global perspective in trying to figure out exactly where the problem lies and does it lie with the opioids. And if it does, then that becomes an issue.

Q So then you would have explored it if you had been made aware?

A Correct.

Q You don't get -- you don't get paid for writing prescriptions, do you, Doctor?

A No. The only payment that comes to our office is when I see Mr. Koon in an office visit and the doctor's office bill.

Q Okay. And you've never been contacted by the DEA, have you?

A No, sir.

Q About anything.

A No, sir.

Q Okay. And you've never been disciplined by the Missouri State Board or physician licensing here in Missouri, have you?

A No, sir.

Q All right. And do you believe you provided proper and -- care to Mr. Koon and complied with the standard of care?

A Absolutely.

Q Okay. I have no further questions.

THE COURT: Cross.

MR. SIMON: Thank you, Your Honor.

THE COURT: You may proceed.

MR. SIMON: Thank you, Your Honor.

**CROSS-EXAMINATION**

BY MR. SIMON:

Q Doctor, do you remember giving a deposition in this case, sir?

A I do.

Q Do you remember in the deposition you told me that you had several other patients on as high a dosage as Brian Koon? Do you recall that?

A I recall saying I might have had up to five.

Q Okay. And that's not the case now today in the

courtroom, is it, Doctor? Right? That's not what you told us this afternoon; correct?

A No. I think one is up to five.

Q Right. And you qualified that by saying that one -- you didn't put that one patient on that dose, some other pain management doctor did; correct?

A Initially, that's correct.

Q Okay. So are you telling us today, are you telling the jury under oath today, that you do not currently have any patient, not a single patient, who you put on as high a dose as you put on Brian Koon? Is that what you're telling the jury today?

A That's correct.

Q And that's inconsistent with what you told me in your deposition under oath; is that right, Doctor?

A Could I take a look at that deposition, sir.

Q Page 52, lines 14 -- 9 through 14, please. I'm sorry. Deposition page 52, line 9 through 14. I've got it. I've got it. I've got you.

Doctor, let's do this. Let me hand you a copy of your deposition. Let me hand you a copy of a portion of your records that are highlighted. And this is a complete set -- Exhibit 1, Doctor, a complete set of your chart for Brian Koon; is that right?

A I assume so. I don't --

Q Okay. I'm going to leave this up here with you too for reference.

Mike, have you got page 52, please.

MR. VENKER: Your Honor, may we approach?

THE COURT: You may.

(Counsel approached the bench and the following proceedings were held:)

MR. VENKER: Transcript pages out of a deposition, your Honor. I think that's improper.

THE COURT: Only if he --

MR. SIMON: I'll clarify. I'll ask the proper question.

(The proceedings returned to open court.)

Q (By Mr. Simon) Doctor, do you remember in your deposition being asked this question and giving this answer?

"QUESTION: Have you given any other patients the same dosage as you've given Mr. Koon?

"ANSWER: Mr. Koon is among the patients that received the higher doses. I do have other patients that are on equivalence of similar amounts as Mr. Koon."

Do you recall being asked that question, Doctor, and giving that answer?

A Yes, sir.

Q Now Doctor, we talked about dose -- you were

asked some questions about dosages, and you told us today under oath that you attempted throughout this four and a half years to use the lowest dose possible. Is that what you tried your best to do? To use the lowest dose possible.

A Yes, sir.

Q And that's because that's what a good doctor would and should do; correct?

A I think a -- I think a reasonable decision in virtually all cases when you're prescribing medications is to use the lowest dose. I think you have to balance benefits and risks.

Q Because you're dealing with a dangerous drug; correct, Doctor?

A Most drugs are dangerous.

Q Okay. This is a Schedule II narcotic, classified by the DEA; correct, Doctor?

A That's correct.

Q And the DEA says that this is a dangerous drug; is that correct?

A Correct.

Q Because it can cause addiction; correct?

A Correct.

Q And it can cause respiratory failure; correct?

A Correct.

Q And it can cause people to die; correct?
A Correct.
Q And it causes 50,000 people a year to die every -- every year; correct, Doctor?
A I accept your statement.
Q Okay. You don't -- Doctor, that's -- that's a prescription medication that is causing -- I'm sorry. 19,000 deaths a year; correct, Doctor?
A I don't have the numbers precisely.
Q Let me ask you this, Doctor: You were in the courtroom here when your expert testified; correct?
A Correct.
Q Okay. And I believe he said up to 19,000 people a year die from prescription opioids; correct?
A I defer to Dr. Guarino's opinion.
Q Okay. We're talking about 50 people a day who die from prescription medication; correct, Doctor?
A Could be correct. I'm not quite keeping up with your numbers, but I understand the issue and I do think this is a problem, yes.
Q Okay. Well, Doctor, it's a prescription drug problem, isn't it?
A There is a prescription drug problem.
Q And the problem is made worse by doctors who provide too many opioids to their patients; correct,

Doctor?

MR. VENKER: Could we approach just briefly.

THE COURT: Sure.

(Counsel approached the bench and the following proceedings were held:)

MR. VENKER: Out of an abundance of caution, I don't think I should have to do this, but I think now we're getting into this opioid epidemic. I just want my objection renewed.

THE COURT: It's renewed and noted for the record and overruled.

MR. VENKER: To the line of questioning. I'm not going to object any more on that ground.

THE COURT: I think it covers anything having to do with the epidemic.

(The proceedings returned to open court.)

Q (By Mr. Simon) Doctor, this is a really serious problem in our country, isn't it?

A I assume you're talking about the opioid epidemic?

Q Absolute -- I'm talking about doctors prescribing too many opioids. That's what I'm talking about. That's a serious problem in our country today; correct, Doctor?

A The problem is not about doctors prescribing

opioids for appropriate indications to compliant patients like Mr. Koon.

Q Okay. And, Doctor, the opioid epidemic is a prescription epidemic; correct? These aren't street drugs. These are drugs that are prescribed by doctors. Is that correct, Doctor?

A It's a prescription diversion problem, sir.

Q Okay. Doctor, you not -- you're not hearing about this problem for the first time in this courtroom, are you?

A No, sir.

Q Did you know about all of this when you were treating Brian?

A Exactly. I knew about all of this exactly when I was treating Brian.

Q You knew about all of these overdoses and these deaths and this epidemic? You knew all that stuff was going on when you were writing these prescriptions?

A Yes, sir.

Q Now Doctor, you had a chart up there and it was III-1. It was Defense Exhibit III-1. Do you remember that one? Can we pop it up there, please, Mike.

Okay. And let me ask you this, Doctor: The information -- where did you get the information to -- did you prepare this chart?

A I did not prepare it personally.

Q Okay. Do you know where the information was gotten to prepare the -- what's on this chart?

A I don't have that information, sir.

Q Okay. Do you know if it was from your medical records?

A I don't know if it was from the medical records.

Q You don't know where it came from; correct?

A I personally don't know.

Q Okay. And, so Doctor, let me ask you this. Just for some clarification. I think you were showing us this chart to show us how your -- in other words, your tapering activity. You're trying to taper the drug down, beginning on July 9th of '12. Is that the reason we were looking at this?

A No, sir. This is to show the increases were a systematic, well thought through plan of action for Mr. Koon. The tapering part on the far end is -- is true and accurate, but the important part of these charts to see is that -- that there were not changes that were occurring on a regular basis. There were long periods of time where Mr. Koon did very well and the changes that did occur were done on a very system -- a very systematic way.

Q Okay. So Doctor, is it your sworn testimony today that you tapered the opioid narcotic medications for

Brian to beginning on July 9th, 2012 through August 28th of 2012? Is that your testimony that you began this tapering process, reducing the dosages?

A That's correct.

Q Okay. Mike, could we please go to Exhibit 36. Let's go to the very last page.

And, Doctor, you're familiar with this document; correct? You were questioned about it at your deposition. Do you recall that?

A It looks similar to what I saw at my deposition.

Q Okay. And it is a compilation of all of the pharmacy records where your office prescribed opioid narcotics. Is that your understanding, Doctor?

A That's my understanding.

Q Okay. And, Doctor, do you understand that you -- your attorneys have stipulated to the authenticity and the accuracy of the information on this exhibit? Do you understand that?

A Yes, sir.

Q Okay. So Doctor, let's take a look -- we're on the -- if you could, Mike, please go down to beginning in July, the entry in July --

MR. VENKER: May I give the doctor our copy, John.

MR. SIMON: Sure.

Q (By Mr. Simon) The last page, Doctor.

A Yes, sir.

Q Okay. And this is the period starting on July 5th, 2012, where you would have began the reduction or the tapering of the medication; correct?

A I believe it was not July the 5th, sir.

Q Okay. You said it was July 9th; right?

A July 9th looks correct, yes.

Q Okay. Let's go to July 9th. And on July 9th -- it says July 9th, 2012, oxycodone, 15 milligrams, 112 pills; correct?

A That's correct.

Q The next line -- and this is five days later, Doctor, July 14th, 2012. The same medication, oxycodone, 15 milligrams, another 112 pills; correct?

A Correct.

Q Okay. And then on 7/20/2012, that would be six days later, we have oxycodone, 15 milligrams, the same medication and another 112 pills; correct?

A Correct.

Q This is all part of the tapering process; correct, Doctor?

A That's correct, sir.

Q Okay. And then the next one is 7/20, which would be another prescription on the same day, and that

would have been 180 hydrocodone pills; correct, Doctor?

A That's correct.

Q And then if we move six days later to July 26th, we have oxycodone IR again, and we have 360 pills. Is that correct, Doctor?

A That's correct.

Q Again, part of the tapering process.

And then when we move down to July 28th, 2012, Doctor, we have OxyContin, and this is the 60 milligrams. This is the more powerful narcotic; correct?

A It's the same medication. Oxycodone is a short-acting form and in a long-acting form, so this is the long-acting form of the oxycodone.

Q Okay. What I'm getting at is the tablet's stronger. The other tablet was 15 milligrams. This is sixty milligrams; correct?

A This is 60 milligrams to be taken twice a day now.

Q Okay. But my point is the pill is four times stronger than the oxydone IR; correct?

A In the milligram amounts, it would be, yes. Is probably one way to look at it.

Q So in other words, you'd have to take four oxydone IR to get the same opioid or narcotic as is in one pill of the OxyContin; correct? 60 milligrams?

A That's not really -- I mean, in the numbers, yes, I guess you're talking about 60 milligrams equaling 60 milligrams. But these are medications of different duration, formulated in different ways so that's not really medically appropriate or correct.

Q Right. I understand that. And I'm not talking about how they're processed by the body. I'm talking about the quantity when the patient walks out of the pharmacy with them in a bottle. That's what I'm talking about. Okay?

A I see.

Q Okay? So then if we move down to the OxyContin on 7/28/12, 60 milligram, 240 tablets. Is that correct, Doctor?

A Yes. That looks to be correct, yes.

Q Okay. And then we go about 11 days later, on August 9th, and we see another 120 pills of OxyContin, 60 milligram; is that correct, Doctor?

A That is correct, yes. What date again? I'm sorry.

Q August 9th, 2012.

A So August 9th. That's a different prescriber. That's not me.

Q That's Dr. Drake; right?

A That's Dr. Drake.

Q Is he at a different office or is he in your office?

A He works out of SLUCare.

Q Oh, same facility; correct? He's a SLUCare doctor; correct?

A Yes, he is.

Q Okay. So Doctor -- let me ask you this: Did Dr. Drake know -- was he familiar with the other prescription that you had already given Mr. Koon?

A Yes. He would have had full access to that information.

Q Okay. He'd look at the chart; right?

A Correct.

Q Okay. And his information would be whatever information is in that chart; right?

A Correct.

Q Okay. So Doctor, let's do this. Then Dr. Drake on August 9th, 2012, again, he -- two prescriptions. One for OxyContin, 120 pills, and oxycodone, 180 pills; correct?

A That's correct, yes.

Q Okay. And then we go from August 9th to August 17th. That's about eight days. And that's your -- that's your script. And that's another 180 pills of hydrocodone; correct?

A That's correct.

Q Okay. Now Doctor, this next one, this is three -- four days later. The last one was 8/17. This is 8/21. Okay? And this is -- is back to the OxyContin, 60 milligram. 322 pills of OxyContin, 60 milligram, prescribed by you on August 21st, 2012.

You know something, Doctor, over the break I looked at this sheet, all the pages, that's the highest amount of pills I could find -- one, two, three -- the whole -- the whole sheet, that's the single largest number of OxyContin pills that I saw in all of these pharmacy records. 322. Did you -- do you realize that, Doctor?

A As I testified earlier, the medications at this point, we have discontinued his -- an immediate release oxycodone and his hydrocodone. Everything is being lumped into his OxyContin. This is part of the taper.

If you actually calculate the total amount of medication he's receiving in morphine milligram equivalence, he has now been lowered down. He is no longer at this point going to be taking his hydrocodone and he'll have only one small prescription for the immediate release oxycodone. So as I previously testified, this is exactly what the plan was for his tapering.

Q This was your plan, what we just went over.

A This was exactly the plan. Total doses are now much lower.

Q Okay. And, Doctor, according to this chart, you prescribed 10,164 opium narcotic Schedule II pills to Brian Koon in the year of 2012. Did you realize that?

A I'm not seeing that. Where is that?

Q It's the total of the pills for 2012.

A Oh.

Q It's 10,164 pills, Doctor.

A That could be correct. I don't count the total number of pills that someone takes in a year's time.

Q Okay. And I calculated during the time you were tapering or trying to reduce it, which would have been the last seven weeks on this chart, you and your office prescribed 2,188 opium narcotic pills to Brian Koon.

Were you aware of that, Doctor?

A I think you misunderstand the taper, sir. There are two different tapers that occurred. Taper number one was when we reduced the immediate release oxycodone. That release -- that dropped him down on his immediate release oxycodone without actually changing the OxyContin or the hydrocodone. That was the first taper. And he actually received less of the immediate release oxycodone. That's what I did at the time I was waiting for the -- an opportunity to talk with Dr. McKean.

The second taper involved taking all of his medications and putting it together and prescribing only OxyContin. So eliminating the hydrocodone and all but a little bit of the immediate release oxycodone. Those tapers definitely took place and they're reflected on this sheet.

Q So Doctor, you talked about looking out for aberrant behavior. Do you remember talking about that?

A Aberrant behavior.

Q Aberrant behavior. And you said that one of the things was drug seeking. He wasn't seeking -- you -- it kind of -- you said that Brian wasn't seeking medication from other providers. Is that what you told us?

A That's correct.

Q Doctor, why in the world would Brian Koon need to seek medication from other providers when every time he asked for an increase of this narcotic medication you gave it to him?

MR. VENKER: Object as argumentative, Your Honor.

THE COURT: Overruled. He can answer.

THE WITNESS: Mr. Koon was never a drug seeker. Mr. Koon took his medication to treat a legitimate pain problem. Every time that he had increases in his pain, I looked at that situation on an individual basis and made

decisions about what was in the best interest of Mr. Koon's pain care. At no time did I ever consider him a drug seeker. He never sought -- he had plenty of opportunities to go elsewhere and get additional medications, which is --

Q (By Mr. Simon) Doctor, let me ask you this: There are several instances in those medical records -- that stack there on the table is the same thing you've got in front of you. I've gone through that many times, and I -- is there one entry in there one time, Doctor, where Brian Koon asked you for an increase and you told him to hold off or told him no? Can you point to one time in four and a half years when you did that?

A I can't point to specific incidents in there. I made individual decisions at individual points in time based on what was best for Mr. Koon.

Q And the vast majority were phone calls; right, Doctor?

A There were many office visits in there. I mean, I saw Mr. Koon on many opportunities in the office. There were many phone calls too. But -- so there are many points of contact. I would -- I would dispute the fact that he wasn't seen in the office and evaluated.

Q Well, Doctor, we can look at the records. But

let me ask you this: There's another comment you made that I want to ask you about. And you said that -- was it April 30th, 2012 was the first time you had a hint that he may have had an addiction or a dependency problem? Is that what you told us? The first time -- you said the first hint that you had was on April 30th of 2012. Do you remember telling us there?

MR. VENKER: I'm just going to object as a mischaracterization of his testimony, Your Honor.

MR. SIMON: The jury will remember his testimony, Your Honor.

THE COURT: Proceed.

Q (By Mr. Simon) Well, Doctor, let me ask you this: Did you have some hint or some -- or was it brought to your attention before April 30th of 2012 that he had a drug problem or an addiction problem?

A There were hints of different types that you get in the course of taking care of a patient like Mr. Koon. There are certain things that happen. So, for example, when the -- when the relative of Mr. Koon's takes his medication, that's a hint. It's not a conclusive argument, not a conclusion that I can -- but it's a hint. There's little hints along the way in everybody at different times that they may have some irregularities.

Q Okay.

A Those have to be taken into the concept of the total care of the patient.

Q So Doctor, let me ask you about these entries. Let me make sure everybody can see them. And I'll read them out loud, Doctor, so -- and these are entries -- over the lunch hour, I went through some of your records, not all of them, and I jotted some of these things down. And if you dispute them, we've got the page numbers and you've got the records right in front of you, we can go look them up. Is that fair enough?

A Yes.

Q Okay. July 8th of '08 -- and you started him in February of '08; correct?

A That's correct.

Q Okay. So February 29th of 2008 was the first time you gave him the -- when you started him on these opioids; right? You gave him 60 pills; correct?

A I gave him 30 pills with one refill. He doesn't get all 60 pills at one time.

Q Fair enough. Fair enough.

And so February, March, April, May, June, July. Five months later, Brian calls your office and he says he's reduced it on his own and starts having symptoms. He starts sweating and yawning and shaking. And he calls

your office, and in the records it says, quote, needs help. And you know what, Doctor, it's underlined in your records.

Is that a hint? Is that a hint to you that he might need a little I help with his medication, that he might be having some type of a dependency problem?

MR. VENKER: I'm going to object to the argument and the multiple question, Your Honor.

THE COURT: I'll allow the witness to answer.

MR. SIMON: Yes, sir. I'm sorry. Sorry, Doctor. Go ahead.

THE WITNESS: At this point in time, Mr. Koon has been taking hydrocodone for approximately four months or so. The concept of physical dependency on an opioid analgesic is one that virtually all patients develop when they've taken this opioid analgesic for more than two or three weeks. So at this point he's well beyond the two or three week period.

The two characteristics of this physical dependence are the development of tolerance, where he may need more medication over time, and the possibility of withdrawal. Now I tell patients once they've been taking a medicine for more than two to three weeks that they should expect, with almost 100 percent certainty, they'll become physically dependent on the medicine. So this is a

physiologic process that we're looking at here. This is not an addiction process.

What he says when he says needs help is that he may at this point -- I mean, the description was he had taken some medication and cut back on it. So it's -- and the symptoms he describes are consistent with the possibility of withdrawal. That would be totally and completely expected at this point with physical dependence. That's a totally physiologic and expected manifestation of the prescription medication that he's received to this point, sir.

Q (By Mr. Simon) Okay. And, Doctor, I'm reading from your records on that date, on July 8th of '88. The jury's seen this. Did increase hydrocodone pills, then tried to decrease pills and then felt very bad. Shaky, nose running, sweating, weak, yawning. Then mood, moody. Then took the medication and felt better within an hour. Underline, quote, needs help. Was supposed to take a total of six a day and he was now taking nine a day.

Do you remember that in the records, Doctor?

A I remember that, sir.

Q Do you remember what your response was when Brian called the office on this day saying he needed help,

was taking more of his pills than he was supposed to be taking? Do you remember what your response was? Refill authorized.

A Exactly.

Q Do you remember that, Doctor?

A That's entirely the medically appropriate thing to do. He had decreased his medication and had withdrawals so you put him back on the dose he's supposed to be taking and he does just fine.

Q You didn't even talk to him that day, Doctor. Did you know that?

A I don't -- I can't recall at this point. I --

Q Your notes indicate you didn't even speak to the man. You just refilled his medications. Were you aware of that?

A I don't know whether I spoke to him or not. No, I can't tell you at this time.

Q So Doctor, were you aware at this time, five months out, you had already given Brian 1,622 narcotic pills?

A That sounds correct.

Q Okay. So Doctor, that's the first entry. Let me run through the rest of them.

7/11/08, took too much medication, running out early. 8/19/08, plans to wean back in one week. June 8th

of '09, gasping for breath, chest pain. He described it as an attack. Calling your office. 2/11/10, trying to wean from pain med. Again talking about trying to get off of it, lower the dose. 2/11/10, agree with slow weaning of narcotics. 4/29/11, this is a letter from you in the file. Erectile dysfunction secondary to narcotic medication. Do you remember writing that letter, Doctor?

A Yes, sir.

Q Secondary means what?

A Means that I believed his erectile dysfunction could be due to his medication.

Q Right. Okay.

Moving on. 5/17/11, pharmacy calling, won't fill without approval. Do you remember those in the records, Doctor, when the pharmacy is getting the script for these huge amounts? They won't even fill it until you call them and tell them it's okay. Do you remember those?

MR. VENKER: I'm going to object as argumentative, Your Honor.

THE COURT: It's cross.

Q (By Mr. Simon) Do you remember those, Doctor?

A Pharmacies are very good with helping to coordinate care with patients, yes.

Q All right. Moving on, May 17th, '11. This is

when his wife called, got into his meds and is now out. That's in your records. April 2nd, '12, calling for pain management referral. 4/30/12, Michelle calls for weaning. 5/24/12, I want off, they're running my life.

All of these are in your records, Doctor; correct?

A Correct, yes.

Q 7/5/12, pharmacy calling, concerned, large amounts again. Five -- 7/5/12, wife told pharmacy she needs to hide his medication from him.

Those are all in your records; correct, Doctor?

A That's correct, sir.

Q So Doctor, did I also hear you say it's your opinion that Brian Koon did not become addicted to opioids? Is that your -- you're sitting here telling us that today?

A I haven't seen Brian Koon for four years, sir, so it's hard for me to make decisions -- medical decisions about him between 2012 and 2016.

Q Well --

A What I told you was that during the time I was caring for him between 2008 and 2012, that yes, I did not -- I did not believe he was addicted.

Q So Doctor, he last left your care on August 30th of 2012; correct? That's the last visit I see in your

notes. Sound about right?

A That was the last office visit, yes.

Q Okay. And 12 days later, he's in detox; correct?

A That's correct.

Q For opioid dependency; correct?

A That's correct.

Q Something that you said you didn't see any signs or hints of; correct?

A No, sir, that's not correct. Addiction and opioid dependency are not synonymous. Mr. Koon had physical dependence on his opioid. His physical dependence meant that if he failed to keep onto his tapered dose that I prescribed that he would, in fact, go into withdrawal. He knew that, I knew that.

The reason he's in detox in September is because he did not manage the taper as we had discussed and planned and he ran out of his medications. At that point in time, everyone involved in his care, Mr. and Mrs. Koon, myself, Dr. Berry and Dr. McKean, had agreed that at this point he's going to decrease his opioids, not going to increase his opioids. So he did go into withdrawal, but only because he failed to keep to his tapered dose.

Q So Doctor, let me ask you this: Should a patient be able to trust their doctor?

A I would hope so.

Q Would you ever criticize one of your patients for following your recommendation?

A For following my recommendation? Would I ever criticize one of my patients for following my recommendation?

Q Yep.

A I can't think of an incident when I would do that, no.

Q Doctor, there's also been some -- some testimony in this case about the fact that Brian was a hard worker. There's no doubt he's a hard worker and somebody who wants to work; correct?

A Yes, a very hard worker.

Q Okay. And, Doctor, it's not the patient who decides how much opioid narcotic medication they get. Would you agree with that?

A I ultimately prescribe the medication because I'm the physician and I'm the person who has that ultimate responsibility. The decisions that are made along the way, particularly with Mr. Koon, were made with his complete and total agreement and his complete and total consent. So this decision was, in fact, a mutual decision. I wrote the prescriptions and signed them, exactly, but the decision was mutual.

Q I'm talking about the amounts, Doctor. Did Brian tell you, hey, you know, Doctor, I think I want this amount or that amount? You decided the amounts to give him; correct?

A The precise amounts, yes. But the total amounts we talked about many, many, many times. He knew he was a high-dose patient. And we talked about that in particular -- we went into that on the last discussion that I had, the one that I documented in the medical record in late 2011.

We had an office visit in which we spent probably three-quarters of that visit doing nothing but talk about his medications. Talking about his amounts, talking about opioid dependence, talking about tolerance and withdrawal and making certain that he knew exactly what was happening, knew that he was one of these high-dose patients, that he was different than the other patients that can get by with less than 100 morphine milligram equivalence. And he was completely and totally able to discuss that issue and was completely and totally in agreement with the course of therapy.

Q And, Doctor, I assume that discussion and the risks and the benefits, all of that's thoroughly documented in your medical records. Would that be the case?

A There are several spots where I documented times where I talked with Mr. Koon and where we spent large amounts of time talking about almost nothing but this.

Q Okay. Well, Doctor, let me do this. We're going to get to that in a second. I want to move on and try to get done.

This -- the need to work, alone, just the fact that somebody wants to work, that's not a reason to put them on opioid narcotics. Would you agree with that?

A That's a tough statement to answer because you're considering many, many more things than a single anything when you make a decision about opioid narcotics. So that is like a totally different way than we would make decisions in the office. We simply don't look at a single factor any time.

Q So that's not the sole factor is what I'm getting at, Doctor. The wanting to work isn't the sole reason to put somebody on a long-term opioid narcotics; correct?

A I would say it wouldn't be the only thing you would consider.

Q Okay. And, Doctor, Brian wasn't on long-term opioid narcotics until you put him on long-term opioid narcotics; correct?

A When you say long-term --

Q Opioid narcotics.

A I did start him on an opioid narcotic in 2008.

Q But he wasn't on them until you put him on them, started him on them; correct?

A He'd been on opioid narcotics in the past on multiple occasions. I did start them in 2008 and used them for his care.

Q Okay. And, Doctor, Brian is working now. Do you understand that?

A I do.

Q And he's not on any of those narcotics today. He's not on hydrocodone, OxyContin, 1500 mill -- he's not on 1500 milligrams of opioids a day. Do you understand that?

A Not at this time, he's not.

Q Now, so Doctor, let me move on to the next topic. There was some talk about other things, other modalities that you tried. And I just want to clear this up because, you know, short of going through every page of these records with the jury, I want to make sure we're clear -- I want to find out what I'm not clear on. Maybe we have some disagreement.

First of all, do you agree that a good doctor should try other things before putting a patient on opioid narcotics?

A The problem with that statement is the before. I think the modalities we use are often kind of intertwined together so use of an opioid agent may be very effective as you're investigating or utilizing other modalities. I think that is a very common practice and often gives you the bridge to get to other therapies that may be very, very effective.

Q Could you put up 60-10, please, Mike.

MR. VENKER: Your Honor, may we approach.

THE COURT: You may.

(Counsel approached the bench and the following proceedings were held:)

THE COURT: All right. I'll be honest, it was up so fast, I didn't see it.

MR. VENKER: This is the safety rules. Would that be the best way to shorthand it? They put these up with Dr. Genecin. I objected at that time. I'm renewing my objection. I think at the time they said that Dr. Genecin had either -- was the source of these or had talked to Mr. Simon about them or whatever. But clearly Dr. Walden hasn't talked to anybody about them. So I renew my objection from before. These should not be up and displayed. I think to say rules in a medical malpractice case when we're supposed to be talking about the standard of care, not just something as simple as

rules. I renew my objection.

MR. SIMON: Tim reminded me the objection was for leading. This has been admitted into evidence. Rules endorsed by our expert. This is cross-examination of the defendant.

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

(The proceedings returned to open court.)

Q (By Mr. Simon) Mike, 60-10, please.

Doctor, do you agree that opioids should not be used if safer alternative are available?

A I believe these alternative that may be safe need to be effective.

Q Okay. Do you believe opioids should not be used if effective safer alternative are available?

A Once again, they can be used together with many different alternatives. And opioid use can be very safe for patients like Mr. Koon. So yes, they're used with safer alternatives.

Q But Doctor --

A They're not excluded until these alternatives aren't effective.

Q And I think that's sort of -- that's what I'm hearing you saying. So you're telling us today that if there is a safer, effective alternative, you wouldn't use

that before putting your patient on opioid narcotics? Is that what you're telling us?

A No, sir, I didn't say that.

Q My question is if there is a safer, effective alternative available, should you use that before you go to opioid narcotics?

A It's a reasonable maxim that has to be applied in a clinical setting with a specific patient, I think. There are very safe uses of low doses of opioids like I used with Mr. Koon that can be very effective and actually supplement the benefits you get from other alternatives.

Q So Doctor, while we've got this up -- we're not really on the topic -- do you agree that when prescribing opioids, the lowest possible dose should always be used?

A I think that's a reasonable general statement.

Q Okay. And let's hit the last one. Do you believe that opioids should be used for the shortest time necessary?

A It's a general statement, emphasizing the important words there are necessary.

Q Do you agree with it?

A I agree with it, yes.

Q Okay. Now, so Doctor, I've gone through your medical records and it looks like beginning in '08, in February of '08, the only thing -- the only thing that you

did from May of '08 forward, until Brian left your care, as far as other modalities was a single referral for a surgical consult. Is that correct?

A No, that's incorrect.

Q Okay. Tell me what else you did from -- well, let's talk about from February -- from February of '08 when you started Brian on opioid narcotics, what other modalities did you use or referrals -- and I'm talking about physical therapy, pain management, counseling, injection therapy, chiropractor treatment. Did you do anything else up until the time he left your care, other than a single referral to Dr. Place?

A Yes, I did.

Q What was it?

A He -- Mr. Koon saw four different general internists in my office from 2008 onward. He used rest, he used heat, he used muscle relaxants, he used six different courses of nonsteroidal anti-inflammatory agents. Ibuprofen, piroxicam, Relafen, Celebrex, indomethacin and Voltaren. He had two surgical consultations.

Q Okay.

A He had --

Q You referred him to one though; correct?

A That's correct.

Q You didn't refer him -- he went to Dr. Heim on his own. You referred him to Dr. Place; correct?

A I referred him to Dr. Howard Place.

Q Okay.

A He had a course of physical therapy, he had --

Q Doctor, you didn't refer him to the physical therapy; correct?

A No, I didn't refer him to the physical therapist. I didn't want him to see a physical therapist until he had seen Dr. Howard Place. I worked with Dr. Howard Place many, many times, and I know that if Dr. Place does not find a surgical lesion to treat, that he will prescribe physical therapy in the exact needs that Mr. Koon had. So I didn't refer him to physical therapy, although I did write it in my note that that would be a possible modality of care. I knew Dr. Place would do so, and I wanted to make sure it was safe for him to engage in physical therapy and I needed Dr. Place's okay to do it.

Q Doctor, let me be a little more specific. And I apologize. Okay. From February -- from the time you referred him to Dr. Place -- and that was on -- he saw Dr. Place on, I believe, May 19th of '08. Does that sound about right?

A That would be about the time, yes.

Q Okay. So from May 19th of '08 when you referred

him to Dr. Place, from that point, for the next four and a half years, until August of 2012, did you refer him for any physical therapy?

A Mr. Koon utilized all of his insurance benefits for physical therapy when he saw Dr. Place. I could have referred him back, but it -- he didn't have any coverage for that. And that's why those terminated and so --

Q Doctor, we're talking about four and a half years. My question is did you refer Brian Koon to any physical therapy during those four and a half years?

A I did not, sir.

Q Did you refer Brian Koon to any pain management during those four and a half years?

A Yes, sir.

Q What pain management -- on his request; right? In February, that would have been Dr. Berry; correct?

A To Dr. -- we talked many times about pain management. Again, he terminated pain management care with Dr. Christopher because the cost was too high. He had to pay a lot of money for pain management and injection therapy. I can't force him to use his money for those services when he's got better uses of it, sir. I did refer him to Dr. Berry as soon as he told me he was ready to go back to pain management.

Q Doctor, so everybody understands, in May of '08,

you gave him -- you referred him to Dr. Place for a surgical consult; correct? Right?

A Yes.

Q And then way later, in 2012, that's when Mrs. Koon called your office and asked for a pain management referral; correct?

A Correct.

Q And that's when you referred to Dr. Berry; correct? At your patients' request. They asked you to do it; right?

A As soon as they told me they were ready to go, I referred them, yes.

Q This is not something that you did on your own; correct?

A Well, they have to go. I mean, I'm not going to force people to do something that they're not going to want to do. I had talked with him on multiple occasions about following the pain management. He terminated that relationship himself. And when he said I'm ready to go back to pain management, I immediately referred him for pain management.

Q So Doctor, from May 30th to the time Brian quit treating with you, from May 30th to the end -- August of 2012, did you, on your recommendation, refer any physical therapy, pain management, counseling, injection therapy,

chiropractor therapy? Any of that?

A May 30th of what year are you talking about?

Q Of '08.

A Of '08. Of those entities that you mentioned, no.

Q Okay. So Doctor, what you did was a single surgical consult in May of -- in May of '08, and you sent Brian to Dr. Berry when they asked to be sent to Dr. Berry four years later; correct?

A It makes no sense to send someone to a pain management doctor when they're already seeing a pain management doctor. So he had had pain management care with Dr. Christopher. So for me to refer to another pain management doctor would have not made any sense.

For him -- for me to refer for physical therapy when he's already in physical therapy or refer for chiropractic care when he's already in chiropractic care would not have made any medical sense. We work within a multidisciplinary team. I think that's the part that you're not quite grasping. The multidisciplinary team --

Q I'm not grasping.

A -- is made up of multiple individuals, and they play different roles in the care of the patient. So Dr. Christopher reported to me her results that she was receiving with Mr. Koon. And so I was aware of what she

was doing.

Q You didn't send him to Dr. Christopher, did you?

A It was not me who sent him to Dr. Christopher, that's correct.

Q Okay. So let's move on to Dr. Berry. You did refer Brian to Dr. Berry at the family's request; correct?

A The family requested a pain management referral; I chose Dr. Berry.

Q Sure, Doctor. And did you -- are you aware of what Dr. Berry did?

A Yes, sir.

Q Okay. He diagnosed opioid dependence. He ordered an MRI. He diagnosed an L4-L5 nerve root impingement. He gave epidural -- ordered epidural injections. Referred Brian to Dr. McKean for counseling. And he recommended a treatment program for dependency. He did all of those things. Were you aware of that?

A Yes, sir, I was.

Q Okay. And he did those on one or two visits; correct?

A Correct.

Q So Brian had been with you for four and a half years, and you didn't recommend any of these things or refer him for any of these things. They asked to go to a pain management doctor, you refer him to a pain management

doctor, and in two visits all of these things are accomplished. Am I understanding this correctly?

A What I wanted from Dr. Berry in his referral, in his consultation, is exactly what I got. I wanted those things. That's why I needed a pain management physician to assist in the care. He needed to be involved in the care of the patient. And I needed his opinion. And I valued that opinion.

Q So Doctor, should you discuss the risks and benefits of long-term opioid therapy -- or opioid narcotics before you give them to a patient?

A Yes, sir.

Q Does the standard of care require you to do that?

A That sounds like a legal question that I'm not sure I can answer. But I think it's a reasonable practice.

Q Okay. 60-5, just so we clear this up, Doctor. 60-5, please, Mike.

And, Doctor, you've seen this before. I showed it to you in deposition. Do you remember me showing you this?

A I don't recall you showing me any exhibits like this, but I do remember these -- these words, yes.

Q Me asking you this. That's fair. You're right.

You're right.

Standard of care. Using that degree of skill and learning ordinarily used under the same or similar circumstances by members of your profession.

Have I read that correctly?

A Yes, sir.

Q Okay. That being the standard of care, Doctor, do you believe the standard of care requires a physician to discuss the risks and benefits of opioid narcotics before the physician prescribes them or gives them to the patient?

A I think it's a good practice to do so.

Q Okay. Is it negligent not to do so, Doctor?

A That again sounds like a legal term that I don't use in the medical practice so I'm not sure --

Q Do doctors -- do doctors using that degree of skill and care and learning ordinarily used under the same or similar circumstances in your profession do that? Do doctors normally -- do good doctors explain the risks and benefits to their patients before they put them on dangerous opioid narcotics?

A I think unfortunately a lot of members of my profession do not do what you say.

Q The folks you work with at SLUCare?

A No, not the folks at SLUCare I'm referring to.

I'm talking about physicians in general in the community. I think this would be something that, as Dr. Gunderson talked about, there is a need in the community and in the practice of medicine for this to be more uniformly done. I think no, it's not typically done.

I think I went way above the -- the norm in talking about this with Mr. Koon because I made sure that he understood the risks and benefits. I made sure I understood his risks and benefits. And we talked about this over and over and over and over again in our office visits and our telephone calls.

Q So Doctor, let me ask you this: Before we get to that, are you telling us that you had the discussion with Brian about the risks of opioid narcotics before you prescribed them to him on February 29th of 2008?

A Yes, sir, exactly.

Q Okay. Let's go, please, if we could, Mike, to Exhibit 1-1. And let's go to page 14. And I know the jury's seen this multiple times. I didn't think we were going to have to do this, Doctor, but we'll look at it. This is the visit where he comes in complaining of back pain. Would you blow up the top part of it, please, Mike.

This is where you were asked earlier, you know, he fell in the shower. And heavy lifting on the job. He comes in complaining of back pain on 2/21/08; correct?

A That's correct.

Q All right. And then let's scroll down to Assessment and Plan, Mike. Okay.

Assessment and Plan. Back pain tender to palpitation over the thoracic area. Will check PA and lateral x-rays of the thoracic and lumbosacral spine to rule out compression fracture. Continue cyclobenzaprine and Advil as needed. Have I read that correctly?

A Yes, sir.

Q Okay. And cyclobenzaprine, that's a muscle relaxer; right?

A Correct.

Q And Advil is an anti-inflammatory; correct?

A Correct.

Q And neither one is an opioid Schedule II narcotic; right?

A Correct.

Q So he comes in with a back problem, back pain, strain. You put him on the muscle relaxant and the Advil; right?

A Correct.

Q And that's on the 21st of February, Doctor; right?

A That is correct.

Q Okay. The next page, please, Mike.

And I'm really going through this, I want the jury to understand how this transpired, Doctor, from what we can see in your records. This is the x-ray that was basically negative. No fracture or subluxation; correct?

A Correct.

Q Okay. And then let's go to the very next page. Page 16 of Exhibit 1-1. Doctor, this is -- this is what I want to talk to you about. This is the -- this is the first time you put him on these narcotics; correct?

A That is correct.

Q Okay. And let's see what happens here. This is 2/29/08. That's eight days later; correct?

A Correct.

Q This isn't an office visit, is it? He's calling in. It says message; right?

A This is eight days after the office visit.

Q Right. So he calls in and it's a message for you; correct?

A Correct.

Q All right. And then it says message, in on 2/21/08, has had x-rays for back. Right here; correct?

A Correct.

Q Okay. And then it says over here, back still giving -- back still giving muscular and vertebrae patient discomfort. Have I read that correctly?

A Yes, sir.

Q So he's calling you and he's saying he's still having some discomfort with his back; correct?

A That's correct.

Q And then he says Advil not helping on some days. Have I read that right, Doctor?

A Yes, sir.

Q Okay. So that's the message. He's saying he's still having some discomfort because the Advil isn't helping him on some days; right?

A Correct.

Q Okay. And then it says here would you call in pain med for patient, question mark. You didn't write that, somebody else wrote that; right?

A That's written by the nurse who took the notes.

Q So the nurse is sending this note to you, saying doctor, he's called and said he's got a little discomfort in his back because Advil isn't working everyday and would you call him something in; right?

A Correct.

Q And you call in 5/500 Vicodin, 30 pills, and you give him 30 on the refill; right?

A It allows him to get one refill after he's exhausted his first 30 pills, yes, sir.

Q Okay. So you give him 60 Schedule II narcotic

pills because he calls in on the telephone and he says he's still having some discomfort in his back on some days; right?

A No, that's not correct, sir.

Q Did I read that correctly, Doctor?

A Well, you read it correctly, but you didn't interpret it correctly.

Q Well, did you --

A Number one, the Vicodin is not a Schedule II narcotic.

Q It wasn't at that time, but it is now; correct, Doctor?

A But that's a very important -- a very important difference. Because a Schedule III narcotic medication can be called to the pharmacy. And so at the time that I called that in, yes, that was a Schedule III and it was entirely legal and customary to call that in to the pharmacy.

Q I'm not asking you about that, Doctor. I'm not criticizing your calling it in to the pharmacy. What I'm asking you here is this doesn't indicate that you spoke to Brian at all.

A Yes, it does. You're incorrect.

Q Where does it show here that you talked to Brian?

A Right above the pharmacy phone number there. Down, down. Over to the right. Up, up. Right there. Discussed with patient.

This is my discussion with the patient when I discussed the risks, the benefits, the adverse effects and the risks for addiction, dependence. This is a short discussion, it's not a long one. I'm not on with him for hours, but this is a discussion where I talked to the patient about this particular intervention and we decide mutually that this is, in fact, the best step we're going to take right now. So I think the testimony previously that I didn't discuss this with him is -- is --

Q Okay --

A -- is misleading.

Q Okay. Well, Doctor, let me ask you this, because I certainly don't want to mislead. Let me ask you this. I looked at your records, and I found two places that said you discussed the risks and benefits -- the risks and benefits of the opioid medications. Two places in four and a half years.

One of them was on 8/18 -- I'm sorry. One was 8/20/09, and that was the first time that I saw it. Let's go, please, Mike, to page 38 of Exhibit 1-1. Can you blow that up, please, Mike.

Okay. So Doctor, if this is August 20th of '09,

this is about 18 months later; correct? About a year and a half; right?

A Correct.

Q And it says back pain, increase OxyContin to 40 milligrams BID. Continue Vicodin as needed for breakthrough pain. Discussed possible adverse effects and risks of dependence. We both agree the benefits clearly outweigh the risks in use of narcotic analgesic.

Have I read that correctly?

A Yes, you have.

Q The other one I found, Doctor, was two years later on five -- I'm sorry, August 18th of '11. And, Mike, if you could, please, go to page 22 of Exhibit 1-1. I'm sorry. It's not -- page 37. Hang on one second, Mike. I'm sorry. Page 56. I'm sorry. Okay. Could you blow that up, please. Okay. I don't see it on there.

Okay. Doctor, can you point to any other entries where you discussed the adverse effects?

A I talked -- we had at least two of our office visits that were spent 60 to 70 percent talking about nothing other than this. These are why I documented these -- these notes.

In the course of my care of Mr. Koon and the other patients that I see in the office, I make these decisions hundreds of times a day. Documenting these

decisions, I probably had ten more phone calls to make when I handled Mr. Koon. Documenting a risk benefit decision in the medical record is not standard care. However, these -- these discussions and decisions happen almost continuously. It would be as if you asked Judge Noble to write a 15 minute explanation of why he decides to sustain an objection or not. He made the decision. And you talk with the patient and you describe it and then you go on.

Q Doctor, let me ask you this. Let me ask you about weaning. Your records do indicate that you were trying to wean Brian; correct?

A There were two different types of weans attempted with Mr. Koon.

Q Okay. And the first one, let's go to Exhibit 1-1, page 25, please.

Okay. And, Doctor, this would have been August 19th of '08 so we're talking about six months, right, after you started the medication; correct?

A Sounds correct, yes.

Q Okay. And it says continue Vicodin and wean as tolerated for back pain; correct?

A Correct.

Q Okay. And then I think there was another one. If we could, Mike, please go to Exhibit 1-1, page 45.

Okay. And this is 2/11/10. Could you blow up the top half, Mike. I'm sorry. Assessment plan on the bottom. All the way down.

Okay. And it says back pain, agree with slow weaning if -- of narcotics. It says if, but I think that means of. Correct?

A Correct.

Q Okay. So Doctor, did you -- do you do any weaning or lowering the amount of -- did you lower the amount of the narcotics any time in the year 2009?

A I guess you're asking if I prescribed fewer narcotic medications, and that was not the process that we were undergoing at that time.

Q In other words, was the dose or amount lowered at any time in 29 -- in 2009?

A Oh, no, it was not lowered, sir.

Q Okay. Was it lowered in 2010?

A No, it was not.

Q Was it lowered in 2011?

A No, sir.

Q So Doctor, let me ask you this: Schedule II narcotics are not allowed to be prescribed over the phone; is that correct?

A That's correct.

Q Okay. And that's federal law? Missouri law?

A That's a federal law.

Q Okay. And Schedule II narcotics, no refills are allowed; correct?

A That's correct.

Q Is that also a federal law?

A Yes, sir.

Q Okay. And Schedule II narcotics, you can only give a 30-day supply? I'll let you finish your drink, Doctor. Ready?

A Ready.

Q Okay. Schedule II narcotics, you can only give a 30-day supply; correct, Doctor?

A That sounds correct.

Q Okay. Is that also federal law?

A I haven't read the law exactly. I don't know if that's in the law or not, but --

Q It's -- either federal law, Missouri law, you're aware that you can't do it; right?

A It's designed so that you get a one-month supply with each written prescription.

Q Okay. Doctor, let me ask you this: You saw SLU's policies and procedures; correct? Earlier when they were up.

A Yes.

Q First page.

A I recall.

Q And let's put up, Mike, if you would, please -- let's put up Exhibit 40-1. Okay. And if you could go to the middle, Mike. Blow that up.

Okay. Number two, Doctor. You're familiar with that; correct?

A Yes, sir, I am.

Q Okay. And can you highlight that for us, please, Mike.

And, Doctor, that says practitioners who prescribe Schedule II controlled substances must maintain a record of all such prescriptions in the patient's medical record; is that correct?

A That's correct.

Q Okay. And is that the policy of St. Louis University?

A Yes, it is.

Q Was it the policy from 2008 to 2012 when you were treating Mr. Koon?

A Yes, it was.

Q Okay. And let's scroll back up to the top. Okay. And it says the purpose of this procedure is to ensure that the prescribing of controlled substances complies with the applicable state and federal regulations. Have I read that directly?

A Yes, sir.

Q Doctor, is it your understanding that Missouri law requires documenting -- that all controlled substance activities are required to be documented in the patient's chart? Is that Missouri law?

A Yes, sir, I believe it is.

Q It's also federal law; correct?

A Correct.

Q And you heard Dr. Guarino testify this morning that it's also the standard of care; correct?

A I -- I don't recall that specifically, but that sounds very reasonable, yes.

Q Okay. So Doctor, federal and state law requires that all controlled substance activities are to be documented in the patient's chart; correct?

A Yes, sir.

Q Okay. And, Doctor, you prescribed morphine; correct?

A Correct.

Q Okay. I think on four different occasions. Is that your recollection?

A That's correct.

Q Okay. And, Doctor, could you point me to where those are in your medical records, please.

A Those would be in -- well, there's a short span

in -- well, June and July, I think, of 2000 -- June and July of 2010.

MR. VENKER: Your Honor, may we approach.

THE COURT: You may.

(Counsel approached the bench and the following proceedings were held:)

MR. VENKER: Your Honor, I'm not sure -- I wasn't sure this issue would even come up, Judge. Nobody has made an issue about it and no expert has testified about it. And what I think John is referring to is there is a page in the telephone encounter records that talk about the morphine prescriptions I think he's referring to. And there's an explanation of it. It just came to my attention in the last couple of days. I really didn't think it was going to be an issue.

MR. SIMON: It's not records?

MR. VENKER: It's electronic records, and so yes, it's in the records.

MR. SIMON: Yes. This has not been produced to us in this case.

MR. VENKER: Judge, I --

THE COURT: So --

MR. VENKER: My point is I didn't think this was any issue at all. I just found out about it the other day. Dr. Walden said he remembered a telephone encounter.

The electronic medical record would be -- I inherited this case. I don't even know that a telephone encounter is an electronic record. But my point is this really doesn't have anything to do with Dr. Genecin or anything about this case, Judge.

MR. SIMON: Judge, this has everything to do about with this case. Because of the authenticity and the credibility of this doctor's records. I intend to show two-thirds of these prescriptions from the pharmacies are nowhere in his records. Okay? This means records -- three-fourths of the prescriptions aren't even in there.

Now we're getting documents produced to us that we asked for during the middle of the examination of a witness? Judge, they can't pull electronic records out during the middle of an examination of a witness. If that's what I'm hearing this is.

MR. VENKER: You've produced a chart of all the prescriptions. You haven't talked at all about how there's no basis for this chart that you've made up. Plaintiff's Exhibit 36 and it goes to 37.

MR. CRONIN: It's been stipulated to you in writing.

MR. VENKER: I'm not debating it. The point is nobody said hey, we have support for these prescriptions, Paul and John. You need to figure out what's going on.

They asked us about it. So this is in that list. These prescriptions are in that list. They're not not there. We haven't hidden anything.

MR. SIMON: Judge, I've never seen this before.

MR. VENKER: I haven't seen it before the other day.

MR. SIMON: We asked for the complete chart of records. We took depositions. We hired experts. We spent tens of thousands in this case. Based on records. And then when we asked this doctor to verify something in his records, they're pulling out new records during the middle of cross-examination?

THE COURT: Go ahead.

MR. SIMON: I mean, this is crazy, Judge.

MR. VENKER: It's not --

THE COURT: Let's not use the word crazy. Now what do you -- so what you're telling me is that this is a telephone record that was not turned over in discovery?

MR. VENKER: Judge, I was --

THE COURT: So I have a piece of discovery that has not been turned over. All right. So what --

MR. SIMON: If they didn't disclose it, they can't use it. I can't question anybody about it.

THE COURT: So here's my ruling. This would fall under late discovery. If the plaintiffs haven't had

time to authenticate, prepare on it, I think it coming in at this late moment would be prejudicial because there is no ability to authenticate it on the stand. So you're going to be allowed to --

MR. SIMON: To confirm that this information isn't in the documents that he has.

THE COURT: Right. On rebuttal, this is not a proper piece of rebuttal.

MR. VENKER: Okay. It is or it isn't?

THE COURT: Is not.

MR. VENKER: Thank you, Your Honor.

(The proceedings returned to open court.)

Q (By Mr. Simon) Doctor, have found any -- any mention of your morphine prescriptions in the medical records that your attorneys produced to us in this case?

A I haven't had a chance to search them. I know they are there. I have no way of prescribing with an electronic health record a medication that isn't recorded within that electronic health record. When I'm prescribing opioid analgesic, I have to enter an order in the electronic health record for that medication. It's printed on a special narcotic controlled substances form with special watermarks and numbers. I have to sign that. And every prescription of any kind, controlled substance

or noncontrolled substances, is contained within that electronic health record. And no other method is used to dispense that medication.

I did, in fact, prescribe morphine for Mr. Koon.

Q All right. Doctor --

A And I prescribed it completely and totally within the law of the State of Missouri and the U.S. Code.

Q Let me help you. Let me help you. Mike, let's go, please, to Exhibit 30, page 24.

Okay. These are the Walgreens records. Let me grab my copy, Doctor, so I can give you a date. What I'm going to try to do is give you a date and maybe that will help you. Okay?

Okay. These are the records that we subpoenaed from Walgreens, Doctor. And so let's go to the first -- the fourth prescription, about the middle of the page, Mike, that says morphine sulfate. Do you see that? Let's blow that up.

Okay. So -- and there are two of them -- we've got two of them there; right, Doctor? And the top one says morphine sulfate, 30 milligram tablets; right? And it's June 10th of 2010. And then the other one is morphine sulfate immediate release, 15 milligram tablets, and they're both -- they look like -- that one's June 9th.

Will that help you with the records? It looks

like the pharmacy indicates that they were prescribed in -- on June 9th or 10th of 2010. Okay?

A I recall prescribing these medications. I know I prescribed these medications.

Q Understood. I'm asking -- these are the records that your lawyers gave us in this case when we asked for all of Brian Koon's medical records. We got an affidavit, they're there in front of you, they're marked as an exhibit.

My question is, can you find these prescriptions in those records?

A There's hundreds of pages here. I don't know how long you want me to search for them.

Q They're in order. They're in date order; correct, Doctor?

A They appear to be. Although I do not see the records from June of 2010, sir.

Q Okay.

A So I can't --

Q Well, Doctor, let me ask you this: Let's go to Exhibit 30, page 21. And Exhibit 30 -- again, Doctor, these are the prescription records from Walgreens. Okay? And I -- as I was going through your chart, Doctor -- and I've gone through it several times -- I couldn't find this prescription in there either. And this is -- Mike, if you

blow up the middle one where it says oxycodone, 5 milligrams, immediate release.

Okay. And this is dated, it looks like, October 27th of '09; right? And, Doctor, certainly you can find that in your records; correct?

A October 27th.

Q Any luck, Doctor?

A I don't -- there's -- there is no mention of that. Although, as you may -- I mean, you've already mentioned the prescription for these Schedule II medications have to be written on a monthly basis.

Q Sure.

A Every month they must be written and signed, and the medications that I prescribed for Mr. Koon, except for the hydrocodone acetaminophen, have to be written every month.

Q Right. So Doctor, you're not able to find any record in your records, the ones that were produced to us, the ones that we've been using for the last three years in this case, you're not able to find any record at all of the morphine prescription on 6/9/10 and 6/10/10, and you're also not able to find any information about the IM drug prescribed -- dispensed by Walgreens on October 27th of '09; correct?

A I find them all in the electronic record for

Mr. Koon. I don't find them in the -- in the clumsy -- kind of clumsy paper record. We use an electronic heath record that reports every medication that's prescribed.

Q I believe you. I believe you. What I'm getting at is we -- we asked for all of your medical records on Brian Koon. We were provided this document marked as Exhibit 1. It's identical to Defendant's Exhibit A. We've been told for the last three years that that is a complete set of all of Brian Koon's medical records; correct, Doctor? Do you know that, Doctor?

A No. I was not involved with that at all.

Q Not only that, Doctor, but did you realize that all of your experts in this case who would come into this courtroom and testify before this jury used that set of medical records? You understand that?

A I hear you saying that.

Q Okay.

A I'm not involved in the medical records department.

Q Understood. So in other words --

MR. VENKER: May we approach, Your Honor?

THE COURT: Yes.

(Counsel approached the bench and the following proceedings were held:)

MR. VENKER: Your Honor, I'm just going to

object. I admit, this is the first time I've been in this situation, but this is -- this information, no one has talked about up to now. No one has complained about up to now. No expert has relied on whatever it is John's driving at. So I object to this really as being beyond the scope of the pleadings. I don't think it's admissible to put a discovery dispute out in front of the jury. I think it's beyond the scope of the pleadings. It doesn't interfere with his expert, Dr. Genecin --

THE COURT: I'm not precluding you, but --

MR. SIMON: I'm going to --

THE COURT: Because -- wait, wait. Here's the issue. I'm not going to stop you, about you've got to remember -- all right. I'm going to let you go.

MR. SIMON: Okay.

(The proceedings returned to open court.)

Q (By Mr. Simon) So Doctor, I want to tell you what I did this weekend. I spent this weekend going through this stipulated exhibit, Exhibit 36. And these are the pharmacy records. Every prescription written by these different pharmacies by your office to Mr. Koon during the time period over the last four and a half, five years. You're aware of this document; correct?

A Yes, sir.

Q And, Doctor, what I did this weekend is I went through and I looked through all of these records and tried to match them up in the medical records that were produced by your lawyers in this case. And what I found was more than half of them --

MR. VENKER: Your Honor, I'm just going to object. This is just speculation.

THE COURT: Overruled. But let's --

MR. SIMON: Speed it up. Yes, Your Honor.

Q (By Mr. Simon) So Doctor, about half of them, about half of the prescriptions are nowhere to be found in the medical records. Now if you want, we can go through them, Doctor, but they're not in there. Were you aware of that?

A I know they're in the electronic record which I used to take care of Mr. Koon. No prescription for any medication, whether it was a Schedule II, Schedule III or uncontrolled -- noncontrolled substance can be prescribed with our system without it being recorded in the medical record. At no time did I ever write a prescription that was not recorded in our electronic medical record. And at no time did I ever -- have I ever in my life written a prescription that's not consistent with federal and Missouri law.

Q So Doctor, I -- the set of records that you have

there, pages 407 to 504, are the records from 2011. 407 to 504. I think page 407 is the beginning and 504 is the end.

Okay. And, Doctor, what I'd like to do is could you take me through those pages and tell me -- identify the prescriptions that you wrote in 2011.

MR. VENKER: Your Honor, I'm just going to object. This is cumulative. I think we've already -- we've already done this.

THE COURT: Overruled. We'll see where this is going.

THE WITNESS: 407, I believe you said?

MR. SIMON: Yes, sir. Page 407.

THE WITNESS: 407.

Q (By Mr. Simon) And, Doctor, I can speed this up a little bit. I found four prescriptions, and one is on page 447 and the other one is on page 448. Do you see those?

A 447, I do see that, yes, sir.

Q Okay. And you see it's Oxy-IR, 480 tablets, 15 milligrams; right?

A Correct.

Q And then on the next one, on page 448, is also 5/17 of 2011, and it's OxyContin, 240 pills at 40 milligrams; correct?

A That's correct.

Q Okay. And then if you could, please, turn, Doctor, to 469.

A Yes, sir.

Q And that's a prescription for OxyContin, 240 pills, 60 milligrams; correct?

A Correct.

Q Okay. And then if you could turn to the very next page, Doctor, page 470. And that's OxyContin, immediate release, 600 pills; correct?

A That's correct.

Q Okay. And, so Doctor, those are the only four prescriptions I could find in your records for the year 2011. Do you see any others, Doctor?

A I haven't looked through all of them. The electronic health record will not, I think, provide you with the information you're trying to find, sir. I think it's recorded in the electronic health record, but I don't see that you have -- that there's necessarily a paper copy or a specific notation of those in here.

Q So we don't have the prescriptions that you wrote here in the courtroom; correct? In your medical records; right?

A They are in the electronic health record of Mr. Koon that was used to provide his care.

Q Okay. My question, Doctor, is in this courtroom and in this case, we have not been provided -- the experts, Mr. Koon -- with all of the prescriptions that you wrote. They're not all in your medical records; correct?

A They are in my medical records, sir. Every one of them is in --

Q Not the ones we have here is what you're saying; correct, Doctor?

A The papers that you provided me right now, I don't see them as I look. But I suspect that they are in the electronic health record. There's no way, sir, that I can prescribe a medication of any kind with our electronic health record without it being recorded. It's recorded permanently in the entire history of every medication a patient has taken and prescribed, that is, is recorded in that record.

Q So are you telling us, Doctor, the complete -- your complete record isn't here? Is that what you're telling us?

A This is not the electronic record that I use to take care of Mr. Koon.

Q Doctor, are you telling us that we do not have your complete -- the complete set of medical records for Mr. Koon's treatment?

A I haven't looked at the whole record. If you want me to look at the record -- I can't -- I can't tell you that. I have to look through this entire volume to know that. But I can tell you that every medication that was prescribed for him was contained in the electronic health record and was done according to the law of the State of Missouri and the United States.

Q So Doctor, if it's not here, that means that the experts that your attorneys have hired in this case were not provided with a complete set of medical records with all the prescriptions; is that correct, Doctor?

A I don't know the answer to that question, sir.

Q Okay. Doctor, before we move off of 2011, I added up those four prescriptions that you just identified and it amounts to about 1,560 pills. 480, 240, 240 and 600. Certainly you wrote more prescriptions for more pills than that in 2011; correct, Doctor?

A Yes, sir.

Q So in other words, Doctor, according to the pharmacy records, I think it was about 13,000 pills that were written; correct?

A I think -- I know it was a lot of pills. I don't know the exact number, sir.

Q Okay. Now Doctor, we talked about dosing guidelines. And you remember the -- the interagency

guidelines for opioid dosing that recommended no more than 100 milligrams, 120 milligrams a day for 90 days. Do you remember that?

A I remember the statement said in general, yes, sir.

Q Okay. And you generally agree with those guidelines; correct, Doctor?

A Yes, sir, I do.

Q You generally agree that the total daily dose should not exceed 120 milligrams; correct?

A In general I do agree with that, yes, sir.

Q All right. And, Doctor, you were here when your expert, Dr. Gunderson, testified; correct?

A Yes, sir.

Q And he wrote a letter to the federal government saying opioids shouldn't -- there should be a maximum amount of 90 milligrams a day for no longer than 90 days; correct?

MR. VENKER: I'm going to object to this witness being questioned about Dr. Gunderson's letter. On foundation.

THE COURT: Overruled. He can answer.

Q (By Mr. Simon) Okay. You from here when it was presented; right, Doctor?

A I was here when it was presented, sir.

Q So Doctor, let's go to -- let's go to Exhibit 37, please, Mike.

Okay. And, Doctor, you're aware this information is not disputed in this case; correct?

A Correct.

Q Okay. Let's go up to the top, Mike. This is the total dose per year. We've seen this before. Go to the second one, Mike, please.

Okay. This is the average daily dose, Doctor. We started out with 49.67 in 2008 and worked your way up to 1,555.94 milligrams in 2012; is that correct, Doctor?

A Correct.

Q So you increased the amount about 30-fold over that four and a half year period; correct, Doctor?

A It appears that your calculation is correct.

Q Okay. And, Doctor, all of that was for your diagnosis of back strain; correct?

A No, sir.

Q Isn't that what you diagnosed, Doctor? Back strain or sprain?

A No, sir.

Q Okay. Did you ever make a diagnosis as to -- as to Mr. Koon's back injury?

A Yes, sir.

Q Okay. And, Doctor, let me ask you this. Page

85, please. Okay. Doctor, do you remember me asking you these questions and giving these answers in your deposition?

"QUESTION: So as far as you know from your treatment, you think it was muscular?

"ANSWER: Muscular contributed to it, definitely.

"QUESTION: All right. Musculoskeletal because of the degenerative arthritis in his back?

"ANSWER: True. And his heavy lifting and manual labor, I think, contributed to him having exacerbations of the pain.

"QUESTION: Sort of like back strain, back sprain; right?

"ANSWER: Similar, yes."

Doctor, do you remember me asking you those questions and you giving those answers?

A Yes, sir, I do.

Q So Doctor, what you're telling us is we don't have all of your prescriptions here today in your medical records; is that correct?

MR. VENKER: Object as asked and answered, Your Honor.

THE COURT: Sustained.

Q (By Mr. Simon) Doctor, but you're telling

the jury that all of the information that Brian or Michelle conveyed to you is contained in the records and we don't have all of them?

A I don't think I said that.

Q Doctor, when Brian and Michelle left your care, made the decision to leave your care, he was on 1,555 milligrams a day; correct?

A I think you said that was the average daily dose so I don't think that --

Q Could have been higher on some days is what you're saying; correct?

A I think when he left my care, he actually was on a taper that was in the neighborhood of -- it would be 240 plus 240 plus 240 or 720. And in morphine milligram equivalence, that would be approximately 1,000. When he started the taper, he was coming down on that taper when he left my care. So he was clearly on his way down on his dosage as we tapered his medication as I prescribed earlier.

Q Doctor, I have no further questions.

THE COURT: Any redirect?

MR. VENKER: Yes, Your Honor.

**REDIRECT EXAMINATION**

BY MR. VENKER:

Q Doctor, would you look at page 83 of your

deposition, line 25.

A Yes, sir.

Q Mr. Simon was just asking you earlier about what was on page 85; correct?

A Correct.

Q But he also asked you what was the cause of Brian's back pain. Do you see that on line 25 at page 83?

A Yes, I do.

Q All right. Let's just read for us your answer from line 5 on page 84 down to line 21.

A When he was seen on multiple visits for back pain starting in 2003, many of these initial visits were for muscular pains of various sorts associated with his -- his job, which involved heavy lifting, manual labor and were -- and resolved after shorter courses of conservative therapy. He began to have more persistent pain in 2008, and that's when further evaluation was performed with x-rays and MRIs and orthopedic evaluations. And the exact cause for his pain was not entirely clear. He appeared to have some degenerative arthritis on various studies, but that's not an uncommon finding on x-rays or MRIs. So many times it's difficult to pinpoint a precise cause of pain for each patient.

Q All right. Mr. Simon asked you whether you ever -- you ever got a diagnosis. Ever got a diagnosis or

made aware of a diagnosis of what his -- Mr. Koon's back condition was or what was causing the pain. I think it goes on to line 85. Do you see your answer there, lines 2 to 5 on page 85?

A Yes, I see that.

Q Okay. And did you say there basically that he had degenerative arthritis?

A Yes, I did.

Q That it was musculoskeletal?

A Correct.

Q And it's issues that wouldn't show on a plain film x-ray; correct?

A That's correct.

Q That's all I have.

MR. SIMON: Nothing further, your Honor.

THE COURT: All right. Thank you, Doctor.

(The witness was excused.)

THE COURT: Attorneys, approach.

(An off-the-record discussion was held at the bench.)

THE COURT: All right. Ladies and gentlemen, I kept you a little long, but I just want to give you a little idea of how the rest of the trial is going to go. I'm going to release you tonight. We're going to stay here, we're going to hammer out all the jury instructions.

We've got a pretty good handle on them, but we're going to stay and do that.

There's an hour more of evidence, and then each side is going to do closing argument. I've given each side an hour. So you will get this case before lunch tomorrow. Okay?

So that being said, the Court again reminds you of what you were told at every recess so far. Do not discuss this case with anyone. Please do not form an opinion about the case until it's finally given to you to decide. Please do not do any research or any independent investigation on your own. And please do not communicate with anybody about the case until it is finally given to you to decide.

We'll be in recess until 8:30 tomorrow morning.

(Court adjourned at 5:15 p.m. until 8:30 a.m., Tuesday, June 28, 2016.)

JUNE 28, 2016

(The following proceedings were had in open court, out of the presence of the jury:)

THE COURT: All right. We're on the record for the instruction conference. We've had off-the-record discussions about jury instructions for a couple days and hammering them out. I put them in order, and I've numbered them.

These are based on the Civil MAI Seventh Edition.

If anyone has objections as I go through the instructions, please stop me at the appropriate time, and we will make a record at that time. The following instructions will be given to the jury for use during their deliberations.

The Court will give 2.01, the standard Instruction Number 1. The Court will give 2.03, the standard Instruction Number 2. The Court will give 2.02, the standard Instruction Number 3. The Court will give 2.04, the standard Instruction Number 4.

And then the Court will give as Instruction Number 5, the burden of proof submitted by the Plaintiffs, and it's MAI 3.01.

MR. BARTH: Can I stop you real quick, your Honor?

THE COURT: Yeah.

MR. BARTH: I understand that is the new version of 3.01 that went into effect January of 2016. I just wanted to lodge a general objection to that new version, and I think the old version more accurately states the law and burden of proof in Missouri. I understand that it is the MAI, but I think that the way the language has been shortened, it's vague and improper and shifts the burden to the defendant thereby violating the due process and other Constitutional rights.

For instance, the old language used to have a

statement about evidence does not cause you to believe a particular proposition, you cannot return a verdict on that proposition; and that language was removed. So my main issue is just it improperly states the law and burden in a civil case.

THE COURT: Okay.

MR. CRONIN: Your Honor, I believe the Supreme Court stated that it is clear reversible error not to give the MAI instructions.

THE COURT: I would agree.

All right. The Court will give Instruction Number 6. It will be MAI 2.05, modified by 35.19, which has been submitted by the Plaintiff. The Court will give as Instruction Number 7, MAI 21.02, modified by 19.01, 37.01, and has the definition of negligence from 11.06.

It's my understanding that the defense will be submitting an Instruction 7A for our consideration?

MR. BARTH: Yes, your Honor. The objection we have to the current Number 7, which is based upon 21.02, again without waiving any submissibility arguments in the directed verdict motions, which goes without saying.

The other issue that we have and brought up in the directed verdict, just to make sure it's preserved, is that we don't believe there was a submissible case made against the actions of St. Louis University independently for

monitoring, as opposed to Dr. Walden.

We think that the evidence was all that Dr. Walden and SLU would be liable vicariously for them, so we think the instructions should be, as in 7A, submitting the actions of Dr. Walden with the vicarious liability tail at the end, which is 37.05(2). So we just didn't want to waive that issue in terms of what we think it should look like.

As far as the disjunctives go under the MAI, they must be free from argument; they must not assume disputed facts; and one of the issues, especially with number two, is over prescription of opioids, which is definitely a disputed fact in the case.

I have submitted an alternative, which I think makes it less argumentative on that basis. And also I did have a problem with the first one, failed to weigh the risk and benefits of prescribing. I think the ultimate action here is that it goes to the prescribing of the opioids, not necessarily the weighing the risk and the benefits, and it has to be an ultimate action. So those were my issues with those.

And as constituted, I think those two disjunctives are vague, overly broad, argumentative and constitute a roving commission. We have submitted 7A for the Court's tendering.

THE COURT: 7A is based on 21.02, modified by

37.05(2)?

MR. BARTH: Yes, your Honor.

THE COURT: Plaintiff's comments on 7A or 7?

MR. CRONIN: Plaintiff believes Instruction 7 as submitted by Plaintiffs is the appropriate instruction. It is in the form required by the MAI.

As to the four allegations of negligence, we believe they were stated as clearly and as straightforward as possible. We believe there is significant and substantial evidence in support of each one of them from our own expert and other witnesses in the case, your Honor.

THE COURT: All right. The Court has reviewed both the two of them, and the Court thinks that Number 7 tracks the evidence and is consistent with the MAI.

MR. BARTH: So 7A will be rejected, your Honor?

THE COURT: Yes, sir.

MR. BARTH: Okay.

THE COURT: All right. And then the Court will give Instruction 8, which will be MAI 33.04(7) modified by 19.01 and 21.02.

MR. CRONIN: No objection, Judge.

THE COURT: Any objection?

MR. BARTH: No, I submitted it.

THE COURT: I'm sorry, Number 8 was submitted by the Defendants?

MR. BARTH: Yes, your Honor.

THE COURT: The Court will give as Instruction 9 MAI 17.02 modified by 19.01, 37.01 and has the definition of negligence under 11.07 submitted by the Plaintiffs.

MR. BARTH: I don't have an objection to that. I just want to make it clear that Plaintiffs are submitting comparative fault on Mr. Koon. I just want to make sure that I don't want any argument in closing that the Defendants made some conscious effort to blame Mr. Koon or want you to assess a percentage of fault to him because that's not the instruction we're submitting.

MR. CRONIN: Your Honor, that's the evidence they presented in the case.

MR. SIMON: That's the Court's instructions. We have nothing to do with the instructions. The Court instructs the jury. These are the Court's instructions.

We get to argue them, I believe, any way that we want, but these are not one party's instructions versus the other. I believe the law is clear that the Court instructs the jury, not the attorneys.

MR. CRONIN: Judge, we will not be saying this is the Defendants' instruction they've asked for. Just arguing to the jury what we heard from the Defendants in the evidence in the case.

THE COURT: Yeah. Your language should track

what went on in the pit, not the instructions. In other words, yeah, whatever language you want to use in argument should be based on the evidence in here, not track the language of the comparative fault. Doesn't sound like that's what you're going to do.

MR. CRONIN: Correct, Judge.

THE COURT: Does that make sense?

MR. BARTH: It does. We've had other cases where they say, then the Defendant submitted an instruction and wanted you to believe Plaintiffs --

MR. CRONIN: Absolutely not. That would be improper.

MR. BARTH: Okay.

THE COURT: And I would second that.

All right. Instruction -- the Court will give as Instruction Number 10, which is 31.04 submitted by Plaintiffs, and that is the loss of consortium. The Court will give as Instruction Number 11, 33.03 modified by 35.16.

MR. CRONIN: No objection, Judge.

THE COURT: That's submitted by the Defendants.

The Court will give as Instruction 12, 21.04, modified by 37.08 and 35.18.

MR. BARTH: Correct.

THE COURT: And that's submitted by the Plaintiffs.

The Court will give as Instruction Number 13, MAI 21.05, modified to remove damages that don't apply, that includes the loss of consortium submitted by the Plaintiffs.

MR. BARTH: Correct.

THE COURT: The Court will give as Instruction Number 14, this is the punitive damage submitted by the Plaintiffs. It's MAI 10.07, modified by 35.19 and references the Dotson vs. Ferrara, 11.05. The defense has submitted an alternate instruction, 14A. Would you share with us why you think --

MR. BARTH: Yes, your Honor.

Again, we would move to object to Instruction Number 14, again, without waiving any argument that we don't believe that there's been a submissible case with clear and convincing evidence still is to come with the motion for directed verdict. Just don't want to waive any of that.

We believe that under 538 --

THE COURT: Hold on. At the bottom of your 14A it says with waiver. It should say without.

MR. BARTH: Wow. That's what happens when you do instructions late at night. Without, yes, your Honor. Thank you for pointing that out.

Without waiving, as 14A should say, under the medical malpractice Chapter 538, there's a specific definition for punitive damages that was set forth starting

in 1986 with the initial tort reform, and that has stayed in effect all throughout. And it said willful, wanton or malicious misconduct is what is required for medical malpractice, which we believe is basically an intentional act, which we talked about in the motions for directed verdict.

We don't believe that MAI 10.01, which is a general verdict director on punitive damages and then for the negligence, accurately states the law on topic for a medical malpractice case. We believe that it is using a lower standard of recklessness that does not comport with the statutory definition of willful, wanton or malicious misconduct.

So I have submitted an alternative, which I think more accurately, we believe, states the law as it would be submitted. And we realize this is not in MAI because we don't believe there's an MAI that specifically addresses the health care provider section.

And the other issue we had is that, again, all the actions at trial as set forth in our arguments to number seven were regarding Dr. Walden and not SLU. And even as the Court was saying, the evidence against Dr. Walden from the deposition of Dr. Genecin -- I'm sorry, the evidence against SLU based upon the testimony of Dr. Genecin in his deposition for failing to monitor was thin, I clearly do not

believe that rises to a level of clear and convincing evidence for a submission of punitive damages against SLU based upon the actions for failing to monitor.

Each one of these disjunctives has to be supported by clear and convincing evidence, and I don't believe that the evidence supports the submission of all four disjunctives with clear and convincing evidence. And in support I would cite the Menaugh, M-E-N-A-U-G-H, vs. Resler, R-E-S-L-E-R, case, 799 S.W.2d 71. That's Missouri Banc 1990, which again just sets the standard for each disjunctive that you put forth in the punitive damages instruction must be supported by clear and convincing evidence or constitutes error.

THE COURT: All right.

MR. BARTH: So and, again, without waiving anything, also I just wanted to say that to the extent if the Court is going to submit the punitive damages instructions, we would just incorporate our affirmative defenses. I don't want to waive any of the due process or Constitutional arguments we have to punitive damages if they are submitted.

THE COURT: So noted. Any response?

MR. CRONIN: No, Judge.

THE COURT: All right. The Court has reviewed 14 and 14A. 14A tracks the evidence as well as tracks the

MAI.

MR. CRONIN: 14, Judge? Or 14A?

THE COURT: The Court believes that 14 tracks the evidence and tracks the MAI. So that will be -- 14A will be rejected.

MR. BARTH: And you were kind enough to write in without on page two of 14A?

THE COURT: Yes, on the dirty copy, yes.

MR. BARTH: Thank you.

THE COURT: Then there's the verdict form A that's been approved, submitted by the Plaintiffs --

MR. BARTH: Correct.

THE COURT: -- and that's 36.22 modified by 37.09 and an illustration of 35.18. And the Court's going to give Instruction 15, which is basically the second package, 2.05, modified by 35.19 submitted by the Plaintiff. And then Instruction 16, which is the punitive damage consideration package B, which is based on MAI 10.2 modified by 35.19. Followed by verdict form B, which is the punitive damage verdict form.

MR. BARTH: Yes, your Honor. It's my understanding that the second part's 15 through 16 and the verdict B are being withheld from the jury on the first phase.

THE COURT: Correct. The jury will have

Instructions 1 through 14 and Verdict A; and depending on the outcome, then we will have the Plaintiffs go through their punitive damage argument and then submit package B for their determination.

MR. BARTH: Very good. Did you prefer that one copy go back to the jury room?

MR. CRONIN: That's what I prefer.

THE COURT: Yeah. Then we'll do -- I actually like the one stapled copy. One clean, stapled copy.

MR. BARTH: Thank you, your Honor.

THE COURT: If you are going to use any -- like, I don't know if you're going to put them on the Elmo and say this is what we want you to fill -- make sure that you've got the right one. Are you talking about the verdict forms? Whatever you're going to put in, make sure it's this version.

MR. CRONIN: Yeah, I've got boards for the verdict form so I can write on them.

THE COURT: Just make sure it's this version.

MR. BARTH: Do you want a clean copy of this too that we can scan in for Mike, or do you want -- we can worry about that.

MR. CRONIN: I don't need one.

MR. BARTH: And there was just one small -- I know John had a motion to take up. Before I forget, can I

do an offer of proof on the medical bills? Just had a quick housekeeping matter, your Honor.

Prior to trial we had done a lot of briefing, and the Court had heard arguments and taken up several briefing on the issue of the medical bills of the Plaintiff. And we would just submit an offer of proof to those medical bills and reincorporate the prior briefing on it. The Court, it's my understanding, has denied the Defendants the ability to introduce these into evidence.

I'm just going to mark them the Centerpoint billing records, which were submitted by Plaintiffs prior to trial under the business records affidavit rule, and Plaintiffs prior to trial have made on the record and made it clear at trial they are not submitting any economic damages.

I'm not going to reincorporate everything, but we just think that there is relevancy to them in establishing damages of the Plaintiff and also setting an understanding for the jury as to what happened and also to remove any confusion. We do think they are relevant for purposes at trial. And those will be R-2. I'll just hand those, the medical bills, and just incorporate the prior briefing, I guess, on both sides on the issue to be fair.

MR. CRONIN: Your Honor, I would just incorporate my prior argument. The medical bills have no

relevancy or relationship whatsoever to the damages actually being submitted to the jury, and introducing them to the jury would be incredibly misleading -- we believe they are not relevant and misleading.

THE COURT: All right. The Court will stick with its previous ruling as to the medical records. The Court does think that they are -- since they're damages are not being asked for, that they are confusing and irrelevant, and that's referring to the Centerpoint billing. I believe the I'm going to go with R-001 is the exhibit.

MR. BARTH: Correct, your Honor.

THE COURT: Centerpoint billing.

MR. BARTH: Yes.

THE COURT: Okay. Business record.

MR. BARTH: Thank you, your Honor.

MR. MAHON: Judge, I think it's R-2-001.

THE COURT: R-2-001. You are correct.

MR. VENKER: We have a motion, your Honor.

THE COURT: Another motion?

MR. VENKER: Yes.

THE COURT: All right. Let's do it.

MR. VENKER: Well, Judge, we -- based on some of the information yesterday, Mr. Simon comments before the jury, we have a motion for mistrial and we have a motion

to in the alternative to have the Judge -- have the Court instruct the jury that Mr. Simon comments should be disregarded about all this alleged discovery misconduct and the credibility attack he made on St. Louis University and Dr. Walden yesterday, and also to prevent Plaintiffs' counsel from arguing to the jury anything about this.

The parties, really at Plaintiffs' suggestion quite some time ago, Plaintiffs' counsel, entered into a stipulation as to the prescriptions that were written in this case. We were approached early on, I believe by Mr. Cronin, to John Mahon and also to me, we have emails, we have statements in depositions where the Plaintiffs' counsel said, this is going to be confusing; let's reach a stipulation on the prescriptions that were written in this case.

We, being cooperative, thought, okay, that makes sense to us, why argue about the prescriptions. And so this stipulation, which I think like any other stipulation would be about foundation and authenticity of the prescriptions is what we entered into, and quite a bit of time was spent with conversations, with recirculating drafts back and forth.

The exhibit, your Honor is Plaintiff's Exhibit 36, which is this long list of prescriptions that Plaintiffs have been using the entire trial, and we were certainly working with them on this. I think people worked with what

the prescriptions that were actually filled were at the pharmacies because prescriptions written and unfilled would not have been anything Mr. Koon would have taken.

So this all made sense to us. No one ever suggested that somehow these prescriptions were not properly reported, which is not any part of Plaintiffs' theory in this case. Neither Dr. Genecin nor Dr. Fitzgibbons mentioned anything about any impropriety. Dr. Genecin relied on these records that the Plaintiff produced as Exhibit 36 early on. He didn't question the amount of the prescriptions or their authenticity.

I don't think it really makes sense for Plaintiff to even challenge it now because it's almost as if they are saying all the prescriptions weren't written, and their claim is that Mr. Koon, of course, was getting all these high-dose opioids. And so I'll admit, it took me a while yesterday to figure this out because I was truly stunned by this situation.

But for one side to basically invite the other to enter into a stipulation as to authenticity and foundation and then have that other side, that inviter say, oh, wait a minute, we don't have the prescription records for these prescriptions, is -- I hate to saith say it -- but disingenuous to put it mildly.

I mean, the parties relied on this, and we moved

forward with the case developing accordingly. So, you know, I don't know what to do, other than to ask for a mistrial at this point because this is really -- SLU's and Dr. Walden's credibility has been significantly damaged by Mr. Simon questions, some of which were pretty accusatory in tone and content, and asked of Dr. Walden who of course had nothing to do with any of this stipulation. He wasn't involved in this. He relied on it and looked at it to come up with his assessment of when the medications were changed.

We used it to make our demonstrative exhibit, Defendant's triple I, which are those the blue bar graphs. So this was a total surprise to us, an unfair one and we think it has resulted in prejudice to us that cannot be fixed at this point, and that's why we're asking for the relief we're asking.

MR. SIMON: Judge, my response is a motion for sanctions against the Defendants in this case, and I don't take this lightly. I have been practicing for 30 years this year. I believe this is the first time that I have requested a court for this relief.

We requested medical records in this case, and we were provided on December 5th, 2014 in response to a formal discovery request, we asked for any and all medical records of any description that are in your possession relating to the care and treatment of Plaintiff Brian Koon.

The response was, see attached compact disc containing copies of medical records of Brian Koon from 4-18-01 through 9-7-12 marked SLUCare, numbered one through 741. Here it is, your Honor. And we've marked that as Exhibit 40-17.

Your Honor, we have worked on this case for three years. Plaintiffs have spent tens of thousands of dollars. My office has spent hundreds of hours on this case. Now, yesterday, on the sixth day of trial, the last live witness called on the stand, I question the witness about the content of the medical records in this case, and counsel approaches with a medical record that I've never seen, never laid eyes on, had not been presented.

Clearly they had it yesterday morning. They brought it to the courtroom with them. And I find out on the stand from Dr. Walden, who admits that the medical records that we have been relying on in this case for three years are not complete.

Your Honor, as you know, you listened to the evidence in this case. The focal point of this case was what's in those records, those 741 pages of records. There was testimony ad nauseam about what's not in the records. Lack of evidence, no complaints, no problems no assessment of addiction, he's doing fine, he's doing okay, there was no hint, I didn't see anything. I don't know what hasn't been

produced in this case, but I know what has been produced is incomplete.

Dr. Walden -- and the timing of this, your Honor, this entire case is about what this doctor did or didn't do as documented in his records. We have spent six trial days on this case. If we now realize, you know, on the sixth day that they selectively provided records to us and didn't give us the complete chart, I would say that the entire proceeding that we've gone through at this point is meaningless, your Honor.

This is Missouri Supreme Court Rule, your Honor, 60.01 -- 61.01, failure to make discovery sanctions. Section D, failure to produce documents and things or to permit inspection. If a party fails to respond, that inspection will be permitted as requested, fails to permit inspection or fails to produce documents and tangible things as requested under 51.08 or timely serves objections thereto that are thereafter overruled, it says the Court can take one of the following.

Number two, enter an order striking pleadings or parts thereof or staying further proceedings until the order is obeyed or dismiss the action or proceeding or any part thereof, render a judgment by default against the disobedient party. Your Honor, here's a highlighted copy of 61.01.

Your Honor, I'll also provide you with a copy of the Norbert decision. This is a Missouri Court of Appeals Eastern District. In that case, it was Judge Romines in St. Louis County who entered a sanction striking pleadings and entering judgment against a party for discovery violations. And, Judge, that wasn't in the midst of trial. That wasn't on the sixth day of trial where they came up and sprung it on the other side. That was before the trial of the case.

Judge Romines entered judgment against that party for discovery sanctions. The Eastern District Court of Appeals, Judge Booker Shaw wrote the opinion, affirmed the awarding of sanctions of striking the pleadings. It was a 3-0 decision. Judge Crehan and Patricia Cohen also signed off on it.

Another case too is the Arrow Trucking case. That's a Western District Court of Appeals. Same thing, discovery violations. And Judge, what makes this case, this situation so egregious is those were situations where it was during the discovery process. Here, look at the timing of this. Look at the timing of this.

I put on this entire case and worked three years with a set of records that aren't complete. I mean, what does a judgment in this case mean, your Honor? If the jury comes back with a defense judgment and we tried this case without the full records and we were led to believe we had

the full records? It is a nullity. It is a nullity. It means nothing.

The only remedy, the only remedy that is fair and just in this case is to strike the Defendants' pleadings, enter a judgment on behalf of the Plaintiff on all counts and proceed to a hearing on damages.

Thank you, your Honor.

THE COURT: All right. I'm going to take that under advisement.

MR. VENKER: Judge, may I respond to this?

THE COURT: Okay.

MR. VENKER: What I would say is the records that John is talking about, Mr. Simon's talking about yesterday is these prescription records. That's what he talked with Dr. Walden about.

This other, whatever he's talking about, nobody has made an issue of, nobody said we're missing something. The prescription records that are shown in Plaintiff's Exhibit 36 is the basis of a stipulation by the parties, and that's what he was asking Dr. Walden about yesterday. That's what he was making all the noise about, all the accusations about, nothing else. And so this is really what it's about.

And the fact is, this has been stipulated by the parties. We were led to believe that there was no reason to

worry about whether or not -- they could have -- through this whole time they could have said, you know what, we've looked at our records, and I see this prescription here, but I don't see a record for that. Do guys have that? No, they didn't do any of that.

We went down this line. We worked with them. We worked with prescriptions that were shown from pharmacies. And so we believed that we were both working in good faith and being open about it and that there was no need to go back and pull whatever it was they say is missing now.

THE COURT: Let me make sure I understand what the arguments are. Everybody is in agreement that Exhibit 36 is a full, complete list of what was dispensed.

MR. SIMON: Pharmacy records.

THE COURT: Pharmacy records.

MR. SIMON: Not the doctor's records.

THE COURT: Okay.

MR. SIMON: Pharmacy records. And that's all we asked, pharmacy records.

THE COURT: Okay. Your argument is that you didn't receive all the --

MR. SIMON: Medical records.

THE COURT: -- medical records.

MR. SIMON: Yes, sir.

THE COURT: Okay.

MR. SIMON: And there's no evidence, Judge, as to what we didn't get. We don't know what we didn't get. That's my point. There's no evidence of what we didn't receive in this case.

THE COURT: So there's no disagreement that the pharmacy records were provided in full.

MR. VENKER: That's my understanding.

MR. SIMON: They weren't provided, your Honor. My office subpoenaed them and prepared that chart. That had nothing to do with the Defendants producing information in this case.

THE COURT: Exhibit 36, has that been stipulated by parties?

MR. SIMON: Yes, sir.

MR. VENKER: Yes, sir, it has.

THE COURT: So the issue is whether you received full and complete medical records.

MR. SIMON: Yes, sir.

THE COURT: Not pharmacy records.

MR. SIMON: Yes, sir.

THE COURT: Okay. What is your reply to --

MR. VENKER: My reply to that, Judge, is I haven't -- well, number one, yesterday all the discussion that Mr. Simon had with Dr. Walden was about the pharmacy records. He attacked him on saying you don't know if

these are in the records, do you, doctor? It was about the pharmacy records; he didn't ask them about anything else.

Dr. Genecin, their liability expert, and Dr. Fitzgibbons have given their opinions. No one has claimed anything is missing. Dr. Genecin didn't ask for anything else that he needed. So this is really just an attempt to try to impugn the credibility of St. Louis University and Dr. Walden in producing records.

John's not saying what is lost, how they've been prejudiced. This is just an attack on credibility so that he can somehow argue to the jury that we're not honest. That's what this is. And it's just a strategy, and it shouldn't be allowed, your Honor.

MR. SIMON: Judge --

MR. VENKER: And we should, at this point with the comments that were made, the case should be mistried. That's what should happen.

MR. SIMON: Your Honor, I think it's fairly telling that none of this -- I mean, they had the document with them when they walked into the courtroom yesterday morning, and it wasn't presented to me. I didn't know about its existence until I asked Dr. Walden, can you direct me to a specific entry in your records.

MR. VENKER: This document --

THE COURT: Can we mark this --

MR. VENKER: We sure can.

THE COURT: -- and make this some type of --

MR. VENKER: This document was offered to -- it has a description of an encounter. This is not a prescription record. Should we give it an exhibit designation?

This exhibit that we're talking about, your Honor, is a one-page at the top right corner it says, encounter date July 9, 2010.

MR. MAHON: We should call it A-000743.

MR. VENKER: All right. This is merely a telephone record. It's not a prescription record that Mr. Simon is talking about. This is basically -- you disallowed us to use it. We didn't use it with Dr. Walden. Dr. Walden testified about this from his memory yesterday about these -- this is the morphine substitute where he testified that he changed the medication to try to see if it would give better relief to Mr. Koon.

So this is not a prescription record, which is what these would involve. And so we weren't allowed to use this. This is not what we're talking about here. This is something totally different. And so I think it's the prescription records that we need to focus on and the fact

that -- basically what he's saying, you don't have any actual record within these records of these prescriptions actually being written. That was basically the attack. And that was all the attack.

And so we had this stipulated document, Plaintiff's Exhibit 36. We're not disputing it. We assumed we had an agreement on it and did not see the need to worry about the foundation for that exhibit being, did in fact, is there a record of some prescription, you know, at St. Louis University for these prescriptions.

MR. SIMON: Your Honor, that was stipulated to right before trial, a couple weeks before trial. We went back and forth with emails. So that means the two years before that, I hired expert, paid them money, took their expert's deposition without that stipulation and they base their opinions on this doctor's medical records.

Dr. Walden said what's not here is part of my electric medical record upon which I base my care. The bottom line is, I'm entitled to get a complete set of the Defendants' medical records in a medical malpractice case, and I'm not -- I don't believe that it's appropriate for me to try to just take what the Defendant wants to select out of that record and provide it to me and base the case on that.

MR. VENKER: He asked Dr. Walden about the

prescription records. That's the quote that John is using here. Dr. Walden said again and again, I'm confident that I can only write a prescription through the electronic medical records. I'm confident that that electronic medical record has the prescription in it.

MR. SIMON: Judge, we don't know what all is not here. That's my point. We don't know what's not here. I mean, we have to take the Defendants' word for it? When we know they've already told us they produced their complete file, and we know that's not the case, and we heard that out of the defendant's testimony.

This is absolutely over-the-top improper, your Honor. They had documents with them sitting at that table that we didn't have, and they're allowing me to go through an entire trial and cross-examine this witness without the benefit of a full set of records.

MR. VENKER: We have not obtained these prescription -- whatever it is John thinks that the foundation for these prescriptions is at SLUCare, we don't have those, Judge. We have not gotten those from our client; we didn't see the need to.

THE COURT: Okay. This is where I'm a little fuzzy. All right. Throughout the trial there's been -- there's been those notes that go up there, and you guys highlight and it says, patient called X and doctor said Y.

MR. VENKER: Yes, your Honor.

THE COURT: Okay. How does this differ from that? Because here's my concern. If it was just this part, I get it. If it's just the prescription part. In other words, these are the prescription, and it matches the prescription here. So that's nothing new.

The part I -- all right. So the information in the top half, I guess that's -- my concern is where -- is there another source of that information that the Plaintiffs have? Their shaking their head no.

MR. CRONIN: Every time we show a note for the prescriptions that are in his records, there's notes about what information he was getting from Brian. Then, during the worse year, 2011 when this got out of control, the prescriptions aren't in there, and there's no notes. So there's no notes for what Brian was telling him in regard to him giving him those prescriptions.

And now the defense in this case is we couldn't have known there was a problem because Brian wasn't conveying any information to us. And there are 75 prescriptions where we weren't given what is in their records for what Brian was telling him.

MR. SIMON: Including discussions, including patient information, the date, the time, whether it was a call, whether it was a visit, who picked it up, who he

talked to, was it Mrs. Koon, was it Brian Koon, what was his response, did he call back, did he not call back. You know, Judge, it's --

THE COURT: All right. Anything else before I take it under advisement?

MR. SIMON: No, your Honor.

MR. VENKER: Not at this time, your Honor.

THE COURT: All right. I'll take it under advisement.

MR. SIMON: Thank you.

MR. VENKER: Judge, could we offer these?

MR. MAHON: About the stipulation, Judge --

MR. VENKER: For our motion, your Honor.

MR. MAHON: About the stipulation we just went back and pulled some of the comments from the depositions of Mark Itskowitz, M.D., labeled Defendant's Exhibit 5L1. And then the deposition of Erik Gunderson, M.D., Defendant's Exhibit 5L2. And then Defendant's Exhibit 5L3 is just a collection of the emails back and forth between counsel about reaching a stipulation as to the prescriptions.

THE COURT: Is this what we're getting ready to hear right now?

MR. VENKER: No, this is part of our motion that we just made on the record. These are exhibits for that.

These are the references we made about Mr. Cronin -- in depositions stating about the stipulation for Exhibit 36, Plaintiff's Exhibit 36, and then different emails exchanged back and forth about that stipulation about the prescriptions.

THE COURT: This is what -- you want me to consider this as well when I take it under advisement?

MR. VENKER: Yes, your Honor.

THE COURT: All right.

MR. CRONIN: My only response is there was no stipulation that they gave us a complete set of his medical records.

THE COURT: I hear you. All right.

(At this time a discussion was held off the record.)

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(The proceedings returned to open court.)

THE COURT: Good morning. Please be seated.

All right. Counsel for the defense, you may continue.

MR. MAHON: Thank you, your Honor.

The Defendants would like to play a portion of the videotaped deposition of Chris Bublis taken May 20th, 2016. It's not necessary to transcribe it.

(At this time the video deposition of Chris Bublis

was played for the jury.)

MR. MAHON: That concludes Chris Bublis's testimony, your Honor.

THE COURT: All right. Attorneys, approach.

(Counsel approached the bench, and the following proceedings were had, out of the hearing of the jury:)

THE COURT: All right. Is there anymore evidence?

MR. MAHON: The only thing we wanted to do is read a couple of the medical records, but it will be no more than ten minutes.

THE COURT: Okay. So you're going to read the records. Anything else?

MR. VENKER: Then we're going to close, make our motion for directed verdict.

MR. CRONIN: Judge, I have not been told what medical records are being read in order to counter designate and make sure they're read in their completeness. There's no more witnesses to question about these medical records.

THE COURT: All right. Let's take a morning break. You guys work that out. We'll argue the motion at the close and then come back and do closings.

MR. CRONIN: Okay.

MR. SIMON: Judge, I have 60 seconds. I want to

read in one thing from the request for production in rebuttal.

THE COURT: Okay. In terms of the earlier motion?

MR. SIMON: Yes, sir.

THE COURT: Okay. I'm going to go ahead and take a break.

(The proceedings returned to open court.)

THE COURT: All right. Ladies and gentlemen, we're going to take our first recess of the morning. The Court again reminds you what you were told at the previous recesses. Until you retire to consider your verdict, don't discuss this case. Do not form an opinion. Please no research or investigation, and don't communicate with anyone by any means.

Court will be in a short recess.

(At this time a short recess was taken.)

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(The following proceedings were had in open court, out of the presence of the jury:)

THE COURT: All right. We're on the record.

The Court anticipates that the defense is going to be resting shortly, and we can take up the motion for direct -- defense's motion for directed verdict at the close of all evidence outside the hearing of the jury.

You may proceed.

MR. MAHON: Thank you, your Honor.

We filed a motion for a directed verdict at the close of Plaintiff's evidence, and we want to -- which the Court denied, but we want to incorporate the arguments set forth in our written motion, but here orally as well. We're filing a written motion for directed verdict at the close of all evidence and not waiving any of the arguments set forth in there. But I'll highlight a few of the points.

We think that Plaintiffs failed to make a submissible case for alleged medical malpractice against the Defendants, and that's based on insufficient expert testimony to establish the standard of care. Plaintiffs' sole liability expert Dr. Genecin testified about his own personal standard of care, and based on standards that either did not exist at the time of the care at issue or did not apply to Missouri practitioners. He did this rather than basing his opinions on the objected, well-recognized national standard.

Also, Dr. Genecin's testimony on this issue was contradictory and not probative. The jury should not be permitted to speculate or guess as to which statement of a witness should be accepted. And with Dr. Genecin, first he said the 2016 CDC guidelines reflect the standard of care and are mandatory. But on Cross-Examination he admitted

they're voluntary, which is the opposite of mandatory. So this is the same witness contradicting himself, and the jury shouldn't be left to guess or speculate on that point.

Also, as was raised at the close of Plaintiffs' evidence, Plaintiffs lack sufficient expert testimony to support a direct negligence claim against St. Louis University for anything other than -- or not based on vicarious liability for Dr. Walden's conduct. The Court limited Dr. Genecin to opinions expressed at his deposition.

And so we've also attached to our written motion a complete copy of the transcript from Dr. Genecin's deposition. So it will be part of the record to make sure, but Dr. Genecin failed to articulate how any actions of St. Louis University or St. Louis University employees other than Dr. Walden deviated from the standard of care and caused injury to the Plaintiffs.

So for all those reasons and those set forth in our motion, we think the Plaintiffs failed to make a submissible case for medical negligence.

We also think they failed to make a submissible case for punitive damages or aggravating circumstances. The standard is a very high standard in Missouri. The Plaintiffs must present evidence which instantly tilts the scales in the affirmative when weighed against evidence in opposition.

And so the Missouri Supreme Court has said that punitive damages are so extraordinary and harsh they should only be applied sparingly. And the Court really has to give this careful judicial scrutiny beyond what's required for the medical negligence claim.

The evidence must be scrutinized in very close detail. It's not just a simple comparative weighing of the evidence, but really the Court must determine whether the evidence is sufficient to permit a reasonable juror to conclude that the Plaintiffs established with convincing clarity, that is, that it was highly probable, that the Defendants' conduct rose to the willful, wanton or malicious conduct that's required by Missouri law.

And we cite to the Dodson case, which is a recent Missouri Supreme Court case where the Supreme Court upheld the trial court's granting of the directed verdict at the close of all evidence on the issue of punitive damages in the medical negligence case. And in that -- in the Dodson case, the Court talked about how the evidence demonstrated that the defendant took affirmative action to address the medical issues.

And I think the evidence in this case is similar. I think the evidence is that Dr. Walden and Mr. Koon weighed the risks and benefits of opioid therapy, including the risk of dependence and addiction and then jointly elected to

initiate and continue that therapy. The evidence has shown Mr. Koon benefited from the opioid therapy in terms of pain relief and improved function, including the ability to work in a full-time capacity in a physically demanding job.

The evidence also shows that in May 2012 at Mr. Koon's request Dr. Walden took affirmative action to address his stated concerns and desire to stop the opioid therapy by collaborating with Dr. Berry and Dr. McKean to develop and initiate a weaning plan. Mr. Koon decided, he agreed to participate in that plan and later decided on his own without consulting his physicians to seek rehab treatment at Centerpoint Hospital.

So I think given the evidence in the case, there isn't anything to support that the Plaintiffs have clearly and convincingly proven that the Defendants' conduct was willful, wanton or malicious. So for that reason I think Plaintiffs failed to make a submissible case for punitive damages.

The only other point on there is just I think there's been some argument that recklessness, which I believe Dr. Genecin testified to which we're now waiving our motion to keep that type of testimony out of the case going to the state of mind of a defendant, there's been some evidence or some argument that recklessness is the same standard of what's required for punitive damages in a

medical negligence case, and I don't think that's correct.

I think it's willful, wanton and malicious. It must be something tantamount to intentional wrongdoing and not just some sort of vague, garden variety, if you will, recklessness standard.

THE COURT: Plaintiff?

MR. CRONIN: Your Honor has already ruled on all of this. Judge, I will incorporate our prior argument. If anything, I think the evidence in this case has gotten stronger and more substantial since the close of the Plaintiffs' case in support of our claims.

THE COURT: All right. The Court's previous ruling on this matter I incorporate in my comments; but to reestablish that I do believe there's been substantial evidence presented by the Plaintiffs such that a jury could find the injuries to the Plaintiffs are a natural, probable consequence of the Defendants acts or omissions; and therefore they made a submissible case as to the medical malpractice.

With regard to the punitive, after scrutinizing the evidence that has been presented so far, there has been substantial evidence presented by the Plaintiffs regarding the fact, which the jury can consider, whether to award punitive damages. I think a reasonable jury could determine that the evidence presented regarding the Defendants' acts

or omissions could rise to the level of intentional wrongdoings or omissions, and as such they can make that determination with convincing clarity. So the motion will be denied.

MR. MAHON: Thank you.

MR. VENKER: Thank you, your Honor.

(At this time a discussion was held off the record, and then the following proceedings were had, out of the hearing of the jury:)

THE COURT: We're back on the record. This is in regards to the discovery issue.

MR. SIMON: It is not a discovery issue per se, your Honor. It's to authenticate Exhibit 1, which was provided to us by the Defendant and in response to our request that they produce all records of Brian Koon.

THE COURT: Your response?

MR. VENKER: I think, again, this is beyond the scope of this case, Judge. Obviously I would object to any further mention, discussion, argument of this discovery dispute which Mr. Simon has raised this morning. This is not the only part of this case.

So I think it's going to confuse the jury. And I also think it's something that is still not really clearly focused to what this is. It's beyond the scope of the pleadings for sure; it's beyond the scope of the issues.

MR. SIMON: There was an issue with Dr. Walden about whether or not the complete file was here and included in what has been marked as Exhibit 1. This information, this evidence, is to show that the Defendant has represented in this case that it is a complete set of his medical records.

THE COURT: Okay. So here's my ruling on this. I think this is a discovery issue. I think this is not relevant for rebuttal evidence. Taking in consideration your motion for a mistrial, the defense believes that this has been -- that Dr. Walden's been cross-examined on the completeness.

I'm not determining whether that was proper or improper, but I do believe your ability to clarify with the witness as to what was submitted and what was not submitted has already been done in front of the jury in a manner that was relative to the timeliness of the issue. I think this being put out of it will be confusing because it will not -- because then there's not a rebuttal whereas they've had the opportunity to cross-examine.

So I do believe the issue has been he injected as to the completeness of the records. So I'm going to deny Plaintiff's motion to read Exhibit 40-19 and 4-19-1 into the record in that I think the issue has already been --

MR. SIMON: Established?

THE COURT: -- established with the witness.

MR. SIMON: Sure. Thank you, your Honor.

MR. VENKER: Judge, in terms of closing argument, I would object to Plaintiffs arguing anything about any of this discovery.

THE COURT: All right. So here's what I'm going to do on the discovery. All right. I think there are -- there are issues with the discovery. I think they are post-trial issues. I think to do anything now would be, not premature, but I think it would be -- well, maybe premature. I think it's premature to take this case from the jury. I think -- the Court would rather see what the outcome of the case is --

MR. SIMON: Okay.

THE COURT: -- and then make a determination on post-trial motions for a couple reasons. One, there's a perceived prejudice, but I don't know if there's an actual prejudice in the way the jury -- I'm not saying that if it goes your way, X, Y and Z, I -- there's some issues, but I got to determine whether they rise to a level -- I think striking the pleadings and doing a default judgment is too drastic. I'm not going to grant a mistrial on the statements. I think those statements did not rise to the level of a mistrial in terms of -- and I believe the Plaintiffs cross-examined him on the completeness, and the

jury can draw whatever inference they want on that.

But I do think those issues should be raised in post-trial motions, and then that will allow me to consider it in the totality. The other thing is I will say that looking at the case law, typically these things are pretrial issues, and usually there is a pattern of repetitive bad behavior. And so to go to the point of the default judgment, the cases that I've looked at are all where the Judge has repeatedly ordered something to be turned over.

In this case, I haven't determined what it is, but it has not been a willful disregard for the Court's orders. I do -- but I'm not minimizing that it's had an effect on the Plaintiffs. At this point I'm trying to weigh the two. And so my option is that I'm not saying that I'm never going to do anything, but I think it's premature to prevent this case from going to the jury and then --

MR. SIMON: Understood. If I could, your Honor.

THE COURT: Go ahead.

MR. SIMON: In this respect, you know, it wasn't brought to the Court's attention pretrial because Plaintiffs relied on the representations of the Defendant. Had it been brought two months before trial or three months before trial, we would have, you know -- it would have been easier to remedy it without being prejudiced.

THE COURT: And the Court is taking that into

consideration.

MR. SIMON: Okay.

THE COURT: The timeliness in which this is done. There's definitely more -- there's way more bullets in my gun pretrial. During, I'm weighing the options of how drastic of a decision to make. That does not say I'm not giving it any weight, but I don't think the solution is striking the pleadings and default judgment, but I don't think the solution on the opposite side is mistrial.

I'm not sure where the middle is, but my thought process is because the case does need to go to the jury. And then if upon reviewing the whole thing there is an error, then I think the opportunity to fix it with a new trial. The Court is very aware of the time and energy and cost that goes in to these trials. And so I'd rather make that decision afterwards than to do something premature.

MR. CRONIN: Judge, certainly I get to talk about in closing argument what happened on the stand. That's what's being asked for me not to be able to do.

THE COURT: Okay. So here's what I think on that. I think Mr. Simon did -- I believe that issue was fleshed out thoroughly with the witness on the stand. Now, I'll give you some room on that, but it is not to the extent that Mr. Simon did.

If you want to make a comment such that --

MR. CRONIN: Just a couple minutes.

THE COURT: No, not even a couple minutes. Based on what they reviewed, in other words, you can make the caveat that --

MR. SIMON: That it wasn't a complete record.

THE COURT: No, not the complete record. Based on the information they reviewed, they came up with this. Because that's fact. Whether it's incomplete or not, but it's based on those things. If you said -- well, I don't know that there's a way to do this.

MR. CRONIN: Mr. Venker's whole argument and defense of the case is going to be that we don't see in the records Brian giving him information to indicate a problem and thus he isn't negligent. And we don't have the records. And that came out in front of the jury. And now I'm being precluded from responding to what their argument in the case is.

MR. SIMON: Judge, very simply, that is our defense -- that's our response to their defense. Their defense is completely based on the absence of entries in the records. We established with the Defendant during the course of the evidence that records are missing. The records are not complete. That was admitted by the Defendant on the stand.

MR. VENKER: Prescription records.

MR. SIMON: We're going to hear Paul argue that there was nothing in the records to show concern or cause or this or that or addiction, and we can certainly say we know all of the records were not here. I mean, you can't tie our hands and not let us respond to their defense in the case. I mean, we're gettin' hit twice now. I mean we're gettin' hit two times.

THE COURT: Okay. Here's what I will let you do. I'm going to let you argue your cases.

MR. SIMON: Okay.

THE COURT: Because regardless of what the topic is, you're going to have an opposite position.

Now, what I don't want is anything that appears that the attorneys are doing anything --

MR. SIMON: Intentional.

THE COURT: -- intentional.

MR. SIMON: Okay.

THE COURT: I don't want anything that anybody is trying to be sneaky, devious, withholding. I don't want that. You can say incomplete record or --

MR. SIMON: For the records.

THE COURT: -- an incomplete set of records. I'm all right with incomplete set of records. But I don't want that, what are they hiding --

MR. CRONIN: I won't, Judge.

THE COURT: I don't want it to be there was some type of game played. I will allow the fact that there's incomplete records but not that somehow this was intentional.

MR. SIMON: Sure. Understood.

THE COURT: I'm going to allow you, if you want to say something to the fact that in your argument that they relied on these records, that's fine. I think that based on what has been said, I think that is an appropriate response.

Now, how this shakes out at the end of days, I don't know. But I think where we are on the road, that is an appropriate response.

Your response, Mr. Venker?

MR. VENKER: I just want to say, I respect the Court's ruling. I just want to make sure that I'm making my record. I object to this topic being dealt with at all in closing argument.

THE COURT: Okay.

MR. VENKER: I think it's better or more appropriate to have it handled as the Court is suggesting with whatever happens post-trial. So I just object to the topic at all of discovery disputes on both sides being mentioned in argument, but I understand the Court's ruling. I just want to make sure -- if I make my

objection now, is it preserved and I don't have to stand in closing argument?

THE COURT: All right. Your objection is preserved mentioning the incomplete records.

MR. VENKER: All right.

THE COURT: You don't have to make that.

MR. SIMON: Thank you, Judge.

THE COURT: All right.

(At this time a discussion was held off the record.)

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(The proceedings returned to open court.)

THE COURT: Please be seated. All right. Does the defense rest at this time?

MR. MAHON: No, your Honor. The defense would like to read portions of just three of the medical records.

THE COURT: That's correct.

MR. MAHON: Thank you.

THE COURT: Please proceed.

MR. MAHON: Mike, could you please pull up Defendant's Exhibit A, page 549? Basically we're blowing up this area right here. And if you could get that little part that you cut off there.

This reads backwards basically. Telephone

encounter, April 2nd, 2012, 10:20 a.m., requesting referral to pain management., April 2nd, 2012, 2:41 p.m., order placed in EPIC. April 2nd, 2012, 3:04 p.m., faxed.

And, Mike, if you could go to page 548, please. Date, April 2nd, 2012, ambulatory referral to pain clinic, Henry Walden, M.D. Please note: The pain center does not initiate, take over/maintain or discontinue narcotic therapy.

That concludes that exhibit.

If you could go, Mike, to Defendant's Exhibit K, page 11. This is from the record of pain management physician Dr. Hugh Berry. Specifically we are stopping -- no, we're doing the top part here, Mike. We're going to stop just underneath this.

This is progress notes by Hugh Berry, M.D., May 18, 2012, 10:04 a.m. Brian M. Koon is a 40-year-old male. Chief complaint, patient presents with, establish care. Complained of right foot soreness. MRI negative for obvious fracture but had edema. Referred to Dr. Esther. Then diagnosed as arthritis. He had a bone scan. Long history of back pain. Can radiate around hips -- it says ant, I think that means and -- and thighs. MRI six years ago showed degenerative disc disease. Chiropractor, PT, injections, epidurals and facets by Dr. Christopher. Now worse. Back "goes out", once a month or so. Work increases

pain. Does mechanical maintenance with heavy lifting. Medications are high dose.

If you could go over to page 12, Mike, please. And we're getting into basically, right here. Okay.

Psych: Denies depression, anxiety, history of drug abuse or addiction. General appearance, alert, cooperative, no distress. And then towards the bottom, assessment, opioid dependence.

Mike, if you could go to page 13, please. We're just focusing, just up here.

Number two, lumbar radiculopathy. Plan, number one, patient to investigate treatment program for dependence. Number two, MRI ordered of lumbar spine to see if there are any interventional options.

Mike, could you go to page 21, same exhibit? And we're just focusing on down here.

This is progress notes by Hugh Berry, M.D., June 8, 2012, 12:03 p.m. Chief complaint, patient presents with followup complained of right foot soreness. MRI negative for obvious fracture but had edema.

If you can go to page 22, please, Mike. This part right here. Medications are high dose.

If you could go to page 23, please. We're getting into the plan part down here. Plan, patient continues to investigate treatment program for dependence. He is

motivated at this point. Number two, MRI lumbar spine. The L4-L5 disc is desiccated with slight loss in height and a mild broad-based disc bulge. The thecal sac is slightly deformed but without central spinal stenosis. There is impingement of the right nerve roots.

Let's go to page four. But without foraminal stenosis. L4-L5, degenerative disc disease with broad-based bulge, right nerve root impingement. He will be set up for epidural injection. Number three, referral for counseling, Dr. Melanie McKean.

Okay, Mike, please bring up Defendant's Exhibit D, page 661. Do you have D?

(There was a discussion between counsel and Mike.)

MR. MAHON: Okay. These are records from Dr. Melanie McKean. The encounter date is August 16, 2012, established patient exam. And then we want to get this portion down here.

Axis one, clinical disorders, mood disorders, major depression disorder-recurrent episode. Substance related disorders, opioid dependence. Other conditions of clinical attention, sleep difficulties, intermittent anxiety.

Could you go to page 662, please? It's this part down here, the subjective.

Routine follow-up patient seen alone. Patient

states his back went out again, resulting in two weeks off of work. Worried about long-term future at work, both physically and financially, stating it's "physically killing me" and also frustrated that supervisor is no longer going to allow him to carry pager "because of my health". He states that was a source of potential extra income. He is concerned if he's no longer able to accumulate days what will happen if he needs additional time off of work for health reasons. Is considering discussing disability options with employer.

Next paragraph. States he feels "like I'm sometimes on the edge" in regards to "falling into" a deeper depression. Denies deep depressive periods or suicidal thoughts.

Page 663, please, Mike.

Discussed this writer's recent discussions with pain specialist Dr. Berry (7-30-12) and PCP Dr. Walden (8-14-12) regarding collaborative approach to mood and pain management. He states small decrease in Oxy IR (75 milligrams, right arrow, 60 milligrams, right arrow, 45 milligrams per dose) has been tolerable. He has noticed some increase in pain but continues eager and motivated by continued weaning. In addition, he states steroid injections by Dr. Berry have been helpful.

If you could go back out, Mike, and just bring up

this big box here, mental status exam.

Eye contact, normal. Speech, normal rate, rhythm and prosody. Behavior, cooperative. Mood, "all right". Concentration, intact. Sensorium, alert. Orientation, person, place, time, situation. Memory, intact. Thought content, logical and goal oriented. Thought process, organized. Clarity, coherent. Content, logical.

If you could go back out one more time, Mike, and blow up this part down at the bottom, please.

Depression indicators, patient meets criteria for DSM-IV MDD. Suicide risk assessment completed. Yes- refer to HPI.

If you could go to page 664, please. Under assessment here.

41-year-old Caucasian male with depressive and anxious symptoms exacerbated by concomitant chronic pain and opioid dependence. Tolerating Duloxetine without side effects. Continues motivated for collaborative approach to weaning off of oxycodone.

If you can go back out and blow up number three. I'm not going to read all of it. Patient aware of collaborative plan to weaning oxycodone. These recommendations will be forwarded to PCP, Dr. Walden.

Then if you could blow up, Mike, the rest of these numbers, four through seven.

Number four, follow up with Drs. Walden and Berry as needed. Number five, encouraged patient to contact St. Louis Behavioral Medicine Institute's pain management program for additional services. Number seven, follow up in four to six weeks.

Now, Mike, if you could blow up this part right down here.

He received the following printed patient instructions. Review information on St. Louis Behavioral Medicine Institute's pain management services. I will forward note from this visit to Dr. Walden to assist in coordinating care. Follow up in four to six weeks. And completed by Melanie McKean, DO, Ph.D.

That concludes the portion of the records the defense wanted to read, your Honor. Thank you.

THE COURT: All right. Does the defense rest?

MR. VENKER: At this time the Defendants rest, subject to our discussion about admitting exhibits.

MR. CRONIN: Same, Judge.

THE COURT: All right. Ladies and gentlemen of the jury, that concludes the evidentiary portion of the trial. We're getting ready to do closing arguments. After closing arguments, you'll be able to deliberate.

During deliberations, you'll select a foreperson. That person will be able to communicate with the Court.

We'll give you some forms. If you have any questions, you want to see exhibits, that will be the way the jury can communicate.

I've given both sides an hour to do their closing arguments. I have given you the forms, so I'm providing lunch for you, so that when you -- hopefully by the time you get done with closing arguments, the food will be here. So I appreciate the fact that when you have food, if you're all present you can deliberate. If you want to say, if we want to stop and eat our food and not talk, no deliberations, that will be up to foreperson. Either you eat and talk, or you just eat. All right? But I figure you deserve -- this has been a long trial, so you deserve to eat.

Just so you know, the Plaintiff will go first and then the defense goes, and then the Plaintiff will have the last say. But before the attorneys make their closing arguments, it's my duty to read you the remaining instructions, starting with Instruction Number 2.

(At this time the instructions of law were read to the jury by the Court.)

THE COURT: All right. Counsel for Plaintiffs, you may make your closing argument.

MR. CRONIN: Thank you, Judge.

OPENING ARGUMENT ON BEHALF OF

COUNSEL FOR THE PLAINTIFF

MR. CRONIN: Good morning, ladies and gentlemen.

THE JURORS: Good morning.

MR. CRONIN: I want to start, on behalf of myself, Mr. Simon, Brian and Michelle, Counsel for the Defendants and the Court, by thanking you for your service. You've been very patient with us. We know you have other places you'd rather be. We know you have families you'd rather be seeing and talking to that you want to get back to and that you have jobs to get back to. But I told you in opening statement, this is an important case. I think everybody in this courtroom now knows that it is.

Our jury system is one of the most important and fundamental pillars of our society. It's one of the most important things in our Constitution. It's one of the things that makes our country great. And it's here to protect the community. There's a reason that everything that happens in our courtroom is public. And it's because everything that happens in this courtroom is about the public's well being and safety.

Everything that John and I have done for the past several years, all the work we put into it --

MR. VENKER: Your Honor --

MR. CRONIN: -- all the depositions --

MR. VENKER: Objection, your Honor. May we approach?

THE COURT: Yes.

(Counsel approached the bench, and the following proceedings were had, out of the hearing of the jury:)

MR. VENKER: I let this go for a while. Your Honor, I'm going to object to an appeal to these people that this case is really for them. I think that's personalizing it to this jury. I think it should be this case is decided on these facts.

I understand punitive damages are being allowed to be submitted to the jury, but I don't think it allows argument that John, Mr. Simon, and Mr. Cronin are working for this jury and that's the way it's starting to sound; and I object to that kind of argument.

MR. CRONIN: That's not where I'm going with it. This is closing argument.

THE COURT: Overruled. I don't think it's risen to the level of personalization. Proceed.

(The proceedings returned to open court.)

MR. CRONIN: Ladies and gentlemen, everything we have done for the last several years was to get here, right now, right now, today. To get through our trial and then be able to turn this case over into your hands. This

case is about years of a reckless, conscious disregard for safety. And it all led to right here. To ask you to deliberate on the cost of that carelessness and indifference.

Ladies and gentlemen, in a little while you're going to have two jobs. One of those jobs is to answer the questions on the verdict form that the Court will provide to you. And the other job is going to be able to talk amongst yourselves and explain to one another why you feel the way you do in trying to answer those questions. And so what I want to try to do is go through some of the evidence with you and try to give you some ways that you can do that.

Let's talk about we've heard in this case. We've heard that the Plaintiffs' anger is misdirected. That's one of the first things you heard in the Defendants' opening. We heard that our claims in this case are ridiculous. We heard that Dr. Walden doesn't have any patients that he has put on this level of opioids. And then you heard that in his deposition he told us he has five patients he's put on this level of opioids.

We've heard that you shouldn't pay attention to any dosage guidelines. Probably because the Defendants don't. We also heard that 100 to 120 morphine equivalent dose is as much as you should go for most people. But that it was okay to blow past it for Brian. And I still haven't

figured out why. I still can't figure out why it was okay to blow past it for Brian.

We've heard that Dr. Walden admired Brian, and that's why he kept giving him Schedule II narcotic opioid pills. We also heard in opening that Brian was disposed to developing an opioid disorder. And yet, the prescriptions for all of those opioids that he got from his physician had nothing to do with causing his opioid use disorder. I still can't figure that one out. How does he get an opioid use disorder and an addiction if he doesn't get the substance from his doctor that causes it? He doesn't. It's impossible.

I still cannot figure out if the Defendants are arguing that Brian never became addicted and that Brian and Michelle are making all of this up, despite the fact that their own addiction expert said that he became addicted, or if they're saying they had no idea of knowing what was going on. I don't know which one they're going with. Maybe they'll finally pick one and tell you.

We've also heard that Dr. Walden would talk about risks with Brian. And about what was going on in his life. Really? The word risks doesn't show up in his medical records for a year and a half. You saw how many opioids he had already given him by that time. And what's more, now we know we don't have a complete set of records. We found that

out yesterday afternoon. The curtain came down, and the truth came out. We weren't given, their experts weren't given, our experts weren't given, and you weren't given a complete set of the Defendants' medical records.

The whole focus of this case, ladies and gentlemen, is about those records. It's about what is in the records and what the Defendants are saying isn't in the records. And now we find out that we didn't get to see what's in the records.

What's more, from the records that we do have, it shows Brian asking for help in the middle of 2008. You saw it. It says, needs help. It's underlined in their own records. We went through about a dozen records that showed clear signs to his health care providers that there was a problem. How many times have we had to stand up and show you things that are in the Defendants' records that you had just been told something contrary about? We kept having to point out what's in their records. The ones we have.

They've told you that the first time they had a hint that Brian had a problem was in April of 2012. And then Dr. Walden tried to help. He didn't try to help. He didn't know what to do. He just kept giving him higher doses. They're trying to tell you that he began trying to taper in the summer of 2012, but we have Exhibit 36. It has all the prescriptions on it. You've seen it. You can ask

to see it. It has all the prescriptions on it.

The biggest prescription he ever wrote of OxyContin was at the end of August. He tried to say he'd switched to just OxyContin at that point, but there's a prescription for Vicodin just four days before it. And then there's a prescription for immediate release oxycodone, you saw it on the exhibit, seven days after it. He didn't switch. He gave him more than ever. If it wasn't for Michelle, she'd be the only Plaintiff sitting in this courtroom because Brian would be dead. His little girl wouldn't have a father.

They tried to tell you Brian's withdrawals could be avoided. Then their own expert came in here last Friday and told you that wasn't true. The taper plan was never going to work. That's not our expert, ladies and gentlemen. That's their addiction expert.

They told you in opening that his family members would testify that nothing happened and Brian was fine and is fine. Is that what you heard? His father -- Brian had to hear from his father's deposition that he didn't want him around. His own father didn't want to see him. And you were told his family members were going to say there was never a problem.

His mother, you heard from her deposition, said she blocked it all out. That's a defense mechanism.

Michelle's brother in his deposition said that Brian was spaced out like a zombie. Those were his words. Those weren't my words. That wasn't a question asked by me. That's what Michelle's brother said. And he said Brian tells me all the time about his memory problems.

They told you that Brian's work records show that nothing was going on. Until we got to my Cross-Examination of those supervisors. They knew that when they played you the first part. When they asked questions of Brian's supervisors, despite the fact that we're not making a lost wages claim, they only went through the records starting in 2008 to say they stayed the same. They didn't ask them and didn't show you the records before 2008 that made clear that it was a steep and steady decline beginning in 2008, which happens to be when Dr. Walden started giving him dangerous Schedule II opioids.

Let's talk about their experts. First of all, the Defendants did not bring you a single retained expert in here who had the same profession as Dr. Walden during the time period in question that were talking about the standard of care. Not one.

Dr. Gunderson told you these things have the same effect on the brain as heroin. They effect the receptors in the brain the same way. Dr. Gunderson didn't know what the doses were when he came in to his deposition to give

standard of care opinions. Let's look at Exhibit 170-4.

The infamous Exhibit 170-4. This is a letter written by Dr. Gunderson, the defendant's expert. Part of the group called Physicians for Responsible Opioid Prescribing. It was written to the government. In it, it says, and this is 2012, "An increasing body of medical literature suggests that long-term use of opioids may be neither safe nor effective for many patients, especially when prescribed in high doses. Unfortunately, many clinicians are under the false impression that chronic opioid therapy is an evidence-based treatment for chronic non-cancer pain -- that's what Brian had -- and that dose-related toxicities can be avoided by slow upward titration. These misperceptions lead to overprescribing and high-dose prescribing." They lead to what happened here.

Let's look at the next page. Here's Dr. Gunderson's maximum recommendations that he put in the letter to the government. They are the same numbers that we have been telling you. The same numbers that our expert under oath on the stand said you don't go above around this range, not for chronic non-cancer pain. You don't even put people on it for chronic non-cancer pain, but you don't go above a hundred.

We've showed you all the guidelines. They all say the same thing. You saw Missouri guideline, and it doesn't

have dosing recommendations one way or the other, but we have a bunch that do. And we have Dr. Gunderson's letter that says maximum daily dose equivalent to 100 milligrams of morphine for non-cancer pain. Maximum duration of 90 days. It doesn't say recommended, it doesn't say sometimes, it doesn't say most of the time; it says maximum.

Statements of scientific basis for petition. You saw these, ladies and gentlemen. These are statements of scientific basis for the petition of their own expert, that they're writing to the government, about how there's no evidence that you should ever be doing this. There's no evidence it's effective. There's no evidence it's safe. We're creating a problem.

The daily maximum in his letter was -- in the letter it says it's designed to be in line with the Washington guidelines that we showed you from 2007 and existing CDC guidelines. Not from 2016. Existing CDC guidelines in his bibliography from 2007. That's before 2008.

And while we're on it, when I showed Dr. Gunderson the doses, when I showed him the bar graph, I showed him the amounts in this case, he told you that he had never prescribed somebody that amount of opiates. He had never gone that high. This is an opioid addiction expert. He doesn't go that high.

And for that matter, SLU's corporate representative Dr. Heaney said he's never gone over a thousand. Not only has he never gone over a thousand, he's never seen anybody go over a thousand. That's the head of internal medicine for SLU.

Dr. Gunderson told you there are no studies that have ever evaluated the safety and effectiveness of long-term opiate use for patients with chronic non-cancer pain. He explained that opioid addictions take over a person's life and destroy lives and families. The same way it has Brian's and Michelle's.

He said what they reported is consistent with what he sees. He told you that addiction is a chronic medical condition that results from changes in the brain, not a moral or mental weakness. It's something that happens to you in your brain. You lose control. That's what addiction is. And it's a terrible feeling.

It alters circuits in your brain responsible for mood, behavior control, judgment, decision making and memory. It strips away a person's ability to feel emotions like love, joy. That's on small amounts. Brian was showered with opioid pills. He was on over 1,500 morphine equivalent milligrams a day for the year of 2012. And over 1,100 for the year 2009.

Dr. Gunderson said opioid addiction creates

emotional distance between the addict and his or her children, and you can live with that guilt forever. You guys saw Brian on the stand. Do you think he's fakin' that? Nobody can fake that. You saw Michelle on the stand. Is this something that really happened in their lives? Do you know how hard that is to lay your whole life out in public for people? Think about how hard that is. The most painful thing you've ever gone through in your life, for years, and to come in and try to explain to people what it was like. What a struggle it was. And then to be challenged that it didn't happen. That's what we saw.

Dr. Gunderson agreed with every diagnosis of Dr. Fitzgibbons, every single one, and they still went after her on the stand. Like somehow what she was doing was disingenuous or dishonest. We asked her to evaluate somebody and do a DSM diagnosis. We didn't know what it was going to be. We asked a psychologist to evaluate him.

And then their addictionologist agreed that everything she said was right, all three of those diagnoses were right. He agreed Brian was addicted, which he said is interchangeable with opioid use disorders. He agreed Brian went through withdrawals and that the symptoms Brian described are exactly what he would expect to see.

He agreed the opioids contributed to cause Brian's depression. Yes, Brian has had some depression in the past.

That has never been hidden from you. I told you that in the beginning of opening statement. The question is whether it became worse. Whether it became recurrent because of the opioids and worse. That's the question. Their expert agrees that it didn't.

When I showed Dr. Gunderson the doses and asked him if it was outrageous, their lawyers didn't want him to answer. Why do you think that is? When they asked him if any of his opinions changed, after I went through the actual facts with him? Their own question, didn't want him to answer it. He said I have a caveat. They didn't want to know what it was.

Dr. Gunderson told you himself that while Dr. Walden was prescribing Brian opioids, the risks outweighed the benefits. That is literally one of the four ways that the Plaintiffs in this case have alleged that he is negligent. Our claims are ridiculous? Their experts agree with them.

Let's talk about Dr. Guarino just for a second. I honestly don't think anybody in this courtroom believes a word he said. I don't. The man's been paid so much money to market opioids for pharmaceutical companies that he doesn't know which way is up, down or sideways. He testified on behalf of another doctor who was convicted of over-prescribing opioids. That's the kind of expert

Defendants brought in in this case to tell you that what the Defendants did was okay.

He doesn't follow his own Washington University -- his employer's conflicts of interest policy about not accepting gifts and trips from the pharmaceutical industry. I can't believe they brought him in here. They knew everything you heard during Cross-Examination before they brought him in here. I deposed him. It all came out.

I want to go through some of the jury instructions with you, ladies and gentlemen. Mike, can we go to Number 1? This is part of Instruction 1. Paragraph 11. Instruction 1 is a big instruction. You heard it at the beginning of the case. You heard the Judge just give it again.

When you go back, you'll select a foreperson and your job is to decide the facts and to arrive at a verdict. The rest of this is about considering the weight and value of testimony. And it's the last sentence. You may give any evidence or the testimony of any witness such weight and value as you believe that the evidence or testimony is entitled to receive. You decide the weight to give to what evidence you heard. That's for you to decide.

This is Instruction Number 4 that your Honor read to you. You're going to get verdict forms to go back that will allow you to return permissible verdicts. And this is

the important part. Nine or more of you must agree in order to return any verdict. It's not unanimous; it's nine or more. A verdict must be signed by each juror who agrees to it. There's going to be lines for you to sign.

Can we go to Number 5? This is the burden of proof instruction. It's how you weigh the evidence in deciding a verdict. And as you were told before, the standard in deciding a disputed fact is more likely true than not true. That's the standard. More likely true than not true.

By the way, I told you in opening you may be able to consider the issue of punitive damages. Your Honor has instructed you on the issue of punitive damages. You get to consider that issue. The burden for punitive damages is that the evidence has clearly and convincingly established the facts necessary to recover punitive damages. Ladies and gentlemen, the evidence in this case is overwhelming.

Can we go to Number 7? This is the verdict director, Instruction Number 7. It's about deciding whether you think the Defendants are negligent. This is the law. This is how it helps you to do that. You must assess a percentage of fault to Defendants whether or not Plaintiff Brian Koon was partly at fault -- we're going to get to that in a second -- if you believe, first, either failed to weigh the risks and benefits of prescribing opioids to Plaintiff.

Dr. Gunderson admitted that one.

Over prescribed opioids to Plaintiff. Ladies and gentlemen, this is all you -- I think this is all you need to see in the case. This is the bar graph with the doses. The highlighted line at a hundred is what our expert Dr. Genecin said. He showed you all kind of guidelines. Do you remember what the red line is? We got that line from Dr. Gunderson's letter to the government. Look how far it goes past it. Over 15 times past it. That's not okay. That's beyond not okay. Is this right? No.

I try to think of -- I have three children, and I try to think of clear examples of right and wrong.

MR. VENKER: I object to personalizing, your Honor.

THE COURT: Sustained. Move along.

MR. CRONIN: Ladies and gentlemen, we live -- there's a lot of gray in the world we live in. A lot of times it's hard to try to find clear examples of right and wrong. This is about as clear as it gets. This is not gray. It's black or white, and it's wrong.

Failed to monitor Plaintiffs' opioid treatment. I think you heard plenty of evidence St. Louis University does nothing to monitor the amount of opioids given to their patients. Dr. Walden went sometimes six months without seeing his patient. Prescribing thousands of pills to him

in between.

Failed to assess Plaintiff for dependency or addiction. We know he was addicted. Dr. Gunderson said it; they still don't think he was. That means he definitely didn't assess him for dependency and addiction.

And here's an important part. There's four of them. The ways we've alleged their negligent. Any one or more of the respects in paragraph first is thereby negligent. That means you only need to find one. I think all four are beyond a doubt, but you only need to find one. And that such negligence directly caused or directly contributed to cause damage to Plaintiff Brian Koon.

And then we see the definition of negligence for health care providers, the failure to use that degree of skill and learning ordinarily used under the same or similar circumstances by members of Defendants' profession. That's the instruction for deciding if the Defendants are negligent and at fault and contributed to cause damage to Brian and Michelle.

Can we go to Instruction Number 9? This is an instruction where you decide if you believe that Brian shares in some fault. Brian's not a doctor. Brian relied on his doctor. But, ladies and gentlemen, these are the instructions you'll be given, and that's for you to decide. And we will respect whatever your decision was -- is.

In assessing a percentage of fault, if failed to provide information to Defendant Dr. Henry Walden. We see like a dozen records where he's telling him and giving him information to show there's a problem. What's in the records we don't have?

Failed to weigh the risks and benefits in using opioid medications. Brian's not a doctor. It's Brian's doctor's job to decide if the risks are too high. He writes the prescription. He listened to his doctor. His doctor was telling him, this is what you need to work.

Failed to follow Defendant Dr. Henry Walden's instructions for opioid use. What instructions? Dr. Walden knew he was going through his pills early; and every single time he'd give him a new prescription, sometimes with higher doses. The instructions were, do whatever you want.

Failed to follow instructions of his physicians for weaning off of opioid medications. Their expert told you that never would have worked. Not our expert, their expert. It wasn't gonna work. He was gonna go through withdrawals. He needed detox. He needed to be taken off of it.

If we go to Number 10, this is Michelle's claim. You will have already decided percentages of fault. If you assess a percentage of fault to Defendants and you believe that Michelle sustained damage as a direct result of the

injuries to Brian, that in your verdict you must find that she did sustain such damage. I'm going to show you the verdict form where all of this is for you to decide and how to fill it out.

Number 14, please. Ladies and gentlemen, this is the punitive damages instruction. Again, I told you in opening you may be able to consider it. You've been instructed on it. You get to consider it. We're going to talk about the evidence in support of punitive damages and the reasons for it in a little bit. But these four here are the same ones that you see in Number 7 for the regular negligence claim. They're the same ones.

Second, knew or had information from which Defendants in the exercise of ordinary care should have known that such conduct created a high degree of probability of injury. Dr. Walden admitted in his deposition that in 2010, 2011, 2012 he knew the amounts he had Brian on were, quote, creating a probability of dependency or addiction. That's creating a probability of injury.

Third, Defendants thereby showed complete indifference to or conscience disregard for the safety of others. And then in Verdict A you may find that they are liable for punitive damages. You may consider harm to others in determining whether Defendants' conduct showed complete indifference to or conscience disregard for the

safety of others.

Now, here's something that bothers people. If you find they're liable in this stage, I'm going to talk to you about it in a second, you will be given further instructions for assessing the amount of punitive damages in the second stage of the trial. It's going to be five minutes of evidence if you decide they're liable for punitive damages. We've been through a lot here, ladies and gentlemen, for a week and a half. It will be five minutes, and then you'll be able to go back, we'll give you the law on how to decide the amount, and then you can decide an amount. Five minutes.

You see the phrase ordinary care? That's defined down here for you. That degree of care that an ordinarily careful person would use under the same or similar circumstances.

We have a transcript of the evidence. We highlighted and tabbed it. We've gone through to review all the evidence that supports our negligence claim, that supports our punitive damages claim. I was thinking last night, how I can possibly go through all of it with you, and I'm not going to do it. There's too much. You heard the evidence. You remember the evidence. This is insane.

I'm just going to remind you of a few key points. We saw the safety rules I showed you in opening. We've gone

through them with the witnesses. They've been agreed to. Every single one of them needs to be followed. That's the standard of care.

Let's talk about the opioid epidemic. You've heard and been shown all kinds of four or five statistics. 165,000 people have died since 1999, and it's going up. 19,000 people per year are dying from prescription opioids. That's over 50 people a day. The annual number of deaths from prescription opioids exceeds the number from motor vehicle accidents. The number of opioid prescriptions filled in the U.S. per year equals our population. Not the number of pills; the number of prescriptions that come from doctors. They don't magically show up in people's cabinets. They're prescribed by doctors. The increase in overdoses has mirrored the increase in prescriptions by physicians.

MR. VENKER: May we approach, your Honor?

(Counsel approached the bench, and the following proceedings were had, out of the hearing of the jury:)

MR. VENKER: I don't think I need to do this, but just cautionary I want to renew my objection about the opioid epidemic. I assume the ruling is the same?

THE COURT: Yes.

MR. VENKER: Overruled?

THE COURT: Yes.

MR. VENKER: Thank you, your Honor.

(The proceedings returned to open court.)

MR. CRONIN: Ladies and gentlemen, this is a doctor problem. People are dying at the rate they're prescribing. And the Defendants are trying to tell you doctors have nothing to do with it.

Ladies and gentlemen, they're not getting the message. These Defendants and other doctors around our country aren't getting the message. Give them one they can't ignore. That's what we're asking you to do.

You've heard about all the risks of opioids, dependence, addiction, overdose, deaths. They knew about all of them. They knew about this problem before 2008. It's been going on for years. Their corporate rep, Dr. Walden, told you they knew about it. Why would you prescribe so recklessly like this when you know about it?

One out of 32 people die when given over a 200 morphine equivalent dose. 200. One out of 32 people. They went seven and a half times past that. What did their corporate representative, the head of internal medicine, say about that statistic? That means 31 of those people are getting the benefit. That's what we heard from St. Louis University's corporate representative, the head of internal medicine. He can live with that statistic. I can't.

Brian was placed on over 200 in 2009, over 500 in 2010, over 1,100 in 2011, and closer to 1,600 in 2012. I

think it was 1,555. The risk of dying goes up steeply past 100 milligrams for 90 days. I think that's what Dr. Heaney told you. This went on for four and a half years. Between the middle of 2008 and 2012, Dr. Walden and SLU didn't try anything else. They've tried to tell you they did. Some other people tried other things. Dr. Walden in May of 2008 sent him to one surgical consult. After that he didn't try anything else. Just bigger and bigger doses of opens.

Dr. Genecin said not only are these amounts excessive and colossal, Brian never should have been on them at all for low back pain. You make a decision to put somebody with chronic low back pain on long-term opioids, I think a 36-year-old man, you're deciding that you're going to put him on Schedule II dangerous drugs for the rest of his life.

Dr. Genecin said that these were done with no legitimate medical purpose. They were not helping him; they were only harming him. Do you think a physician does that lightly? Do you think a physician flies to St. Louis from Yale, comes into a courtroom in St. Louis to tell people that something another physician is doing is reckless and dangerous? Do you think they do that lightly? No.

He testified this was reckless. The amounts, the duration, the lack of monitoring, no assessments, giving three different types in addition to Ambien, all reckless.

He unequivocally said the evidence in this case in his opinion supports a finding of recklessness and conscience disregard for safety.

We heard Dr. Walden, according to his records, in 2008, 2009 and 2010, in his deposition he began by February of 2010 to think it was a good idea to begin weaning Brian off of opioids. And then they were never reduced. They just kept going up.

When another SLUCare doctor, Dr. Brinker, put Brian on OxyContin in 2009, he said -- and I had to show you the record -- switch him. Switch to OxyContin from Vicodin for better control. Follow up with Dr. Walden. He followed up with Dr. Walden. No switch. Just added. The oxycodone IR shows up in the pharmacy records without being mentioned in Dr. Walden's records. It shows up in the pharmacy records before it's ever mentioned in his records, that we have.

There was no plan. There was never a plan. Look at everything that Dr. Berry figured out in one or two visits. Brian has an opioid dependence problem. He needs an MRI. He got an MRI. He has a disc bulge, nerve root impingement, investigative treatment program, go see a psychiatrist. That took Dr. Berry one or two visits.

Pharmacies warned them it was too much, and they kept goin'. And did most of this over the phone. They were

monitoring him? I don't think so. There's no mention in the records of risks from February '08 to the middle of '09. By that time he had given him over 4,000 pills and over 50,000 milligrams. The only other time risks and benefits are mentioned is the end of 2011. Think about how much he had been given already by then.

Ladies and gentlemen, I wish -- I think we all wish that we had a system where you could undo what happened, where you could turn back time and give those years back to Brian and Michelle. Wish you could wave your hands and take away all the pain they've gone through. We wish you could put in a verdict form that Brian and Michelle could look at each other again, feel the way they used to feel before all this happened, see the person they married again, and that Brian could stand up, take his wife by the hand and walk her out of here and go home to Emily together. We don't have that system. It's impossible. Brian's going home alone.

We have a system of justice. You are that system. It demands compensation for what's been lost. It's a crude system, but it's the only system we have. What do we value more than our families, than our happiness with our families together? Our ability to look ourselves in the mirror and not be disappointed or disgusted with what's happened in our lives. What's that worth? The love, companionship and

trust of our families. Conduct like this is what destroys families.

Paintings get sold for 25 or $50 million, and we don't bat an eye. Because they're unique. Those are big numbers. Brian lost years of his life, the first three years of his daughter's life and he lost his family because of what this did to him. He'll suffer that forever. And Michelle lost just as much. How much do you think they value that? How special and unique do you think that is to them?

Here's the scale that you decide compensation for damages on. What did it feel like to them? Not somebody who didn't have to go through it. What was it like for them? What is it still like for them? That was difficult to watch them go through. This didn't all just happen to them in the hour they were on the stand. This is every day.

Can you pull up Instruction 12?

THE COURT: You're at 42 minutes.

MR. CRONIN: Okay. Ladies and gentlemen, this is the instruction on damages. And before it gets up, here's the important part. Total amount of Plaintiff Brian Koon's damages. If you decide that Brian Koon shared -- was negligent and shared in some fault, you don't reduce your damages number for Brian's fault; the Court will do that afterwards. Total amount of damages is

what you put on the lines. And the same for Michelle. Such sum as you believe will fairly and justly compensate for the damages sustained and reasonably certain to sustain in the future that were caused or directly contributed to be caused by the Defendants' negligence. Here the Judge will reduce them if there's any fault for Brian.

Think about what this did to their lives. It wrecked them. It wrecked her. It wrecked their family. It stole their future, their happiness together. Brian lost his ability to control his own actions. What a terrible feeling that you can't trust yourself. He lost over four years of his life. Michelle lost the man she had decided to spend the rest of her life with.

She felt alone, unwanted, unloved. She told you it destroyed her as a woman. It got so dark Brian put a gun to his head and almost pulled the trigger as he saw no way out. He barely recalls the birth of his daughter. He doesn't recall her baptism, watching her first steps. How does that feel to know that?

You heard about the first time he saw his daughter with clear eyes on his sixth wedding anniversary. He didn't even know she had been able to walk and run and talk for a year. Michelle didn't take a single pill. She went through four years of hell with sober eyes. She had to watch it

happen and tear their life apart.

Can you pull up the verdict form? Ladies and gentlemen, I'm going to show you the verdict form.

Judge, can I use some more of my time if necessary?

THE COURT: You may.

MR. CRONIN: Here's the verdict form. This is where you assess fault on the claim of Plaintiff Brian Koon for compensatory damages. I've got the same thing here as there.

Ladies and gentlemen, I'd suggest to you this is what your number should be. Defendants Henry Walden and St. Louis University, 100 percent. Plaintiff Brian Koon, 0 percent. Total, 100 percent. That's how you fill out the form. Those are the lines.

Then down here is for determining Brian's damages. I'm going to show you the next page, which is deciding Michelle's damages. I want to talk to you about punitive damages for a second. To punish and deter. They have no policies about monitoring the amount of opioids given to their patients. Dr. Heaney told you they didn't see a reason to do it. The single page they have about opioid prescriptions hasn't been updated since 1998. That's almost 20 years ago.

This kind of conduct is wrecking lives. This will

continue until someone stands up and shouts, enough. No more. Punitive damages are stopping damages. They're about stopping. We're not going to put up with this anymore. We're not going to let it happen anymore. This is a sad case. And the reason that it's a sad case is because this is avoidable. This can be fixed. Don't waste this opportunity. The next time there's a story on the news about this happening to somebody else, I think everybody would want to know that they did what they could to stop it.

Ladies and gentlemen, there's no such thing as a big verdict or a small verdict; there's only a such thing as a just verdict, by following the instructions that the Judge gave you of the law. I can't decide the number for you. That's for you guys to go back and talk about amongst yourselves. All I can do is make a suggestion.

This cost Brian over four years of his life, a big part of his daughter's life. Past non-economic damages, $4 million. Ladies and gentlemen, this is for you to decide. It's just a suggestion. And it's still not over. There's a whole another category of damages following the instructions of the Court how to determine them. Future non-economic damages, I would suggest a number to you of $2 million for a total of six. And I think Michelle went through more than Brian did. I think the numbers should be the same for her. You saw and heard Brian and Michelle. I

don't think twice that is enough for what they've gone through and what they're going to keep going through.

Ladies and gentlemen, we're not asking for sympathy. You've been told that at the beginning of the case. We're asking for justice. If you want to stop this, if you want to figure out what we can do today in this courtroom, that's what this line is for. We, the undersigned jurors, find the Defendants Dr. Henry Walden and St. Louis University are liable for punitive damages.

I showed you in the instructions. The instructions for assessing the amount are in the second stage of the trial. It will be five minutes. And then you'll be able to go back and figure out an amount. Think about what you've heard in this case. Follow the law that the judge has given you. That's all we're asking you to do. We have it for a reason. This law is here for a reason.

Thank you.

THE COURT: You have a full ten minutes remaining.

MR. CRONIN: Thank you.

THE COURT: Counsel for defense?

MR. VENKER: Thank you, your Honor.

THE COURT: You may proceed.

FINAL ARGUMENT ON BEHALF OF
COUNSEL FOR THE DEFENDANT

MR. VENKER: Good morning, ladies and gentlemen.

THE JURORS: Good morning.

MR. VENKER: This is my last opportunity to speak to you in this trial. I appreciate your attention you've given us through all the evidence. I know at times it had to have seemed a little bit tedious to you, and I appreciate that.

You may recall that I told you in opening statements that there were a lot of disputes in this case, and you heard Mr. Cronin argue the Plaintiffs' side, what they believe the evidence has shown. Obviously we disagree with almost everything he said, and I'll do my best now to review with you what I think is important.

In doing that, I don't mean to discount or diminish what you yourself as you've listened to the evidence has thought was significant to you in terms of doing things that jurors are supposed to do, judge the credibility of witnesses, evaluate evidence and testimony. And in the end, deliberate together as a group to decide what the facts really are. That's why this jury system is here, is to allow parties to resolve these disputes peacefully as opposed to getting handled in some other way.

So there are a lot of things I want to go through

with you, but one thing I want to remind you is that as jurors you should and you're encouraged to use your common sense, rely on your life experiences, because that's what you bring to this process. Each one of you has your own life experiences. And together, as a group, that should be a really good crucible of bringing together the disputes and discussions you may have about what you've heard here this a little more than a week. And I can't encourage you enough to do that.

In opening statement, I told you, and it's a rule that applies to myself, me, as well as to Mr. Cronin, I told you then what I thought the evidence would be. Maybe sometimes I got a little over zealous in my opening statement. But with that, I told you at the time, you have to go with what the witnesses say and what the evidence has been through the other sources here such as documents, exhibits, medical records, photographs. And so, again, what I see -- or what I'm about to tell you about is what I think the case has shown about Dr. Walden's care of Mr. Koon in these four, four and a half years or so.

There was some talk about the Hippocratic Oath. And I guess I would just that say if the Hippocratic Oath, the spirit of that oath is physicians should do no harm, then I submit to you there should be a counter spirit on the patient's side, that the patient should be honest and

forthright with his or her physician. Because without that candor, without that information, the physician does not have the full information he or she needs to help that patient the best they can.

And so as you think about the evidence and you analyze the case, you need to think about that aspect of this. And we talked about this in both jury selection and some in opening statement about the relationship between physician and patient and how important that open channel of communication is.

Now, I told you too that I think there was and I think there is misdirected anger by the Koons towards Dr. Walden. Mr. Koon has had more than his fair share of challenges, ladies and gentlemen. I don't diminish that, and I don't mean to be disrespectful with anything I've said or anything I'm going to say today.

But he's had a challenge in terms of being adopted and not knowing his biological parents; having had cancer; having had psychiatric issues as a teen, and depression. This chronic pain that we've talked about throughout has been the theme of this trial. That's really why we're here is because Brian Koon had chronic pain and tried to live with it and tried to support his family, be a responsible citizen, and Dr. Walden tried to help him do that with these pain medications.

And now, again, as you've seen from the evidence, and I won't go through all of it, Dr. Walden started being his doctor in 2001. He didn't rush him to opioids. And I'm confident that you understand from the evidence that Dr. Walden is nothing close to the kind of pill-pushing doctor that the Plaintiffs want to say is -- essentially he's part of the opioid epidemic, which couldn't be farther from the truth as you've seen through all the evidence here, I'm quite confident.

But in terms of that, the fact is, with Mr. Koon and these challenges, it just would be wrong to allow that anger to be misdirected, that frustration to be misdirected at Dr. Walden for his role in trying to help Mr. Koon get through that challenging period of time when the pain was so great that he had to have the pain medications. And it's clear the pain medications did benefit Mr. Koon, and he told you so himself, and we saw it in the medical records. Not only from Dr. Walden's medical records but also other health care providers.

And so really, as I told you in the beginning, and I still think it's true now, this case is really about pain, the intense pain that Mr. Koon was suffering and that Dr. Walden tried to help him with.

Dr. Walden, you've heard some about. Obviously here, been in St. Louis for a lot of years and then moved

around; but came back to St. Louis to go to medical school. Went on a scholarship. As part of that scholarship, he knew he'd have to serve underprivileged areas, underserved areas with medical help. Four years he did that. Does that seem like the kind of person who would be careless with prescribing opioid medications which he knew had their dangers and risks from the very beginning?

No dispute in this case that even in a small amount, opioids can pose danger. Not that they in fact will be dangerous, but they can pose dangers. And physicians experienced like Dr. Walden know that. He's not hiding from that. He's didn't say it wasn't dangerous. He says yes, it is, and I know that. So in terms of how he approached Mr. Koon's care as well as how he approached his other patients.

So after those four years of providing service to the underserved in those medical communities up in north city, north county, he went back to SLU as a full-time professor and became part of the faculty there. He teaches medical students; he teaches residents. I think that's the kind of person who's interested in the future of the community, interested in the future of the people here in St. Louis and their welfare. You've heard he's got teaching awards for that because he communicates so effectively to medical students and residents. And isn't that important to

all of us?

You heard about Dr. Walden telling you how early on especially he respected Mr. Koon for his focus and his desire and his work ethic to keep earning a living for himself and then for his family by that time. He and Michelle were married in 2006. And Dr. Walden has had other patients not nearly as motivated as Mr. Koon. So from that standpoint that also makes this a difficult situation for Dr. Walden.

But in terms of all the things he did, all the office visits, all the different times, you saw the evidence and the charting, I'm not going to go through it now, that Dr. Walden talked with Mr. Koon. There were two separate occasions that were actually charted about dealing specifically with dependency and addiction issues for opioids. One was in that 2009 time frame.

But Dr. Walden told us, he counseled Mr. Koon before actually starting with the first opioid prescription back in 2008. In 2009 he did it, and he did it again in 2011. Why did he do that? He already told Mr. Koon once. You know why he did it. He told you. Because that's what it takes. People sometimes lose focus on this. And these are drugs that you have to be worried about.

And so he wants to know how Mr. Koon is feeling. He wants to know even the simplest things in the office

visits. Are you light-headed? Are you drowsy? Are you having any difficulties or mental impairment of any kind? No information like that has been given to Dr. Walden through those years. The first indication was in this April, May 2012 time frame. Before that, there wasn't any of those indications, and Dr. Walden was on the lookout for those with Mr. Koon.

And it was up to Dr. Walden to elicit that information. He wasn't relying on Mr. Koon solely to come in and tell him. But, he does need a patient like any doctor does need a patient, to be honest and forthright and talk to him about the issues, talk to him about the concerns, let him know if there's a problem.

Dr. Walden has experience. It's not as if Mr. Koon is his only opioid medication patient. You heard him testify he has about 700 patients; and despite the characterization of him somehow being a big part of the opioid epidemic, only 18 of them are on any kind of opioid medications at all. Ladies and gentlemen, that's really well under -- I think it's not even 2 percent.

So if Dr. Walden is somehow a part of this opioid epidemic, he's pretty conservative in terms of who he decides should have opioids in his own patient population. And of those, he talked about the numbers who were on certain levels some were on, a certain range. And he did

say there is a patient he has who he inherited from a pain management specialist, and her dose is still above 2,000 milligrams morphine equivalent dose per day. And she's been on those doses for almost two decades, and for about eight years under Dr. Walden's care. And that is something that can be handled appropriately, and it is.

There's all sorts of patients. You heard about them. Sickle cell disease patients, multiple sclerosis patients. Those people can't be receiving those kinds of doses. Even this woman that Dr. Walden told you about. He didn't say she was slurring her speech or could barely walk in had to be wheeled in in a wheelchair.

And you heard about the genetics, the possibility which really all goes back to the patient dependent dosing. Even Dr. Genecin -- and we'll talk about Dr. Genecin in a while. Even Dr. Genecin agreed, it is patient dependent. And it's not something that the medical community even fully understands yet. Research is undergoing. People are trying to figure out why this is. But the fact is, it's true. And the parties agree on that. So I'll talk to you later about Dr. Genecin in terms of what he was saying on that topic.

But about the prescriptions that Dr. Walden -- I'm not sure if they're implying he gets paid for writing prescriptions like a pill-pushing doctor does in a back alley, but he doesn't get paid for prescriptions. He gets

paid if Mr. Koon comes in the office. That's not where the opioid epidemic is happening, in doctor's offices? No. That's somewhere else. This is not an opioid epidemic case, ladies and gentlemen. Not even close.

This is someone under a doctor's care for years at a time with records, with prescriptions being made. They're high dose. We haven't pulled back from that from the beginning, ladies and gentlemen. They are high dose. And in some patients, that's appropriate.

Even Dr. Guarino -- we'll talk about Dr. Guarino. But even he said, I have a few people at that level. Okay, it's rare. Unusual. You heard Dr. Heaney, the SLUCare CEO even say, that's unusual. Okay, so it is. But the fact is, it still exists, and it's still accepted as a medical course for the appropriate patient.

And what did Mr. Koon tell Dr. Walden? Well, he had some -- he said he had some memory problems, but, again, I don't mean to be disrespectful, but we heard from Dr. Gunderson that memory problems are not something related to opiate use. And so Mr. Koon said, there's a lot of things he couldn't remember. We'll talk in a little bit about what he did remember.

But I wanted to point out one thing that he did remember, and that is that when he was asked, could it be that you were lying or withholding information from

Dr. Walden, he said, well, I may well have, yes. Okay. I mean, so he's not going so far to say he's actually lying, but he said he may well have. Well, so I submit to you that that is probably a concession on his part, a concession that in fact he did not fully disclose to Dr. Walden what he was doing.

And I suppose the comeback in the rebuttal, and I don't get to talk again, will be, well, he was on these opioids so he doesn't know what he was doing. Ladies and gentlemen, I don't know what to say about that. These are drugs. He's been advised of the risks. I'm not sure how close it is to saying somebody who had too many drinks, didn't know what he was doing because he had too many drinks. We've thrown that out years ago as a defense to anything, haven't we?

And so I think there is a serious obligation on behalf of the patient, but it's not a sophisticated obligation. It is true. Dr. Walden is a doctor. He's not expecting Mr. Koon to know what he knows. But Mr. Koon has to tell him what he knows. He has to tell Dr. Walden what he knows so Dr. Walden can analyze it and take it into account and process it. People aren't radios or cars. They are a sophisticated organism.

And it isn't just one rule for everything. And information has to be taken in and processed. They don't

call it a differential diagnosis for nothing. It's a list of potential conditions somebody could have. In your car when your oil is low, the oil is low. It's that simple.

When somebody is complaining of certain symptoms, it could be five, ten, 20 different things. That's why doctors have to know the information, and it's so important to do that. And it's not unfair to request people like Mr. Koon to keep his doctor informed. Nobody's asking him to do research. Nobody's asking him to go on the Internet and figure out what his condition is. No.

Dr. Walden is an experienced internal medicine physician. He had practiced for well more than 20 years when Mr. Koon first saw him.

I know what Dr. Walden saw -- Mike, can you put up 75-2 -- when he saw Mr. Koon? This is Plaintiff's Exhibit 75-2, number 13, ladies and gentlemen. You've seen it before. I showed it to you. Plaintiffs' counsel didn't show it to you.

Now, this is in late 2009 because you can see Emily is already there in the picture. And I don't know if it's like a gender thing, but I bet the women can tell better than the guys can how old Emily is in that picture. But the fact is, she was born July. It's later 2009. From Mr. Koon's own testimony, by this time he was unable to control his ability to take the right amount of pills.

Now, in this picture -- I know you're not experts at detecting addiction or people who are addicted or dependent, but I submit to you this is who Dr. Walden saw, a normal male who came in his for office visits. This is in late 2009, ladies and gentlemen, when Mr. Koon says he's already basically out of control.

All right. Let's talk about Dr. Gunderson and Dr. Guarino. So Dr. Gunderson, an addiction specialist, a new part of medicine these days. They weren't really around. He told you, I was in one of the pilot programs for these things. In fact, in 2003 and 2004, he finished his internal medicine residency, board certified internal medicine doctor, Mr. Cronin says, well, they brought an internal medicine doctor here. That's not true. He's board certified -- there are -- he's one of the few percentage points of board certified internal medicine physicians in the country. Okay? So he's gone through that rigorous training, Dr. Gunderson has.

And he decided to do something a little different. He decided he wanted to help people with addiction. Okay. That's a good thing, isn't it? I think it is. So he goes to that special fellowship training. So we wanted to bring him to you so that you could understand it from that perspective.

Dr. Genecin just wants to say, well, he's an

addict, and he's an addict forever. You know, kind of this old adage. You know, once you're a -- toss him off. Once you're a drunk, you're a drunk. Well, that's not right. That's not respectful, and it's not accurate.

Dr. Gunderson has the skill and the training to be able to analyze what someone was doing, how they were progressing. But it's true, he sees people at the end of that line. They have already gone through all that course. Has he prescribed in this range for patients? Well, no, he's an addiction specialist. I mean, he's at the other end of whatever it is these people have been through. Has he seen patients in this dose range? Yes, he has. He said that. So he's had that experience.

What he told you was, Mr. Koon does have predisposition for becoming addicted to opioids. He also said that that's a genetic function and that until somebody's exposed to whatever it is they might be addicted to, they aren't addicted because they haven't been exposed. That's common sense. Again, you can draw on your common sense and your life experiences. We all know that. We all know some people who can handle certain alcohol or not. Some people react violently to those kinds of things.

So these opioids are simply the same way. So that's what Dr. Gunderson was saying is, Dr. Walden didn't

cause him -- and he did say that -- didn't cause him to become opiate dependent. That phrase, that opioid use disorder that the DSM, the Diagnostic Statistical Manual, it's a psychiatric manual, that they use to broaden out and try to break out in terms of, you know, is it really dependency or is it addiction or is it now this kind of smooth art board spectrum, if you will, where the colors are changing as opposed to boxes along the way.

So he said, yeah, he did get that opioid use dependent. Dr. Walden didn't cause that. He has the predisposition to it. And so, what he also brought to us is that it is a very treatable condition. He talked about Mr. Koon's ability to get off the opioids for his surgeries. You heard all that evidence. I think the natural feeling for people is if somebody is an addict, they shouldn't be exposed to that substance again. Well, Mr. Koon was. So what does that make him then? I mean, is he just somebody who's incredibly strong internally?

And that's why I thought Dr. Gunderson would be a good witness to explain how those things happen. He says basically with the appropriate therapy, the Suboxone that Dr. McKean was discussing going forward, that Mr. Koon had a great chance of pretty much a full recovery and could have a normal life. He's seen that in patients. He told you that being off to get off Suboxone in the

beginning was pretty remarkable, that not many patients do that.

This withdrawal issue, he told you that really the fact is that someone would have gone through the withdrawal Mr. Koon went through, it's a very subjective thing; some patients don't even go through withdrawal. But Mr. Koon would have gone through it even if the dose were lower, that's what he told you. And he could have avoided some withdrawal, maybe not totally, but some, as opposed to what he put himself through needlessly.

Dr. Guarino told you he's a pain management specialist. We thought he should be here because Dr. Genecin said, well, Dr. Walden should have referred Mr. Koon to a pain management specialist. It made sense to bring a pain management specialist for you to hear and to listen to and have him explain to you about that. And Dr. Guarino said, I do get referrals from internal medicine doctors. And, yes, I do prescribe in these doses, not very much; it's not for everybody. Not everybody can handle those genetics.

And so, in terms of that, the experts we tried to bring you, we brought you, rather, I tried to have them explain and be able to explain to you. Now, two things that Dr. Guarino said that I do want to emphasize is, he talked about the annular tear on that MRI. That is the

tear in the disc material that Mr. Koon had. He had two tears, two annular tears, as a cause of pain.

Dr. Genecin was trying to say, there was no cause of pain and the MRI was normal. Well, it wasn't normal. There was a source of pain there that clearly was identifiable and recognized by certainly by Dr. Guarino; I think Dr. Walden as well.

In terms of the addiction itself, you know, these drugs can be addictive, that's true. But you heard from Dr. Guarino that the actual number of people who become addicted is very, very small. I don't mean to diminish the potential for addiction. I think the way to look at this though is not that they're highly addictive and that a lot of people who take the opioids are going to be addicted. It's just that the very few who are -- you know, that's like strapping yourself to a rocket; you don't know where that's going. So that's why the caution is there to say, we really got to be careful with this.

In terms of the claim that Dr. Walden and SLU acted with conscious disregard and recklessness for Mr. Koon, I think it is ridiculous, ladies and gentlemen. I think Dr. Walden has proven that he's taken good care of Mr. Koon. It is true he did develop the dependency, but that can happen through genetic makeup of Mr. Koon.

If you believe the Plaintiffs theory, it's a

little confusing. But back in 2009, Mr. Koon wasn't on 1,100 milligrams of opiate every day; he was on about 200. So I'm not sure I understand the Plaintiff's theory, if it's this high dose, it's supposedly so reckless. Mr. Koon is claiming in 2009, when he was only at about 200 morphine equivalent doses a day, that that's what he lost control by that time. So anyway, I just put that out there for your consideration.

In terms of Dr. Heaney testifying, he testified that SLUCare relies on its physicians, good physicians like Dr. Walden, to do the monitoring, to watch the patient. Otherwise, who's watching Dr. Walden then? Is there another doctor behind him? And who's behind that doctor? The idea is to get the doctors who can do it right in the first place. And other than that, you're talking about having somebody follow around the doctor who's providing care. That's not right.

Let's talk about the dosing of the opioids themselves. We talked about patient dependent dosing. That is something both sides agree on. And again, that's that physiology of different people reacting differently. So we heard from Dr. Guarino about hypermetabolism, that is hyper means high, so somebody absorbs or uses up, I should say, those opioids quicker. And so they would need a higher dose. Somebody else, what's called

malabsorption, something in the digestive tract where they don't absorb the opioids like anyone else does, like most people do. And so, either way that person is not getting the full effect --

MR. CRONIN: Your Honor, can we approach?

(Counsel approached the bench, and the following proceedings were had, out of the hearing of the jury:)

MR. CRONIN: That was just an argument that Brian had a genetic disorder, which was excluded in a motion in limine that's just been violated.

MR. VENKER: Judge, it was a motion -- the motion in limine was ruled on, but in evidence it was my understanding motion in limine are kind of advisory rulings. So during the trial, the evidence came in about genetics. I'm not saying he had it. I'm just saying this is a phenomenon out there. I will not argue that.

THE COURT: Overruled. Go ahead.

(The proceedings returned to open court.)

MR. VENKER: Just to be clear, ladies and gentlemen, there's been no genetic testing to confirm that Brian Koon had those. I'm just saying that it's out there, and they're using the genetics to explain this patient dependent concept.

So what I would say too is, about the opioids for him, for Mr. Koon, it's clear that they benefited him. He

told you so himself here in the courtroom when he said, well, basically, yeah, if they weren't addictive, I would want the pain relief. And he did get pain relief. He got the medications and after that, you may remember that in June of 2014, he applied for disability because he wasn't taking the pain medication, and he said I can't work anymore.

So I can't emphasize enough. Again, it's going to be natural to feel empathy for Mr. Koon. I'm not asking you not to feel any. This is tough. I mean, to have this kind of pain at this intensity, I can't imagine what it would be like day in and day out. I really can't, but you have to be able to put aside that empathy or sympathy and decide this case on the facts and the law.

In terms of Brian Koon, we talked already about some of the information he's provided and didn't provide to Dr. Walden. I guess I would say a couple things about both he and Michelle Koon in terms of what they relayed.

Just to give an example, they talked about this driving incident where Brian fell asleep at the wheel or nodded off, it's not clear which. They both attributed that to the opioids. They weren't really sure when it was, except that it supposedly happened after Emily was born because she was in the car. Okay. Scary incident. He described it as such. I can only imagine. Well, Emily in a

car at all, whatever age, that Mrs. Koon would be very excited about this and scared.

If they thought it was due to the opioids, don't you think they'd tell Dr. Walden, hey, I just nodded off driving down the street. And if he didn't tell Dr. Walden, wouldn't you think Michelle would call Dr. Walden and say, what in the world is going on here? Brian's falling asleep at the wheel. They don't remember if they told him. They don't remember if they told him? I mean, that's what this case is about, that Dr. Walden has been ignoring information they gave him. But they didn't tell him this. There's no memory of that.

And this thing about falling asleep on the porch, same thing. If they thought it was related to the opioids, why didn't they call Dr. Walden and say, hey, this is a problem for me. There's something wrong here. So I think those are things they're not telling -- and is it just Dr. Walden? Well, you know, maybe not.

They've talked about Brian contemplating suicide. I'm not going to dispute with you whether he did or didn't, ladies and gentlemen. I think suicide is a scary thing, I really do. And every time I hear about it, even if I don't know the person, I think it's a disturbing event. But my point here is, he does this. He's at the bottom. I can't even imagine how that would be to be that, that low that

you're just so helpless and hopeless.

He goes to Centerpoint, and they ask him if he's contemplated suicide, and he says no. Does he not want the help? Why would he not tell those people? I'm not saying he didn't contemplate suicide. I'm just saying why wouldn't he tell them? They want to help him. He's gone there because he's hit rock bottom. So is he just not able to understand the importance of that? He did tell them that when he was 15 years old that he tried to take his own life -- I guess I should say he had psychiatric issues then. So I don't know. I mean, if he did contemplate suicide, then like I say, I feel for him. But in terms of why wouldn't he tell the health care providers that? I can't think of anything more important to tell the health care providers about.

Okay, Dr. Genecin. So, Dr. Genecin, he's a internal medicine, part-time internal medicine doctor, who basically has no patient on opioid medication over a hundred milligrams a day. Okay? So he says, after that, I give it to a pain management specialist. Okay. Well, I mean what the Plaintiffs are claiming happened here happened with Mr. Koon, over a hundred milligrams of morphine equivalent dosing a day. So what did Dr. Genecin have to add?

Well, you know, he brought a lot, didn't he? Like I said, he's not even a full-time doctor. He told you he's

made more than a million dollars in the last 18 years doing medical-legal consulting. He doesn't treat patients above the hundred milligram a day dose. So why is he here?

As a matter of fact, he told us, I got the case material on January 30, and within the next day after a couple hours, and you've seen the records, there's stacks of records here, depositions, a lot of stuff. He spends less than two hours on the file and calls up the lawyers and says, this is negligence, I'm sure of it. Wow, okay. He got $14,000 a day. Mr. Cronin said he didn't come here lightly. Well, no, he didn't come here lightly. He earned $14,000 those two days he was here in St. Louis to testify. So he certainly had his reasons for coming.

He talked about really confusing, conflicting information, didn't he? He talked about the CDC, which just came out in 2016, by the way, four years after the care stopped here. And he says, this represents the standard of care. This is required. This is mandatory. And then I had to show him, didn't I? And he said, he believes experts are here for the truth. They should bring out the truth. They're supposed to champion the truth.

I said, well, doctor, doesn't it say right here that it's voluntary? Yeah, it says that. Isn't voluntary the opposite of mandatory? Well, yeah, that's true too, it is the opposite of mandatory.

And so here he is, coming all this way to basically try to tell you that some guideline, a part of a educational pilot program in the State of Washington and the CDC guidelines from four years after the care in question should somehow be the standard of care in this case. And I submit to you that that is ridiculous.

Now, in terms of the different things Dr. Genecin had to say was the medications didn't benefit Brian at all. Well, you heard Mr. Koon say they benefited him. We saw the records testify about them. He said he wouldn't take them if they didn't benefit him. So for Dr. Genecin to say they are no benefit at all, that doesn't make any sense.

Then he said there's this hundred milligram a day limit. Absolutely, nobody goes above it. Where's the chart? Mr. Cronin was showing you. Here's the line; here's the line; here's the line. But then what did Dr. Genecin say? Well, you know, I have some exceptions to that. There's the Genecin exception to that. I can go over a hundred milligrams a day if my patients have chronic postsurgical back pain where surgery failed. And if they have sickle cell disease, well, that's different. Well, it's not different, ladies and gentlemen. Those are the kind of patients who deserve that care. It's not his personal exception. But he was saying, absolute, absolute. Then he said, well, yeah, there are; there are exceptions,

you're right.

Then he said that the opioids put patients into a state of narcosis. Well, you know, I assumed it was something to do with narcotics. I looked it up. Narcosis means a state of deep unconsciousness caused by a narcotic. So that's what Dr. Genecin thinks, that Mr. Koon was in a deep unconsciousness, a state of deep unconsciousness. Is that what the evidence was? No. Never. Some instance where he supposedly fell asleep at the wheel that nobody told Dr. Walden about. That's about as close as it got, isn't it?

Dr. Fitzgibbons. I don't know what to say about Dr. Fitzgibbons. She didn't really come to try to help Brian Koon. She was hired by the Plaintiffs' law firm, paid by them. She wasn't enlisted to try to treat or help Mr. Koon. I don't really know what she did other than say that Mr. Koon and Mrs. Koon's accounts were consistent with each other about how they laid out the history. But taking into account that Mr. Koon told her that he has no memory, and he relied on Mrs. Koon for everything that he knew about the time period, which seems a little bit circular.

Family members and coworkers, you heard their testimony. The family members, I'm sure, wanted to help Mr. and Mrs. Koon, and I understand that, I do. But in terms of the picture Dr. Genecin wants to paint for you versus what

the family members told you about, night and day in terms of what the issues are.

And it sounds like Mr. Koon's father, once he learned he was on some kind of medication, told him to get off. Well, I mean, there's people probably maybe some on this jury who would turn down opiates. I know people that would. They're just too afraid to take them. That's their rights. Maybe that was Mr. Koon's dad's approach, you know, they're just not the thing to do.

So, in terms of the records that Mr. Cronin was saying that we don't have, ladies and gentlemen, there's a lot of information here. We have the prescriptions, the stipulated exhibit, Plaintiff's Exhibit 36 that talks about the prescriptions. That's what this case is all about. They put those numbers up. And I showed you the difference. This was just an example. We showed you the blue graphs compared to the spiked climb. Same evidence, but we obviously see this case very differently.

You know, Dr. Walden told you there were at most ten increases on these medications for all three medications over that four-year period, on average, three per medicine. That's not escalating every month to where Mr. Koon -- if that happened, he would have been wiped out and truly a zombie within three months, four months of the first initiation of this therapy, and we know that didn't happen.

And so there's enough information and evidence for you to make a decision based on the evidence that you've just seen here in the case. And remember, Mr. Koon saw a lot of other health care providers. He saw the surgeons, Dr. Howard Place for that evaluation in April of 2008. And he saw Dr. Heim, the neurosurgeon. Dr. Ann Christopher, the pain management doctor. He saw his own chiropractor, Dr. Mistretta, Dr. Norton, Dr. Esther. Plaintiffs didn't come forward with anything out of those records that said they're showing here Mr. Koon was impaired by these opiates.

Okay. Some final thoughts for you. Like I said, the case is really about the pain that Mr. Koon has -- had, I should say, but still has, and Dr. Walden's efforts to try to help him. The -- I think one of the observations about these bars, the bar graphs we have is that Mr. Koon towards the end in that September '11, September 2011, for almost up to August 9th of 2012, for almost ten months, if he was somehow dependent or approaching addiction, wouldn't he have been asking for more pills?

But instead, in later 2011, he goes to the chiropractor. I mean, I think that's good. So he was not saying, oh, I'm hurting still; Dr. Walden, give me some more opioids. No, he's thinking clearly enough to say, okay, let's see if I can do something else about this. And the fact that Dr. Walden didn't send him there doesn't really

matter. The fact is that Mr. Koon exercised that judgment, I'm going to go see the chiropractor. Is that somebody who's mentally impaired from opioids? I don't think so. It doesn't make any sense, ladies and gentlemen. And, again, you are to use your common sense and life experience in deciding this case.

Now, it's time really for me to sit down now, so I won't be able to talk to you again. I will ask you now though when you come to your conclusion in this case if you would return a verdict in favor of Dr. Douglas Walden and St. Louis University on all claims. And you can do that just by writing 0 percent fault assessed to Dr. Walden and St. Louis University on that Verdict A.

Thank you, ladies and gentlemen.

THE COURT: All right. Thank you, Counselor.

Mr. Cronin, you've got ten minutes.

FINAL ARGUMENT ON BEHALF OF

COUNSEL FOR THE PLAINTIFFS

MR. CRONIN: Ladies and gentlemen, over 37,000 pills for lower back pain. That's what's ridiculous. This bar graph is ridiculous. This is their expert's line. Not once have we said it's for any patient. All those guidelines are for chronic non-cancer patients, like Brian. If somebody has terminal cancer, yeah, they can go higher. If somebody has sickle cell disease, okay. You

still should be careful with it. You still shouldn't go here. But the guidelines are about chronic non-cancer pain.

Their whole defense is based on what isn't in their records. And what Brian said, should be in their records. We don't have all the records. There are 75 prescriptions required by Federal law to be in their records --

MR. VENKER: Your Honor --

MR. CRONIN: -- and they aren't in them.

MR. VENKER: May we approach, your Honor?

THE COURT: No, you may not. Let's move along.

MR. VENKER: Thank you.

MR. CRONIN: We should see all patient encounters in their records when there are prescriptions written.

I think I just heard that the medical community doesn't understand these opioids. Why are they giving them? We just heard a post hoc justification for the amount of opioids that Brian was given to discuss a genetic disorder that Brian doesn't have. Hoping you'd get confused by it. Brian doesn't have a genetic disorder. You didn't hear any evidence in this case that Brian has a genetic disorder. That was made up. Dr. Walden never thought he had a genetic disorder, and that's why it was okay to go to these doses.

Is that what this courtroom is for? To make things up four years later and in closing argument?

It's not a doctor problem? It's the only place they come from. Can you imagine walking out of your doctor's office with 322 OxyContin pills in your hand, 600 oxycodone pills, 180 Vicodin. The middle of 2008. Needs help. That's in their records. The ones we have. Needs help. That's what Brian told his doctor. Needs help.

Ladies and gentlemen, all Brian asks is that you do whatever you think is fair and right and what was proved by the evidence. Brian and Michelle can only take this so far. The rest is up to you. One out of 32 people die when on over 200 morphine equivalent dose. That's three out of 100. SLU is okay with that statistic. We're not.

There are some things that you can't do anything about. There's a lot of things you can't do anything about. This isn't one of them. You have an opportunity to do something important, and don't let it pass you by. This problem starts with doctors, and we can try to do something to end it. You have the power to stop some of this. If it helps one person, if it saves one family, it's worth it.

How about this? Is the type of person whose opioids are working to control all their pain the type of person that goes to the chiropractor on their own?

I'd also lastly just mention, Mr. Venker didn't

say one word about damages and the appropriateness of those numbers that were put on the verdict form. Consider that.

Thank you.

THE COURT: All right. Ladies and gentlemen, it's now time for you to return to your jury room, select a foreperson, deliberate and arrive at your verdict. Maureen's going to swear in the bailiff.

(At this time the deputy was duly sworn by the deputy clerk.)

THE COURT: All right. Will the two alternates, if you'd grab your stuff and come back? As soon as the food gets here, we'll get it to you. All right?

(The jury retired to consider their verdicts at approximately 12:38 p.m.)

QUESTIONS RECEIVED FROM JURY

(At approximately 1:12 p.m., a question was received from the jury, and the following proceedings were had:)

THE COURT: We're on the record at 1:12, and the question states and I quote, "What do we do when we're deciding on a foreman?"

MR. CRONIN: Wow, that's interesting.

(At this time a discussion was held off the record.)

THE COURT: We're on the record. The question was, "What do we do when we're deciding on a foreman?" It's a consensus after talking to both counsel that we refer the jurors to Instruction Number One, paragraph 11, which says, you will retire to the jury room for deliberations. It will be your duty to select a foreperson. I'm just going to put paragraph 11.

MR. VENKER: We're in agreement with that, your Honor.

MR. SIMON: Plaintiffs are in agreement.

(At this time a discussion was held off the record.)

THE COURT: Okay. I'm ready when you guys are. Anybody want to go first?

MR. CRONIN: Yes, Judge.

THE COURT: We're on the record for admission of exhibits. Both parties agree that this will be done during deliberations. So starting with the Plaintiffs?

MR. CRONIN: Your Honor, Plaintiffs would move for the admission of -- should I just -- John, are you okay with me listing them all out or go one by one?

MR. MAHON: Maybe just one at a time.

MR. CRONIN: For Plaintiff's Exhibit 1, SLUCare medical records.

MR. MAHON: No objection.

MR. CRONIN: Plaintiffs Exhibit 1-1, a subset highlighted SLUCare records.

MR. MAHON: I don't have that one on my list, but it's if it's part of the --

MR. CRONIN: It's part of the set.

Plaintiff's Exhibit 10, medical records of Centerpoint.

MR. MAHON: No objection.

MR. CRONIN: Plaintiff's Exhibit 30, Walgreen's pharmacy records.

MR. MAHON: No objection.

MR. CRONIN: Plaintiff's Exhibit 31, Schnuck's pharmacy records.

MR. MAHON: No objection.

MR. CRONIN: Plaintiff's Exhibit 36, dosing table, prescription table.

MR. MAHON: No objection.

MR. CRONIN: Plaintiff's Exhibit 36-1, which is the highlighted version of the prescription table that John used yesterday during cross of Dr. Walden.

MR. MAHON: No objection.

MR. CRONIN: Plaintiff's Exhibit 37, which is the dosing summary, with the average daily dose and things like that.

MR. MAHON: No objection.

MR. CRONIN: Plaintiff's Exhibit 38, the bar graph.

MR. MAHON: No objection.

MR. CRONIN: Plaintiff's Exhibit 40-1, policies and procedures of controlled substances, SLU's policies.

MR. MAHON: No objection.

MR. CRONIN: Plaintiff's Exhibit 40-5, letter from SLUCare director to Brian Koon dated 7-28-14.

MR. MAHON: I think that was used in Brian Koon -- with Brian Koon.

MR. CRONIN: It was used in Dr. Heaney's Direct.

MR. MAHON: No objection.

MR. CRONIN: Plaintiff's Exhibit 40-19, Defendant's Response to Request for Production.

MR. SIMON: We're just offering them.

MR. CRONIN: We're just offering them. We understand your ruling 40-19 and 40-19-1 are Defendant's Responses to Request for Production. We understand your ruling, but we're offering them.

THE COURT: Gotcha.

MR. MAHON: Yeah, we do object to it, but I mean, it didn't come into evidence so I think the question isn't whether it's being admitted into evidence. You're just offering it to preserve the record.

MR. SIMON: Exactly.

THE COURT: The objection will be sustained.

MR. CRONIN: Exhibit 50-1, DEA drug scheduling.

MR. MAHON: No objection.

MR. CRONIN: Exhibit 50-3, the PDR for OxyContin.

MR. MAHON: No objection.

MR. CRONIN: Exhibit 50-4, the Washington Interagency Guideline on opioid dosing for chronic non-cancer pain.

MR. MAHON: Yeah, that we do just restate our objections that had been raised in motions in limine and throughout the trial to the use of that guideline from the State of Washington.

THE COURT: It will be overruled.

MR. CRONIN: Plaintiff's 50-6, the CDC guidelines, dated 2016.

MR. MAHON: Same objection.

THE COURT: Overruled. It will be admitted.

MR. CRONIN: Plaintiff's 50-16, which was the article "A Flood of Opioids, a Rising Tide of Death". It was introduced with Dr. Heaney, and he authenticated it.

MR. MAHON: Okay. Yeah, we do object to that, just subject to the motion in limine and throughout the trial, objections about the opioid epidemic.

THE COURT: Overruled, it will be admitted.

MR. CRONIN: Exhibit 50-23, which was the opioid use in Missouri article also used with Dr. Heaney.

MR. MAHON: Yeah, same objection.

THE COURT: Overruled. It will be admitted.

MR. CRONIN: Exhibit 60-5, it was the standard of care slide used with Dr. Genecin to define standard of care and ask if he would give opinions using that definition.

MR. BARTH: That wasn't the safety rules, was it?

MR. CRONIN: No, it was that degree of skill and learning.

MR. MAHON: No objection.

THE COURT: All right.

MR. CRONIN: Exhibit 60-6, which is slides listing out the risks of opioids, dependence, addiction.

MR. MAHON: We objected to that at the trial, and we assert the same objections that were asserted then.

THE COURT: It will be overruled. Admitted.

MR. CRONIN: Exhibit 60-7, which listed out side effects of opioids.

MR. MAHON: Same objection.

THE COURT: Overruled. Admitted.

MR. CRONIN: Exhibit 60-9, which was the slide with the general safety rules.

MR. MAHON: Same objection that we asserted in the trial.

THE COURT: Overruled. Admitted.

MR. CRONIN: 60-10, the slide with the rules for prescription opioid -- for prescribing opioid narcotics.

MR. MAHON: Same objection.

THE COURT: Overruled. It will be admitted.

MR. CRONIN: 60-11, the rules for monitoring.

MR. MAHON: Same objection.

THE COURT: Overruled. It will be admitted.

MR. CRONIN: 60-12, the slide for rules for when a patient becomes addicted.

MR. MAHON: Same objection.

THE COURT: Overruled. Admitted.

MR. CRONIN: Plaintiff's Exhibit 75-1, which were pre-2008 photographs of Brian and Michelle. I don't remember which specific photo I used. I think it might have been photo two.

MR. MAHON: I thought that the only ones that were used were from 75-2.

MR. CRONIN: No, I showed a picture of them together before 2008, and then I put a post-2008 picture up. Those were the last two things I did with Michelle.

THE COURT: There was a pre and post photo.

MR. MAHON: I didn't remember it that way, but I

don't have an objection to the photos themselves.

MR. CRONIN: Exhibit 75-2, the post-2008 photographs.

MR. MAHON: No objection.

MR. CRONIN: Exhibit 85-1, the videotaped deposition of Dr. Henry Walden. And, Judge, we have versions of all of the depositions that were played with all of the lines that were played by both parties pre-highlighted for the Court.

MR. BARTH: The way we've done this before is that we've marked it as an exhibit just so we don't lose it because I think we had an appeal where they were lost and we've tried to recreate them. So we've done it as an exhibit with the understanding that the jury is not going to be able to take that testimony back.

THE COURT: Okay.

MR. BARTH: Everybody's in agreement to that.

MR. CRONIN: Yeah.

MR. MAHON: So just so we're clear, 85-1 --

MR. CRONIN: Is the highlighted version.

MR. MAHON: Yeah, it's not the video deposition; it's just the transcript.

MR. CRONIN: The transcript, yes. Okay.

MR. MAHON: While we're on that, do you want to just run through all of them that are here?

MR. CRONIN: Yeah, I'll go through them. Exhibit 85-3, which is the transcript for the deposition of Dr. Tate.

THE COURT: Any objection?

MR. MAHON: No. Same concept, I think.

MR. CRONIN: Exhibit 85-4, the deposition transcript of Bublis. Exhibit 85-5, the transcript of Dan Skillman.

MR. MAHON: No objection. Some of these -- just for the record, some of these are depositions offered in the defense case, but just for ease of organization, we've just grouped them all together in this 85 group exhibit.

THE COURT: Perfect.

MR. CRONIN: Exhibit 85-6, transcript of Caroline Koon.

THE COURT: No objection?

MR. MAHON: No objection.

MR. CRONIN: Exhibit 85-7, the transcript of W.C. Koon, Junior.

MR. MAHON: No objection.

MR. CRONIN: Exhibit 85-8, transcript of Michael Burke, Senior.

MR. MAHON: No objection.

MR. CRONIN: Exhibit 85-9, the transcript of Michael Burke, Jr.

MR. MAHON: No objection.

MR. CRONIN: Exhibit 150, the transcript of Dr. Anthony Guarino, which was used during Cross-Examination.

MR. MAHON: Yeah, I don't know -- I mean, that's something that's used for Cross exam; I don't know that it comes in as an exhibit.

MR. CRONIN: Yeah, I don't know. If they object to it, Judge, I'm not going to fight for it.

THE COURT: All right. Sustained.

MR. CRONIN: It wasn't shown to the jury.

Exhibit 150-6, Washington University policy of conflict of interest in clinical care.

MR. MAHON: No objection.

THE COURT: That will be admitted.

MR. CRONIN: Exhibit 150-9, Dr. Guarino's article and assessment protocol to guide opioid prescriptions for patients with chronic pain.

MR. MAHON: No objection.

THE COURT: It will be admitted.

MR. CRONIN: Exhibit 150-12, you excluded this, Judge, but I have to offer it. It is the opinion report authored by Dr. Guarino in the criminal case.

MR. MAHON: We just assert the same objections during the trial.

THE COURT: You're the one -- yeah, so it's still not coming in.

MR. CRONIN: Okay.

THE COURT: So the objection's sustained.

MR. CRONIN: This is along the same line, Judge, 150-17, the Purdue Pharma plea agreement. Your Honor sustained the objection, but we're --

MR. MAHON: We'll assert the same objections.

THE COURT: It's still sustained.

MR. CRONIN: Exhibit 170-4, it's Dr. Gunderson's letter to the FDA.

MR. MAHON: No objection.

THE COURT: All right. It will be admitted.

MR. CRONIN: Judge, I think that is it for the Plaintiff's exhibits.

THE COURT: All right. If something comes up that they ask for, we'll address it at that time.

Now, Defendants?

MR. MAHON: One second, Judge. I'm just checking these depositions to make sure we got them all.

Okay. From the Defendants' side, Exhibit A, the records of St. Louis University.

MR. CRONIN: No objection.

THE COURT: A will be admitted.

MR. MAHON: Okay. Exhibit C, which is kind of a

subsection of Exhibit A, but they're the records specifically of Howard Place, M.D.

MR. CRONIN: No objection.

THE COURT: It will be admitted.

MR. MAHON: Exhibit D, the medical records of Melanie McKean, DO.

MR. CRONIN: No objection.

THE COURT: It will be admitted.

MR. MAHON: Okay. Exhibit J, the records of Mistretta Chiropractic.

MR. CRONIN: No objection.

THE COURT: They'll be admitted.

MR. MAHON: Exhibit K, the records of SSM Medical Group Hugh Berry, M.D.

MR. CRONIN: No objection.

THE COURT: Admitted.

MR. MAHON: Exhibit M, the records of Jeffrey Norton, DC.

MR. CRONIN: No objection.

THE COURT: It will be admitted.

MR. MAHON: Exhibit N, the records of St. Luke's Internal Medicine, James Esther, M.D.

MR. CRONIN: No objection.

THE COURT: It will be admitted.

MR. MAHON: Exhibit R, the records of

Centerpoint Hospital.

MR. CRONIN: No objection.

THE COURT: It will be admitted.

MR. MAHON: And then there's R-1, which is I think another set of records from Centerpoint Hospital.

MR. CRONIN: Is that the bills?

MR. MAHON: No, not the bills; that's going to be R-2. But R-1 -- we got two different sets from Centerpoint, and they're an updated set.

MR. CRONIN: Assuming there's no bills included, Judge, then I would have no objection.

THE COURT: All right. It will be admitted without bills.

MR. MAHON: R-2 then are the Centerpoint bills that we made an offer of proof on earlier, but they were excluded from the trial itself. And so I think we just, as we did earlier on the record, we just offer R-2 not to be admitted into evidence but just to preserve the record.

MR. CRONIN: I would object to that, Judge.

THE COURT: Previous objection sustained. R-2's not coming in.

MR. MAHON: Exhibit Z, records of Ann Christopher, M.D.

MR. CRONIN: No objection.

THE COURT: Z will be admitted.

MR. MAHON: Exhibit DD, records of SSM St. Mary's.

MR. CRONIN: No objection.

THE COURT: It will be admitted.

MR. MAHON: Okay. Exhibit JJ, records of Robert Heim, M.D.

MR. CRONIN: No objection.

THE COURT: Admitted.

MR. MAHON: Exhibit PPPP -- it's going to start to get a little -- the Avinza prescribing information.

MR. CRONIN: I have an objection to that, Judge. That was never disclosed to us.

THE COURT: I believe you objected to it, and I allowed it, so it will be overruled.

MR. CRONIN: But where are we at here? I saw some that --

MR. MAHON: Oh, well I haven't gotten there yet.

MR. CRONIN: Okay, I see where we're at. All right.

MR. MAHON: Okay. Then DDD, employment records from the City of St. Louis Parks Department.

MR. CRONIN: No objection.

THE COURT: It will be admitted.

MR. MAHON: And then, yeah, I think that's the only one we used on that one.

Exhibit FFF, which are records from the Social Security Administration.

MR. CRONIN: I would incorporate my prior objections in motions in limine, your Honor.

MR. BARTH: That was the disability application statement, I believe.

THE COURT: Yeah, you were allowed to make that statement so -- you were overruled, so that remains overruled.

MR. MAHON: I think we had Exhibit JJJ, the CV of Erik Gunderson, M.D.

MR. CRONIN: No objection.

THE COURT: JJJ is in.

MR. MAHON: Then just while we're on this topic, we've already addressed this issue, but the Board of Healing Arts letter, Exhibit HHH-1, that's not being offered to be admitted into evidence. It was excluded from the trial, but I just want to make a record of that exhibit so the issue is preserved, HHH-1.

MR. CRONIN: Same objections we asserted previously, Judge. Those were sustained.

THE COURT: It was sustained, so it's not coming in.

MR. MAHON: Okay. Exhibit III-1. Those are the -- it's a series of three bar graphs that were --

there's electronically but they're also on the poster boards.

MR. CRONIN: No objection.

THE COURT: It will be admitted.

MR. MAHON: Exhibit OOO-1, the Missouri guidelines from 2007.

MR. CRONIN: No objection.

THE COURT: It will be admitted.

MR. MAHON: Exhibit TTTT, which was Exhibit B-1 from Brian Koon's deposition. It's some handwritten notes. I think at the top of the first page it says step one.

MR. CRONIN: No objection. I used them.

THE COURT: TTTT will be admitted.

MR. MAHON: Then UUUU, which is a similar exhibit. That's Exhibit B-2 from Brian Koon's deposition. It was the notebook of handwritten notes.

MR. CRONIN: No objection; I used them.

THE COURT: Wouldn't B-2A make more sense than UUU or --

MR. CRONIN: So B-2 was what his exhibit was in the depo, but here in trial was UUUU.

THE COURT: Uh-huh, I'm trackin'.

MR. CRONIN: This is what we deal with in these civil cases, Judge.

THE COURT: This is a whole new world.

MR. CRONIN: Wait until you have a product case. Our exhibit list will be much longer.

MR. MAHON: I think that concludes the defense exhibits.

MR. CRONIN: No more from us, Judge.

THE COURT: All right. If there is anything they ask for from the jury, we'll take it up at that time if it's not already been discussed. Okay. This concludes the matter on the record.

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QUESTION RECEIVED FROM THE JURY

(At approximately 2:17 p.m. another question was received from the jury, and the following proceedings were had:)

THE COURT: All right. I received two questions. One is "Can Juror 649 take a smoke break?" I anticipate my response is going to be, bailiff will take any smokers out. While the smokers are out, nobody deliberates until all 12 are back. In agreement with that?

MR. CRONIN: Yes, sir.

MR. VENKER: Yes, sir.

THE COURT: All right. The next question is, "Could we please get the following exhibits: Number one,

pharmacy records. Number two, medical records specifically mentioned as evidence." And then there's an arrow that says, "2008 to 2012 risk benefit discussions. 2008 to 2012 records of medication increase requests." And the next one says, "any prior records detailing other instances of opioid use." End of question.

MR. SIMON: There were no records I don't think admitted of prior opioid use. There was mention of it but no records.

MR. VENKER: I thought it was involved in his records in 2003, I'm not sure.

MR. SIMON: I'm saying were they introduced?

MR. VENKER: I thought the chart -- I could be wrong.

MR. CRONIN: The chart goes back that far. I don't know if the record was shown.

THE COURT: The pharmacy records are 36, right?

MR. CRONIN: Are they asking for the table or the specific pharmacy records?

THE COURT: The words are pharmacy records.

MR. SIMON: I would say the table.

MR. VENKER: I'm good with that.

THE COURT: So, number one, I'm going to say Exhibit 36. So it says, medical records specifically mentioned as evidence. And then there's an arrow that

points for medical records and it says, 2008 to 2012, semicolon, risk benefit discussions. And then it says another line, 2008 to 2012 records of medication increase requests. And then the third line says, any prior records detailing other instances of opiate use. Any prior records. So I don't know what the definition of prior is.

MR. SIMON: Are you saying the chart goes? Can we go off the record for a second?

(At this time a discussion was held off the record.)

THE COURT: All right. We're on the record. The answer to the second question is -- we're going to send back Exhibit 36. And that's been agreed to by both parties. And for the question regarding medical records, the Court is going to respond that the jury be guided by the evidence as they remember it.

MR. SIMON: Thank you.

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VERDICTS RETURNED

(At approximately 4:53 p.m., the jury returned their verdict in open court:)

THE COURT: All right. Please be seated.

Would the foreperson please stand?

Has the jury reached a verdict?

THE FOREPERSON: We have, your Honor.

THE COURT: Would you hand it to Ali? All right.

All right. The verdict form has been signed by 11 jurors, and it appears to be in order. So I'm going to have the clerk publish the verdict.

THE CLERK: On the claim of Plaintiff Brian Koon for compensatory damages for personal injury, we, the undersigned jurors, assess percentage of fault as follows: Defendant, Dr. Henry Walden and St. Louis University, 67 percent. Plaintiff, Brian Koon, 33 percent. Total, 100 percent.

On the claim of Plaintiff Brian Koon for compensatory damages for personal injury, we, the undersigned jurors, find the total amount of Plaintiff Brian Koon's compensatory damages, disregarding any fault on the part of Plaintiff Brian Koon to be for past non-economic damages, 1 million. For future non-economic damages, 400,000. Total damages 1,400,000.

On the claim of Plaintiff Michelle Koon for damages due to injury to her husband, we, the undersigned jurors, find that Plaintiff Michelle Koon did sustain damages as a direct result of injury to her husband. We, the undersigned jurors, find the total amount of Plaintiff Michelle Koon's damages due to injury to her husband, disregarding any fault on the part of Plaintiff Brian Koon

to be for past non-economic damages, 1 million. For future non-economic damages, 200,000. Total damages, 1,200,000.

We, the undersigned jurors, find the Defendants, Dr. Henry Walden and St. Louis University, are liable for punitive damages.

THE COURT: All right. Is there a request to poll the jurors?

MR. VENKER: Yes, your Honor.

THE COURT: All right. Would the clerk poll the jurors?

THE CLERK: As I call your number, please rise.

Juror 456, is the verdict I just read in this cause your verdict?

JUROR NO. 456: Yes.

THE CLERK: Juror 139, are the verdicts I just read in this cause your verdicts?

JUROR NO. 139: Yes.

THE CLERK: Juror 204, are the verdicts I just read in this cause your verdicts?

JUROR NO. 204: Yes, but I disagreed on one of them. Does that matter?

THE COURT: Yeah, you can sit down. Thank you.

THE CLERK: Juror 779, are the verdicts I just read in this cause your verdicts?

JUROR NO. 779: Yes.

THE CLERK: Juror 212, are the verdicts I just read in this cause your verdicts?

JUROR NO. 212:

THE CLERK: Juror 420, are the verdicts I just read in this cause your verdicts?

JUROR NO. 420: Yes.

THE CLERK: Juror 649, are the verdicts I just read in this cause your verdicts?

JUROR NO. 649: Yes.

THE CLERK: Juror 349, are the verdicts I just read in this cause your verdicts?

JUROR NO. 349: Yes.

THE CLERK: Juror 339, are the verdicts I just read in this cause your verdicts?

JUROR NO. 339: Yes.

THE CLERK: Juror 355, are the verdicts that I just read in this cause your verdicts?

JUROR NO. 355: Yes.

THE CLERK: Juror 994, are the verdicts I just read in this cause your verdict?

JUROR NO. 994: Yes.

THE CLERK: Juror 393, are the verdicts I just read in this cause your verdicts?

JUROR NO. 393: Yes.

THE CLERK: Jurors polled.

THE COURT: All right. Attorneys, approach.

(Counsel approached the bench and a discussion was held off the record, out of the hearing of the jury.)

THE COURT: All right. Ladies and gentlemen, this portion of the trial, the Plaintiff's going to present some evidence, and then both sides are going to argue -- I mean, Plaintiff is going to present some evidence, I'm going to read you some instructions and both sides are going to do a five-minute argument, and then you'll go back and consider punitive damages.

Counsel for the Plaintiff, you may proceed.

MR. SIMON: This is very brief, ladies and gentlemen. It's financial information of St. Louis University.

Assets as of 2015, total assets, $2,000,127,374. Liabilities, 2015, $455,060,000. Net -- total net assets as of year ending 2015, $1,000,672,314. Thank you.

THE COURT: All right. You may proceed with argument.

MR. CRONIN: I think the instructions --

THE COURT: Yes, Instruction Number 15. Instructions 15 and 16 and general Instructions 1 through 5 apply to the determination of the amount of punitive damages to be assessed against Defendants Dr. Henry Walden and St. Louis University. Use Verdict B to return your

verdict as to the amount of punitive damages.

Instruction 16, in addition to any compensatory damages you assessed in Verdict A, you may assess an additional amount as punitive damage and such that you believe will serve to punish Defendants Dr. Henry Walden and St. Louis University for the conduct over which you found the Defendants are liable for punitive damage and will serve to deter Defendants and others from like conduct.

You may consider harm to others in determining whether Defendants' conduct showed complete indifference to or conscious disregard for the safety of others. However, in determining the amount of any punitive damage award, you must not include damages for harm to others who are not parties to this case.

Plaintiffs, you may proceed.

MR. CRONIN: Judge, can I have one minute for rebuttal?

THE COURT: Yes.

MR. CRONIN: Ladies and gentlemen, thank you again for your time. This is the important part of the case. The deciding fault part of this case is over. The deciding the amount necessary to compensate Brian and Michelle for their loss part of this case is over. You've already decided those. All that's left is the amount of punitive damages that you believe the Defendants should be

liable for in this case. That's all we have left. I only have a couple things I want to say to you.

I'd like to have you take a look at the jury instruction that the Court just read for you. Instruction Number 16, you can have it to take back. You may assess an additional amount of punitive damages in such sum as you believe will serve to punish for the conduct you already found liable and deter Defendants and others from like conduct. You may consider harm to others in determining whether Defendants' conduct showed complete indifference to or conscience disregard for the safety of others. You've done that.

In determining the amount of any punitive damage award, you don't include damages for harm to others who are not parties to the case. That means you're not trying to figure out an amount that would be appropriate for all the other people that this has happened to. All you're thinking about is what is the right amount to punish, and the important part, deter. Those are the only things you consider under the law that the Judge has instructed you on.

This is in your hands. You can do something to stop this. It's natural to start talking about and wanting to consider other things when you go back there to figure out a new number, but any suggestion that it's anything other than an amount to punish and deter is not following

the law.

The next time -- I told you this earlier, ladies and gentlemen. The next time you see a story on the news about something happening because of prescription opioids to a person or to a family, you want to be able to know that you did everything that you could so that it wouldn't happen, so that this doesn't happen again to anybody else.

What does deter mean? It means to stop. It means, enough. It means no more. This shouldn't happen ever again to anybody else. That's what deter means. Punitive damages are stopping damages.

If someone has $15 and you fine them a dollar, they can brush it off. What if somebody has $1.6 billion? What amount will they not brush off? What amount will they remember so that this doesn't happen again? What amount will everybody else see so that they don't do it again? So that this doesn't happen to anybody else again?

The Defendants prescribed Brian over 37,000 pills. A thousand dollars a pill, that's $37 million. That's a big number. People struggle with big numbers. I struggle with some big verdicts that I see. But this law is here for cases like this.

What is sufficient to punish and deter? Maybe three times that isn't enough. That's for you to decide. Go back. Talk about it. What does it take to stop it from

happening? That's all we're asking you to think about.

Thank you, ladies and gentlemen.

THE COURT: Counsel for the defense?

MR. VENKER: Thank you, your Honor.

Ladies and gentlemen, Dr. Walden and St. Louis University hears you loud and clear. We can't get to the nationwide opioid epidemic from here if that's what people are considering. St. Louis University is a not-for-profit. It's been here in St. Louis for almost 200 years. It's not ExxonMobil. It's not some huge company. It's a public institution, open to the public for teaching and education.

So if you decide to award an amount, it would not have to be anything super big. I mean, SLU is a part of this community. It will get the message if that's what you send. It doesn't have to be any significant amount. I think -- I know, that St. Louis University and Dr. Walden respect you as a fact-finding body and take seriously what your findings are.

And so I would just ask you to consider that when you determine this and that the message itself about what you're feeling as opposed to any large dollar amount would certainly be sufficient to send a message to let St. Louis University, its doctors, and others to know that if that's the message you want to send.

The instructions are that you may find punitive

damages. It doesn't mean that you have to find a large amount. So I would just ask you to consider that, and again, respectfully ask that you consider what would actually communicate to St. Louis University in terms of it being willing to hear that message. And that's what I really wanted to say, ladies and gentlemen.

Thank you for your time.

THE COURT: All right, the final word?

MR. CRONIN: Thank you, Judge.

Ladies and gentlemen, I showed you in the jury instruction, it's to deter the Defendants and others. Ring the bell so everybody else can hear it. Send a message from coast to coast that this is not going to happen anymore.

Thank you.

THE COURT: All right. Ali, here's the instructions. You're still in charge of the jury.

(The jury retired to consider their verdict at approximately 5:01 p.m. and returned to the courtroom at approximately 5:11 p.m.)

THE COURT: All right. Please be seated.

Madam Foreperson, have you arrived at a verdict?

THE FOREPERSON: We have, your Honor.

THE COURT: Will you hand it to Ali?

All right. There are nine signatures. It appears to be in proper form.

Madam Clerk, would you publish the verdicts?

THE CLERK: We, the undersigned jurors, assess punitive damages against Defendants Dr. Henry Walden and St. Louis University at 15 million.

THE COURT: All right. Is there a request to poll the jury?

MR. VENKER: Yes, your Honor.

THE COURT: All right. Please poll the jury.

THE CLERK: As I call your number, please stand.

Juror 456, is the verdict I just read in this cause your verdict?

JUROR NO. 456: No.

THE CLERK: Juror 139, is the verdict I just read in this cause your verdict?

JUROR NO. 139: Yes.

THE CLERK: Juror 204, is the verdict that I just read in this cause your verdict?

JUROR NO. 204: No.

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JUROR NO. 420: Yes.

THE CLERK: Juror 649, is the verdict I just read in this cause your verdict?

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THE CLERK: Juror 349, is the verdict I just read in this cause your verdict?

JUROR NO. 349: Yes.

THE CLERK: Juror 339, is the verdict I just read in this cause your verdict?

JUROR NO. 339: Yes.

THE CLERK: Juror 355, is the verdict I just read in this cause your verdict?

JUROR NO. 355: No.

THE CLERK: Juror 994, is the verdict I just read in this cause your verdict?

JUROR NO. 994: Yes.

THE CLERK: Juror 393, is the verdict I just read in this cause your verdict?

JUROR NO 393: Yes.

THE CLERK: Jurors polled.

THE COURT: All right. The Court accepts both Verdicts A and B for the record.

All right. Ladies and gentlemen of the jury, you are discharged from further service. Yea. On behalf of

Division 21 and the 22nd Circuit, I want to thank you. I know it has been a long week, but you are vital to the administration of justice; and without your willingness to serve, the whole process falls apart. So I do realize that this has been a sacrifice of your time.

I'm always curious to make sure your experience, at least the hospitality has been well. If later on you have any issues about how we treated you or how we moved you back and forth, please share with us and we'll try to make sure we do a better job of it. Because we do want to make this as painless as possible knowing it is an inconvenience.

You were previously under a veil of secrecy and silence. It has been lifted. You are free to talk to anyone or no one at all. Sometimes the attorneys, the parties, like to hear your thoughts, but you are under no obligation to speak with anyone about this case unless you decide to do so. That's the case.

You can go back to the jury room. Ali will give you all your phones and all your paperwork and then you will be free to go. And again, thank you for your service.

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THE COURT: We are on the record, Brian Koon and Michelle Koon versus Henry Walden and St. Louis University, Cause Number 1422-CC01258. We are having post-trial discussions regarding the judgment. There's been several documents filed from the -- there's a judgment -- proposed judgment filed by the plaintiffs, there's a plaintiffs' response to defendants' motion to apply Chapters 538 and 510, there's objections that were filed by the defendants to plaintiffs' proposed judgment. There are motions by the defendant to apply 538 and 510 and Missouri law, and then there's memorandums of law by the defendants regarding 510, 535 and Missouri law, as well as objections to the proposed judgment.

Those are the documents that we are working off of. The Court's roadmap for the discussion is to use the plaintiffs' response to the defendants' motion to apply 538, 510 and Missouri law, in terms of how we navigate through the discussion today.

The first point would be whether there should be noneconomic -- whether there should be a cap on noneconomic damages in this case. So let's start with that as the first topic.

MR. VENKER: Judge, we, obviously, as you have identified, have filed various pleadings. But the motion

objections and the memorandum of law in support in -- so we don't waive any of those points that we make. But I think this is somewhat repetitious.

In terms of the damages cap, the statutory damages cap in 538.210, it has been stricken by the Missouri Supreme Court in the Watts case. We acknowledged that in our pleadings that we filed. At the same time, we believe that we need to at least raise the issue that we believe that case, the Watts case, was decided erroneously. But we understand what the current law is, and we've made this assertion really under the provisions of Rule 5503 that allow us to point this out and ask for a change in the law.

And that's our position on the noneconomic damages cap, Judge.

THE COURT: Your response.

MR. CRONIN: Your Honor, the Missouri Supreme Court has declared that cap unconstitutional as it violates the right to a trial by jury.

THE COURT: Okay. As to point one, I'm going to concur with the Missouri Supreme Court, Watts V Cox -- or Watts V Lester E. Cox Medical Centers, in that there is not a cap on noneconomic damages in the case.

All right. Point two. Plaintiffs should be entitled to post-judgment interest at a rate of 5.5 percent per annum from the date of judgment as entered by the Court

until it is satisfied.

MR. CRONIN: Paul, I can jump in, if you want. Your Honor, we acknowledge that there is a statute, and case law upholding it, that we don't get post-trial judgment in a med malpractice case. We are just preserving our objection that it violates equal protection of the law guaranteed by the federal and state constitutions.

THE COURT: I was so proud I found the Mackey V Smith case. You guys saved me all the energy. I guess you concur with the Mackey case or the law?

MR. VENKER: Yes, the statute says no post-judgment interest.

THE COURT: All right. I'm going to concur with the Appellate Court, Western District, on the Mackey V Smith, in that there's no post-judgment interest for med-mal cases. All right.

All right. Future damages -- third issue would be future damages should be awarded in this case are not subject to periodic payments. All right. Since the defendants are asking for the periodic payments, let me hear your thoughts on the payment plan.

MR. BARTH: Yes, Your Honor. Under Chapter 538.220, any judgment in excess of $100,000 for future payments is subject to periodic payments. So we're hereby

invoking that provision and would ask that the Court issue periodic payments for that amount.

I've done my rough math, I don't know if I'm correct on this or not, but the future noneconomic damages for Mr. Brian Koon were $400,000. And then if you minus his 33 percent at fault, it takes us to $268. And then for Michelle Koon, her future noneconomic damages were $200,000, minus the 33 percent, takes us to $134.

I believe then the attorneys' fees -- they have a right to take that off the top, if they would elect to do so, which I'm assuming they're going to do. If not, they can waive that. So that's $402,000 in future that we would ask be put into periodic payments. And then minus the 40 percent for the attorneys' fees, which I'm assuming that's what it is, but I'm not --

MR. CRONIN: It is.

MR. BARTH: I'll let Mr. Cronin pipe up on that. Would take us to $241,200 that are subject to periodic payments.

MR. CRONIN: I concur with that math.

THE COURT: Okay. That's the number we're operating on is $241,200.

MR. CRONIN: That's correct.

THE COURT: All right.

MR. BARTH: And we also filed a brief on the

topic, the Court has discretion on how to allocate those future payments. I think our main analysis was following the medical payment, one that has the payments extended out throughout the lifetime of Mr. Koon, is one option. The statute doesn't offer a whole lot of guidance. Judge Ohmer recently had an opinion in the Hamm case that we have attached to our memorandum -- Judge Wilson. I'm sorry, Judge Wilson. Where he also took the future noneconomic damages and tied them to the life expectancy.

That would be our proposed judgment for the $241,200.

THE COURT: All right. Do I have the Hamm case?

MR. CRONIN: I think they attached it as Exhibit B or C to their memo that they filed yesterday.

Is that right?

MR. BARTH: Yes, we did, Your Honor. We did. It should be --

THE COURT: Okay. I just caught it. I got it, Exhibit B. All right. Your initial thoughts?

MR. CRONIN: So, Judge, I only briefly had a chance to read that Hamm order, because the memo was filed at 4:00 P.M. last night. But, the circumstances of that case are pretty different from this one. If I'm right, I think that case involved permanent catastrophic injuries to a minor. And the Court was concerned about whether it

was in the minor's best interest to give her eleven million dollars right away.

Also, in that case there was, I think, an extensive life care plan that set forth what kind of treatment she would need, et cetera. And then it's broken up for medical and nonmedical.

So, the defendant correctly stated that this Court has complete discretion in determining the amount of any noneconomic future damages to be paid in whole or in part in periodic or installment payments.

Also, after you reduce fault and attorneys' fees the Court -- the Missouri Supreme Court in Sanders V Ahmed said, quote, the statute does not require any other amounts to be apportioned to future payments. In Sanders, the Missouri Supreme Court upheld the denial of periodic payments for future noneconomic damages.

We would ask that the same be done here, Judge. If the defendants are willing to compromise, we would be willing to do a three year installment payments for the $241,000 at a 3 percent interest rate.

What they are proposing, I think, over 30 years would result in $8,000 paid a year. On that amount, SLU, earning a reasonable 5 percent investment rate, would be making $12,000 a year on that amount.

So, I really don't see any rational basis for

spreading this out for 30 years for $241,000.

THE COURT: All right. And I -- I read Hamm quick, but what caught my attention is that in Hamm there are -- this -- in this case, it's just future noneconomic damages. In the other case, there were future economic -- there's --

MR. BARTH: Correct.

THE COURT: And those were awarded in lump sum. If I read it right. Those -- the -- there was some that were awarded in lump sums, and then there was the future ones that were spread out --

MR. BARTH: Right.

THE COURT: -- for a period of time. So, in the amounts that -- which were awarded in lump sum were, I think, less than the amounts that were awarded --

MR. BARTH: If I remember correctly, all -- I don't think anybody disagrees, all past damages are always lump sum.

MR. CRONIN: All past damages and attorneys' fees.

MR. BARTH: And attorneys' fees.

THE COURT: Right. I'm not disagreeing. What I'm saying -- I'm looking at the amounts. In other words, if you have X amount, and then you have this big giant elven million, then spread the eleven million out. But

the other part they're like, okay, this -- in terms of -- and this is just my thought process. I'm looking at the amount of money, not the particular type. And in the case -- I think one was $350,000 lump sum, and another -- that's just a quick read. $194,000 lump sum, that type of thing.

So I guess my issue is the $241,000 -- talking the amount of money, why does $241,000 need to be spread out over a lifetime -- over a person's proposed lifetime versus that being a lump sum, based on the amount of the lump sum.

MR. BARTH: And I would agree the Hamm circumstances are different than ours, in that it did involve a catastrophic loss, that Judge Wilson, I believe, did tie into the future medical payments. So we do understand that that is different.

And, again, this is just trying to get a baseline of where to start. We could also try to agree to something less, whether it's ten years or five years as well.

THE COURT: I mean, I can't begin to understand the economic -- the issues that SLU has, but their proposed three year 3 percent for $241,000 does not seem, on its face, an unreasonable negotiating point.

MR. VENKER: Well, I understand, Your Honor. We

thought this morning we'd just -- the Court would decide whether it was willing to entertain the future payments or not. And then we would decide then at that point.

Because the way the statute is supposed to work is, when you put out in periodic payments, those amounts are supposed to be reduced to a present value. And that's where the interest comes in.

THE COURT: Right.

MR. VENKER: As opposed to it be being reduced to present value, then putting interest on. Because, like we say, from 538.300 there isn't supposed to be interest.

So what we thought we'd do today is to see whether the Court would say, yes, these periodic payments can be -- I'll allow that, but then let the lawyers try to figure out what that would be, come back to the Court and say here's what we have either agreed to or not. And if we have to actually put on evidence of what the present value is through an economist, that would be what we'd ask for.

And we did ask for that in our papers that we filed.

MR. CRONIN: Judge, we're here for this hearing today. It's been a month since our verdict. We don't need to delay this any longer. We don't need an economist. This is very simple, it's completely within the Court's discretion. I think our proposal is very

reasonable. I think not spreading it out at all is very reasonable.

So that's our position, Judge.

THE COURT: Here's my thought. The -- I'm a pretty simple person. I shouldn't say the easy button, but I'll use that phrase. The easy button is to say no and pay a lump sum.

But I think that the fact that the plaintiffs are saying we would do a three year, 3 percent, I think that's -- that's middle of the ground without all the economists and all that. I mean, I don't -- like I say, you guys know I'm not -- this isn't my giant cup of tea. But I think that the fact that they're actually even offering up anything is generous. And I think three years, 3 percent, on $241,000, I think that's quite generous.

But if you guys are saying that you need to do the special math on three years, 3 percent, then the easy button is just to say give them $241,000 and be done with it. There's no math to do.

The delay is not so much on either party, part of the delay is I was on vacation.

MR. CRONIN: I understand, Judge.

THE COURT: I don't want to put it as if the defendants have been dragging their feet. the Court is -- I would say for a good ten business days the Court has

been unavailable due to either vacation or a busy docket.

But are you saying three year, 3 percent is something that you guys couldn't figure that out today?

MR. VENKER: I don't think we can figure it out today, Your Honor. I'm not a numbers person, that's one of the reasons I became a lawyer. So I couldn't begin to figure out what the present value of this would be. And I would say three years sounds short to me. I guess, you know --

THE COURT: Better than zero, though. Because that's what I'm leaning -- I'm leaning towards zero.

MR. VENKER: I would argue that.

THE COURT: So I think three is a fair compromise.

So I guess I don't want to put words in your mouth. Are you saying if it's three, 3 percent, that's something you -- I mean, you guys can object to anything.

But is that something that's unbearable?

MR. VENKER: Well, unbearable --

MR. SIMON: That's a good question.

THE COURT: Because, I mean, if I was talking to a -- yeah, I have to put it in the context of we're talking St. Louis University, and, so, I -- you know, I'm aware that, you know -- this is our city, but at the same time I don't think -- if we were talking eleven million,

this would be a different question, I'd say, okay, let's spread this out.

But we're talking, you know -- in hindsight, we're talking one -- one child's education -- one tuition payment for one child at SLU. And there's twenty thousand students in one of the universities.

So in terms of is this something that I think is bearable by the weight of the University, I think so. Is it something that they want to do? Possibly not. But I think it's better than two hundred forty-one lump.

MR. CRONIN: Judge, it's also in the context of at the same time there's going to be 16-point something million dollars due in a lump sum. So this seems kind of silly, that we're taking $241,000 and we have to spread it out over a lifetime when there's 15 million in punitive that's going to be due in a lump sum.

THE COURT: And I will tell you, not only that, I'm not -- and I'm still not a hundred percent versed where the fifteen goes, but this actually goes to the victims.

MR. CRONIN: Yes.

THE COURT: And so the Court is more inclined to do something more immediate with something that goes to the victims versus whatever happens to the punitive, and whether even the punitive even exists. So for all intents

and purposes this could walk away with the only thing that comes out of this case. And I think a more immediate payment plan is more palatable than any --

I will tell you right now, I definitely will not go along with any type of lifetime -- life of the remaining plaintiffs. I can live with the three year, 3 percent. But if you guys can't, then I would go with the just lump sum now.

MR. VENKER: Can we have a minute to confer, Your Honor?

THE COURT: Yes, please.

(Whereupon, a short recess was taken.)

MR. VENKER: So, Your Honor, our position still is we wanted the opportunity to take that number and reduce it to present value, if the Court was going to allow us to do periodic payments. So that's where we're at. In saying this, I realize, you know, you may rule that -- that it ought to be a lump sum payment. But that's really our -- our position is that we, you know, still want to have the opportunity to -- to do the present value and -- and stretch out longer than the three years. But that's -- we understand you may well rule against us on this.

THE COURT: All right. So then what I'll do is -- since it is the Court's discretion as to whether to do

whole or in part, I'm going to do in whole so that the -- the 24 -- the $241,200 will be due in a lump sum payment.

MR. CRONIN: Thank you, Judge.

Then that takes us to item four, which is --

MR. VENKER: Chapter 510, is that what it is, Judge?

MR. CRONIN: Punitive.

THE COURT: That's the punitive cap.

MR. VENKER: Oh, yes, sorry.

THE COURT: Okay.

MR. VENKER: So that's -- yeah. Chapter 510 is the punitive cap, Your Honor, and that one is to some degree parallel to the Watts decision, because in this -- in the Missouri Supreme Court case as well they found the right to jury trial was violated, and so they struck those caps.

Again, we realize that the case is there declaring it to be -- the punitive damage caps to be unconstitutional, but we want to preserve the point of error, we think that decision, especially in relying on the Watts decision, is in error.

So that's our position on this, Your Honor. But we understand what the law currently is.

THE COURT: Plaintiffs?

MR. CRONIN: Yeah, Judge. In Llewellyn V

Franklin the Missouri Supreme Court provide that punitive cap unconstitutional. And the other thing I would add is we're talking about a 5.7 to 1 ratio of punitives to compensatory damages, which is well within ratios that have been upheld by the U.S. Supreme Court.

THE COURT: All right. I will agree with the plaintiffs, and I will concur with Llewellyn V Franklin, and with their decision, the award is not excessive. Since there is no cap, I'm going to deny the defendants' motion on that point.

I believe those are the four points. Is there anything that I'm --

MR. VENKER: Yeah, that covers it, Your Honor.

MR. CRONIN: That's it, Judge. And our proposed judgment did not include anything about post-judgment interest, so I believe, according to the Court's rulings, today our proposed judgment would be in line with --

THE COURT: The way I read it is I have to at least mention that the Court has considered it and that --

MR. CRONIN: Okay.

THE COURT: At least the way I read the Bible by Dierker. That it's got to at least be mentioned in there. So, I will -- but other than that --

MR. BARTH: Judge, the only other issue we did want to bring up, the last sentence of the judgment --

more of a technical aspect -- it finds no just reason for delay and certifies the judgment is final for purposes of appeal. We would just ask that that sentence go out. We still want to have time to do our post-trial motions. Which we get thirty days.

MR. CRONIN: They're right, Judge.

THE COURT: All right.

MR. BARTH: It was just an oversight.

THE COURT: All right. Drop the second to last sentence. What about the costs of the action be taxed to the defendants. Is that an issue?

MR. CRONIN: I believe that's the law, Judge.

MR. VENKER: We agree, Your Honor.

THE COURT: All right. So the only thing I'm going to add to --

MR. CRONIN: We have to file a bill of costs, and we'll do that along with the post-trial motions.

THE COURT: So the only thing I'm going to add to the proposed judgment is I'm going to delete the second line and I'm going to add a line that the Court has considered post-interest judgment and denied it, blah, blah, blah.

MR. VENKER: Pursuant to statute.

THE COURT: Pursuant to statute.

MR. VENKER: And, Judge, we've prepared a simple

written order, I believe, that deals with the issue of the July 12th entry on the June 28th jury verdict that we discussed off the record.

THE COURT: All right. Done. Anything else for you gentlemen?

MR. BARTH: I think that's it.

MR. VENKER: That's it for today, Your Honor.

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POST-TRIAL MOTIONS 9-23-16

THE COURT: We are on the record for Brian Koon and Michelle Koon, Plaintiffs, versus Henry D. Walden and St. Louis University, Cause Number 1422-CC01258. I have before the Court defendants' motion for JNOV or a new trial. And I have the plaintiffs' response to defendants' motion for JNOV or new trial.

All right. Mr. Price, you may proceed.

MR. PRICE: Your Honor, we're going to ask you to consider all the issues we've raised, but we're only going to argue a few of those today given the time restraints. Mr. David will argue Dr. Genecin's undisclosed opinion, the failure by plaintiffs' to establish the standard of care, the failure to make a submissible case, and the improper admission of testimony from Dr. Heaney.

I'm going to address the erroneous punitive damage instruction, the repeated evidence and focus on the opioid epidemic in the trial, and the inadmissible hearsay evidence of speculation regarding Dr. Walden slipping through the cracks of DEA, and the licensing board's failure to investigate him, and then the refusal to allow him to respond with the Board of Healing Arts' letter closing his case.

I'd suggest that -- if it's agreeable, to go

point by point, and we'll let Michael David start with his issues.

MR. DAVID: Good morning, Judge. Counsel.

THE COURT: Good morning.

MR. DAVID: I have to say that the proceedings prior to this were kind of deja vu all over again.

THE COURT: Hope they weren't too traumatic.

MR. DAVID: No, they were not.

You may be -- be reminded that my involvement in this case was very limited until, actually, after it was over. It consisted solely of actually coming to court and reading a deposition, because I was available in the office and other people were not.

But after the trial I was asked to look at a few things, and I did. I reported my findings to -- or thoughts to Paul Venker and to our client, and they've asked me to articulate here what I, in effect, told them.

And as Ray Price mentioned, the first thing that I want to talk about is Dr. Genecin's deposition and the issue of new opinion.

You know, in this case, as I think more complex cases exist, we have some luxury of having a transcript to work from. It's kind of the ability -- the availability of an instant replay, so to speak, that otherwise we rarely, rarely have. It's allowed me to look at the

deposition transcripts and the trial transcripts so that I can, in another vernacular, kind of envision the battlefield.

And the lead up, obviously, to the issue we're talking about really started during the argument on motions in limine wherein the Court indicated to the parties that -- as it relates to Dr. Genecin's opinion, that the Court would wait and defer that issue to trial. Which the Court obviously did.

So I looked first to the transcript of the trial to try to get a handle on what it was that really you were faced with, and how you were faced with it. What I've done here is copy the trail transcript, kind of mark what I think to be the relevant portions of that transcript.

THE COURT: Thank you.

MR. DAVID: And I kind of want to go over that. And I think it's important to go over this, because that's the only way, I think, that we can really get an accurate reading of whether the runner was out or whether the runner was safe.

So, what I would like to do is just -- unfortunately -- and I don't think there's really any other real way to do it besides just gut through and slop through the mud to try to get some points across.

THE COURT: Let's dive in.

MR. DAVID: I'm sorry?

THE COURT: Let's dive in.

MR. DAVID: Okay. Obviously -- and I understand that no trial judge can read the transcripts of depositions prior to the course of the trial. If that were the case, you'd have to set aside the couple of weeks before the trial starts to read through things that you wouldn't ultimately need to have known.

So I look to, again, the portion of the transcript that starts on Page 175 and talks about references to the deposition transcript. So, I think you have to almost go back and forth at some point during the course of this to really do some comparison.

What we have here first, at least, is the description of -- or the attempted description by plaintiff -- or plaintiffs to establish why the deposition provided notice of opinions against SLU's independent theories of negligence.

And, you know, there's references to Pages 30, 55, 56, and 57 of the deposition -- and I'll give you those in just a minute and we'll go through that -- to kind of try to piece together the theory or the justification. It's -- I'm going to try to point out that I believe that kind of gave a -- a skewed or hodgepodge -- led you to the wrong conclusion, quite candidly.

So I'm going to go through those issues on the deposition. And I've got copies of that as well. And, again, I have marked these in kind of threefold, and you can -- the last page on this copy here would indicate my code, to the best that I could do it, quite frankly, the technology of getting these things color-coded. I was kind of impressed myself, being able to do that with some help.

So, I think it probably makes more sense to go through these provisions as they are discussed in the -- the hearing that took place with the Court outside the hearing of the jury, as well as some of the provisions that plaintiff has referred to in their response to our motion, which is -- are a forward on the theory that -- all of them read objectively, that these equally apply to St. Louis University.

So, I'm just going to start from the beginning. If you look at Page 29 of the deposition, lines twenty-four, through Page 31, line three, you --

THE COURT: Wait. Based on the bottom of this?

MR. DAVID: Yes, yes.

THE COURT: So Page --

MR. DAVID: 29 of the deposition.

THE COURT: All right. Got it.

MR. DAVID: All right. Starting with line

twenty-four, when the comments were he failed to set appropriate monitoring parameters. Well, it's --

THE COURT: Hold on. I think -- make sure we're on the same sheet. Because my -- are you talking about Page 24?

MR. DAVID: I'm talking of the deposition. Right.

THE COURT: The deposition. Now we're tracking.

MR. DAVID: I'm sorry, I don't know any other way to do this.

THE COURT: That's perfect. I was just looking at the bottom of the big sheet. I got you. He failed.

MR. DAVID: He failed. Not it failed. Or they failed. He failed. And then the comment goes on to had Dr. Walden met the standard of care. And always using the word he rather than they or it.

The next reference that -- again, I'm kind of mixing the references that plaintiffs used in the oral argument before you with what they have said in their response.

So then you go to Page 49 of the deposition, line eleven, and --

THE COURT: Can I mark on this? Is this mine?

MR. DAVID: Oh, yes, that's yours, that's yours. Where the reference -- which, again, this is tendered for

the purpose of establishing that St. Louis University as an institution is all over the deposition.

Well, that portion of the deposition talks about Dr. Walden's patient. And -- it's just by way of, again, an example. Again, I hate to do it this way, but I don't know any other way. Page 55, on line four, which was one of the provisions that was discussed in the oral motion, they talk about the medication management system, in which we, meaning Dr. Genecin, works, does not allow doctors to prescribe in the way Dr. Walden prescribes.

And it talks about state legislation requires certain things. It doesn't say the institution requires certain things, it doesn't say St. Louis University should require certain things, it says state legislation requires certain things.

And, you know, he's talking about, again, state regulations monitoring doctors. Not state regulations monitoring hospitals. And I don't know how that even begins to tell us that he meant healthcare employers. Even if that's, in fact, what he did mean.

If you go then -- staying on the same page -- down to line twenty-one, into line fifteen, on Page 56, he does talk about the Yale health system, about having controls in place. He doesn't say anything about the hospitals or employers having to do that. And he doesn't

say anything about that being needed unless it is to comply with state law. Because he says we comply with Connecticut law. And then he says everyone who is prescribing is required to go through training, and is required to have systems in place.

And this is probably as good a place as any to hit this issue squarely. Doctors prescribe, hospitals don't. Doctors prescribe. And that's throughout the course of the -- of the trial, the positions that experts and the doctors are saying, doctors are the ones that prescribe.

Certainly a doctor is a healthcare provider, but a healthcare provider need not be a doctor. And, so, only a doctor can prescribe. I think this is going to run throughout the course of my comments here and probably Ray Price's as well.

You have an attempt to bootstrap in SLU by saying, well, Dr. Walden is an employee of SLU. No question about that. But, still, it's the doctor that prescribes and not the institution.

Going back to the recitation of the -- it's supposed to say that the institutional involvement is throughout the course of the deposition. You know, turn to Page 57, line twenty-three, and through 58, line three. And the question is does Missouri have the same controls

as Connecticut. Obviously, no. And then Dr. Genecin follows up with doctors are required to adhere to the standard of care.

And then, again, following up on provisions that are supposed to show the application to the University, if you go to Page 86, line three, and through line twenty, and talking about Dr. Walden's office notes, and it talks about the standard of care requires a doctor to specifically inquire with respect to monitoring. Nothing about a hospital or institution.

Moving to Page 92, line twenty, through Page 93, line nine, where they're talking about year-end drug screens, that was part of a safety monitoring system, the reference is one of many failures on the part of Dr. Walden, not on St. Louis University or the institution.

Page 98, line twenty-two, through 99, line thirteen, talks about monitoring. And the question was are you saying that for every time Mr. Koon gets opioid analgesics that he needs to have a face-to-face visit with the prescriber. And the comment was other than a -- other than every other refill or every two months. But, again, with the prescriber. The prescriber can only be Dr. Genecin. Could theoretically be another doctor. But there are -- there was no testimony about another doctor. It's clearly not the institution.

So, I think that also leads us, unfortunately, to the discussion of the allegation of the trick questions that you rejected. But I think it's important to talk about these alleged trick questions.

In the response to our motion, plaintiffs, at Page 12 of their -- of that response, talk about, and I quote, "every single one of Dr. Genecin's opinions was provided squarely to defendants at his deposition", referring to opinions against St. Louis University. And then a comment that the defense counsel tried to limit the scope of Dr. Genecin's testimony.

Well -- and then in support of that, in the response, was the comment everyone who is prescribing; i.e. defendant SLU, is required to have a system in place. I think that's another example of the confusion that the merger of -- of Dr. Walden and SLU -- the attempted merger of them. And, again, it's SLU doesn't prescribe, Dr. Walden prescribed.

But let's take a look at Paul's trick questions. Where you look to Page 27, lines eight through twelve.

THE COURT: All right. Where are you right now?

MR. DAVID: On the deposition again. I'm sorry. Where Paul asks Dr. Genecin, "so why don't you tell me, in what I'll call headline fashion, or the main headings, of what your opinions are in the case." Now, how unusual

would that be, to find out what topics you might need to inquire on. And Dr. Genecin responds, "my opinions are really quite narrowly focused on Dr. Walden's prescribing practices."

I can cite a dozen lines where Dr. Genecin's opinions talk about he. Never using the word they, never using the word it, never talking about St. Louis University.

At some point Dr. Genecin says something to the effect of there may be some opinions that I will have doubt, but I think this pretty much covers it. At that point he had not talked about anything involving SLU. And he continues after that at various points to make references to he. He failed -- he did this, he failed this. Never a they or an it.

Last -- perhaps the last trick question was -- by Paul, Page 31, lines eight through ten, are there -- are other opinions that you have, Doctor, other than what you've told us about in terms of main opinions. No. Apart from his management of Mr. Koon's pain. That was Dr. Genecin's answer.

And then talking -- Dr. Genecin talks about whether the programs are in place. I think that's important. That was kind of a focus of plaintiffs, to try to bootstrap St. Louis University. He still says doctors

are required to adhere to the standard of care. I mean, I could go on, but I think that gets the flavor.

Again -- and then there was -- even on cross-examination, to try to finish up the deposition -- Mr. Simon, I believe it's not you. Was it your son? Okay. Mr. Simon, the junior, asked questions about did Dr. Walden do or breach the standard of care. Not did St. Louis University.

Judge, any -- first of all, again, envisioning the battlefield, people are under the gun during a break, jury is out of the room, you were showed a few portions of a deposition that almost remind me of the movie Ransom Notes, where the note is cut out from -- the words and letters are cut out from newspapers and magazines to kind of get the message across.

But I submit that any fair and complete reading of this deposition can lead to no other reasonable conclusion than that it was -- his opinions were directed only to Dr. Walden, in that he did not opine as to St. Louis University in any way. Especially as against any -- well, I would conclude that any -- any independent -- as to plaintiffs' independent claims against St. Louis University, I'd say the testimony is too transparent to even be characterized as thin. And it simply just can't come in.

I know what I am asking is an onerous task, and I do not do so lightly, because I have been there. But I -- you're likely to hear some counterarguments, and I respect the counterarguments, and you may end up scratching your head like you probably did at the time the oral presentation was made.

Again, so I don't make this request lightly, I'm going to ask -- I think the only way you can get a true feel of this deposition is, unfortunately, to read it.

And what I've done here, in case you'd rather not read my marked copy, is I've provided -- I'm providing an unmarked copy. So depending on how you wish to review -- review this -- I don't have an extra copy of the unmarked copy. I'm sure you gentlemen have it. And really don't need an unmarked copy, because I suspect you're going to be arguing from your marked copies. But I wanted to provide this to the Court.

THE COURT: Thank you.

MR. DAVID: That gets us -- quite frankly, there's a good argument to be made that we could actually stop our argument here and just say, Judge, that alone is enough to grant either a JNOV against St. Louis University or a new trial. Either of those remedies, because of the impact on Dr. Walden, almost maintain -- mandates a new trial, at a minimum, as against both -- both defendants.

But we're not even done with Dr. Genecin.

MR. CRONIN: I'm sorry. If we're going to a new point, Your Honor, would it be possible to respond to the first point before we move on to the second point?

THE COURT: Are you on to a new point?

MR. DAVID: Well, I need to make one other comment about the other point, and then I think that might make some sense, too. Depends on whatever you wish to do.

THE COURT: I would prefer that. That way my notes can --

MR. DAVID: I get that, too.

The -- you know, one might talk about prejudice. And I know there's this discussion that's already occurred that, you know, without -- in view of Dr. Genecin's deposition, the defense was really not on notice that there was any real evidence against St. Louis University independently.

And that -- you know, why should -- the fact that the pleadings involved a claim against St. Louis University, despite the fact that the notice of Dr. Genecin has a -- as an expert, as against defendants, I don't think answers the question. Because the whole process of discovery is really designed to find out, okay, of the pleadings, what are really going to be at issue.

And, so, when you see the deposition of Dr.

Genecin, you're left with the question why would St. Louis University -- or why would anyone prepare to defend against an opinion that was never given.

So there was no notice for us to -- to get an opinion, as against plaintiffs' separate allegations against St. Louis University. And, so, that's -- that's the reason that we were caught flatfooted.

I think even though some of the points I want to talk on do touch on Dr. Genecin, that, really, I would say, at this point, now might be the time for counsel to respond to the new opinion question. And I'll yield the floor. If I can get my stuff together.

MR. CRONIN: Your Honor, I have a tremendous amount of respect for Judge David, and I respectfully disagree with him. I want to address a couple of things that were said about hospitals don't prescribe.

First of all, SLU is not a hospital. SLU is a healthcare provider, as they have admitted, and their conduct is Dr. Walden's conduct. They are a healthcare prescriber, and as a healthcare prescriber they are prescribing to patients through their employee doctors. Walden is their agent, his prescribing is theirs, his conduct is theirs. The doctor and the institution are one.

And, by the way, Dr. Walden was not the only SLU employee doctor that prescribed opioids to Brian. He wasn't

even the first one that prescribed OxyContin to him. That was a different SLU doctor. That is still SLU's prescribing to him.

With respect to the testimony in the deposition, and -- arguments that there's inconsistencies about -- just talking about Walden, but separately talking about medication management system, testimony on some pages of a deposition does not erase his testimony on Pages 55 through 58. It doesn't.

Whether they said your opinions are about Walden, yes, it doesn't erase that he says, on Page 56, everyone who is prescribing is required to have systems in place. That's not something a doctor does, that's something an institution like SLU does to ensure that patients are not getting too much. And this is Page 56 of the deposition, Judge. And that doctors are not exceeding safe practice with respect to their prescribing.

And then on the end of Page 57, and beginning of Page 58, that's -- the standard of care is still the same, whether you -- whether the program is in place or not. He's saying that system, the medication management system, whether there are -- Missouri has the same laws as Connecticut has, the standard of care is the same for that system.

Now, there was some discussion about whether

they had notice about evidence against SLU. The corporate representative notice, which led to us deposing Dr. Heaney on these exact topics, was sent out very shortly after Dr. Genecin's deposition, and before they had to disclose experts.

We argued and did briefing about this issue, whether Genecin gave these opinions before their experts testified. Before they made the decision they didn't want to get an expert on the issue, they knew our position was that he gave these opinions, before all of their experts testified.

And, Judge, we have rehashed and repeated these same arguments, I think this is probably the fifth or sixth time since the pretrial, that Dr. Genecin didn't express any opinions that would implicate SLU at the deposition.

The Court made a specific finding at trial that he had, looking at all the same deposition testimony that Your Honor is being presented with today, and was presented with previously. Dr. Genecin was not asked about and did not express a single new opinion at trial. We stayed within the depo as the Court directed.

And specifically, Your Honor, we -- I asked you what our question could be. And it's on the last page of the trial transcript that was provided. I -- I went

through those same pages, 55 through 58 of the deposition, and I said how about this, Judge, because we want to make sure we're sticking to your ruling. A healthcare prescriber that is prescribing is required by the standard of care to have a medication management system in place to monitor the patient. The Court; yeah. That's what Dr. Genecin was asked at trial. And that's what he said the standard of care required. That was his testimony establishing the standard of care for a healthcare prescriber, which SLU is.

St. Louis University was named as a defendant in this case from the beginning. There was a separate count against them. Not just for vicarious liability, there was -- Count II was against St. Louis University as a healthcare provider. There's no late attempt to bootstrap. We named them as a defendant. We could have dismissed Dr. Walden from the case and they're still responsible for Dr. Walden's conduct as a healthcare prescriber.

All of Dr. Genecin's opinions about Dr. Walden equally apply to St. Louis University as a matter of law regardless. But, in addition, he specifically stated at trial, just like he did in his deposition, everyone who is prescribing, that means SLU, is required to have systems in place to ensure that the patients are not getting too

much, the doctors are not exceeding safe practice with respect to their prescribing. He opined that the standard of care requires prescribers of opioids to have a medication management system in place just like the Yale health system has to monitor the prescription of narcotics to patients.

They knew that Dr. Genecin had said that in his deposition. And we argued about whether that was enough for SLU before they chose to pick which experts they wanted to bring into court. This wasn't a new thing that happened at the pretrial. They knew about it.

The Court specifically ruled that I think this deposition does touch on the topic of systems. We differ in our -- this is a quote from you, Judge. "We differ in our interpretation of this. I don't think that the plaintiff should be precluded from going down this road, because you don't have that defense counsel made a determination that they didn't reach a certain level in that."

And at trial Dr. Genecin testified, quote, the standard of care requires that a prescribing healthcare provider has a medication management system in place to make sure patients do not receive excessive or too much dosage of opioids.

He didn't say SLU, he said all prescribers,

which is exactly what he said in his depo. SLU is a prescriber. Simply put, there was no new opinion, no surprise, no trial by ambush.

The nature of defendants' duty to plaintiffs must be, and was established by expert medical testimony, and once the duty was established, whether defendants were negligent under the evidence becomes a fact question for the jury. Whether there was a breach of the standard of care is a matter for the jury's determination.

I did that in our brief with the case, it's a direct quote. So, plaintiff needed to present evidence that the standard of care for healthcare prescriber like SLU requires monitoring, having a medication management system in place, and we did that.

So, in order to prove our case then we had to show with evidence whether they had such a system or not. Dr. Heaney's testimony was certainly relevant in that respect, and he admitted on the stand that, quote, during the time period in question SLU was not monitoring opioid analgesics as a practice.

He admitted they do not have a system in place to monitor narcotics prescriptions. Exactly the kind of system that Dr. Genecin said healthcare prescribers have to have in place. That element of the claim cannot be disputed, it's a party admission, and it's certainly

relevant because it addresses the standard of care set by Dr. Genecin.

Moreover, Judge, there wasn't a separate verdict director submitted to the jury for defendant SLU. So this is a meaningless argument. The single verdict director on negligence in this case required the jury to conjunctively find that both defendant SLU and defendant Walden were negligent for any one of four disjunctive submissions. One of them was monitoring.

So, if the jury found that SLU was negligent for failing to monitor, they couldn't do that without also finding Dr. Walden was negligent for failing to monitor. And if Dr. Walden is negligent for failing to monitor, SLU is on the hook for his conduct. It doesn't matter.

If we strike all the SLU testimony, the result is the same in the case because the jury, to reach its conclusion, had to find that Dr. Walden was negligent. And employment is admitted in this case. SLU is responsible for it.

Your Honor, under Missouri law -- and this is going to address any JNOV arguments that are being presented. The standard for JNOV was not provided to the Court or cited by the defendants in their pretrial. And I think that's pretty telling. The Court must view the record in the light most favorable to the verdict and give

plaintiffs the benefit of all reasonable inferences, and evidence that conflicts with the verdict must be disregarded.

With that standard in mind, a motion for JNOV should not even be seriously considered and should be promptly denied. Thank you, Judge.

THE COURT: All right.

MR. DAVID: Judge, I would like to take just a couple of minutes to rebut, before I go on, if that's all right.

THE COURT: All right.

MR. DAVID: I think I still heard the ultimate confusion about whether St. Louis University is a prescriber. A doctor is obviously a healthcare provider. Not all healthcare providers are doctors. Would we not agree that a nurse, even an LPN, is a healthcare provider? That doesn't mean that they can prescribe. The notion that somebody can prescribe is something that is for a doctor.

I want to talk a little bit about the notion that Dr. Walden and St. Louis University are one and the same. That is not true. Respondeat superior says that the employer is responsible for the actions of the employee. Not that they're one and the same. And I don't think that's how many angels can dance on the end of a

pin.

The hospital may very well be -- and I would concede is liable for the actions of Dr. Walden under respondeat superior. That doesn't mean that Dr. Walden is responsible for all of the acts by St. Louis University that are independent of the claims against him.

And if this -- the plaintiff had, in fact, dismissed St. Louis University out of this -- it depends on what they dismissed St. Louis University out of. If they dismissed St. Louis University on these independent theories of negligence, then we wouldn't be here talking about this -- this opinion.

And if they dismissed -- and dismissed Dr. Walden -- first of all, they couldn't dismiss Dr. Walden against the independent theories against St. Louis University because he has no responsibility for that. And if they did dismiss Dr. Walden on the issues of respondeat superior, the instruction would still say Dr. Walden did X, Dr. Walden did Y, and that, therefore, St. Louis University was responsible for his conduct.

And there would be another instruction if -- if SLU had not admitted the employment relationship and admitted respondeat superior, there would be an additional element that he acted within the scope of his employment. Which in this case would not have been necessary.

And I -- I think it's a very broad statement to say that the word systems implies St. Louis University, too. I dare say that an example for you to be able to handle the matters that you've handled before we started, you have to have some systems in place so you don't miss any one of the guys in the yellow jumpsuits -- or orange jumpsuits that we just saw. And you're not an employer, you're an employee of the State. I guess an appointee of the State, but technically an employee of the State.

So I think, again, this is another example of -- when you start thinking of these things as the same, that that's -- leads to unsupportable conclusions.

I'm trying to read some of my notes that I scribbled down while we heard the argument. I think that is basically the point.

Again, I point that there are sections of his deposition where the questions are asked about whether or not SLU prescribes, and the questioner is corrected by saying, no, that the doctors, physicians prescribe.

And regardless of the note -- you know, we -- well, I don't think I really need to say much beyond that. Again, the issue of respondeat superior does not say that the parties are the same. It says that the one party is responsible for the conduct of the other.

I want to talk about the -- about the

admissibility as against the defendants.

THE COURT: All right. So we're on to point two?

MR. DAVID: Yeah, I guess you could call that point two.

MR. CRONIN: I have nothing else on point one, Judge.

MR. DAVID: The reliance by Dr. Genecin on the 2016 CDC guideline, I think, is misplaced. You have a -- a report and publication that -- which the testimony basically says that the creation of the document started around 2013, which is after the end of Dr. Walden's care of Mr. Koon.

It does reference certain articles that were written during the course of that -- of that care, but there's nothing that indicates those articles have been authenticated as learned treatises, and if they were, in fact that, there's no reason why those couldn't have been used.

There's been illusions to a 2007 CDC report that I don't think anybody ever saw, so we don't know what it really says. But that -- clearly I would not be able to make this argument against a 2007 governmental report. But the 2016 report, again, doesn't provide us with a standard of care required of the doctor during the time of

the treatment. Which is fundamental to plaintiffs' obligations in this case.

And the reason it is so important and so damaging is that report carries with it the imprimatur of the Federal government to indicate that, you know, this is the -- this is the gold standard. And, so, admission of that is devastating and improper.

References to the group in the state of Washington who published the 2007 report. Well, that was not a government report, didn't talk about Missouri, and it really did talk about that it was a -- it was kind of a pilot project just being lanched. It really wasn't, again, a guideline for practice in Missouri. No foundation as to the patient safety rules, rules of opioid prescribing was presented to establish those, its legitimate bases for his opinion. And, again, we talk about his opinion against Dr. Genecin, because they -- he's never really offered an opinion as it relates to St. Louis University.

Without these things by Dr. Genecin, doctors -- Dr. Heaney's testimony becomes much more narrow than it turned out to be. I'm going to let Mr. Price talk about the opioid epidemic, which also was the subject of Dr. Heaney's testimony.

But we really wouldn't have had testimony on the

2016 CDC guidelines or this report from this group of doctors from the State of Washington, nor would we have testimony -- I'm going to touch on this topic in just a minute -- about the relationship of St. Louis University with the pharmaceutical companies.

So, before I -- before I do that, I don't know if you want to respond to those points at this point.

MR. CRONIN: No, if you -- if all of these are going to have to do with the submissibility of our case, I'll just wait. Thank you, though, Judge.

MR. DAVID: Sure. Let's talk about the testimony relating to the relationship of the pharmaceutical companies to St. Louis University.

It's clear that -- and understandable that plaintiffs would want to try to tar an institution with some, "and you know they do some work with these drug companies", kind of like with a wink. You know, we know what that means. But there's no testimony as to what does that, in fact, mean.

It would be, in my judgment, similar to a trial of maybe one of the gentlemen that were here this morning charged with a burglary, and allowing in evidence that the defendant in one of those cases was caught with people that we know are burglars. Nothing else, no other tie to the charge for which the defendant was on trial.

Obviously, the State would love to be able to do that. I don't think there's any judge that I know of that would allow that in.

And this is very similar to that. Especially when you're thinking in terms of -- well, really, it's true, whether it's St. Louis University or Dr. Walden, but it's -- as true as it is for St. Louis University, it's at least doubly true for Dr. Walden, because there wasn't even a connection of Dr. Walden with any of these companies.

So, all it is is some kind of mud and an inference that because of -- an inference that because of this there must be something nefarious, with no evidence that there was. No evidence to support that conclusion. Not even the evidence to support the inference, actually, other than the fact that these two facts exist. Well, so what.

And it's clear that the intent -- and I'd like to use it if I had it, even though I don't think I would have been allowed to use something like that -- is to inflame the prejudice of the jury and appeal to their baser instinct.

So, I think what we have here is a situation where clearly there -- I guess the issue -- I would agree with Mr. Cronin to some degree about, you know, what the

standards are for JNOV, but I don't think that precludes somebody from saying that, well, you know, that evidence came in, so you have to give it the weight if you conclude later on that that evidence should not have been admitted. That would be kind of circular reasoning.

The evidence should not have been admitted, that cannot form the basis of denying a JNOV. A JNOV presumes, I think, that the evidence that is admitted was properly admitted.

And, so, I think that under all the circumstances here -- and I'll let Mr. price go on further, but all the circumstances here lead to the conclusion that you can make an argument for JNOV against Dr. Walden, but it's a slam dunk, or close to it, as against St. Louis University.

The effect of that -- of that evidence that comes in against St. Louis University that should not have really taints Dr. Walden having a fair trial at minimum.

So, I think the conclusion of everything would lead you to granting the JNOV as against St. Louis University, and new trial as to Dr. Walden. Certainly, at a minimum, a new trial to everybody, to let all these things flesh out and have it tried with the proper evidence.

So, I think now might be the time for me to hand

off to Mr. Cronin.

THE COURT: All right.

MR. CRONIN: So, Your Honor, I'd like to address the submissibility issue first, and then move on to the guidelines of pharmaceutical companies.

I know defendants are arguing the guidelines pharmaceutical companies section in the submissibility section. I don't think that's proper. I'll point out why. But I'll address those after I show the Court that we definitely had a submissible case.

So, Your Honor, the plaintiffs believe the defendants' motion is defective in three ways. First, they raise new arguments that weren't asserted in their motion for directed verdict, which is prohibited. That includes that the admissibility of the guidelines somehow was grounds for a motion for directed verdict.

That wasn't in their motion for directed verdict. They argued it shouldn't have been admitted, and maybe it can be grounds for argument for a new trial, but not a grounds for an argument for JNOV, and the same thing for the pharmaceutical companies.

So, the initial bulleted list for introductory argument, which -- in the motion, which spills over into the JNOV section, were not raised in the motion for directed verdict, they cannot be raised in a JNOV, plain

and simple. They're precluded from obtaining JNOV on grounds not spelled out in the directed verdict motion.

Second, Judge, they are asking the Court to consider extrinsic issues, specifically those extrinsic issues such as alleged evidentiary errors, which is improper in a JNOV. The only permissible issue raised in a motion for JNOV is whether plaintiffs have made a submissible case.

And you cannot ask the Court to consider evidence that weighs in favor or against the verdict. That has to be completely disregarded. All evidence must be used in the light most favorable to the plaintiff, giving them the benefit of all inferences and disregarding all of defendants' evidence. Any evidence that conflicts with the verdict must be disregarded. There has to be a complete absence of probative facts to support the jury's conclusion.

Your Honor, we were in here for a week and a half. I don't think that can reasonably be argued here. The evidence was overwhelmingly one-sided in plaintiffs' favor.

Almost every element of plaintiffs' case was ultimately admitted by either the defendants themselves or their experts. To succeed they have to show that none of our claims had any factual basis. And there was a

mountain of evidence to support all of them.

Your Honor, I can go through the treatment history, if you'd like. And I have it here to read it into the record, about the amount prescribed, the total pills, how much each year.

THE COURT: That's not necessary.

MR. CRONIN: I think the Court probably knows it as well as I do at this point. But suffice it to say we have extensive evidence that Dr. Walden breached the standard of care, that it caused Brian's and Michelle's harms and damages.

Dr. Genecin is imminently qualified in the same area of medicine as the defendant. He's an internal medicine doctor, just as Dr. Walden is. He's been practicing for a long time. He's the head of Yale Health. He's a very respected physician. He didn't just base his opinions on guidelines, he looked at -- his opinion is based on his years of practicing internal medicine, including the decisions about whether to prescribe opioids to patients for chronic pain.

He specifically testified that his opinions utilized the objective standard of care that is generally accepted in the profession. All of his testimony would be based upon a reasonable degree of medical certainty. He testified at length and set out each -- each requirement

of the standard of care, about doing an initial risk assessment, not placing somebody with chronic low back pain on long-term opioids at all, not exceeding certain amounts. Even for somebody who can be placed on long-term opioids, not going more than 90 days, continuing to monitor, assessing for addiction.

He laid all of those out one at a time, tied up the breach of each one of those, and discussed the evidence that showed how it was breached, and testified that each one of them independently caused or contributed to cause Brian's and Michelle's injuries. I can cite to the record for each one of them, Judge. We have done so in our brief already.

I don't think we're addressing the punitives on the JNOV yet.

THE COURT: No. Not yet.

MR. CRONIN: I believe. So, I'll go past that. But Dr. Genecin also provided the testimony necessary for that, and there's evidence outside of that that supports that.

So, Judge, I'll move on to the guidelines briefly. Dr. Genecin discussed the CDC guidelines. They were discussed with other witnesses as well. Those CDC guidelines were published in 2016. Dr. Genecin did not say that they set the standard of care. Nobody ever

suggested they set the standard of care. He testified those guidelines reflect what the standard of care has already been for the profession.

They don't set it, and they're not mandatory, and it was pointed out to the jury that they are not mandatory, but it's evidence for them to consider in deciding what they think the standard of care was and should be.

This argument was invalidated by their own expert's testimony at trial. Dr. Gunderson was on the stand on Friday of the first week of trial. He was a signatory to a petition sent to the FDA in 2012, during the period of treatment in this case, by a group of physicians known as the Physicians For Responsible Opioid Prescribing.

Dr. Gunderson wanted label changes made that mirrored what our expert said the standard of care was. And that included a maximum daily dose of 100 milligrams for non-cancer pain, maximum duration of 90 days.

In other words, the defendants' expert believes that that's what should be being done, and it's the exact same thing that our expert said, and the exact same thing that's in those guidelines.

To support those recommendations, in 2012 he and the other signatories relied on sets of guidelines that I

went through with him. We went to the cites at the end of the letter, it included a CDC guideline dated 2007 that Dr. Gunderson told us made the same 100 morphine equivalent recommendation as the 2016 guideline.

So the CDC was already saying the same thing in 2007, before Brian started getting prescribed. That's what his testimony was, that it was -- he cited to it because it was in line with what he was saying in his letter. So the CDC was saying the same thing before Brian started getting treated that they said in 2016.

It also cited to the guideline from the Agency Medical Director's Group from Washington, which is the other one that Dr. Genecin relied on, it existed before 2008, and it is a source that Dr. Gunderson, their expert himself, also cited to as a reliable source in support of what he was saying for why they shouldn't prescribe more than 100 for more than 90 days. So their own experts find this as a reliable guideline, and it's the same thing that our expert relied on.

Regardless, Judge, our expert didn't need to rely on any of these guidelines. His testimony was also based on his own experience. So, evidence of industry standards, Judge, is admissible proof in a negligence case. We didn't argue they set the standard of care, neither did Dr. Genecin. They helped to demonstrate the

outrageousness of the prescriptions written, because the defendants massively exceed those recommendations.

And it's difficult, Your Honor, for me to understand how they can complain of prejudice about introducing guidelines which contain numbers that are the same as the numbers in their own expert's letter to the FDA during the period of prescribing in this case.

Their expert made the same recommendations that's in the guidelines the jury heard. And he cited to the guidelines we used when he did it. That was all coming in no matter what once they decided to call him to the stand.

With respect to pharmaceutical companies, Judge, again, I don't think this is an appropriate thing to argue in a motion for JNOV. Maybe a motion for new trial. This isn't plaintiff making things up to tar defendant SLU. It was admitted by their corporate rep, it's undisputed evidence, we stuck exactly within what the Court told us we had to do.

We specifically allege that SLU knowingly prescribed high doses of opiates for a financial incentive -- with a financial incentive with knowledge of the risks. We were limited to presenting only evidence of relationships with pharmaceutical companies that manufacture the opioids given to Brian, and that's all we

did.

SLU overprescribed opioids, we showed they have close ties to the pharmaceutical companies that make those opioids that were prescribed, and we alleged they had a financial incentive for their conduct. Evidence for financial incentive for defendants' conduct was relevant, admissible in support of plaintiffs' punitive damages claim.

And moreover, Judge, I didn't mention that in opening or close. I don't think. I don't think. If I'm misstating, I apologize. I don't believe I did. It wasn't highlighted -- it was just a video depo. It wasn't highlighted in opening or close. So, I don't see how it can be argued that it's prejudicial when it wasn't argued in closing argument or highlighted. It's a single video depo, it's relevant to the case, and it's undisputedly true.

Judge, I think that addresses all of the points.

THE COURT: All right. Next point? Or do you want to rebut?

MR. DAVID: Just for one minute.

THE COURT: Quick rebuttal.

MR. DAVID: Very quick. As to the 2016 CDC guideline, you know, the comment was that it wasn't set -- it didn't set the standard, it reflected the standard. I

don't know what reflected the standard means if it doesn't mean that it really is the standard.

The letter Dr. Gunderson sent -- I just want to point out that was sent asking people to look at this, it was sent on July 25th of 2012. The treatment of Mr. Koon ended on August 30th of that same year.

The fact that the notion on the pharmaceutical company was not argued, who needed to? If that evidence comes in, the -- the illusion of impropriety is enough.

That's all. Thank you.

THE COURT: Okay.

MR. PRICE: As I stood by your bailiff's desk I saw her handcuffs, I became frightened the worst time to speak is before cocktail hour or a late lunch. I will hurry as fast as I can go.

THE COURT: No, no hurry. We're fine.

MR. PRICE: I don't know if you have our reference on suggestions. We also filed last night our suggestions in support. And I'll give you a copy of those just to have.

Your Honor, I think -- I'm going to talk about three things. And I hate to tell you I think they're big problems. First, I think the punitive damage instruction submitted here was erroneous because it was not modified in accordance with Section 538.205. 538.205.11 defines

punitive damages regarding healthcare providers as punitive damages intended to punish or deter willful, wanton or malicious misconduct, including exemplary damages and damages for aggravating circumstances.

538.210 then goes ahead to say an award of punitive damages against a healthcare provider, governed by the provisions of 538.205 to 538.230, shall be made only, only upon the showing by a plaintiff that the healthcare provider demonstrated willful, wanton or malicious misconduct with respect to his actions which are found to have injured or caused or contributed to cause the damages claimed in the petition.

Missouri law has been consistent and clear. Statutes prevail over MAI, not the other way around. Way back in 1997 Judge Dewayne Benton wrote a case, State V Carson, 241 SW2nd 518. Procedural rules adopted by MAI cannot change the substantive law and must therefore be interpreted in the light of existing statutory case law.

In 2007 Judge Mike Wolf wrote in State V Taylor, 238 SW3rd 145. When an approved instruction conflicts with the statute, the statute prevails. Clear, consistent Missouri law. Judge Benton and Judge Wolf, not the same kind of judges, perhaps. That's always been our law. This is not discretionary. This is not a maybe. This is not take a chance.

Section 538.210.6 is not subject to MAI that controls it. The legislature laid down the law. If the courts are doing their job and respecting the separation of power, they must follow what the Supreme Court has said. The jury had to find willful, wanton, or malicious misconduct. And the only way they can find it is by a question submitted to them in an instruction, and that was not submitted to them in this case.

Now, moreover, I would suggest to you in the record there's no evidence against Dr. Walden, or especially SLU, that could support a finding by clear and convincing evidence of willful, wanton, malicious misconduct. Each of those terms carries with it a meaning of an intentional wrongful, willful, wanton, and malicious misconduct. Conscious disregard or complete indifference, which is the way you looked at it, is simply a different, lesser standard.

At best, in this case, there may be evidence of negligence. I would argue to you that there's not evidence of a conscious disregard or complete indifference. There's certainly not evidence of intentional, willful, wrongful misconduct.

Let's just think about the evidence in the big picture here. I agree it's all in plaintiffs' favor, but -- admittedly Dr. Walden prescribed a significant amount

of medication to Mr. Koon. But he said he increased the dosage because the patient had developed tolerance, that the patient needed a higher dose to continue working, the patient wanted to continue working, the patient did not inform him of any difficulties with the medication, he did not overdose.

Remember, this is a case where there are no economic damages. No economic damages. Now maybe he was negligent, but on those facts I don't see how you have conscious disregard -- conscious disregard or complete indifference. Certainly not willful, wanton or malicious misconduct.

Now, let's look at SLU. The claim against SLU is that it didn't have some amorphous monitoring system. And I will point there is no evidence whatsoever in the record about what kind of a monitoring system, when it was supposed to kick in, what it was supposed to do, when it became the standard in the industry. No evidence of that. There's just maybe a monitoring system.

I would submit that there are key dates that are important here. Treatment, I believe, was between 2008 and 2012. There's no kind of any of this amorphous monitoring system even to the dates of this patient's treatment. There's just no evidence that allows you to say SLU was consciously indifferent, completely

disregarded, certainly not willful, wanton, malicious misconduct.

And then I would like you to recall that in this case punitive damages were submitted jointly. Jointly. That means if it fails to one, it has to fail to both, because you don't know who the jury found the punitives really against.

So, here, if there is a bad instruction, or insufficient evidence as to one, there has to be a new trial as to the other.

I would submit here you have no choice but to grant a JNOV as to SLU on punitive damages. If you do that, you have to give a new trial to Dr. Walden on punitive damages because you don't know how that instruction would have been followed by the jury.

At the very least, there needs to be a new trial for both of them. But it's simply the wrong standard.

MR. CRONIN: Your Honor, again, I have a tremendous amount of respect for Judge Price, but I respectfully disagree. Fortunately, we have the case of Dodson V Ferrara from this year that addresses whether we used the right MAI instruction for a punitive damages claim in a med-mal case.

From 2016, Missouri Supreme Court says -- specifically rejected the same arguments that defendants

make here and has stated that the correct instruction to use in a medical malpractice case involving punitive damages claim is the same as for any negligence claim, the MAI instruction that Your Honor submitted to the jury in this case.

Your Honor, I believe, was familiar with the Dodson case at the time he made that decision, it addresses this argument, it eliminates this argument.

The instruction given to the jury is the instruction that the Missouri Supreme Court says should have been given. The Court applied the clear and convincing standard when determining if the instruction should be given. And Your Honor went further in his finding of determining that the evidence was sufficient to submit it than conscious disregard.

Your Honor said, quote, a reasonable jury could determine that the evidence presented regarding the defendants' acts or omissions could rise to the level of intentional wrongdoings or omissions, and as such they can make that determination with convincing clarity. So the motion will be denied. That was the Judge -- Your Honor's decision after hearing the evidence in the case.

In other words, based on clear and convincing evidence presented by the plaintiffs in support of their claim, a reasonable jury could find the defendants not

only exhibited complete indifference or conscious disregard for the safety of others, but that their conduct rises to the level of intentional wrong.

The Court applied the correct standard in denying defendants' motion for directed verdict. And, Judge, I think -- I'm trying to make a distinction, because the instruction issue is only for the new trial motion. Not part of the JNOV motion. It's part of the new trial motion, not the JNOV motion. Moving to whether there was sufficient evidence, that's part of the JNOV motion.

So, Your Honor, I also want to point out -- and this isn't in our brief, but it's in our pretrial briefing about it. The law is very clear. If the conduct of Dr. Walden was such to justify punitive damages, and it's admitted that his conduct was within the scope of employment of SLU, they're on the hook for the punitives.

There's no separate determination that needs to be made if SLU did something different. That doesn't need to happen. They're on the hook for Walden's conduct. That's sufficient for punitives. That's -- that's clear case law that was provided to the Court in the prior brief.

So, Judge, again, I have about four pages I can read into the record about -- because we're here saying

whether we had sufficient evidence for punitives. The evidence that supports the jury's finding of punitive damages is clear and convincing and overwhelming. I just want to point out a couple things.

THE COURT: Okay.

MR. CRONIN: Outside of what our expert said, which -- which is sufficient enough, that as a physician in this area of medicine the evidence supports a finding of recklessness, which is legal equivalent of willfulness anyway, and a conscious disregard for safety.

We also have Dr. Walden's testimony from his deposition, which was played to the jury, where he admitted that the amount he gave to Brian in 2010, 2011, and 2012, created a probability of the risk of endangering.

That's conduct with knowledge of the danger. That's intentional conduct. He admitted that in his deposition, that he knew in 2010, '11 and '12 the amount he was prescribing created a probability of addiction.

Frankly, that's all the evidence we need to submit our punitive damages claim. But I want to go to something that Dr. Heaney was asked about as my last point. And when he was presented with the statistic of one out of 32 people who were given 200 MED die of an overdose, his -- and by the way, they went seven and a half times past that. His response was that means 31 out of those 32 people are

getting a benefit. And I think that was pretty clearly showing the jury the defendants' attitude towards caring about the risks that patients are under when prescribing these amounts of opioids.

Judge, I could list off a lot of other evidence, I don't think Your Honor needs me to do that, you probably remember it from the trial.

So, with that said, Judge, I would just remind the Court that all evidence has to be viewed in the light most favorable to the verdict, all the defendants' evidence to the contrary has to be completely disregarded, and as such I think the defendants' motion for JNOV on punitives should be denied.

And I've explained to the Court why the punitive damages instruction was correct and such motion for new trial on that basis should be denied.

THE COURT: What was the other case you gave? Not the Dodson case. What was the case you read -- when you first started, you gave me another case.

MR. CRONIN: The one --

THE COURT: You said 2016.

MR. CRONIN: Dodson is the 2016 case. That's the Dodson case.

THE COURT: Okay.

MR. CRONIN: The other case I referenced, which

was in prior briefing, about the employer being on the conduct for punitives for --

THE COURT: I know you said 2016. Later you said Dodson.

MR. CRONIN: I'm sorry. Those are the same cases, Judge.

THE COURT: All right. We're good.

MR. PRICE: Your Honor, I wouldn't come up here and misrepresent the law of Missouri to you and tell you that the law is one way when there's a Supreme Court case the other way.

THE COURT: Right.

MR. PRICE: I wouldn't do that. I'm going to read some of Dodson to you so you can see. And I want to tell you what happened in Dodson.

First of all, there was a claim in Dodson for punitive damages against a doctor doing the heart procedure. That claim was then not submitted -- or not -- the Court determined that it ought not to have been submitted. It didn't even get to the instruction stage.

And here's what Dodson said. Okay. This is Dodson versus Ferrara. "To make a submissible case for aggravating circumstances damages against healthcare providers in medical negligence action, a plaintiff must show that the healthcare provider demonstrated willful,

wanton or malicious misconduct with respect to its actions which are found to have injured or caused or contributed to cause the damages claimed in the petition." That's the language they used.

And then they went ahead and said, just a little later, Section 538.205.10 defines punitive damages as those intended to punish or deter willful, wanton or malicious misconduct, which includes exemplar damages and damages for aggravating circumstances.

Now Dodson does discuss this particular doctor's actions in terms of conscious disregard and incomplete indifference. But because they said the evidence doesn't even get there, they don't deal with it. And most particularly, at footnote 13 -- footnote 13 in the case -- I only have one copy. I'm not going to hand it to you. Nor -- and then they talk about defendants. Defendants provide no reason why a claim for aggravating circumstances damages. Aggravating circumstances damages under Chapter 538 should be analyzed differently from other wrongful death claims. Okay. That didn't have anything to do with it.

Nor do they dispute this standard for punitive damages or aggravated circumstances damages as set forth in MAI 102, MAI 1007, and MAI 6.02. That issue wasn't disputed, and wasn't even addressed in Dodson. To say

that Dodson addressed it and decided it is flat wrong according to the language of Dodson.

And let me suggest to you, when a court says in a footnote that that issue was not disputed, what that is is a clear signal that there is an issue there, that had it been disputed, it would have been resolved and pay attention.

Now, I also want to talk about one other issue that plaintiffs brought up in response. They talk about it all doesn't make any difference because SLU may be vicariously liable.

This case wasn't submitted just as to vicarious liability. I'm sure you recall that a vicarious liability submission you do all your instructions against the employee. And then there's a tag-on, and I think it's MAI 35 something, that says and if you find this was the employer, you shall find.

That's not how you submitted this. You submitted this independently against SLU. Independently. An independent cause for punitive damages on their own behalf. Therefore you have to look at this independently. And this is not just a tag-on.

And because you submitted it jointly, if that submission was wrong as to SLU, it's wrong as to the doctor as well, and there needs to be -- I think, as to

the evidence, the evidence didn't get there. We might disagree about that. But certainly because it's the wrong submission, there has to be a new trial.

MR. CRONIN: I just have one thing.

THE COURT: Briefly.

MR. CRONIN: Judge, there was no argument by the defendants that there should be separate punitive damages submissions to the jury for SLU and Dr. Walden. That issue has been waived.

The jury found that Dr. Walden's conduct was -- rose to a level of punitive conduct and as such SLU is responsible for. There was no argument SLU should have a different assessment made to it or that the instructions should -- there should be separate instructions for them. That issue is no longer in the case.

MR. PRICE: Your Honor, I'd submit that's the instructions you were given. That just doesn't work.

Your Honor, now I turn to the next one, and that's about the evidence of the opioid epidemic.

THE COURT: All right.

MR. PRICE: This case ran off the rails. And it ran off the rails early. It ran off the rails in voir dire. In voir dire a juror asked -- a potential juror asked counsel where punitive damages go. The response was all I can tell you is they're not to compensate the

plaintiff. I don't believe I can tell you where they go.

Now, this is a real problem, this statement. There's a motion for mistrial right then, right there. The problem is while punitive damages don't compensate plaintiff, when they tack on I can't tell you where they go, it implies that they go someplace else. And we know they go -- or at least half of them go to plaintiff. And these punitive damages aren't going to be available as a magic cure to any opioid epidemic.

Then right into opening statement plaintiff continues his theme he's setting up. This is in the third paragraph, right away. And I -- I'm going to read it to you so you remember the flavor of how pervasive and extensive this was.

"Ladies and gentlemen, our country is in the middle of a prescription opioid epidemic. It's an epidemic that is claiming the lives of 165,000 Americans since 1999. Upwards of 20,000 people are dying every year from it. Prescription opioid overdoses have quadrupled since 2000. And, again, we're not talking about heroin in these numbers, we're talking about prescription opioids. And they are prescribed by physicians." Interesting, physicians, not institutions.

"You probably saw the news. Prince -- here we are talking about Prince -- Prince just died from a

prescription opioid overdose. Since 2002 deaths from prescription opioids have surpassed those of cocaine and heroin combined. Over 2 million people in the United States suffer from substance abuse disorders related to prescription opioids. The number of prescriptions filled in our country every year is equal to our population. Not the number of pills, the number of prescriptions. Physicians have made it the worst manmade epidemic in the history of modern medicine."

Plaintiffs carried this theme forward with their first witness, Dr. Genecin. Here's what he said. "And that's the reason for the epidemic of deaths from prescription opioid analgesics prescribed by primary care doctors." And then he said, "and part of the epidemic of street-related complications is the fact that people take legally prescribed opioid analgesics. In other words, not just heroin, but also these medicines you get at the drugstore, at the pharmacy, and use them for sale."

But, Judge, this case has nothing to do with illegal sale of drugs. Illegal use of drugs. At all. And it's got nothing to do with Prince. This testimony injected unproven, uncharged crimes and was inflammatory and prejudicial, and absolutely more prejudicial than probative.

Finally, in plaintiffs' closing argument he ties

it all together. From voir dire, to Dr. Genecin, and then to closing statement.

"Everything that happens in this courtroom is about the public's wellbeing and safety. Where do those punitive damages go? Let's talk about the opioid epidemic. You've heard and have been shown all the kinds of four or five statistics, 165,000 people have died since 1999, and it's going 19,000 people per year are dying from prescription opioids. That's over 50 people a day. The annual number of deaths from prescription opioids exceeds the number of motor vehicles accidents. The number of opioid prescriptions filed in the United States per year equals our population. Not the number of pills, the number of prescriptions that come from doctors. They don't magically show up in people's cabinets, they're prescribed by doctors, they increase in overdosing -- the increase in overdoses has mirrored the increase of prescriptions by physicians."

And then even after objection, "ladies and gentlemen, this is a doctor problem. People are dying at the rate they're prescribing, and the defendants are trying to tell you doctors have nothing to do with it. Ladies and gentlemen, they're not getting the message. These defendants and other doctors around the country aren't getting the message. Give them one they can't

ignore, that's what we're asking you to do." And then, "the problem starts with doctors, and we can try to do something about it."

Your Honor, Dr. Walden and SLU have nothing to do with the opioid epidemic across the country. They have nothing to do with 165,000 deaths across the country. They have nothing to do with any deaths. Remember, this is a noneconomic damages case. The prescribing behavior of other doctors, they have nothing to do with that. Or especially the illegal sale or use of prescription drugs.

This case needed to be tried on Mr. Koon and his treatment by Dr. Walden. Not on all of this other extraneous, prejudicial argument. The opioid epidemic evidence in this argument spun this case out of control from voir dire, through closing argument, and it's no wonder it resulted, in a noneconomic damage case, in a $15 million punitive damage award against an individual doctor and a not-for-profit educational institution.

And this punitive damage award will have nothing to do with curing the opioid epidemic around America. This money is going someplace else, and we all know where it's going. And if you don't enter a JNOV, you should grant these defendants a new trial on actual and especially punitive damages so this case can get tried straight up on the evidence of Brian Koon, Michelle Koon,

Dr. Walden, and whatever evidence they can put together on SLU.

Again, the key years here are 2008 to 2012. There's no tying of any of this epidemic evidence to the years of these -- the treatment of these people.

This is simply more prejudicial than probative in any way. I mean, the argument that it's probative is it was supposed to put SLU on some kind of notice. Well, when? Notice had to be in the years 2008 to 2012. There's no talk in any of this argument about notice at the relevant time.

The fact that this country has a serious drug problem is no news to anybody. I mean, that's not notice to anybody about what ought to happen. Certainly not knowledge -- knowledge of notice is knowledge of this doctor's practice, or knowledge to SLU, not some amorphous notice to everybody everyplace else.

But I'll tell what you this was. This was surely inflammatory and prejudicial. And I think you can see that in the $15 million verdict that ought not to be there.

THE COURT: Rebuttal?

MR. CRONIN: Judge, again, I think some of -- most of what was just argued was not raised in the motion for directed verdict and, therefore, cannot be considered

in a motion for JNOV. At most it can be considered in a motion for new trial.

Let me start with the voir dire issue. In voir dire a party has an absolute right to -- in a case where punitive damages are at issue, to question about bias with respect to that issue. Plaintiffs exercised that right during the voir dire process. Mr. Simon explained accurately what punitive damages are. They are not to compensate the party for the harms and losses, but where the law says, because the conduct is such, that you will be instructed to award an amount sufficient to punish and to deter the defendant and other from like conduct in the future. When that was explained it was not objected to, because it's accurate. That's what the jury instruction says.

The jury can only consider an amount sufficient to punish and deter. They cannot consider where it goes. They're not allowed to consider where it goes. They can't be told where it goes.

Venireman Rosen stated she had a question. Do those punitive damages go to the defendants -- she didn't ask the plaintiff -- or where does that money go. Plaintiffs' counsel tried to redirect the conversation back to the purpose of punitive damages saying all I could tell you is they're not to compensate the plaintiff.

100 percent accurate. I don't believe I can tell you where they go. Because he's not allowed to. And Your Honor told him he's not allowed to.

There was no statement or suggestion or implication that plaintiffs will not receive any part of the punitive damages award. The jury can't consider that. John did not imply the punitive damages award would go to fight the opioid epidemic. That's, frankly, ridiculous, to suggest that he implied that.

Luckily we have a transcript to show us exactly what was said. More importantly, what John said was in no way misleading. He responded to the question with 100 percent accuracy, as the Court acknowledged at the time, and that's in the transcript. It was an attempt to blunt the issue. That is verbatim what Your Honor said.

"The jury is not allowed to consider where it goes, they're only allowed to consider the amount necessary to punish and deter according to the instruction. The amount necessary to deter gets us into talking about the problem."

Harm to others, to the extent they're arguing this is an attempt to punish SLU for harm to other people, it is specifically in the instruction that the jury is not allowed to do that, to award for harm to other people. We have to assume the jury followed the instruction. We

can't start leaping to conclusions that the jury didn't follow the instructions.

With respect to the opioid epidemic. Again, this is something we have argued ad nauseam, repeatedly, probably fifteen times throughout the trial. I would like -- before I go into the rest, Dr. Heaney admitted they knew about all this before 2008. They were on notice. He admitted it on the stand. He knew about this problem before 2008.

Yes, plaintiffs have a negligence and punitive damages claim. In order to prove both we have to show the danger created by the kind of conduct that the defendants exhibited, and the dangers they knew about when writing the prescriptions.

All of the statistics that were cited to the jury by me were then supported by the evidence in the case. And, in fact, they were all admitted to by their experts. So, there's no -- no misleading nature of the statistics, they're all completely true.

Their experts agreed we are in the middle of an opioid epidemic, and with the statistics associated with. The defendants admitted we're in the middle of an opioid epidemic, and that they knew about it before and during Brian's treatment.

This is not a new phenomenon, it's been going on

since the '90s. Your Honor probably knows more about it than anybody in this courtroom. You deal with it every day. The defendants -- it allowed the jury to assess the defendants' conduct in the environment in which they acted and compares defendants' conduct with their knowledge of the dangers. It is impossible and unfair to try a negligence case in a vacuum, especially a case with punitive damages.

And, Your Honor, it was pointed out the jury already knew about this. This is not something they didn't know about. They started talking about it and raising their hand unprompted, almost from the jump, in voir dire. I think there was a former soldier who started talking about how bad this prescription opioid pill problem is in our country before a word was said about it by us.

These prescribing practices are causing the epidemic. That was discussed with Dr. Gunderson. That internal medicine doctors who were prescribing without regards for the risks was contributing to cause this problem. These statistics showed the jury the harm their conduct is causing. The Court has ruled on this issue time and time again and should not reverse its ruling now.

Moreover, the statistical evidence was relevant to reviewed -- refute statements made in defendants'

opening statement and by their expert. Which was a new opinion given at trial that we didn't have a chance to address. That addictions or problems from these opioids are rare, that it's a small percentage, and then Dr. Guarino gave a specific percentage that he never said in his depo. That wasn't true, and the statistics show it wasn't true.

The defendants were not punished for uncharged crimes or injury that it inflicted on nonparties. The jury was specifically instructed not to do that in instruction sixteen. And, in Missouri, the jury is presumed to follow the instructions of the court.

Requiring the defendants to defend their actions as they took them in the real world and with actual knowledge of the ongoing epidemic was anything but unfair. The opioid epidemic was something they were keenly aware of. Evidence of the epidemic was relevant and admissible and it assisted the jury in assessing defendants' conduct in deciding whether it fell below the standard of care, and deciding whether their conduct should be discouraged in the future and refuting their defenses.

A motion for new trial on that basis should be denied, Your Honor.

THE COURT: Follow up?

MR. PRICE: First of all, I would like to point

out although I'm complaining about plaintiffs' counsel giving you bad instruction contrary to statute, bringing in this opioid epidemic and all that, I don't mean to be disparaging or disrespectful. They are brilliant attorneys and have done a fantastic job in this case. I told that to Mr. Simon yesterday.

But that doesn't mean that it's not error and that doesn't mean they didn't lead you down the primrose path from beginning to end.

MR. SIMON: Maybe not.

MR. PRICE: Maybe the end is not over. I hope. But I'll say, you know, if the voir dire comment was a one off, it would be a different thing. But when you read the whole transcript, you see that was part of the theme, is to focus the jury on everything except Dr. Walden and SLU, and to talk about epidemics, talk about punitive damages and where that money might go.

I would also say that Dr. Heaney's testimony -- he knew about this problem. Well, who didn't know about the problem? That's not what we're talking about for notice in punitive damages.

For notice in punitive damages, for willful, wanton, malicious misconduct, it has to be a lot more specific than that. That they know they have a problem with their doctor, they have to do something like this,

they have to have an experience like that. That evidence is just not in this record.

Your Honor, I would like to turn now to the DEA evidence and suggest that this prejudice that we had with the opioid epidemic was just compounded with the admission of Dr. Genecin's pure speculation that this state's licensure board or the DEA should have investigated Dr. Walden's prescription levels.

And it was further compounded by Dr. Fitzgibbons' double hearsay testimony about what Mr. Koon told her about what Dr. Berry told him, that he was surprised the DEA hadn't noticed his pain prescriptions. He said it was unfortunate that Brian had slipped through the cracks. And Michelle Koon's testimony that Dr. Berry said that it was unfortunate that Brian slipped through the cracks and somehow the DEA managed to miss that one.

This evidence is all hearsay. Sometimes double hearsay. It is all speculation as to what the DEA or the Missouri Board of Healing Arts might or might not do. It all infers uncharged criminal or unprofessional acts. It is as prejudicial as prejudicial can be.

This evidence was absolute poison. Poison. And if there's any probative value to it, hearsay, double hearsay, speculation, it is so far outweighed by the prejudicial effect of it it ought not to have been

admitted.

And then once plaintiff opened the door to refuse Dr. Walden the opportunity to respond with a letter from the Board of Healing Arts, the only regulatory body that actually looked at the file, that had decided to close the file without taking action, just made this a horribly unfair trial.

I've read the transcript. I believe I understand your thinking at the time, that all that was needed was Dr. Walden needed to state that he had not been disciplined. But that wasn't enough. The argument that he slipped through the cracks implies that there should have been an investigation, and that had there been an investigation he would have been disciplined.

The only way for him to fairly respond to this insinuation is to put the truth before the jury, the piece of paper from the source of the institution that investigated and closed his file, so they could see that hearsay speculation was wrong, he had not slipped between the cracks.

None of this poison should have been admitted. But once it did, Dr. Walden was entitled to fully respond, not kind of respond. What in effect happened was you sent a man with a pocketknife into a gun fight. And no wonder how it came out. Just can't be right.

When you take the opioid epidemic, you add it with all this DEA poison about uncharged criminal or unprofessional acts, it completely distorts what should have happened in this trial.

So, Your Honor, we're asking -- there's just no real probative value to it, it's all prejudice, it's all poison, and, with all due respect, it was all wrong.

We've talked about JNOV, and I think that's right in a number of these circumstances. You also have the alternative of a new trial, to try this case straight up on the evidence that should be in and should not be in and see what the jury does.

I would also remind you that you have the evidence to award a new trial based on the weight of the evidence. And here the weight of the evidence is not so significantly -- or I just can't get around the prejudicial fact of all this poison, and mistrial of the case, and misfocus of the case on facts that weren't at issue regarding the doctor's treatment, regarding SLU, and a massive $15 million punitive damage award against a doctor and a healthcare provider.

And I'm just going to add one more thing. Now there may be a temptation to say let the Court of Appeals straighten this out. But these are really issues that are meant for the trial court to address. So that's what all

of our post-trial rules are about, giving the Court a second chance to reflect on what happened outside the heat of battle, after everybody's pushed and pulled you through trial, and decide whether justice has been done.

And in this case I don't think justice was done. And I would particularly ask you to consider Dr. Walden, who, if he has to wait through appeal, it would be another year or two of his life looking at a $17 million judgment hanging over his head every night.

Thank you for your consideration.

THE COURT: Thank you.

MR. CRONIN: That last basis that was just given, it is not an acceptable or permissible argument to make to the Court. Consider that Dr. Walden has to have a verdict that a jury heard all of the evidence in and assessed the damages as they saw fit, that he's got that hanging over his head. That is not the issue that we're here for today.

THE COURT: I'll give it its proper weight.

MR. CRONIN: Okay. So, Judge, it was pointed out that these are issues for the trial court to decide. I agree. And the trial court did. Multiple times. Over and over again.

And, so, if we were to reverse those rulings that have been argued five, ten, sometimes fifteen times, go

back, reset the case for trial -- which is prejudicial to my clients -- and reverse the rulings and then try it again, changing some of those rulings, we're still going up to the Appellate Court, because then we're going to argue that they were improperly not admitted.

So, I would -- with regards to Dr. Genecin, he did not say -- he did in his depo, he didn't at trial, that Dr. Walden should have been investigated by the DEA or Missouri Board of Healing Arts, because Your Honor wouldn't let him say it.

I believe -- oh, here it is. Nothing specific to Dr. Walden was mentioned. He said the DEA and state licensing boards are the entities charged with protecting patients from prescribing patterns like the one you saw in this case. He didn't say he should have been investigated, he didn't say he slipped through the crack. That didn't come out of Dr. Genecin's mouth, because the Court stopped him, wouldn't let him say it. He did in his depo, not at trial.

Each and every piece of evidence that I think they're arguing was hearsay, complained of by the defendants, is either not hearsay or fits a well-established exception to the hearsay rule.

Brian's and Michelle's testimony about their conversations with Dr. Berry and their pharmacists were

not hearsay, because they were not offered for the truth of the matter asserted. They were offered to show the effect they had on Brian and Michelle, because it woke them up to go to -- that he needed to go to rehab.

And the question was specifically asked that way to make clear that it was not to elicit hearsay for the truth of the matter asserted. That's how I asked it, to make clear that it wasn't for that purpose, so it's not hearsay.

Mr. -- I don't think they addressed that one. The Board of Healing Arts letter.

Judge, with respect to the amount, they keep referencing $15 million. I asked for thirty-seven in punitives. They didn't give me the amount that we thought was appropriate. They read the jury instruction about the proper amount to award based on what was sufficient to punish and deter, and they came up with fifteen, in light of the fact that defendant SLU has a net worth of $1.6 billion.

I would say, Your Honor, that amount probably isn't sufficient to accomplish the purpose, but I'm not up here asking for additur.

As for the Board of Healing Arts letter, Judge -- this is the last topic, I think. I promise. For me.

THE COURT: Okay.

MR. CRONIN: I think this issue is just as bad as the missing records issue, which we haven't talked about here today. It's a letter dated February 17th of 2016. Documents of that nature were requested in discovery at the beginning of the case. They were never produced. Defense counsel is CC'd on the letter that was sent out in February of 2016. They produced it for the first time at 7:08 A.M. on the sixth day of trial.

Plaintiffs have no way of knowing what records were sent to the Board. Presumably, since defense counsel is on the letter, they picked records to send to the Board. I don't know what they decided to send to them. Certainly we didn't get an opportunity to talk to the Board or make sure they saw everything the jury saw in this case. And there's no way for us to find that out on the last day of trial.

And the standard -- I have no idea what the Board standard is for deciding whether to investigate a file, should proceed or be closed, but it certainly is not the same standard that the jury was here to decide in this case.

And offering the letter for its truth, that Dr. Walden was cleared of any wrongdoing, would be both untrue and for an impermissible purpose. They closed their investigation. I don't know why that decision was made.

It's my understanding Dr. Walden is now retired. Maybe that had something to do with why the decision was made.

The Court allowed defendants to ask Dr. Walden on the stand whether he had been investigated and disciplined over plaintiffs' objection. While that line of questioning has been found to constitute absolute reversible error under Schnell V Capital Regional Medical Center, the Court allowed them to do it to address the fact that the DEA was mentioned. And he testified he has not been disciplined by anybody.

So, while they shouldn't have been allowed to do it, they were allowed to do it, and the jury heard. The letter is irrelevant, inadmissible, even on its best day, and was properly excluded, Judge.

MR. VENKER: Your Honor, if I might, just on this one last little piece about the letter.

THE COURT: Hit me.

MR. VENKER: Because I don't believe Judge Price knows about that. The interesting thing about the letter, Judge, is we never intended to use it at the trial because we do think it's a different standard for that administrative body, and we never would have except that the testimony that came in was that supposedly Dr. Walden had slipped through the cracks, that no -- the DEA, nor the Board of Healing Arts, had detected his supposed

wrongdoing.

And, so, I don't think we had a choice but to have the letter -- at least offer the letter. Is it a privileged document. The objections were made during written discovery that it is privilege. We had no intention of using it. We think that the plaintiffs' really opened the door and really gave us no choice but to have that letter come forward. We believe the letter itself does show that the Board -- again, a different standard, but we didn't open that door -- found no wrongdoing by Dr. Walden.

The Court sustained plaintiffs' objection but allowed us to ask Dr. Walden simply the question of whether he's ever been disciplined or contacted by the DEA. And while we appreciate the Court's effort to be fair to us, our problem is the testimony from the plaintiffs' case was that Dr. Walden had slipped through the cracks.

And, so -- more than the implication that no one found out. And, so, for Dr. Walden to simply only be able to say no one has ever contacted me and I've never been disciplined doesn't really help us refute the testimony that the plaintiffs were allowed to offer, which basically meant he got away with something.

And, so, that's what I would offer in response to what Mr. Cronin had to say.

THE COURT: All right.

MR. CRONIN: Could I just briefly, Judge? We never got a privilege law.

THE COURT: You never got what?

MR. CRONIN: We never get a privilege law, which they're required to give to us. We never got a privilege law.

What they talked about, about slipping through DEA, it came out in testimony a year before the trial. It's not something that came out the first time at the trial. It came out a year before the trial at our plaintiffs' depos. At that time they think the door was opened and it potentially could have come in. We certainly should have gotten the letter whenever they received it. Even so it's still inadmissible, it's reversible error to let it in.

THE COURT: All right. Does that go through the points we went through -- you intended to go through today?

MR. PRICE: Yes, sir. Thank you for giving us this time.

THE COURT: Oh, you're welcome. I've got some stuff. All right. I'm -- well, what's the best word for me to use? I would like some supplemental information regarding the Dodson case. I'd like to hear the defendants' interpretation of Dodson and I would like to hear the Plaintiffs' interpretation of Dodson.

And what would be a fair amount of time for you -- for you guys to produce something?

MR. McPHERSON: Seven days, Judge?

MR. CRONIN: Sure.

THE COURT: All right. So in a week can I get a supplemental response just regarding that case law? All right? And its effect on jury instructions specifically. All right?

Anything else by either party?

MR. CRONIN: No, Your Honor.

THE COURT: All right. That concludes the matter on the record. Thank you.

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CERTIFICATE

I, Renee Lynn Bierman, Certified Court Reporter, do hereby certify that I am an official court reporter for the Circuit Court of the City of St. Louis; that on June 20, 21, 22, 23 & 24, 2016, I was present and reported all the proceedings had in the case of BRIAN KOON, ET AL., Plaintiff, vs. HENRY WALDEN, M.D., ET AL., Defendant, Cause No. 1422-CC01258.

I further certify that the foregoing pages contain a true and accurate reproduction of the proceedings.

In compliance with Supreme Court Rule 84.18, I certify that the cost of preparing this transcript is as follows:

/S/Renee Lynn Bierman

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RENEE LYNN BIERMAN, CSR, **CCR #**701

22nd Judicial Circuit - City of St. Louis

State of Missouri

CERTIFICATE

I, Mindie J. Meseke, Registered Professional Reporter and Certified Court Reporter, do hereby certify that I am an official court reporter for the Circuit Court of the City of St. Louis; that on June 21, 23, 27 & 28, 2016, I was present and reported proceedings had in the case of BRIAN KOON, ET AL., Plaintiffs, vs. HENRY WALDEN, M.D., ET AL., Defendants, Cause No. 1422-CC01258-01.

I further certify that the foregoing pages contain a true and accurate reproduction of the proceedings.

/S/ Mindie J. Meseke

MINDIE J. MESEKE, CCR RPR
CCR #403

## CERTIFICATE

I, Alice M. Baker, Certified Court Reporter, do hereby certify that I am an Official Court Reporter for the Circuit Court of the City of St. Louis; that on June 22 and June 27, 2016, I was present and reported the proceedings had in the case of BRIAN KOON, ET AL., Plaintiffs, vs. HENRY WALDEN, M.D.,ET AL., Defendants, Cause No. 1422-CC01258. I further certify that the foregoing pages contain a true and accurate reproduction of the proceedings.

/s/ Alice M. Baker

ALICE M. BAKER, CCR #0361