No._____

IN THE SUPREME COURT OF THE UNITED STATES

ELZA BUDAGOVA.,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

On Petition For A Writ of *Certiorari* To The United States Court of Appeals for the Ninth Circuit

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APPENDIX (VOLUME IV) – PRESENTED SEPARATELY UNDER S. CT. R. 14.1(i)

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someone look at data when they're thinking about developing a new indication for a drug when they want to see what key opinion leaders think about different ideas, they will -- they will develop that's known as an advisory board. And they'll invite people to attend, and there's usually give-and-take for a day or two; they'll present data, things of that nature, and they'll ask your opinion.

Q And how frequently have you consulted with drug companies about prescription drugs for pain medica- -- prescription pain medications?

A Probably -- that's what I'm asked to do most of the time, except for the -- maybe the companies that are involved in major invasive therapies for pain.

Q Have you previously been licensed in any other states besides California to practice medicine?

A Yes.

Q And what other states have you been licensed in?

A Missouri, Georgia, Massachusetts and Pennsylvania.

Q And based on your more than 20 years of practicing pain medicine, have you had the opportunity to speak with other physicians who also specialize in pain medicine?

A Yes.
Q And how frequently do you consult with other physicians in your same specialties?
A Well, quite frequently. Part of the -- the process of sharing knowledge is to go to national meetings, see what other people are thinking. I usually attend several a year to see what colleagues are up to, to find out what's cutting edge, what people are thinking and what potentially is new.
Q You mentioned that you're the head of pain management at UCLA right now; did I get that right?
A Yes.
Q And do you also treat patients?
A Yes.
Q Where do you treat patients, what city?
A In Santa Monica.
Q And how long have you been treating patients in Santa Monica?
A Let me go back. I also am now seeing patients at UCLA proper. So I guess -- so I guess it's in Westwood.
Q So do you see patients at both those locations?
A Just began seeing patients again at UCLA proper, yes.
Q And how frequently do you treat patients in the

specialty of pain management?

A At least four days a week; sometimes five.

Q Have you been previously -- have you previously consulted as an expert?

A Yes, I have.

Q And how many times have you been retained as an expert?

A 50 times perhaps.

Q And what kind of cases have you been retained as an expert?

A They varied from civil to federal court. It could be -- many times it could be as a causation; it can be what the diagnosis is; occasionally, I'll be asked to opine regarding future medical care. I've worked for the U.S. attorney's maybe four or five times in the past over 20 years.

Q And over the past 20 years, what percentage of your time is spent on these expert consultations as opposed to patient care?

A I would say probably less than 5 percent.

Q Less than 5 percent on the expert consulting?

A Correct.

Q And were you retained in this case to review records?

A Yes, I was.

Q Were you paid for your time?
A Yes, I was.
Q And how much are you paid an hour?
A $500 an hour.
Q And do you -- approximately how many hours have you worked on reviewing charts in this case?
A 79 hours.
Q Currently in the field of pain management for you, are you treating chronic pain patients?
A Yes, I am.
Q And how much of your time is treating chronic pain patients?
A I would say 90 to 95 percent of time I'm dealing with chronic pain.
Q Based on your more than 20 years experience, you're consulting with drug companies; you're consulting with your colleagues, your Board certifications and all your other qualifications, are you familiar with the standard of care in pain management?
A Yes, I am.
Q As part of your job in pain management practice, do you prescribe opioids?
A Yes, I do.
Q And are you familiar with the different levels of narcotic controlled substances?

A Yes, I am.
Q How are you familiar with those?
A Very.
Q And how long have you been prescribing controlled substances?
A Over 20 years.
Q Have you received training in the proper prescribing of controlled substances?
A Yes, I have.
Q Where did you receive that training?
A I received it as part of the fellowship for pain medicine during my anesthesiology residency and during my internal medicine residency.
Q And have you ever authored any periodicals or peer reviews involving the proper prescribing of opioids or controlled substances?
A Yes, I have.
Q And how frequently have you done that?
A Um, I've written reviews on the topic; I've written chapters on the topic.
Q Have you provided any faculty or instructional -- I'll withdraw that question -- have you ever instructed other doctors or medical students on how to prescribe controlled substances?
A Oh, yes. Yes.

Q How frequently have you done that?
A Quite frequently, because you at least -- once a month we have two new residents that rotate through. I have five fellows a year. We spend a lot of time going over proper methods of administering opioids to patients.
Q Have you ever been asked to lecture on the subject of controlled substances?
A Yes.
Q And how frequently -- or can you give the jury an example of the type of lectures you've given on controlled substances?
A There are certain societies that I'd like to speak to: The American Society of Regional anesthesia. I've occasionally been asked by the American Society of Pain Medicine, IASP, to give some talks; I've spoken against physician assistant suicide, in favor of better pain medicine and sometimes hospitals will invite me to speak against -- for that.
Q What's the IASP?
A International Association for the Study of Pain.
Q And are you a member of the International Association for the Study of Pain.
A Yes, I am.

Q How long have you been a member of that?
A Probably 20 years or so, maybe more.
Q Have all of your lecture opportunities taken place inside the United States?
A No.
Q And have you ever spoken in other countries about pain management and the prescribing of opioids for pain management?
A Yes, I've spoken in Japan and Korea, Australia, most of Europe and frequently in South America.
Q Based on the training and qualifications that you've just discussed, are the familiar with the standard of care in the medical industry for the proper prescribing of opioid controlled substances?
A Yes, I am.
Q Are you familiar with the idea of prescribing for a legitimate medical purpose?
A Yes.
Q What does that mean?
A Legitimate medical purpose means that there's -- that there's a contract between the patient and the physician; that I'm going to administer a drug after I evaluate you, after I do a physical exam, that is comprehensive; and I come up with an idea and assessment of what's going on. I then will give

informed consent. I will see you back periodically. I will follow the rules and regulations of the particular state that I'm in. I'm going to document things accordingly, and then the patient has an idea that this drug that I am suggesting they take, may actually help them for what the assessment is that they have.

Q Dr. Ferrante, are you allowed to prescribe narcotic controlled substance without a legitimate medical purpose?

A No, that would be diversion.

Q What is "diversion"?

A Well, "diversion" is when a doctor -- or when a doctor or another healthcare professional knowingly and with full cognition, deviates as you said, from legitimate medical purposes -- in other words, there has been a breach of the standard of care, and that breach is -- is -- is known. That physician or other healthcare professional openly does that. In other words, legitimate medical care is abandoned, and there's another motivation besides properly helping someone or giving them something that is going to make them better, and other motivations are there, usually profit.

MS. MORTON-OWENS: Your Honor, at this time, the United States tenders Dr. Michael Ferrante as an expert in pain management and the proper prescribing of

opioid controlled substances for pain management.

MR. SHERMAN: Your Honor, could we have a short sidebar for a moment?

THE COURT: Yes.

(Sidebar.)

MR. SHERMAN: I don't have any objection to his expertise, but I do object to his testimony. There are no doctors in trial on this case. Whatever opinions he may give about whether doctors in this case did or did not follow, except with medical practice, is not the issue in this case. And since there's no doctors, what is the point of his testimony?

THE COURT: Everything I've heard him say relates to civil cases. The standard of practice relates to negligence in a civil case. I'm not sure what the relevance is in this case.

MS. MORTON-OWENS: Your Honor, the -- under -- under law, one of the elements that the -- one of the elements that the United States must prove is that these OxyContin prescriptions were issued without legitimate medical purpose outside the standard of practice of medical care. That is -- we have to demonstrate the -- what is the medical standard of care. That's what we're required to do. That's with every --

THE COURT: It's not a crime if you act

MS. MORTON-OWENS: Okay.

MR. CANTALUPO: Thank you, Your Honor.

(Sidebar concluded.)

THE COURT: You may step down, doctor.

Sometimes to save time, we try to make sure everybody is not strained beyond something that they're here to talk about. So this will just take a second. No one is trying to tell them what to say or anything else, but sometimes certain topics are just not relevant and just essentially to save time -- we're just saving a little bit of time right now.

(Pause in the proceedings.)

THE COURT: Okay. That didn't take very long.

Thank you.

So you can resume your testimony of Dr. Ferrante and just to be clear: Dr. Ferrante is a medical doctor. His testimony is not being offered by the Government against any of the -- if I can refer to them as the pharmacy defendants; is that correct?

MS. MORTON-OWENS: Correct. This testimony is being offered against defendants Budagova and Garrison.

THE COURT: Okay. So just to help the jury sort of keep track of relevance. You may proceed, or I should say possible relevance.

MS. MORTON-OWENS: Yes, Your Honor. And just

so the record is clear, the United States has tendered Dr. Michael Ferrante as an expert in pain management, as well as the prescribing of opioid controlled substances to treat pain management.

THE COURT: I've heard no objection. So you may proceed.

BY MS. MORTON-OWENS:

Q Dr. Ferrante, what is an opioid?

A An opioid is a class of drug that binds to a particular receptor in your central nervous system. It has morphine-like properties. Most of them are derived from the molecule morphine. And it causes pain relief.

Q And is -- are opioids used to treat chronic pain patients?

A Yes, they are.

Q Are there different types of opioid drugs?

A Yes, there are.

Q And are you familiar with the drug OxyContin?

A Yes, I am.

Q What is OxyContin?

A OxyContin is derived from -- or Oxycodone is derived from taking the morphine molecule and moving it around a little bit, and it is a long acting preparation.

Q What do you mean by long-acting preparation?

A Well, it is used either every eight hours or every 12 hours.

Q Are opioid drugs used to treat certain -- well, I should back up. Are there different types of pain?

A Yes, there are.

Q And what types of pain are there?

A There are -- there's basically two types of pain certain people will -- will basically throw headache in as a different type of pain. It has combinations of the two. So I don't separate them.

Um, there is what's referred to as no susceptive pain and no susceptive pain and no susceptive pain is the type of pain that comes from muscles. It comes from joints. It comes from your skin. It is mediated by a number of chemicals in your body. You can actually trace nerves that go from the peripheral all the way up into the brain. Different types of pain is neuropathic pain. Neuropathic pain, there are really no nerves that, you know, you can point and say, uh-huh, this is carrying this from here to here. It -- neuropathic pain really is where you have a nerve that is damaged; then you have about nine different reasons why that nerve can cause pain, but there are two big groups. There's no susceptive. There is neuropathic now. There's a sub-group of no susceptive, and it's

broken into somatic which is the joints, the muscles, the skin and the visceral which means, you know, from internal organs, such as your stomach, your pancreas, things of that nature.

Q So just so that the jury understands, there's different kinds of pain?

A I beg your pardon?

Q There's different kinds of pain?

A Yes, there are.

Q And is OxyContin used to treat all kinds of pain?

A It -- it can be.

Q What about opioid drugs in -- in general? Are there certain types of pain that it's more effective to use an opioid drug than another drug?

A Yes, it is. It is -- opioids are less effective in neuropathic pain. They're also less used in people with headache on a chronic basis.

Q What are the effects on the human body when somebody takes OxyContin?

A Um, the opioids have a number of -- of effects which are good and bad. The main reason for using opioid would be to give someone pain relief. There are a number of other effects, respiratory depression, because it affects certain areas of the brain and

reduces -- reduces your ability to breathe properly. There is constipation. There is mental clouding. If you take enough of the drug, you can get high -- euphoria. There is biliary spasm. There's a whole host of nausea, vomiting. There's a whole host of different other effects.

Q Is there a standard of care for conducting a patient evaluation for somebody who is seeking pain management treatment?

A Yes, there is.

Q And what is that standard?

A The patient really needs to be evaluated, such that a history is taken that's fairly comprehensive and that a physical exam is done. The physical exam needs to really embrace whatever the patient's problem is. So if they come in with a neurologic problem, you focus on the neurologic problem. If they're -- um, you may ask about other things, to get a better idea of a patient in a broad range. The physical exam, similarly, can either be general or it can be focused or it can be a combination of both. From that, and in review of laboratories that may be provided or that you obtain, consultations with the doctor that you may have been provided or would obtain, you basically come up with -- I think the patient has X, Y or Z, called an assessment

and then you develop a plan. And if the plan has opioids involved, you then go over with the individual what that -- you know, what are the good points of opioids and what are the bad points of opioids.

Q And when a patient comes in for the first time, is that when you conduct the evaluation?

A Yes.

Q And in pain management, what's the -- the ultimate goal of treating the patient?

MR. CANTALUPO: Your Honor, I object; relevance -- this whole line of questioning; move to strike.

THE COURT: Overruled.

THE WITNESS: Repeat the question, please.

BY MS. MORTON-OWENS:

Q Yeah. In pain management, is the goal just to treat the pain or are you trying to treat what's causing the pain?

A Well, it can be both. Obviously, if you can figure out what is causing the pain, you treat the -- the ultimate source and the pain will either diminish or go away. So what you want to do is come up with differential diagnosis and try to attack the problem and its source. And, you know, you may decide that the individual is warranted because t of the severity of the

pain, that they obtain some pain relief. And you may decide that nothing could be done about it. So, therefore, you try everything you can before you put somebody on an opioid, and then what you do is -- if they fail everything, then you put them on an opioid.

Q I'm going to talk to you more about the opioid in a minute. I'm going to talk to you about the documentation that is required when you see a patient. What is that standard? What do you have to document?

A There are a number of things that you have to document. You have to document that you, in fact, did an evaluation and that there is, you know, a history that's obtained, the physical examination, the assessment and the plan. The -- you want to date your notes. You want to sign your notes, you want to make sure you comply with local regulations or the individual state regulation. The -- the -- you want to write the opioids in a manner that is common jargon for an individual to obtain, so someone -- another physician could see it, and they would know what you were prescribing.

Q Is a patient chart a legal document?

A Yes, it is.

Q And is it acceptable to just take an oral history and not document anything?

A No, it's not.
Q Initial consultations for somebody seeking pain management treatment, that's the standard of care for approximately how long those evaluations should be?
A Well, in -- usually pain patients are complex. And because of this, I would say probably you -- maybe a half hour would be about the average for a new patient.
Q And what about obtaining medical records if the patient is seeing another physician?
A That would be part of the process because if -- particularly, for opioids while we want to believe our patients, sometimes you want verification that they're actually receiving what they say they're receiving.
Q And so in those circumstances, do you obtain the records from any other physicians that might be treating the patient?
A Yes, we do.
Q When somebody is -- is being treated for pain management, are they usually being treated by other physicians, as well?
A Um, they may be treated by a host of physicians, except for the provision of the opioid. Only one individual should be writing for that opioid. It -- it -- it really prevents, you know, problems such as diversion; people being -- getting too much drug,

things of that nature.

Q Is a doctor allowed to pre-sign a prescription?

A Never.

Q Are people allowed to write on pre-signed prescriptions?

A No.

Q If a pre-signed -- if there is a pre-signed prescription, is that a legitimate prescription?

A No, it is not.

Q In connection with this case, were you asked to -- were you asked to review patient records?

A Yes, I was.

Q And approximately how many patient records were you asked to review in this case?

A About a hundred to 150.

Q Were you also asked to review a videotape?

A Yes, I was.

Q And have you been asked recently to look at specific exhibits in this case?

A Yes, I have.

Q In reviewing the medical charts, did you identify breaches in the standard of care such that prescriptions were written for no legitimate medical purpose?

A Yes, I did.

Q Can you briefly describe just some of the indications there were that these prescriptions for OxyContin were written with no legitimate medical purpose?

A You mean for me to describe the breaches?

Q Yes, sir.

A Okay. Got it. Number one, the -- we've spent a lot of time about evaluation. I -- many times a patient wasn't -- wasn't evaluated. Many times there were clinical vignettes which you could go from chart to chart to chart and see the same clinical vignette there with some very, very, very minor modification. There --

Q Let me interrupt you there. What do you mean by a vignette?

A A little clinical history that would be repeated time and time again.

Q You mean like it was almost identical from chart to chart to chart?

A Almost identical.

Q Regardless of the patient's age?

A Yes, there were four of them. There was a cervical individual -- an individual who had usually neck pain and arm pain. There was an individual who had low back pain and leg pain; there was an individual who had a flue-like syndrome, and there was another clinical

vignette, who had peripheral vascular disease.

Q And these are just repeated over and over again in the approximately 100 to 150 charts you reviewed?

A Correct.

Shall I continue?

Q Yes, sir, continue.

A Yeah. There has to be, you know, a -- an evaluation that concludes a medical exam. A treatment plan has to be -- has to be done. This is a doctor -- or individual has to think about all they found and then come up with an idea, Well, the patient has this. And because the patient has this, I -- in assessment, we are going to then give them or do for them or suggest they get X, Y and Z.

A lot of types in the charts, that didn't occur. People were just given OxyContin, 80 milligrams, three times a day over and over and over and over again. No physician does that. No physician does that.

Q Are you familiar with the idea -- oh, I'm sorry. Continue, Doctor.

A The -- the -- there's, obviously, informed consent. Many times the patient would have signed informed consent, but there was no counter-signature by a healthcare provider, suggesting that there had actually been a conversation between the healthcare

provider and the patient. Just to sign a piece of paper is a piece of paper. It's not the process of informed consent. Informed consent is wherein, you know, I give you the risks, the benefits, the alternatives. You then as the patient make an informed decision, and we decide together whether or not, you know, you wish to proceed along this line because of the risk benefit ratio.

There is, um, periodic review. I see you back again. I don't just give you a drug and then basically a lapse of time goes away, and then I give you that drug again. If I'm going to give you OxyContin, 80 milligrams three times a day, I want periodic review. I want a treatment option -- a treatment plan that says you're going to -- you're going to do this, and you're going to get better and I'm going to measure it this way, and you don't just give somebody repetitive -- repetitive dosing.

The other things that I saw is that there was -- that basically a -- people were being given prescriptions without documentation of a visit. So I can't say whether that individual was seen on that day and was evaluated and -- and the process repeated. There also appeared to be a segregation of the charts, so that if there was a pink-colored chart, that means the patient didn't really have insurance and that

patient was treated differently from other people; so that they would only get a prescription for OxyContin, but they wouldn't get anything else. That -- that's not done. It's just you treat people all the same. That's the standard of care.

You then -- medical necessity: Many times, medical necessity for administering the OxyContin was not apparent; was not recorded. The patient was just given the OxyContin, but you couldn't -- as I said before, you know, everybody got 80 milligrams of OxyContin three times a day. Well, why? And many times that wasn't there.

Q Are you familiar with the idea of "titration"?

A Yes.

Q What is titration?

A "Titration" is a process wherein you start at a low dose and you see what the patient needs in order for them to get better. What titration does is it keeps the patient on the lowest dose because, remember, addiction and respiratory depression occur with these drugs. So you want to try and limit those, while still giving the patient the benefit of the reason why you're prescribing them. So the titration is basically you start at the lowest potency drug -- at the lowest dose possible, and then you escalate. You have the patient come back; you

see how much they've used; you is see how much they haven't used. And if the you think it's applicable to go to a higher dose, you do.

Q And when you're discussing the idea of titrating, would it be fair to say titrating up; is that how you say it?

A Titration up. You can use the terminology titration down, but most of the time, it's upward.

Q If you were deciding to titrate somebody up, all the way to OxyContin, 80 milligrams, what are the lower dosage of opioids or other pain meds that lead you up to OxyContin, 80 milligrams?

A Well, OxyContin, 80 milligrams is a dose that right out of the bat, you use for major trauma of cancer pain. You would -- if a patient comes to you, de novo, i.e., the first time you really got to sit and think very, very hard before you want to start an individual on that.

There are a number of -- of other drugs. There is something that are called Class II's -- or Scheduled III's. These are drugs that can be refilled. These are drugs that you can give call-in. These are drugs that you can fax in. Examples of these would be -- would be a lower tab into basically October the 6th and Tylenol number three, a number of agents such as this. These

are agents that we would use for low -- for mild pain problems. Tramadol is another good example; that's called a Schedule V. You then see if the patient could be controlled on these. You add in a long-acting if you think the individual doesn't have episodic pain -- continuous pain. In that situation, an individual would need a drug that gives you a more consistent blood level. And these drugs are usually referred to as countenance, short for continuous. There's a morphine Contin; there's an OxyContin. Methadone is an example of a drug that can be used for such. Dilaudid is usually a short acting drug, though, it's classed among the Schedule II's, but they do have long-acting Dilaudid's.

THE COURT: We're at 3:00.

MS. MORTON-OWENS: Yes, Your Honor. That's fine.

THE COURT: Is this -- okay. Thank you, ladies and gentlemen. I'm going to read you an instruction. I'm going to see you Tuesday, at 9:00 a.m.

And this is our first recess instruction: We are about to take our first break during the trial. And I want to remind you of the instruction I gave you earlier. Until the trial is over, you are not to discuss this case with anyone, including your fellow

we were all working. And so I just -- I want to thank you and just explain that to you.

So you may go ahead then, Ms. Morton-Owens.

THE CLERK: With the Court's permission...

To the witness, you have been previously sworn. You are still oath.

GOVERNMENT'S WITNESS, FRANCIS FERANTE, PREVIOUSLY SWORN.

THE WITNESS: Yes, I understand it.

THE CLERK: Restate your full name for the record.

THE WITNESS: Francis Michael Ferante.

MS. MORTON-OWENS: May I proceed?

THE COURT: Yes.

REDIRECT EXAMINATION

BY MS. MORTON-OWENS:

Q Just to orient the jury, where we last left off, you had mentioned that you reviewed about 150 charts in this case; did I get that right?

A 100 to 150, yes.

Q And in reviewing those charts, did you find evidence or indication that the prescriptions for OxyContin were not written for a legitimate medical purpose?

A Yes.

Q I want to go through a few of those examples -- but before I do that, you said that you've been treating pain in a pain management setting for about 25 years; is that right?

A 20 years.

Q 20 years. And based on what you've seen in your practice and in the industry practice, how often does OxyContin, 80 milligrams get prescribed?

MS. PODBERESKY: Objection; relevance.

THE COURT: Overruled.

THE WITNESS: Very rarely. I maybe prescribed it twice annually.

BY MS. MORTON-OWENS:

Q If I were to tell you that approximately 90 percent of all prescriptions coming from a specific physician were for OxyContin, 80 milligrams, would that indicate no legitimate medical purpose for the prescriptions?

MS. PODBERESKY: Relevance; goes to the issue for --

THE COURT: It's an incomplete hypothetical, but he can answer it.

THE WITNESS: Yes.

BY MS. MORTON-OWENS:

Q I want to go through a few of the charts that -- that you reviewed, in fact. And I apologize one second.

MS. MORTON-OWENS: Your Honor, if I could have just one moment with Defense counsel; I apologize.

(Counsel confer.)

MS. MORTON-OWENS: Your Honor, based on an

agreement with the Defense we're going to conditionally admit Government's Exhibit 329, Mr. Clerk 329...

THE COURT: Very well.

(Whereupon Government's Exhibit 329 is admitted hereto.)

BY MS. MORTON-OWENS:

Q If you could pull up Government's Exhibit 329...

And this is a medical chart for Kerri Ford. Did I get that right?

A Yes.

Q And is this one of the medical charts that you reviewed in forming your opinion regarding the medical necessity of these prescriptions?

A Yes.

Q I believe you mentioned before that it would be highly unusual to prescribe OxyContin on a first visit. Did I get that right?

A Correct.

Q And why is that?

A Because it's not -- number one, it's not a first line drug of choice. Number two, it completely avoids the process of titration. Number three, it can have harmful effects on an individual who is has not received opioids before, such as respiratory depression and depth.

Q Now, in reviewing this chart -- and, Dr. Ferante, I'm going to have you first look at page 81 which would appear on

the screen...

Do you see this prescription for OxyContin?

A Yes, I do.

Q And the date of the prescription is for May 12 of 2009; is that right?

A Correct.

Q Did you find corresponding notes to go along with the prescribing of this prescription for OxyContin?

I believe it would be on page 41 and 43. We could put them on the screen.

And if you could blow that up as well.

A That is dated on 05/12/09.

Q Based on your review, does this appear to be a visit note, corresponding with the prescription for OxyContin?

A Yes, it does.

Q And were you informed that this is the handwriting of David Garrison?

A Yes, I was.

Q And in reviewing this, do you see any justification listed for a prescribing OxyContin, 80 milligrams for a legitimate medical purpose?

A No, I do not.

Q If you could turn to -- do you see any indication on either that page or the other page -- the following page, indicating that the patient had already been taking

OxyContin, 80 milligrams or OxyContin at all?

A No, I do not.

Q Can you look at Government's Exhibit page 78 and 77. If you can put them side by side...

And Dr. Ferante, what is listed on the -- I believe the left side of your screen?

A Yes, ma'am.

This is what appears to be a urine tox screen.

Q And are those the results for the urine tox screen?

A Can will you blow them up, please.

Q Yes, sir.

Does that show that, in fact, the person -- this Kerri Ford was actually not taking OxyContin at all.

A It's correct. The individual had no OxyContin in their blood stream -- Oxycodone, excuse me.

Q So someone tested the -- the patient potentially, and it was -- the results were never taking OxyContin before?

A There was --

Q I'm sorry. I'll withdraw that question. They at least weren't taking it at the time?

A That is correct.

Q And if you could turn to page 80...

And blow that up.

Is it -- is that also what you were informed was the handwriting of David Garrison?

A Yes, ma'am.

Q And is that a prescription again for OxyContin from June 11th of 2009?

A That is correct.

Q Can you look back at page 77, the negative OxyContin blood test and blow up the date of receipt.

This report was received in May of 2009; did I get that right?

A Yes.

Q And then another prescription for OxyContin, 80 milligrams was issued to the same patient after these results were received?

A Yes.

Q Based on your training and experience, what would happen if somebody actually took OxyContin, 80 milligrams without having it in their blood stream or any titration to that drug?

A They would stop breathing. If they were resuscitated in time, they may have brain damage or they'd die.

Q Do you see any indication of notes corresponding to even a visit for the June 11th, 2009, prescription for OxyContin?

A No, I do not.

Q Dr. Ferante, based on your training and experience, if an individual patient were to actually fail a drug test, what does the standard of care say about what a doctor or a

physician's assistant is supposed to do in that circumstance, if they learn their patient isn't actually taking the drugs?

A At this point, what we would do is we would sit down with the patient and politely confront them with the results of the tests. At this point, I would let them know that if they had not been taking the medication than wherein the medication had been going, I would have a high suspicion for diversion. I would also at this time, say that I'm going to continue to treat you, but I'm not going to be furnishing any opioids of any kind to you, and I will provide you with -- you know, with addiction specialists, rehab specialists, if you so desire; but you're not going to get any opioids from me again.

Q So is there any medical purpose to issue another prescription for OxyContin once you receive these negative drug tests?

A None whatsoever.

MS. MORTON-OWENS: If you can pull that one down.

BY MS. MORTON-OWENS:

Q How, if at all, does age of the patient, play into whether or not OxyContin, 80 milligrams should by prescribed to a patient?

A When an individual gets older, they become more susceptible to the effects of opioids. So a dose that in a 30-year-old might have one effect, it would be amplified in

an individual who was elderly.

Q And when you were reviewing the medical charts from Lake Medical Group, did you see circumstances where much older people were receiving prescriptions for OxyContin?

A That is correct.

MS. MORTON-OWENS: Can you show up -- Government's Exhibit 307 conditionally admitted without objection?

THE COURT: Very well.

(Whereupon Government's Exhibit 307 is admitted hereto.)

BY MS. MORTON-OWENS:

Q And this is a patient chart for Ms. Kirakosian (phonetic) -- is this one of the charts you reviewed in forming your opinions today?

A Yes, it is.

MS. MORTON-OWENS: If I can have page 20 put up on the screen, please...

BY MS. MORTON-OWENS:

Q Is this a prescription for OxyContin from -- I'm going to have to look at the screen -- May of 2010?

A Yes, it is.

Q And were informed that, in fact, this is the handwriting at least of the OxyContin for Elza Budagova?

MR. CANTALUPO: Objection; relevance.

THE COURT: "I want you to assume for purposes of this question," you can ask it that way.

MS. MORTON-OWENS: Yes, Your Honor.

BY MS. MORTON-OWENS:

Q Assuming for the purposes of this question, that that is the handwriting of Elza Budagova and David Garrison. Based on your review of the chart, how old was this patient?

A 77.

Q And in reviewing the chart for Ms. Kirakosian, did you see any medical necessity or legitimate purpose for the prescribing of OxyContin?

A No, I did not.

MS. MORTON-OWENS: If you could turn to Government's Exhibit 365.

Mr. Clerk, again, conditionally admitted.

THE COURT: Very well.

(Whereupon Government's Exhibit 365 is admitted hereto.)

BY MS. MORTON-OWENS:

Q Is this a chart for Tahesian (phonetic) -- I mean, is this a chart that you reviewed in forming your opinion today?

A Yes, I did.

MS. MORTON-OWENS: Can you pull up page 39...

If you can back out for one second.

BY MS. MORTON-OWENS: Did you see a -- a cosign, meaning, a doctor signing off on this medical note?

A There is no co-signature.

Q And for the one that we looked at for Kerri Ford, that

we'll assume is David Garrison's handwriting, did you see a doctor's signature there?

A No, I did not.

Q Is that appropriate?

A No.

Q Why not?

A The -- in order to have the ability to sign a form, the -- and to administer a narcotic, the physician's assistant has to get a cosign. If they have not -- if they are licensed, they do not have to get the cosign, if they've taken a particular test. If they are unlicensed, they can't be writing narcotics in one way or form or evaluating patients, despite any designation of -- of signatures of -- of services.

The other thing is, just in simple terms, we don't know who authored this. We don't know because there is no signature. What -- what is really going on here -- and it sort of invalidates whatever is said.

Q So when a -- a doctor or a physician is completing the medical chart, are they required to sign the charts?

A Yes.

Q And if somebody hypothetically is using another person as a translator, is that supposed to be noted in the chart as well?

A Yes, it is.

Q Did you see any notation in any of the charts you reviewed that someone was using a third individual as a translator?

A No.

Q Turning now to Government's Exhibit 365 and this page -- this is a notation. Do you see any support for the conclusion that OxyContin was medically necessary?

A Could we blow that up, please.

Thank you.

No, there is none.

Q Now, it says, I believe -- and it says patient -- or "PT needs OxyContin, 80 milligrams." Is that a legitimate justification to prescribe OxyContin, 80 milligrams?

A No, it is not.

Q Why not?

A The patient doesn't have number one, a really good history or physical exam here. The patient does not have any testing to see whether or not -- we don't even have a pain score to know how the severity of the pain was, even though it says "severe low back pain."

You can't really just provide OxyContin at a very dose, just sort of willy-nilly out of the air. You really need medical necessity for it. This could have been handled with perhaps physical therapy, with perhaps anti-inflammatories, with perhaps muscle relaxants, with

perhaps other kinds of mild narcotics. It's a leap of faith to think that OxyContin would be appropriate.

Q What if the patient says, "I really need it"?

A That doesn't matter. If they're opioid naive and they say they really need it, they could turn dead.

MS. MORTON-OWENS: Turn to page 63...

And if you can blow up the note...

BY MS. MORTON-OWENS:

Q Is this a prescription for OxyContin, 80 milligrams, 90 pills, purportedly in the handwriting of Elza Budagova, for the purposes of your testimony today?

THE COURT: What's -- the objection is -- you said the "purportedly"?

Is that the issue?

MR. CANTALUPO: Yes.

MS. MORTON-OWENS I'll rephrase.

THE COURT: Thank you.

BY MS. MORTON-OWENS:

Q For purposes of your testimony today, were you informed that this could be the handwriting of Elza Budagova -- for the purpose of your testimony?

MR. CANTALUPO: Objection; foundation.

THE COURT: Just assume, subject to proof later.

MS. MORTON-OWENS: Sorry, Your Honor.

Subject to proof later, you assume this is the

handwriting of Elza Budagova?

THE WITNESS: Yes.

BY MS. MORTON-OWENS:

Q And what about there where it says "DX," do you know what that says next to it?

A Could we blow that up, please.

Part of it says "the degenerative joint disease." The other first three letters, I do not know. On -- it looks like radiculitis below or something that looks like Chlorinin H/S but -- it looks like from what I can make out here -- excuse me. It's "osteoarthritis/degenerative joint disease." Don't know what the next word means; don't know what the next characters mean; radiculitis."

Q And what type of regularity did you see essentially the same diagnoses for each one of these patients in the medical charts that you reviewed maybe three or four different diagnoses?

A Quite frequently. As I said previously, there were four clinical vignettes that were repeated; one of them was radiculitis in a low back pain. The other one was in the cervical. Another one was -- was cough flu-like syndromes; another one was -- which one didn't I mention? Peripheral vascular disease, and then there was a significant number which were osteoarthritis and degenerative joint disease.

Q And in your patient population, do you only have four

different types of patients?

A No, ma'am.

Q Why not?

A I guess I'm lucky.

Q Do patients typically present with identical diagnoses?

A No, they don't. Everyone is different.

Q What about everyone saying that they had the same level of pain?

A Um, that's impossible because people will have different levels of pain, depending upon the diagnosis, the natural history, where in the natural history they exist. People have different tolerances to pain.

Q When an individual is placed on an opioid narcotic, what is the requirement for a physician or a physician's assistant to document the effects -- in other words, in a follow-up, to document how that drug is or is not working?

A Well, there's the -- as I also mentioned on Friday, you have something that is called "periodic review" wherein you invite the patient back, so that you -- what you outline in your treatment plan which is in all your notes, basically you said objectives so you can see whether or not the patient meets objectives and you can document whether they have not met there, and then you figure out reasons why they may have not met there. And if appropriate, you raise the dose or you lower the dose.

Q Did you see any evidence in the approximately 100 to 150 charts that you reviewed of any periodic review?

A Um, occasionally there was.

Q How frequently?

A Infrequent.

Q Do you see any notation of periodic review in the handwriting that you'll assume for today's testimony as Elza Budagova's?

A No.

MS MORTON-OWENS: Turn to Government's Exhibit 438, which I believe is conditionally admitted, subject to agent recall.

THE COURT: Very well.

(Whereupon Government's Exhibit 438 is admitted hereto.)

BY MS. MORTON-OWENS:

Q Is this another chart that you reviewed in forming your opinions today?

A Yes.

BY MS. MORTON-OWENS:

Q If could you turn to page 17 -- I apologize, page 19...

If you look side by side at Government's Exhibit -- at page 17 and page 19...

Do these purport to be visit notes for the patient, dated in approximately July 2010?

A Correct.

Q And did you see any justification for the medical necessity for OxyContin in the patient chart of Xanamaro (phonetic) Government's Exhibit 438?

A No, I did not.

Q Turn to page 41.

And is this another prescription for OxyContin, 80 milligrams, 90 pills in what you'll assume for today's testimony, is Elza Budagova's handwriting signed by David Garrison?

A Yes.

Q In looking at the two pages, Government's Exhibit 17 and 19, is this an example of how there was no periodic review -- no attempt to even check on whether or not the drugs were working?

A Could we put those two exhibits back up, please.

The -- they occur sequentially. I see no evidence within the record that there was an attempt in the original treatment plan an assessment of 071310 to actually meet objectives which in the individual could then be reassessed, even though the second piece of paper on the right is a month later. It -- there really once again is no attempt to say, Well, did it work? Did it not work? Is she getting better? Do we need to put in consultants? No thought process here; no assessment.

Q Was there any indication that this patient had been

taking prior pain medications that would allow for a patient to safely take OxyContin, 80 milligrams?

A No.

MS. MORTON-OWENS: Turn to Government's Exhibit 271.

Mr. Clerk, it's already in evidence...

BY MS. MORTON-OWENS:

Q Is this a patient file for a Dominique Abed? Was this another one of the charts that you reviewed in forming your opinions today?

A Yes, ma'am.

Q Take a second -- is this patient approximately 22 to 23 years old when the prescriptions for OxyContin were written?

A That's correct.

Q And in reviewing the chart for Ms. Abed, did you see any evidence of the medical necessity or legitimate medical purpose for the OxyContin that was prescribed in her name?

A No, ma'am.

Q In somebody who is in their early 20's, what would you expect to see in order for them -- in order for the medical necessity of OxyContin, 80 milligrams to be prescribed?

A Usually trauma. Maybe a little unfortunate individual who has cancer for one reason.

Q And in that circumstance, would you expect to see some

objective documentation of trauma?

A Yes, ma'am.

Q And what is objective documentation of trauma?

A Has a fracture, major bleed, abdominal trauma. It would be pretty well documented what was going on.

Q What about like from an X ray?

A An X ray for a broken bone would work, yes.

Q In the approximately 100 or so charts that you reviewed, did you see any evidence of X rays?

A No.

Q What about MRI's?

A One out of a hundred 50.

Q And turn to go Government's Exhibit 219 again. Mr. Clerk, again 219 conditionally admitted and is the chart of Mher Derderian another chart you reviewed in forming your opinions today?

A It's correct.

Q Is Mr. Derderian approximately 20 years old?

A That is correct.

Q Turn to page 12 of that chart and blow that up... assuming for today that this is David Garrison's handwriting, did you see any legitimate medical purpose to prescribe this 20-year old OxyContin, 80 milligrams?

A No.

Q Now, in this circumstance, there appears to be a

signature on this page; is that right?

A Yes.

Q If the OxyContin is not for a legitimate medical purpose, does it matter who signs the chart?

A No.

Q Did you find circumstances -- you can pull that down now. Did you find circumstances where you found prescriptions for OxyContin in these charts but no documentation that a patient was even at the clinic?

A That is correct.

Q And how frequently did you find that?

A Quite frequently.

Q And turn again to -- back to Government's Exhibit 271, that's Dominique Abed's chart...

And it will be on there. And I don't know if we can put them up at the same time but page 14...

A Could we put it up because I don't have Ms. Abed's chart anymore.

Q Page 14?

A If we could put it up here.

Q Page 14, and page two...

In this circumstance there were three prescriptions for OxyContin for this approximately 22-year old; is that right?

A That is correct.

Q And did you see visit notes -- you'll have to have the agent hand back Government's Exhibit 271. Looking at these prescriptions, all three of them together, one dated November 20th, of 2008; one dated July 27th of 2009 and one dated September 18th of 2009, is there an issue with having gaps in therapy, Dr. Ferante?

A Absolutely.

Q What is a gap in therapy?

A Gap in therapy is where there is no periodic review. In other words, the individual just comes back, sort of out of the blue and you've provided them with the same drug.

Q What's the problem with just -- every time someone comes in whenever they come in, just handing them a bottle of OxyContin?

A Well, you could kill them, number one. It causes respiratory depression. It opens you up to diversion. They're coming in; you haven't followed them. You've giving a potent opioid. And the fact that they're coming in sporadically gives one the idea that the drugs are being used for something -- it's not a legitimate medical purpose, i.e., diversion.

Q In reviewing these charts, did you see notations of drug tests that weren't like the pack panel we showed just a moment ago -- just handwritten drug tests?

A Yes, I did.

Q Is that unusual?
A Very.
Q Why?
A Because that can be forged. And what you want is, you want a drug test that comes from a -- an established accredited laboratory, so that you know that the results are valid what they say they are.
Q And if you could turn at Government's Exhibit 319...
MS. MORTON-OWENS: Mr. Clerk, 319 again is conditionally admitted.
THE COURT: Very well.
(Whereupon Government's Exhibit 319 is admitted hereto.)
BY MS. MORTON-OWENS:
Q And page 221 of 319...
And looking at the top prescription there, dated August of 2008. Is that what you see?
A I'm not sure what the final letters are -- numeral. It could be an eight; it could be a nine. I don't know. It says 818 I'm sure of that -- and then I'm not sure what it says afterward.
Q Did you see any medical necessity in this chart for prescribing OxyContin, 80 milligrams for Mr. Griffith or Rupachild (phonetic)?
A Yeah. No, I saw none.
Q And if you can take that down.

In reviewing the approximately a hundred or so medical charts that you reviewed, did you see examples of OxyContin being prescribed too soon -- and I apologize. I'll back up.

A Oh, yes.

Q A moment ago, you talked about the gaps in therapy are a problem. You can't prescribe OxyContin and then wait and then prescribe it again.

What about when it was prescribed and then two immediately prescribed again?

A Yeah. It calls into question the possibility of diversion when an individual returns for a prescription, you know, sooner than one month. Usually we want them to come back close to when the prescription is going to run out, so that we can basically evaluate them and then go ahead and write them another prescription.

Q What if somebody loses their prescription?

A The -- obviously, that can occur. And it is the repetitive nature by which that would occur. People can have these things stolen. We ask for a police, you know, record file; -- some documentation from an authority that these effects did occur. Obviously, if this repeats, it calls into the question the possibility of diversion.

Q And, Dr. Ferante, would you need to note in the chart if that were happening?

A Yes.
Q What about if somebody says they lost their bottle of OxyContin, do you need to note that?
A Yes, it may happen; but you'd note it.
Q Can you -- are there any circumstances in which you could think of that you would not note something in the medical chart -- that the doctor wouldn't note what the patient is telling them?
A No, ma'am.
Q Why not?
A Because the purpose of documentation is so that I have a record or another physician coming behind me has a record of what has occurred with this patient.

So if I also, you know, want the ability that if an individual repetitively loses, repetitively says they're stalling, I then to have a high end of suspicion that these drugs are being used for not a legitimate medical purpose, so then I can go back and say, Well, on such and such a date you did this and such and such a date, you did this; therefore, I have a high suspicion. And I can't write opioids for you anymore.

Q You mentioned on Friday that part of the -- the process of the initial evaluation is obtaining the medical records from the patient's other treating physicians. Did I get that right?

A Correct.
Q What if you can't obtain those records?
A Then you can't obtain them.
Q Have you encountered circumstances where you're for some reason unable to obtain the records?
A Yes.
Q Is that for all your patients?
A No.
Q For most of your patients, are you able to obtain those records?
A Yes.
Q If you could turn up from Government's Exhibit 319 which is now conditionally admitted, pages 225 and 224...

Are these examples of prescriptions, one dated 06/30 of 2009 and one dated 07/03 of 2009?

A That is correct.
Q And if I ask you to assume for the purposes of today's testimony that this was Elza Budagova's handwriting --
A Yes.
Q -- absent a notation that something had happened to the patient's medications, is there any legitimate medical purpose to prescribe OxyContin, 80 milligrams three times a day, 90 pills, less than four days apart?
A No.
Q Are there any specific dangers with prescribing

OxyContin and psych meds?

A Yes.

Q What are those?

A An individual who is taking psychiatric medication may have an ability to kill themselves by suicide. And, obviously, you would want, if you were going to consider instituting opioid therapy on an individual such you'd want to co-manage the individual with a psychiatrist. And you'd certainly want to limit the dose of medication because such an individual might go home and might take handful and pass away.

Q Did you see any indication in any of the approximately 100 to 150 charts you reviewed of any consultation with other doctors?

A No.

Q No psychiatrists?

A No psychiatrist.

Q Now, did you see any indications in these medical charts of prescribing OxyContin and antipsychotic medications?

A Yes, I did.

Q And in those medical charts did you see any indication of why those medications would be appropriate or medically necessary?

A No, ma'am.

Q And turn up Government's Exhibit 307, which is in

evidence and page 21...

I think you might need to take a look at the original. I don't know if that one is still in front of you.

A No, this is Mr. Robichaud (phonetic) in front of me.

Q Dr. Ferante, what is Zyprexa?

A Zyprexa is an antipsychotic. While it can be used for psychosis, it could also be used in cases of severe depression.

Q And if somebody is suffering from extreme depression, is it dangerous to provide them with OxyContin?

A Yes because there's a high degree of potential suicide, and suicidal ideations. And you wouldn't want to, in essence, hand them a loaded gun.

Q Is there anything in reviewing this prescription or this chart that would justify prescribing both, OxyContin, 80 milligrams and Zyprexa?

A No, ma'am.

Q If you could turn to -- you mentioned before that prescribing OxyContin or dispensing OxyContin, there's respiratory problems that are associated with opioid drugs; is that right?

A Correct.

Q What is Advair?

A Advair is an antiasthmatic used as an inhalant.

Q And if somebody has asthma or a -- another respiratory

problem or there are significant dangers with prescribing them OxyContin?

A Yes.

Q And looking at page 20 of Government's Exhibit 307 for that same patient, Ms. Kirakosian -- in this case was Advair prescribed in the name of the patient?

A Yes, it was.

Q And did you see any justification in the chart for the medical necessity of that drug?

A No.

Q You can turn to Government's Exhibit 330...

MS. MORTON-OWENS: Mr. Clerk, 330 which will conditionally be admitted...

(Whereupon Government's Exhibit 330 is admitted hereto.)

BY MS. MORTON-OWENS:

Q And this is for Ms. Fuller. And page 24, please...

In reviewing this chart, does is it appear that this patient is take antipsychotic medications?

A It is. The patient is taking four of them.

Q Four different antipsychotic medications?

A Yes. Depakote is used for severe depression; Abilify and Zyprexa are antipsychotics; or Zeperatol, antipsychotic.

Q And in reviewing this chart, is this patient also prescribed OxyContin?

A Yes, they were.

Q And can you turn to the front, page one of Government's Exhibit 330. You meant this -- on the front of this chart, it says M-cal M-care. Is that for Medi-cal and medicare?

A Yes.

Q In reviewing these charts did you see a difference between how an individual with purported insurance was treated and how someone purportedly who had no insurance was treated?

A Yes, I did.

Q And what was that?

A If you have a pink chart -- yeah, a pink chart, the -- all you would find might be an office visit note and a prescription. If you had medicare or Medi-cal, you would find a number of ultrasounds; you might find laboratories; you would not find MRI's or X rays, but you'd find, you know, various testing for inner ear things, EMG's; but you'd never find those on the pink charts.

Q Does that support your conclusion that there was no legitimate medical purpose for the OxyContin?

A Correct.

Q How so?

A The -- because you have to -- you want to administer a potent opiate when there's a reason to do so. So if I have a blank chart and all I have is an office visit and I give this

person OxyContin, it's really very questionable, if not illegitimate practice. It's the repetitiveness which I saw which makes it illegitimate.

Q So do I understand your testimony correctly, that maybe one or two of these charts might not have been a problem, but it was the fact that you saw consistencies throughout the 100 to 150 that you reviewed?

A Yes, ma'am.

Q And why?

A Because physician's are supposed to write these drugs for people who need them and not for the purposes of diversion. We're also not supposed to kill people which if someone took this drug and was naive or had severe restrictive lung disease or severe asthma, they may very well die.

MS. MORTON-OWENS: One moment. One moment with counsel...

(Whereupon counsel confer.)

MS. MORTON-OWENS: Your Honor, at this time, the Government seeks conditional or moves conditionally into evidence, Government's Exhibit 1757 which is a video as well as the transcript for that video, and we'd ask that the clerk be able to hand out the transcripts.

THE COURT: Very well.

(Whereupon Government's Exhibit 1757 is admitted hereto.)

THE COURT: Again, just the video is the evidence, not the transcript.

MS. MORTON-OWENS: Your Honor, I've also asked that Government's Exhibit 361, a patient chart for --

THE COURT: Folks, don't open this yet, please.

MS. MORTON-OWENS: One moment, Your Honor. We seem to have the wrong number.

I apologize, Your Honor. We want to make sure we have the right exhibits...

Government's Exhibit 314 has been placed before the witness as well.

BY MS. MORTON-OWENS:

Q And, Dr. Ferante, in forming your opinions today or in addition to your opinions today, were you also asked to watch a portion of an undercover video?

A Yes, ma'am.

Q And in conjunction with that video, were you asked to review the patient chart that resulted from the video?

A Yes, I was.

Q And let me go through -- and go through portions of that video with you. And this is Government's Exhibit 1757A, which is the tab 1757A.

Go ahead and start playing.

(Whereupon video is played in open court.)

BY MS. MORTON-OWENS:

Q Based on that statement, did you understand that the patient, Charles Pacheco had never been to the clinic before to see that doctor?

A Correct.

Q And would that mean that this would be an initial evaluation of the patient?

A Yes.

Q And how long based on your training and experience should an initial evaluation last?

A About 30 minutes on the average.

Q Not four?

A No.

(Whereupon video is played in open court.)

BY MS. MORTON-OWENS:

Q Dr. Ferante, is it normal to just ask the patient how much they weigh?

A It can be done.

Q Do you usually weigh the patient?

A You usually do.

(Whereupon the video is played in open court.)

BY MS. MORTON-OWENS:

Q Dr. Ferante, have you ever prescribed OxyContin, 80 milligrams for carpal tunnel?

A No, ma'am.

Q Why not?

A It -- it's -- the pain of it can be handled by other medications. It's usually not severe enough to warrant something like OxyContin, 80.

Q And what about physical therapy.

A Physical therapy will work, yeah.

(Whereupon video is played in open court.)

BY MS. MORTON-OWENS:

Q Is Dr. Ferante, what is the sternum?

A Sternum is your breast bone.

Q So that's in your front?

A Correct. The bone that runs right here.

Q Not in your back?

A Not in your back.

(Whereupon video is played in open court.)

BY MS. MORTON-OWENS:

Q That evaluation was five minutes and 5 seconds; is that right, based on the playtime of the video?

A Yes.

Q And, Dr. Ferante, now can you turn to Government's Exhibit 314.

MS. MORTON-OWENS: And the Government moves this conditionally into evidence, we believe without objection.

THE COURT: Very well.

(Whereupon Government's Exhibit 314 is admitted hereto.)

BY MS. MORTON-OWENS:

Q Is this the patient chart for Charles Pacheco?
A That's correct.
Q And assuming for the purpose of your testimony today, you believe it was Charles Pacheco who was being examined during that video?
A Yes.
Q Will you pull up page 18. Are you familiar with the drug, Motrin?
A Yes, I am.
Q And is Motrin treated for breakthrough pain of OxyContin, 80 milligrams?
A It can be. It's not usually used as such.
Q Is that because Motrin at an 800-milligram dosage would be unlikely to assist somebody who has built up such a tolerance to OxyContin, 80 milligrams?
A Well, if they need OxyContin three times a day, I don't think Motrin is going to touch them.
Q What about Tylenol 500. Are you familiar with Tylenol 500?
A Yes.
Q And what is Tylenol 500?
A It's pseudoephedrine. It's another type of anti-inflammatory. Actually, it's not an ant-inflammatory, but it's classified as such.
Q For Tylenol, can you explain to the jury, what's a

normal dose to treat, say a headache?

A You could take 200 milligrams. Some people will take 500 milligrams or 400 milligrams.

Q To treat a headache?

A Yes.

Q So would Tylenol, 500 milligrams once a day, typically treat breakthrough pain for somebody taking OxyContin?

A No.

Q Let me turn to page 35 of Government's Exhibit 314...

Are these the visit notes for the January -- for January 13, 2010, for the visit of Charles Pacheco.

A Yes, it is.

Q And if you turn to page 36 of that same exhibit...

These appear to be the notes that were being written during the video?

A Yes.

Q And based on your review of this medical chart as well as the video that you reviewed in Government's Exhibit 1757, was there a legitimate medical purpose for the OxyContin prescribed to Charles Pacheco?

A No.

MS. MORTON-OWENS: One moment, Your Honor.

No further questions, Your Honor.

THE COURT: Very well.

MR. BELTER: Your Honor, I'm just going to need a

THE COURT: Correct.

MR. SHERMAN: Well, Your Honor, can we deal with this a little bit more later.

THE COURT: No. I think I've dealt with it.

MR. SHERMAN: Okay.

THE COURT: Go ahead.

CROSS-EXAMINATION

MR. BELTER:

BY MS. MORTON-OWENS:

Q Dr. Ferante, you told us on Friday -- you gave us sort of an overview of your -- your experience but also your training and your specialty in pain management. We've heard testimony from Dr. Santiago last week. You're familiar with that name?

A Yes.

Q You've never interviewed her or had any contact with her?

A No.

Q Okay. We heard from Dr. Santiago that she had taken a one-week course in pain management. When I listened to your testimony last week, that's quite a bit less than you've had, won't you agree?

A True.

Q And your attitude or your thought about a one-week course in pain management, would that in your mind qualify an

individual or qualify a physician to prescribe OxyContin?

A It makes no difference. It's -- it's what's determined by the law of the state.

Q All right. And so a physician couldn't dispense or can prescribe OxyContin without being a specialist in pain management?

A No, that's not true.

Q Okay. So you would have to be board-certified?

You'd are have to be a specialist in pain management?

A No, theoretically any physician could write for OxyContin.

Q Any licensed physician?

A That is correct.

Q Okay. So if Dr. Santiago is a licensed physician at the time that prescriptions are being written by her or signed by her, that would be -- that would be okay?

A Well, you need to know what you're doing. I would assert from my review of the records that that did not occur in this case; but legally, it was possible.

Q But what I would like to do is focus on the question I'm asking.

A Okay.

Q And you can certainly have an opportunity, I'm sure, on redirect to answer any additional questions.

So with respect to Dr. Santiago and so long as she's a licensed physician in the state of California, there's nothing that stops her from prescribing OxyContin?

A A licensed physician in the state of California can prescribe OxyContin.

Q Okay. You've reviewed records you told us between a hundred and a hundred 50 patient files; correct?

A True.

Q And you saw prescriptions signed by a Dr. Artice Woodward?

A Yes.

Q And you saw prescriptions signed by a physician, Suzanne Seideman?

A Yes.

Q And you saw prescriptions signed by Morris Halfon?

A Yes.

Q Okay. I believe you also saw prescriptions signed by a Dr. Farmer?

A Yes.

Q Okay. And what about -- and also, you saw prescriptions signed by a physician Ken Thomas?

A That -- I don't have a memory of that name.

Q Okay. If -- do you recall seeing prescriptions signed by a doctor or a physician, August can Knebel?

A Yes.

Q And last, did you find -- or did you see prescriptions signed by a Dr. Payem Maroney?

A Yes.

Q Okay. Now, if those doctors -- if those physicians were licensed by the state of California at the time that they were signing prescriptions, there's nothing that would stop them from signing prescriptions?

A They would have the right to prescribe OxyContin in the state of California.

Q All right. Thanks.

With respect to pain management, just the concept of pain management, you -- you as a physician would see patients who are -- come to you when they report that they have severe pain and they need some form of medication to help deal with it. Would that be a layman's term of describing patients who come to see physicians with respect to pain?

A No. I would say the patients come with varied degrees of pain, and that they're looking for A., a diagnosis and then B., some form of treatment which doesn't necessarily, you know, predicate the use of medication?

Q Okay. And so the patient comes to the physician to report a condition?

A True.

Q And then the -- the physician is -- evaluates what's

been told to them or what's being reported, and then they, as you say, develop a treatment plan?

A True.

Q Okay. And this -- these conditions -- this pain, that crosses all socioeconomic lines; would it not?

A Pain would cross socioeconomic lines, yes.

Q Okay. So, for example, patients that you see in your present clinical practice, based on where you told us you practice, those individuals may be individuals of greater wealth than the individuals that might have been going into the Lake clinic or the Lake Street clinic?

A Possibly.

Q Okay. You've told us that your evaluation would generally be about 30 minutes?

A For a new patient.

Q For each patient?

A New patient, yes.

Q Okay. What about a returning patient?

A That can vary anywhere from five minutes to 45 minutes.

Q Okay. And what would be the difference?

A The degree of most of them are not 45. Most of them are either 5 to 15, or 20. The difference is the -- the complexity of the problems; the fact that you're unfamiliar with the patient at a new visit.

Q Okay. So a new patient you would expect that individual

to having a longer interview -- a longer evaluation period?

A True.

Q Okay. And a returning patient, depending on the complexity of the initial treatment plan, that -- that returning patient could be anywhere from a few moments or a few minutes rather up to 20, 30 minutes?

A Yes.

Q And would you -- would the recorded history -- in other words, the recorded documentation in a patient's file, would that be something that might be used to shorten the visit -- shorten the evaluation?

A Possibly.

Q In other words, I guess what I'm getting to -- or what I'm getting to is every patient contact, there's a lot of factors that go into -- come into play in determining how long you are going to spend with a patient?

A There are a number of factors, yes.

Q One factor might be if you've had a -- you've done a clinic evaluation of a patient, then you have had the treatment plan devised and you're merely checking to see if a patient's on track, so to speak?

A Yes.

Q Okay. We have physicians like yourself and these other doctors that I mentioned, and then there's an individual -- or a person may be a physician's assistant; correct?

A Correct.
Q Well, what's the difference?
A The physician has a medical degree, the physician's assistant does not. The physician's assistant acts as an agent for the doctor of osteopathy or the M.D. based on a set of designated set of services, and the physician needs to be available for contact.
Q Okay. Would this be correct or incorrect that the physician is actually the supervising individual?
A That would be true.
Q All right. And, in fact, the physician is expected to supervise the physician assistant?
A True.
Q Okay. Are there standards or are there protocols or regulations with respect to the relationship between a physician, an M.D., and a physician's assistant, a P.A.?
A Yes.
Q And is there -- are there standards with respect to the actual contact that the physician should have with the physician's assistant?
A Yes.
Q And can you just describe for us some of those?
A Sure. The physician's assistant is acting as the agent for the -- let's say M.D. the -- the physician's assistant if the individual is licensed, can perform evaluations -- can

do anything with minor procedures, anything with respect to assessment.

If the individual -- so a new patient could be seen singly by a licensed P.A., and then the physician would need to be in contact. The physician's assistant could not write for an narcotic, unless they were a licensed P.A. and also had gone to a course. That course would allow them to write the Schedule II's and other controlled substances without a countersign. If they do not attend the course -- and the course is optional -- then they will need a countersign and they'll need a countersign within seven days.

Q Okay. So to break that down, if a physician's assistant is doing the initial contact with a patient, would you expect the -- if there was going to be a prescription for a Schedule II narcotic -- or in this case an OxyContin, you'd expect the physician's assistant to have some consultation after the original assessment with the physician?

A Yes.

Q Okay. And after that consultation with the physician, would the physician's assistant be permitted to -- to actually prescribe the OxyContin?

A If there was a designated -- the designation of services and if the physician had been contacted, yes.

Q Okay. And so what's the designation of services?

A What a --

Q I believe you said -- or was it delegation of services?
A Thank you.
Q Thank you?
A A P.A. could perform certain services that the supervising M.D. will allow. And there's basically you write these out, and there's also if you're going to form a -- if you're going to prescribe certain medications, there also needs to be a formulary.
Q Okay. And that would be -- that would be something that the supervising physician would set -- set up; is that right?
A That's correct.
Q Okay. It wouldn't be the physician's assistant setting it up?
A That is correct.
Q Okay. And so again, it's the supervising physician who has the final word on -- on either setting up that type of prescription protocol; correct?
A The -- the physician has the ultimate responsibility for the delegation of services.
Q Okay. And the physician has the ultimate responsibility in prescribing the Schedule II narcotic?
A The physician -- the P.A. acts as an agent for the physician.
Q Okay. And so the physician -- the M.D., has the final word on that?

A Well, I'm not sure what you mean by final word.

Q Well, you would expect that the M.D., the supervising physician would have either agreed or told the physician's assistant that a Schedule II narcotic could be prescribed?

A That is not necessarily true.

Q Okay. Under what circumstances would it not be?

A Number one, if you have an unlicensed P.A.

Number two, where you have a licensed P.A. who has not undergone the opioid course. That individual will need countersignature. The -- if the individual has passed that course and attended it, then they don't need countersignature immediately, but they need it seven days later.

Q All right. And so the seven days is where the physician has to basically make sure that they've checked the work and countersigned?

A True.

Q Okay. And what's the seven-day? Why is it seven days?

A I believe that's what it says on the P.A. law. I don't know why.

Q Okay. So this is a possible scenario: That a physician's assistant has seen a patient; has prepared some kind of documentation about the contact; has now -- has now contacted the supervising physician and a decision is made by the supervising physician to prescribe the Schedule II narcotic; is that correct?

I mean, that's a possible scenario?

A That is a possible scenario.

Q And at that point, the prescription could be given to the patient?

A Yes.

Q And that would be signed by the physician?

A That would be signed by -- it depends on who is writing it.

Q All right. The physician's assistant could actually write it; correct?

A That is true.

Q But so long as now the patient's file within seven days is countersigned by the physician?

A That is correct.

Q Okay. So there's seven days there where the physician needs to go back and confirm the work?

A True.

Q Okay. What happens if all the -- all that I've just described happens, but the physician never goes back and signs off on the work?

A I guess that's a breach of the standard.

Q That would be a breach by the physician?

A If the physician does not countersign?

Q Yes.

A Yes.

Q All right.

Does the medical doctor that's the physician under the protocol -- or under the practice in California, are they expected to sign off on all physician's assistant documentation?

A Yes.

Q And there's no -- you're not aware of any standard that they're -- they're expected to sign off on a percentage less than a hundred percent?

A Not that I'm aware of.

Q All right. I'm going to show you -- see what's on the screen there. And this is a -- this is page 40 of Exhibit 314 which you were shown earlier this afternoon. You see this prescription?

A Yes, sir.

Q This is for Mr. Charles Pacheco?

A Yes.

Q Okay. And we see a prescription note or a prescription pad. And it appears that there is two names, Dr. Susan Seideman, correct, on the left?

A Correct.

Q And then David Garrison. And it's designated as a P.A.?

A Correct.

Q Okay. And this would be one of the prescriptions for Mr. Pacheco?

A It says "Charles Pacheco."
Q Yes. And this would be a prescription that appears to have been -- at least the check at the upper left-hand corner is for Susan Seideman, M.D.?
A That's correct.
Q And then the signature appears to be Dr. Seideman?
A That is also correct.
Q I'm showing you now page 38 of Exhibit 314. And it's page 38 and 39. I'll scroll it down, and I'm going to ask you a question or two.

Do you see that -- those charts?

A Yes.
Q What are those?
A It's an EKG.
Q Okay. Why would an individual who is coming to a clinic and ultimately is discussing a pain issue with either a physician's assistant or a doctor, why would he have an EKG?
A That's a good question. I don't know why they would have an EKG.
Q Okay. Well, if a doctor asked for an EKG, do you expect that somebody in the medical doctor or the physician's office to follow through with that?
A Yes.
Q Okay. If you asked for somebody in your -- in your practice to perform a particular test, would you expect them

to do that?
A Yes.
Q Okay. You wouldn't expect them to question it?
A No.
Q All right. Again, this would be Exhibit 314, and I think you've already testified about pages 35 and 36. Those were what appears to be contemporaneous notes that Mr. Garrison would have been making when he was interviewing Mr. Pacheco on the screen?
A I believe so.
Q Okay. Would that be normal practice that it needed a physician like yourself, or a physician's assistant would be making contemporaneous notes while they're interviewing an individual?
A Yes.
Q This is Exhibit 314, page 5. Do you recognize what that would be?
A This is the HIPAA notice of privacy.
Q Okay. And what -- why would a patient or a new patient sign or be presented with a HIPAA notice of privacy practice?
A Um, I guess to ensure security that it's not supplied to sources that wouldn't need it for medical purposes.
Q You recall from the interview that we watched in court not too long ago that Mr. Pacheco was saying that he was, in essence, first time coming to the clinic?

A Yes.
Q Okay. And based on his chart that you reviewed, he didn't come back to the clinic?
A That's correct.
Q Okay. With respect to individuals coming back to the clinic -- I mean, coming back to see you, if you were to tell a patient -- a new patient to come back in 30 days or come back in six weeks, you would expect them to do that?
A Yes.
Q And if they don't do it, what control do you have over that?
A None.
Q None absolutely; correct?
A Correct.
Q Last week the U.S. attorney asked you some questions with respect to oral histories; do you recall those?
A Yes.
Q Okay. And we've heard from Dr. Santiago that she oftentimes relied on oral histories from patients. You've told us that you wouldn't generally do that; is that right?
A Could you define better for me what you mean by oral history?
Q Well, a patient comes to you and you've never seen them before and you sit down with them and you start asking them some questions. You take contemporaneous notes about that;

is that right?
A Correct.
Q And if that's all -- if now you spend the next 30 or 40 minutes talking with them, that's in essence, an oral history?
A That's correct.
Q Okay. You would like to have medical documents to support what they're saying?
A Yes.
Q Okay. But what happens if there is no documents?
A Then it depends on the severity of what they're asking for. Mr. Pacheco came in, asking for narcotics on the first visit.
Q Sure.
A Definitely a red flag.
Q Okay. So it's a red flag. And for you as a physician, you wouldn't necessarily have given him OxyContin?
A No physician is under any -- you know, impetus to supply a narcotic on any visit.
Q Okay. And if a doctor like Dr. Seideman prescribed that, right -- you're saying that that isn't something you would do, but obviously, she did?
A Well, she has the right do that, yes.
Q She has the right to do it?
A Right.

Q Okay. You've testified about this repetitive patterns of verbiage or vignettes?

A Yes.

Q Okay. I just wanted to go through that with you for a few minutes.

And you've indicated there were -- what you saw before -- different patterns that sort of jumped out at you; is that right?

A Correct.

Q And the first was a -- the low back pain pattern; correct?

A Yes.

Q And if a person is suffering from low back pain, is it possible that you would at some point prescribe OxyContin?

A At some point if a patient is presenting low back pain, yes, at much reduced dosage, yes.

Q Much reduced dosage.

And you talked about triation [sic]?

A Titration.

Q Titration. So that would be the increased or elevation of particular pain medication as a patient was being seen; is that right.

A Correct.

Q Okay. So if a person came to a physician and -- complaining of lower back pain, at some point if that lower

back pain persisted over a period of time, you could see where OxyContin could be prescribed?

A Possibly, yes.

Q Okay. What about, is it upper respiratory infection pattern?

A Yes.

Q What did you take that to mean?

A Flu-like syndromes; upper respiratory infection; cold.

Q All right. And is it your testimony that under no circumstances would OxyContin ever be prescribed for that type of illness?

A Yes.

Q Okay. And with respect to the -- one of the other patterns is the claudicatory peripheral vascular disease pattern?

A Correct.

Q What did you -- what did you take in -- what was that sort of being used to describe; what kind of combination of symptoms?

A A patient would have pain on walking. They would have pain in their calves. They would need to stop frequently. They would probably have hypertension and cardiovascular disease associated with it.

Q And at some point if somebody had that kind of persistent pain over a prolonged period of time, would --

could you see where a physician would prescribe OxyContin?

A Highly unlikely but possible.

Q It's possible; correct?

A It's possible.

Q And then there was the fourth type, and it's cervical -- help me with this next word -- it's neuralgia?

A Neuralgia.

Q Yeah. And what is that describing?

A Nerve pain.

Q Nerve pain?

A Radiculopathy.

Q And how would that -- how would that present itself?

A Pain in the back, shooting down the arm.

Q Okay. And that would be something that could be as a result of what?

A Disc herniation. Basically the degenerative disc disease.

Q Okay. And that -- that type of an injury -- that type of physical ailment could actually cause quite a bit of pain or discomfort; right?

A It can.

Q If it was prolonged, would it be possible for a physician to prescribe OxyContin?

A It would be possible.

Q Okay. You're saying you would be extremely cautious

about doing that; is that right?
A Correct.
Q Okay. Would you tend to agree that you may be an individual having your experience and your education that you would be cautious about it, but that there are doctors who are not so cautious?
A No.
Q You're saying doctors are not cautious about that?
A No. I'm saying that the prescription of 80 milligrams is unwarranted and basically a breach of proper medical practice to a new patient, as well as individuals with respiratory disease.
Q Okay. And so if Dr. Santiago and Dr. Halfon and Dr. Knebel and Dr. Farmer and Dr. Woodward, if they were prescribing that medication, you're saying that they were not -- they were not acting appropriately?
A Yes.
Q Okay. And with respect to physician's assistants, if the doctors were telling them that -- or they were confirming or saying, Go ahead and prescribe that, then it is the physicians who are acting inappropriately?
A The P.A. acts as the agents of the physician.
Q Yeah. And but if the doctor is telling them to do it -- if the doctor -- the supervising physician is saying, Go ahead and prescribe it, the P.A. has the right --

A To also say, listen, I think this is unsafe practice.
Q Okay. And the -- and the prescriptions that you've seen up to this point these are signed by physicians at the clinic?
A Correct.
Q And as you've -- you sort of I guess in a sense, you told us that the physician is the supervising individual -- the person with the final authority.
A It is the supervising individual. However, the P.A. where the practice is unsafe, does have the right to say to the physician that I think this is unsafe.
Q Okay. But ultimately, it's the physician's responsibility to know -- know the appropriate practice; is that right?
A It is the physician and the supervisors, but the answer remains the same. The P.A. does not have to participate if they think it's unsafe.
Q Okay. You indicated -- or you talked about in your testimony that you didn't see any consultation with any kind of pain management specialist?
A Consultation with anyone.
Q Okay. And that would be with other physicians with respect to MRI's or X rays or any of these types of things; is that right?
A Yes, that's correct. As well as just asking another

physician their opinion.

Q And you would expect that the physicians at the -- at the Lake street clinic would be doing that?

A Yes.

Q With respect to ordering any type of radiographic, you know, follow-up X rays, CT's or MRI's would you also expect the physicians to recommend or to order those types of tests if they felt it was appropriate.

A I would expect them to order those tests, particularly, for individuals with spinal pain.

Q And with respect to the -- you talked about adequate informed consent. Who would you expect to be doing that at the clinic?

A The individual making the contact.

Q And would -- if the -- if it was being prescribed by a doctor, would you expect that the doctor -- an M.D. would be doing that?

A Not necessarily, no.

Q Okay. Who would you expect to do that?

A If the P.A. is seeing the patient, I would expect the P.A. to do it.

Q And if the P.A. was not seeing the patient, would you expect the doctor to do it?

A Well, it depends once again on -- if he sees the patient, that individual should be the one administering

informed consent.

Q Uh-huh. And would the informed consent be a form or would the informed consent be where you sat down with the patient and just talked about it?

A It's the latter. It's really the process of explaining the risks and benefits and alternatives to what you're proposing.

Q Okay. And so if an individual sat down with a physician or the physician's assistant and they discussed briefly, you know, how that medication would affect them, would that be adequate?

A Would that be adequate? No. There would need to be a countersignature of the patient on the informed consent form -- or in order to memorialize the event. Informed consent may have been given, but there still needs to be a signature of a health practitioner. It could be a P.A.; it could be an M.D. on the informed consent forms to memorialize it.

Q Okay. And so you would expect either the P.A. or the M.D., who was prescribing to have some form of signature or documentation that they've conducted the informed consent?

A Either.

Q And what about a person who is returning -- a patient who has come back a second, third, or fourth time, and they're getting multiple prescriptions?

A I'm sorry. I don't understand your question.
Q Sure. Would that -- would you expect that there's an informed consent every single time that the person is being prescribed the medication?
A No, only as medically indicated.
Q Okay. And that would be if a person is returning that that wouldn't necessarily be required?
A It depends on the individual clinical scenario at the time.
Q All right. You're aware -- or maybe you are or maybe you're not; but there was a urine -- or urine testing screen or urine screening capability at the Lake Street clinic.

MS. MORTON-OWENS: Objection. Assumes facts.

MR. BELTER: Did you know?

THE COURT: Overruled.

THE WITNESS: I know that there were forms that were signed and that were -- that certain urine screens were not sent out; whether or not they had the ability to perform tox screens at Lake clinic, I don't know.

BY MR. BELTER:
Q But you did see some indication -- at least by way of forms in some of the patient files that there was --- there was some indication of a urine testing?
A Well, once again, it is highly irregular because I don't know whether or not the urine was even tested.

Q We don't know that. I'm asking you whether or not there was an indication in the file?
A Repeat that. I didn't hear you. I'm sorry.
Q Sure. You say you don't know if it was tested?
A That's correct.
Q Right. But if you looked at the file, there were forms -- there were indications that the urine was being tested?
A Those may have been forged for all I know. Once again, the -- the real validity is from a clinical laboratory; not necessarily what's someone may or may not do at their own clinic.
Q Okay. Did you interview any of the patients?
A No.
Q You looked at the files?
A Yes.
Q Okay. So everything you're telling us is based on the files?
A That's correct.
Q You weren't there talking to any of the doctors? You haven't talked to Halfon or Seideman --
A No.
Q -- or a Knebel?
A No.
Q You didn't talk to Santiago?

A No.

Q Okay. And these are the physicians who were signing off on the prescriptions; correct?

A True.

THE COURT: Do you ever run across any sort of an indelicate subject, doctors who are sort of too old to be in the game and maybe just shouldn't be practicing?

THE WITNESS: Yes, sir.

THE COURT: Is that -- is that -- how does the profession deal with that? I mean, what do you do? You get old folks that either just got out of the game and they don't know they're out of the game.

THE WITNESS: Usually it's the institution that they're in. For instance, if they were going to get hospital privileges, the credentialing process would weed them out.

THE COURT: Would you hope; right?

THE WITNESS: You would hope. Yes. Well, that's what's supposed to happen. The -- in an office practice, you would expect that there would be an office manager. There would be an individual who would be managing, who would intervene if something of that nature was discovered.

THE COURT: Thank you.

THE WITNESS: You're welcome.

MR. BELTER: Actually, I have no further questions at this time.

Thank you.

MR. CANTALUPO: Good afternoon.

CROSS-EXAMINATION

BY MR. CANTALUPO:

Q Can you describe the responsibilities of an office manager?

A Well, the office manager would see the day-to-day efficiencies through the patients. There would be an overall director -- an M.D. who would be responsible for ferreting out the hypothetical individual that the judge brought up.

Q But in terms of the office manager's responsibility, you would agree that they're responsible for the day-to-day operations of the medical office?

MS. MORTON-OWENS: I'm going to object as outside the scope of this individual expertise.

MR. CANTALUPO: It's cross.

THE COURT: It's kind of vague as to general office managers or --

BY MR. CANTALUPO:

Q Well, when you mentioned "office manager" in your answer to the Court's question, did you have in mind a particular type of office manager?

A No.

Q You were talking about someone hired by the doctors to take care of the administration of their practice?

A No. I was talking about the -- the M.D. who would be the head of that practice. Usually the complaints would be brought first to the office manager, who would then go directly to the M.D.; but the resolution comes from the M.D.

Q Okay. But going back to the office manager, the office manager's function for the M.D. is to handle the administrative responsibilities of the practice?

A To a certain extent, yes.

Q You testified last week you have testified as an expert over 50 times?

A Correct.

Q Do you recall that?

And each one of those times was for the Government?

A No.

Q You testified in civil cases?

A Yes.

Q And in those civil cases you testified for either the plaintiff or the defendant?

A Correct.

Q In criminal cases have you ever testified for the defendant?

A Probably not.

Q And you're being paid for your services in this case by the Government; correct?

A Correct.

Q And you expect that when all is said and done, you will have earned approximately $50,000 for your services in this case?

A Possibly, yes.

Q Is that a fair estimate?

A Fair estimate.

Q You also in your testimony just a little while ago, mentioned health practitioners. What is a health practitioner?

A It's an overly broad term. It could mean a nurse; it could mean a P.A.; it could mean a doctor; it could mean someone who is in the field of medicine, nursing; physician's assistant; nurse practitioner.

Q And that definition would necessarily include only people licensed to be healthcare practitioners; correct?

A That calls for a legal opinion. I can't answer that question.

Q Have you ever engaged in health practitioner, other than an M.D. in your practice?

A I beg your pardon? Can you repeat the question.

Q Have you ever engaged in your practice of health practitioner, other than an M.D.?

A Yes.

Q And each of the times you did that, they were a licensed professional; correct?

A That is correct.
Q Now, you -- you said you reviewed I think it was 150 patient files in this case?
A 100 to 150 -- somewhere in there.
Q Are you aware of the number of total patient files that were discovered in this case?
A I know they were much larger.
Q Do you have any idea the percentage of those files -- of the larger group that you reviewed?
A No.
Q Did you provide to the Government any sort of criteria as too which types of files you should review?
A No.
Q You were just given this 150 or so files and asked to review them as you testified on direct?
A Yes.
Q And it be correct to say that in those 150 files you reviewed, you never saw my client, Elza Budagova's signature on any document; correct?
A Correct.
Q She didn't sign any prescriptions; correct?
A That is correct.
Q She never signed any patient notes; correct?
A That is correct.
Q And in viewing those patient files, you have no

knowledge whether or not she actually interviewed a patient or questioned a patient, do you?

A That is correct.

Q You have no knowledge whether or not she purportedly examined a patient; correct?

A Correct.

Q It is true that in writing a prescription, -- a healthcare practitioner or a doctor could assign someone else to write the body of the prescription. And by "body," I mean the name of the patient, the address of the patient, perhaps the medication prescribed, the dosage, how often to take; that can be done by anyone other than a licensed healthcare practitioner; correct?

A Not to my knowledge.

Q But you do know that every prescription needs to be signed by someone licensed to issue prescriptions; correct?

A Correct.

Q And that can either be a doctor -- a medical doctor or a physician assistant; correct?

A Correct.

Q Now, you testified last week and some of today about the -- the standard of care and the duty of care that a medical practitioner must exercise in examining and treating patients; you recall all that; right?

A Yes.

Q That's -- those standards and that duty, you learned that in your education, your training, and your experience; correct?

A True.

Q And when you were discussing how you would administer that duty, you were speaking in terms of licensed healthcare practitioners and doctors; correct?

A True.

Q If -- if a person is not licensed and works at the clinic, you wouldn't expect them to know what the standard and duty of care is, would you?

A I would expect them not to be making diagnoses; not to making assessments. They couldn't really provide treatment plans and examine patients.

Q Correct. They couldn't do any of that stuff?

A If they were unlicensed. Correct.

Q And if they were unlicensed, they wouldn't even know what the standards and the duties were?

MS. MORTON-OWENS: Objection. Calls for speculation.

THE COURT: Argumentative.

BY MS. MORTON-OWENS:

Q Do you know whether or not my client, Elza Budagova, knew of any standard of care or duty of care?

A It would be speculation to me to say what she would or

would not know.

Q So you don't know?

A Once again, I'd be speculating.

Q And I don't want you to speculate.

MR. CANTALUPO: I have no further questions.

MR. JOHNSTON: Your Honor, in light of the Court's admonition that this witness' testimony is not offered against my client. I have no questions.

THE COURT: Very well. Any further questions?

MS. MORTON-OWENS: Yes, Your Honor.

THE COURT: Go ahead.

REDIRECT EXAMINATION

BY MS. MORTON-OWENS:

Q Dr. Ferante, on 1757, the video, did you see any informed consent?

A No.

Q Did you see a doctor purporting to be Dr. Susan Seideman?

A No.

Q Are you just allowed to make stuff up in a medical chart?

A No, ma'am.

Q And what if a P.A. is completing a prescription without the doctor's knowledge, is that a legitimate prescription?

A No. The P.A. has to act as the agent of the physician.

Q Now, a medical doctor doesn't just have a right to write a prescription for narcotics, regardless of medical necessity, do they?

A No, they do not.

Q It requires medical necessity in order to write for a narcotic; right?

A Correct.

Q Can you pretend to be a doctor and have it be legitimate?

A No. No, no.

MS. MORTON-OWENS: May I have a moment with counsel?

(Whereupon counsel confer.)

MS. MORTON-OWENS: Subject to conditional admission, the Government moves Government's Exhibit 131, 132, and 133, Mr. Clerk, into evidence.

THE COURT: Very well.

THE CLERK: For the record, I have those admitted already as of October 1st.

MS. MORTON-OWENS: Thank you. Thank you. They're already in evidence.

Then, Agent Zavala, could you publish Exhibit 131...

BY MS. MORTON-OWENS:

Q Dr. Ferante, in front of you, do you actually have

prescription pad -- excuse me -- prescriptions that are Government's Exhibit's 131?

A Yes.

Q And those are the original prescriptions; is that right?

A Correct.

Q And is that also what's appearing on the screen?

A Yes, ma'am.

Q If I told you that that was a pre-signed prescription bearing defendant Garrison's handwriting, would that be a legitimate prescription?

A No, ma'am.

Q Are physician's assistants allowed to pre-sign prescriptions?

A No, ma'am.

Q Going to Government's Exhibit 132 which is already in evidence as well...

You have the hardcopy in front of you.

Are those prescriptions? And are they pre-signed prescriptions?

A Except for the bottom one, they look pre-signed -- well, excuse me. That is also pre-signed because there's no name. There's no date attached.

Q And if I told you -- excuse me -- if I told you to assume that the handwriting that says OxyContin, 80 milligrams was the handwriting of Elza Budagova, is it

improper for an unlicensed individual to write on a pre-signed prescription?

A No, ma'am.

Q Turn to Government's Exhibit 133, which is already in evidence as well...

Are those pre-signed prescriptions for a Dr. Morris Halfon?

A Yes, ma'am.

Q And once again, is it -- is a prescription legal if a doctor pre-signs it?

A No.

Q And can a physician's assistant complete a pre-signed prescription?

A No.

Q Let me look at Government's Exhibit 166...

Mr. Clerk, 166 is also in evidence?

THE CLERK: Yes, 166 is in evidence.

MS. MORTON-OWENS: Can you publish page two of Government's Exhibit 166...

Does that purport to be pre-signed prescriptions for a Dr. Susan Seideman.

THE WITNESS: Yes.

BY MS. MORTON-OWENS:

Q And could a physician's assistant complete a pre-signed prescription for Susan Seideman and have it be a legitimate

prescription?
A No.
Q And can you turn to Government's Exhibit 314 page 40 it's already in evidence. This is the prescription that defense counsel for Mr. Garrison went over with you; is that right?
A Yes.
Q And if I told you that the handwriting on the prescription -- to assume for today that the handwriting on the prescription was David Garrison's, did you see any evidence in the video that Susan Seideman cosigned that prescription?
A No.
Q And look at the top there where it's checked Susan Seideman; do you see that?
A Yes.
Q Could it also have been checked David Garrison?
A It would have to be.
Q And if the physician's assistant is treating the patient and prescribing the medication, what needs to be done with the prescription in order to note that it was the physician's assistant that actually prescribed the medications?
A It has to be signed.
Q By the physician's assistant?
A Yes, ma'am.

Q And would it also have to be checked to show that it was physician's assistant and not the doctor that completed this prescription?

A Yes, ma'am.

THE COURT: I can just see the court reporter has really struggled with that last -- just if you could slow down a little bit, please.

MS. MORTON-OWENS: Yes. Sorry, Your Honor.

BY MS. MORTON-OWENS:

Q Did you see any evidence in the patient records that you reviewed that you were told to assume had David Garrison's handwriting in it -- on any attempt to treat the underlying cause of the pain?

A Repeat your question. I don't understand. I'm sorry.

BY MS. MORTON-OWENS:

Q I'll back up.

For the medical charts that you reviewed, you reviewed numerous that had -- the Government told you to assume, had defendant David Garrison's handwriting in it; is that right?

A That's true.

Q And after time, you actually began to recognize that handwriting, given the number of times you saw it?

A That is true.

Q And based on that review, did you see any indication that defendant David Garrison treated patients for the underlying cause of the pain?

A No, there was no medical necessity.

Q What about medical necessity for the OxyContin?

A No.

Q Is someone who is a physician in another country allowed to operate without a medical license here as a physician or a physician's assistant?

A No.

Q Even if a doctor cosigns their notes?

A They're still not allowed.

MS. MORTON-OWENS: One moment, Your Honor.

No further questions of this witness.

RECROSS EXAMINATION

MR. BELTER:

BY MR. BELTER:

Q Dr. Ferante, the -- Exhibit 1757, the video that we saw today, obviously, that's about five minutes long?

A About that, yes, sir.

Q And that starts with Mr. Pacheco sitting down with Mr. Garrison?

A Yes, sir.

Q It clearly does not show what occurred prior to that?

A Correct.

Q Okay. And from looking at the Pacheco file, there are some other forms that Pacheco signed; is that correct?
A Yes.
Q Okay. And there was vital signs?
A Yes.
Q They do not appear to have been discussed during the video; is that right?
A Yes.
Q And then -- not to be facetious, but there's no video from the time that Garrison and Pacheco end their -- their conversation where either Pacheco might have seen Dr. Seideman or had any other involvement with anybody else in the clinic?
A Correct.
Q So based on the video, you're not saying that there's no consultation with the medical doctor, Seideman, based on the video?
A What was in the video, there's no evidence that there was any consultation.
Q Right. And there's no evidence that there wasn't?
A Correct.
Q Going to the pre-signed prescriptions...

You're saying that the best practice -- or the practice would be that a physician, if they pre-signed prescriptions, that it would be frowned upon that the

physician's assistant would then fill out the prescription?
A You can't pre-sign prescriptions.
Q Okay. But how about if you sat down and went through a treatment plan; you talked about an evaluation; you talked about the assessment; you talked about meeting and communicating with the patient and now you the physician's assistant is sitting with the doctor and they're coming up with a treatment plan and the doctor signs the prescription and says, Fill out for 80 milligrams of OxyContin?
A That's not a pre-signed prescription.
Q That's not a pre-signed prescription; right?
A Correct.
Q Because it's being signed contemporaneous with the treatment plan?
A Correct.
Q All right. So there's no -- if that was the scenario, that's -- that's maybe not the best practice, but that would be all right?
A If the physician is speaking to the P.A. --
Q Yeah.
A -- and contemporaneously signs that, it's okay, if it meets medical necessity.
Q Okay. And the medical necessity is -- at least at that point, something that the medical doctor -- the M.D. would at least, be involved in making the decision -- a final decision

whether or not that was going to be what was going to happen?

A Yes.

MR. BELTER: Okay. Thank you.

No further questions.

MR. JOHNSTON: No questions.

MS. MORTON-OWENS: No questions, Your Honor.

THE COURT: Thank you. You're excused.

MR. GELBERG: Your Honor, the United States calls Larry Curry. And if I could ask exhibits 283, to 287 to be I placed on the witness stand.

GOVERNMENT'S WITNESS LARRY CURRY, SWORN.

THE CLERK: Sir, please state your full name and spell your last name for the record.

THE WITNESS: Larry Darnell Curry, C-u-r-r-y.

The CLERK: Thank you.

DIRECT EXAMINATION

MR. GELBERG: Good afternoon, sir.

THE WITNESS: Good afternoon.

BY MR. GELBERG:

Q Where were you living in 2008 and 2009?

A I was homeless on the streets, Pasadena, Los Angeles area.

Q And when you were homeless in Los Angeles, was there a particular part of the city that you were living in?

A Mostly downtown, Los Angeles.

Q And if I could publish Exhibit 2 at page two which is in evidence...

Mr. Curry, do you recognize what's on the screen in front of you?

A Yes, sir.

Q And how do you recognize it?

A It was a medical clinic that I used to go to on 7th street in the MacArthur Park area.

Q It was near MacArthur Park?

A Yes, sir.

Q And, sir, were you paid to go to this medical clinic?

A Yes, sir.

Q How much were you paid?

A It was $300 at that time, plus a lunch for the wait.

MR. GELBERG: And I could ask you to bring up Exhibit 32, which is also in evidence.

BY MR. GELBERG:

Now, sir, do you recognize the person who's pictured in Exhibit 32?

A Yes, sir.

Q And how do you know this gentleman?

A He was one of the guys that -- I can't say he recruited me, but he was the one that managed the situation I was in at clinic, taking me to the clinic, and, you know going through the procedures of -- of seeing a doctor and getting a

prescription and giving me money for the prescriptions and all that.

Q And, sir, just if you can move the microphone just a little closer to your mouth that way. Thank you.

And did this gentleman, do you know his name?

A I just knew the nickname of Green Eyes.

Q And did Green Eyes ever pay you himself?

A Most of the money came from him. He is the only person that I actually dealt with, you know.

Q And how did you hear about the clinic that we were looking at earlier?

A Well, I was living downtown, Los Angeles, and there was a guy -- I was at a bus stop across the street from a place called the Wine Guard Center, and someone asked me while I was at the bus stop if I had a red, white, and blue and if I'd like to go in for a physical.

Q And what's a red, white, and blue?

A It's the social security card -- the Medi-cal card. It's a red, white, and blue Medi-cal card that social security give you to go see the doctor and get medical --

Q So it was for your health insurance?

A Yes, sir.

Q So there was someone who was out on the street and asking you and others if you had red, white, and blue?

A Yes, sir.

Q Sir, was that your Medi-cal card?
A That's the state blue, red, and white -- yes, that's a state card -- it is a Medi-cal card.
Q So you were receiving medical at that time?
A Yes, sir.
Q Now, so it sounds like when you went to this clinic, you filled out some forms?
A Yes, sir.
Q What happened after you filled out the forms?
A Well we'd fill out the forms and gave them to Green Eyes, and he'd turn them in. And we waited. After about maybe a short amount of time, I think he got the prescriptions; called us outside; and took the prescriptions; gave us some money, and we went our way.
Q Did you ever see a doctor at that clinic?
A I've never seen a doctor there, sir.
Q Were you ever examined at that clinic?
A I don't remember being examined there, sir.
Q So you talked just a moment ago about -- you filled out these forms and you were waiting for Green Eyes to get the prescription?
A Yes, sir.
Q Do you know what the prescriptions were for?
A They were -- well, these were prescriptions that he had told me to ask for, and I assumed they were pain pills. I --

they told me what OxyContin was. So I knew it was a pain pill.

Q So pain pill prescription?

A Yes, sir.

Q But again, you had never been treated or examined by anyone at the clinic?

A No, sir.

Q And what happened after Green Eyes got these prescriptions?

A Well, he would -- he wouldn't get the prescriptions. He would give me the -- the prescription -- the -- you know, the slip to get the prescriptions -- you know, the -- the -- yeah, the actual prescription, you know, that was -- that was on a piece of paper and we took that to the pharmacy to get the actual OxyContin.

Q Let me ask you about that -- about going to the pharmacy. Did you go by yourself or did you go with other people?

A Someone always drove us to the clinic -- to the pharmacy.

Q So there -- was it like in a van or in a car?

A Yes, sir, it was in a van.

Q And how many other people that had come to the clinic to get prescriptions -- patients how many people were with you in the van?

A The van is usually full -- at least -- it is usually full, minimum of six to nine.

Q Oh, I'm sorry. You said that it was full?

A Yes, the van is usually full, six to nine.

Q And then there was a driver driving you?

A Yes, sir.

Q And if we could bring up -- or publish for the jury, please, Exhibit 1125 which I believe is in evidence...

Now, Mr. Curry, do you recognize what's in the picture here in Government's Exhibit 1125?

A Yes, I recognize that place.

Q Is that one of the places you were driven by the driver from the clinic?

A Yes, sir.

Q With the prescriptions?

A Yes, sir.

Q Now, thinking about this particular pharmacy...

Can you tell the jury what happened when you would arrive with the van full of people?

A I think this is Huntington Park, I think. And he would drive us up there, and we would all go in to the pharmacist; go up to the window, and we give her our prescription and we would wait a few minutes -- maybe 15, 20 minutes. She would call us back, and she would give us our -- our filled prescription.

Q And what would happen once you would get the prescription?

A Well, once we get back into the -- we get back into the van, the drivers would take the prescriptions; take out of it what he want, and whatever is left -- I had a toothache. So I kept my penicillin or whatever I needed for my personal self, but the OxyContin he took those.

Q So there might be some drugs that you kept yourself, but you would hand over the bottle of OxyContin back to the driver?

A Yes, sir.

Q And, again, you never took any of the OxyContin?

A No, sir.

Q Now, thinking back to that time when you were in the pharmacy, did the -- did the pharmacist ever talk to you about the side effects of OxyContin?

A No. No pharmacist ever talked to me about the side effects of OxyContin.

Q Did the pharmacist ever ask you, Mr. Curry what other medications are you taking in addition to OxyContin, anything like that?

A No, no. No pharmacy never asked me those questions.

MR. GELBERG: If we could please publish Exhibit 286, please. And if we could bring up page 1 and 2 side by side...

BY MR. GELBERG:

Q Now, is the prescription on the left for you? I'm never sure on the monitor.

The prescription and the copy of the ID; do you see that?

A Yes, I do. I see.

Q And is that a prescription for you? I think it says "Curry, Larry"?

A Yes, sir.

Q For OxyContin?

A Uh-huh.

Q Now, looking at the next page...

Do you see it's almost -- it's hard to see. It's like a little printout where it says "OxyContin" there?

A Yes, sir.

Q Do you see that?

A Yes, sir.

Q And it says "co-pay, $1,300"; do you see that?

A Yes, I -- well...

MR. GELBERG: If we could blow that up for Mr. Curry, please...

THE WITNESS: Uh-huh. Yes, I see it now. It says $1300.

Q And then there's a date there, and I believe it says 05/29/09; do you see that?

A Yes, sir.

Q Sir, on May 29, 2009, did you have $1300 to pay for a bottle of OxyContin?

A I never had $1300 to pay for a bottle of OxyContin.

MR. GELBERG: If we can now turn to Exhibit 285, please and -- I'm sorry, page 287. And if we could put the prescriptions side by side -- the page 1 and 2 side by side.

BY MR. GELBERG:

Q Now, starting on the first page, page one, do you again, see it's a prescription for "Larry Curry." That's you; right?

A Yes, sir.

Q Now, again, for OxyContin. And this was is written on a pad for an Eleanor Santiago.

Were you ever treated by Eleanor Santiago at the 8th Street clinic?

A I never met her, and she never did anything. I've never been examined by her or anything like that.

Q Now, if we could blow up -- oh, it's already -- the -- the other side of the screen, it's got that sticker. Do you see that -- that little printout where it says "OxyContin"?

A Yes, sir.

Q And this date is 07/21/09; do you see that?

A Yes, sir.

Q And do you again see co-pay $1300?

A Yes, sir, I see it.
Q So I take it in July of 2009, you also didn't have $1300 to pay for OxyContin.
A That's correct.
Q Let's look at one more.
MR. GELBERG: If we could please bring up Exhibit 285...
And if we could have page 1 and 2 next to each other, please.
BY MR. GELBERG:
Q So again, on one side of the page is a prescription for you, Larry Curry; is that right?
A Yes, sir.
Q For OxyContin?
A Yes, sir.
Q And then on the other side, we've got one of these sort of sticker-looking things. And if we look at -- can you see that date there in the middle?
A Uh-huh.
Q I believe it says 06/29 -- no -- sorry, 06/26/09; do you see that?
A Yes, I see it.
Q And then do you see where it says "plan," down in the left-hand corner?
A Yes, sir.

Q And what does it say next to "plan"?
A It says "cash."
Q And then next to "price," do you see it says $1,190?
A Yes, sir, I see that.
Q And again, I take it in June of 2009, you did not have $1,190 to pay for OxyContin?
A That is correct.
Q Now, just taking you back to when you were at the clinic, if we could take that down, please.

Do you remember ever getting any medical tests?

A No, sir, I do not.
Q So I take it if you don't remember getting any medical tests, you don't remember going back to the clinic on back-to-back days to get more tests?
A I've never done that, sir.

MR. GELBERG: If I could just have a moment...

BY MR. GELBERG:

Q I just want to show you a couple more things from -- a couple prescriptions from your patient file.

If we could go back to Exhibit 283 and put page 69 and page 70 back to back -- or side by side. Sorry.

So, sir, I guess we'll start on the right-hand side where you see the two prescriptions. Do you see that, sir?

A Yes, sir, I see them.
Q Sorry. Just looking at the date. Can you make out the

detail. So why don't you just take a minute and look at it. It is being printed right now. And you can tell me that what you propose to do, conforms precisely with what I've written in the order or not.

MS. MORTON-OWENS: Yes, Your Honor.

THE COURT: Okay. So we'll take five minutes.

(Brief recess.)

(Whereupon the following is held before the jury:)

THE COURT: Go ahead.

MS. MORTON-OWENS: Yes, Your Honor. The United States calls Donald Sullivan to the stand.

GOVERNMENT'S WITNESS, DONALD SULLIVAN, SWORN.

THE CLERK: Sir, please state your full name and spell your last name for the record.

THE WITNESS: Donald Lawrence Sullivan, S-u-l-l-i-v-a-n.

THE CLERK: Thank you.

DIRECT EXAMINATION

BY MS. MORTON-OWENS:

Q Dr. Sullivan, can you tell the jury what you do for a living?

A I'm a clinical professor of pharmacy at the Ohio State University College of Pharmacy and director of experiential programs for the College of Pharmacy.

Q What are experiential programs?

A Experiential programs are what the pharmacy students do throughout there for us. We're a 4-4 program. So it's a four-year pharmacy degree. The students have a previous degree when they come in. So they have to do around 1460 hours of experiential education out at -- in pharmacies, in hospitals, community pharmacies, retail pharmacies in their last year --

THE INTERPRETER: For the interpreter, could you please slow down.

THE WITNESS: So the students do 1460 hours in their last year before they graduate, and they do a combination of 300 hours during their first three years where they're out spending time in community pharmacies, retail pharmacies, hospital pharmacies. And I'm in charge over all of that experiential education that they do out in the field away from the stuff they do in the classroom.

Q How long have you been a pharmacy professor?

A I've been at the Ohio State University for just about six weeks now, but previously, I was at Ohio Northern University for approximately 17 years as a professor of pharmacy practice there.

Q And taking a step back, can you explain what your general education was before you became a professor in pharmacy?

A I graduated with my pharmacy degree in 1990. I have a

bachelors in pharmacy and became a licensed pharmacist. I got a masters degree in 1991 in Pharmacy Administration and I got my PhD in Pharmacy Administration in 1996, all three degrees from the Ohio State University.

Q And how long was your pharmacy education -- how long was school for you.

A The bachelors degree for me -- the true pharmacy school for me was five years.

Q And what about the masters' program?

A The masters' program I completed in about a year and a half. The PhD program took -- the PhD portion of the program took me from December of '91 until December of '96, so almost five years to finish the PhD part.

Q As you were referring to -- as a professor you were teaching in a community pharmacy setting -- or you're overseeing the clinical studies in a community pharmacy setting, what is a community pharmacy?

A A community pharmacy, we tend to lump everything into two big buckets. One bucket is institutional pharmacies; that's hospitals, nursing homes where patients stay at those institutions usually overnight. Community pharmacy is what you would think of as outpatient pharmacy, like CVS, Wal-Mart Kroger's. Independent pharmacies, Kaiser, I know is very big out here and they fill prescriptions for patients that come in; bring the prescriptions in, and then the patients leave

with them.

Q And you mention you've been teaching pharmacy for about 17 years, did I get that right?

A I started at Ohio Northern University in the fall of 1997.

Q Is there any specific area of pharmacy practice that you specialize in?

A So I specialize in a couple of areas, really three big ones: One is pharmacy law or pharmacy jurisprudence; the second is, over-the-counter products. I taught and ran an over-the-counter products at Ohio Northern University for almost 15 years. And then the last bit of my teaching that I do is in general pharmacy business topics which will be Economics, Finance, Marketing, Human Resource Management; I'm kind of the business aspects of working in a pharmacy, whether it's an independent or it could be in a chain pharmacy.

Q And are you a member of any pharmacy associations on the national level?

A Yes. I'm a member of several national pharmacy organizations: the American Pharmacist Association, which is the largest organization -- national organization of pharmacists; the National Community Pharmacists Association; that's the organization that anybody can join it, but it is primarily independent pharmacists who join that -- community

pharmacists; and then I'm also a member of the American Society of Health System Pharmacists, and that organization is primarily the institutional pharmacists that I talked about: the hospital pharmacists; the nursing home of pharmacists, but anybody can be a member of any of these pharmacy organizations that I'm a member of. It's not -- it is not limited to where you practice or what you do.

Q And how often do you have to consult with other members of the pharmacy field?

A Pharmacy is one of these professions that is changing virtually everyday. There is always new drugs; new laws; new therapies; new practice standards. So I would say at least on a weekly basis -- sometimes on a daily basis, I'm consulting with my colleagues to try and stay up on what's going on in practice, in addition to the vast amount of reading I do in the professional pharmacy and medical journals to try to keep up with what's going on with -- in the profession itself.

Q Have you spent much of your time researching community pharmacies and studying the trends?

A Absolutely. My background is community pharmacy. When I was in graduate school, I worked for a chain pharmacy for about three years. And a lot of what I teach is community pharmacy and what goes on in community pharmacy and the trends in community pharmacy. So that's a big area of focus

for me. A lot of my recent research has been looking at where the practice of pharmacy is going five years from now, ten years from now, so I can help better prepare our students for what they're going to be having to practice in; not just now but well into the future as well.

Q Now, outside of teaching pharmacy students, do you spend much of your time teaching other professionals about community pharmacy and other pharmacy practice?

A Yes, I do.

Q And can you give an example of what trainings you've provided?

A So one of my more recent trainings was just at the end of July in Las Vegas, Nevada; major wholesaler called Amerisource, they bring all their community pharmacists in once a year for a big annual meeting, and they provide a series of educational programs for those pharmacists and I actually did two continuing education programs there; one on an update on federal pharmacy law and the second one was a one and a half hour course on drug diversion detection and analysis in community pharmacies.

Q And how much of your time has been spent on that subject?

A It's really become a big interest of mine over the last probably three to four years; but I have been teaching pharmacy law and giving educational programs to pharmacists

and sometimes nurses and doctors and even lawyers sometimes ever since -- almost ever since I started at Ohio Northern University in the fall of 1997.

Q Do you also teach continuing education to pharmacists -- already licensed pharmacists?

A Correct.

Q And how much of your time is spent teaching existing licensed pharmacists on the practice of pharmacy?

A I probably in an average year do between seven and eight continuing education programs for practicing pharmacists during the course of a year.

Q And for each one of those presentations do you have to conduct research?

A Absolutely.

Q Have you, in fact, also instructed the Ohio Supreme Court on some of these issues?

A The Ohio Supreme Court reached out to me based on a presentation somebody had heard me do on drug diversion and asked me to design a one and a half to one hour and 15-minute continuing education program on drug diversion for the Ohio Supreme Court educational network.

Q Have you authored any books?

A Yes. I've authored a few books. The last one I did was a guide for pregnant patients on drugs that are safe to take during pregnancy.

I've written a book on -- these are all consumer drug books -- written a book on generic drugs for consumers. That was my first one that got published, and then I wrote an extremely large book around 19 -- started it in 199- -- around 1995 which was meant to compete with the Pill Guide which is the most commonly used consumer drug reference that lists -- it's a book where consumers can pull it out and look up drugs and side effects and how they're used. Well, a publisher wanted to have somebody write a competing book to that -- to the Pill Guide. So the publisher partnered with the American Pharmacist's Association, they put their name on it, and I wrote the book. And it had, gosh, probably somewhere between 5 and 7 or 800 prescription drugs; and it took me almost a year to write it.

Q And based on that research, have you studied the trends in different drugs and their popularity with prescribing and dispensing?

A One of the things I pride myself on is trying to keep the best I can up to date on the current trends in prescribing, dispensing, and patient care.

Q Have you provided any trainings to law enforcement agents?

A Yes, I have. I was -- I first did my first training for the DEA I want to say it was probably around 2012 where I was asked if I would come in and train DEA agents in, Quantico,

Virginia on drug diversion techniques, tips, analyses, how physicians try to hide drug diversion; how pharmacies try to hide drug diversion in the prescriptions that they fill. So the first one I did, I'm pretty sure was in 2012, and I've done anywhere from two to five of these a year ever since. They're usually short little three-hour blocks. So it's not like I'm there for a week. I come in for a few hours and that's it.

Q And have you been consulted as an expert before your work in this case?

A Yes. I've been consulted as an expert by the DEA. This is my first criminal trial. The ones I've been involved with in the past have all been administrative hearings where they were looking to do something with the person's DEA license. I've -- I answer probably between 2 and 300 pharmacy law questions a year from pharmacists that call me and just ask -- usually they're questions related to control substances because that's where pharmacists get more nervous about making sure they want to do the right thing. I've also been consulted a couple of times by a couple of large retailer or chain pharmacies where they asked my opinion on practice-related issues and I gave it, and I've never heard from them after that. So I don't know how that was ever resolved, but --

Q When you've been reviewing materials to -- to determine

whether or not the practice that you observed was usual within the industry, have you always found fault with the materials you've reviewed?

A No. There's been times I have not found fault. I've had DEA agents call me and asked me to --

THE COURT: You've answered the question.

Thank you, sir.

Just to speed things up, if you can just sort of limit your answer to what is exactly asked.

THE WITNESS: Okay. Yes, Your Honor.

MS. MORTON-OWENS: Thank you, Your Honor.

THE COURT: Thank you.

BY MS. MORTON-OWENS:

Q And you were retained in this case; is that right?

A Correct.

Q Are you being paid for the time that you spent reviewing the materials in this case?

A Yes.

Q And how much are you paid an hour?

A 250 an hour.

Q Approximately how many hours have you spent reviewing and preparing to come to court today?

A Well over a hundred.

Q And what were you asked to do in relationship to -- let me take a step back.

Were you provided with specific materials?

A Yes, I was.

Q Were you directed on what findings you should make?

A No.

Q Approximately how many materials were you provided?

A I was provided somewhere between 8 and 10 CD's worth of material of which there were thousands and thousands of records in those -- on those CD's.

Q Were you provided with any arguments of counsel?

MR. SHERMAN: Excuse me, Your Honor. I'll object.

THE COURT: Sustained.

BY MS. MORTON-OWENS:

Q Were you provided with any witness statements or what witnesses might say?

A No.

MR. SHERMAN: Your Honor, I'll object.

THE COURT: Sustained.

BY MS. MORTON-OWENS:

Q Your Honor, if we could approach?

THE COURT: You just -- sure.

(Sidebar.)

MS. MORTON-OWENS: I apologize, Your Honor. During opening statement, the defense said this was a DEA-hired gun and that his --

THE REPORTER: I can't hear.

opinion about that data, whether it's customary or not.

He can be -- he doesn't -- he has to have a basis for a hypothetical answer to --

MR. SHERMAN: He can -- you can maybe ask a hypothetical, but once she gives him the data in this case and ties it with a hypothetical, then he's commenting about this case, but once she gives him the data in this case and ties it with a hypothetical, then he's commenting about this case. If she wants to ask a hypothetical question, Is it customary in the industry to do this or this happen, that may be one thing; that's within your work, but if she's going to say, Wait a minute, did you review the material in this case and then follow it up with a hypothetical question, the implication is, it's based upon the data he received in this case, and now he's commenting upon this case.

THE COURT: Well, he's only going to comment on those areas that deal with custom and practice. So I'll deal with the questions as they come up.

Sidebar is concluded.)

THE COURT: Go ahead.

BY MS. MORTON-OWENS:

Q You said you were provided with eight CD's of material; is that right?

A It was somewhere between 8 to 10, I can't -- there was a stack of them. I can't remember exactly how many.

Q And what type of information was contained on the CD's?

MR. SHERMAN: I'll object, Your Honor.

THE COURT: Sustained.

BY MS. MORTON-OWENS:

Q Did you review records of the pharmacy -- the pharmacy records in this case?

A Yes.

MR. SHERMAN: Excuse me, Your Honor.

THE COURT: Let me see you again at sidebar. I'm not sure I understand.

(Sidebar.)

THE COURT: I think the concern is that what he may be doing is laying a foundation, I reviewed all of these records. Based upon that review, my opinion is that certain things violated the custom and practice in the industry.

MS. MORTON-OWENS: It is the same -- the same as the doctor who just testified that he reviewed the medical charts, and in those medical charts there was unusual activity and he pointed to that unusual activity. That's what we understood Dr. Sullivan is going to do --

THE COURT: That's fine. I don't see an issue with that.

MR. SHERMAN: He specifically said he can't give an opinion as to what the pharmacist did in this case and by doing exactly what she just said, you're allowing her to do

I think it's clear.

MS. MORTON-OWENS: I understand the Court's order.

THE COURT: Okay. Thank you.

(Sidebar concluded).

BY MS. MORTON-OWENS:

Q Dr. Sullivan, were you provided pharmacy records in this case?

A Yes.

Q Prescriptions and other type documents?

A Yes.

Q And you reviewed those documents?

A Yes.

Q Are you familiar with what opioid drugs are?

A Yes.

Q And what is an opioid drug?

A An opioid drug in layman's terms, we most oftentimes call "pain killers." Those drugs use -- they're used primarily for pain relief.

Q And are opioid drugs usually controlled substances?

A As far as I know, every opioid is a controlled substance.

Q Are there different types of opioid drugs?

A Yes.

Q And based on your study of various prescription drugs, about how many opioid drugs are there?

Q Is that a red flag?

A Yes.

MR. SHERMAN: Your Honor, excuse me. I'll object. There is no foundation for that. I'll object on the grounds that there's no indication that any of this was known to the pharmacies. And second of all, Your Honor, he is commenting upon the medical practice.

THE COURT: Overruled.

BY MS. MORTON-OWENS:

Q You may continue.

You need me to ask the question again?

A Please.

Q You mentioned that you saw that each -- that the patients from Lake Medical Group received between one and four prescriptions. Did I get that right?

A Correct.

Q And you mention that was a red flag. What -- why is that a red flag?

A OxyContin, 80 milligrams is for chronic pain patients. The standard of practice you would expect to see patients on these medications for long -- that medication for long periods of time.

Q In reviewing the -- and just to be clear, did you receive any medical charts? In other words, what appeared to be doctor records?

A None.
Q Your records were confined to what was at the pharmacy; is that right?
A Correct.
Q In reviewing the prescriptions, were you provided with any diagnosis information on the prescriptions themselves?
A Yes.
Q Was that a red flag?
A Yes.
Q Why?
A Most physicians do not take the time to write detailed diagnoses on the prescriptions that they write.
Q Did you observe any red flags in what the diagnoses were that were listed on the prescriptions?
A One of the more common ones I saw was LBP, which is the common abbreviation for lower back pain.
Q Is that a red flag?
A Yes.
Q Why?
A Lower back pain pharmacists are trained -- is a very subjective measure and a lot of times is used on prescriptions where there are issues with the prescription themselves.
Q I'm going to step a back and go back again. You mentioned you were familiar with the package insert for

OxyContin. Let me make sure there's no objection...

MS. MORTON-OWENS: Your Honor, without objection, the Government moves in Government's Exhibit 1576.

THE COURT: Very well.

(Whereupon Government's Exhibit 1576 is admitted hereto.)

MS. MORTON-OWENS: Publish page one.

BY MS. MORTON-OWENS:

Q And, Dr. Sullivan, is this the package insert from approximately 2009 from Purdue Pharma for OxyContin?

A Yes.

Q And do you see the beginning there where it says "warning"? What does that refer to in the pharmacy industry?

A That's referred to by the Food and Drug Administration as a black box warning.

Q And do you see there where it says the dosage information, 10, 15, 20, 30, 60, 80, and 160. Was 160 milligrams of OxyContin available in the United States in 2009, 2010?

A No.

Q So the highest dosage available was 80 milligrams in the United States?

A Yes.

MS. MORTON-OWENS: One second, Your Honor.

BY MS. MORTON-OWENS:

Q And for 1576, what does the black box warning indicate

for the use of OxyContin, 80 milligrams --
A. Can you --
Q -- or for OxyContin in general?
A Can you blow that up a little bit, please.
MS. MORTON-OWENS: You can just blow up jut the "warning" portion.
THE WITNESS: Thank you.
BY MS. MORTON-OWENS:
Q Do you see there where it says, "OxyContin, 60 milligrams, 80 milligrams" -- and we know 160 wasn't available "or a single dose greater than 40 milligrams are for use in opioid-tolerant patients only," what does that mean?
A Opioid-tolerant patients means those patients who have been taking opioids already and have developed a tolerance to the dose, so that higher doses are needed.
Q Are you familiar with -- on the side effects of OxyContin?
A Yes.
Q What are the side effects of OxyContin?
MR. JOHNSTON: I'll object, Your Honor. It's beyond the scope of the witness' expertise.
THE COURT: Sustained.
BY MS. MORTON-OWENS:
Q The package insert, this is something that accompanies

No._____

IN THE SUPREME COURT OF THE UNITED STATES

ELZA BUDAGOVA,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

On Petition For A Writ of *Certiorari* To The United States Court of Appeals for the Ninth Circuit

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PROOF OF SERVICE

I, David A. Schlesinger, declare that on April 17, 2019, as required by Supreme Court Rule 29, I served Petitioner Elza Budagova's MOTION FOR LEAVE TO PROCEED *IN FORMA PAUPERIS* and PETITION FOR A WRIT OF CERTIORARI on counsel for Respondent by depositing an envelope containing the motion and the petition in the United States mail (Priority, first-class), properly addressed to him, and with first-class postage prepaid.

The name and address of counsel for Respondent is as follows:

The Honorable Noel J. Francisco, Esq.
Solicitor General of the United States
United States Department of Justice
950 Pennsylvania Ave., N.W., Room 5614
Washington, DC 20530-0001
Counsel for Respondent

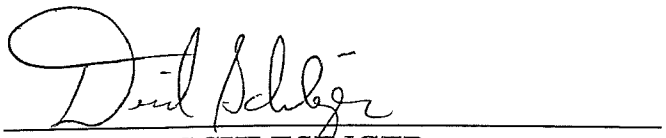
Additionally, I mailed a copy of the motion and the petition to my client, Petitioner Elza Budagova., by depositing an envelope containing the documents in the United States mail, postage prepaid, and sending it to the following address:

Elza Budagova
c/o Armen Shahbyza

Los Angeles, CA 90029

I declare under penalty of perjury that the foregoing is true and correct.

Executed on April 17, 2019



DAVID A. SCHLESINGER
Declarant